

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672

2201 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

819

Tom Macchia ,Co-Chair
Health Care Committee
Green Party Of Alaska

July, 22 1992
Health Resource and Access Task Force

Dear Task Force Members,

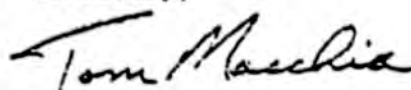
On behalf of The Green Party, thank you for the opportunity to testify before your task force. As I said in testimony the straw vote taken in your Monday July 21st meeting makes me feel hopeful.

I had conversations with a few of the Task Force members after our testimony that expanded on my comment regarding a stronger consumer input. I encourage you to think in terms of using the upcoming teleconferences as an opportunity to create community consumer health committees which I hope will provide grass-roots input to the Task Force and act as advocates for the plan the Task force puts forward. Creating a sense of ownership in the plan by the citizens of Alaska will give us the pressure group we will need to carry it through. In addition it will set a precedent for a feature that I hope will be included in any comprehensive reform package, strong consumer participation. It has been my experience, in counseling and in other health work, that people, especially Alaskans feel most comfortable with change when they feel in control of the circumstances. Also some of the most valuable lessons I've learned in medicine have been from frank feedback from my patients.

With regard to a question that was asked about surveying on health care in Alaska I will fax the results of a 1990 question we inserted in a political survey. It showed support for "guaranteed comprehensive health care for all Alaskans, regardless of income or health status."

Again thank you for the chance to provide some input. I'm looking forward to seeing you all in August.

Sincerely,



Tom Macchia
Green Party Health Care Co-Chair

From: Tom Macchia
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To: Nancy Cornwell

2 pages

ph: 465 2933
fax: 465 3234



Marketing and Research Group

August 27, 1990

FOR IMMEDIATE RELEASE

Sample size - 825 random proportioned telephone interviews with adults head of household 19 years or older. The survey was taken between March 20 and April 20, 1990 for a variety of clients. The overall margin of error was approximately $\pm 3.5\%$.

Question:

How do you feel about guaranteed comprehensive health care for all Alaskans, regardless of income or health status?

Strongly for	34.3%
Somewhat for	37.2
Not sure/Don't know	5.2
Somewhat against	13.0
Strongly against	10.4

Respondents had clear feelings one or the other about this question.

Of male respondents, 64.5% supported the concept and 77.3% of women interviewed supported it.

Only 34.5% of those strongly supporting this idea were men; 65.5% were women opposing this idea 63.9% were men and only 36.1% were women.

Women were least undecided with only 33.2% indicating unsure whereas 56.6% of men felt likewise.

Opinions were generally distributed evenly over age of respondents: there was no statistical significance.

Kenai Peninsula Borough Economic Development District (Alaska) Health Plan Development Project

OVERVIEW

The Kenai Peninsula Borough, Alaska is located south of Anchorage, encompassing over 25,000 square miles with a population of over 40,000 people. In November, 1991, the Borough Assembly passed a resolution establishing the 30 member Health Care Advisory Council and requesting the Kenai Peninsula Borough Economic Development District (EDD) to administer the work of the Council. Since January, 1992, the Council has been aggressively pursuing a course to accomplish its mission:

SUBMIT A REPORT TO THE BOROUGH ASSEMBLY MAKING FINDINGS AND RECOMMENDATIONS AS TO OPTIONS FOR THE ESTABLISHMENT OF A BOROUGH-WIDE INSURANCE PROGRAM WHICH WOULD MAKE AFFORDABLE HEALTH INSURANCE AVAILABLE TO ALL RESIDENTS AND THEREBY INCREASE ACCESS AND UTILIZATION OF THE LOCAL HEALTH CARE SYSTEM.

Kenai Peninsula Borough residents are concerned about the accessibility and rising costs of health care. This concern is particularly acute for low income residents and the many workers in high risk, seasonal, small business occupations. The expectation that the state or federal governments will act to establish a program to meet the needs of those who cannot afford insurance is not being realized as lawmakers continued to be mired in debate between competing interests.

Over the past several months the Council's members have worked in committees and sub-committees defining elements of the proposed plan to be revealed in a workshop on October 16-17, 1992, in Kenai, Alaska. The day and a half workshop provides an opportunity for in-depth discussion of plan elements as reviewed by chosen experts in the area of funding, delivery of health services, benefits design, organization of structure, and implementation and management.

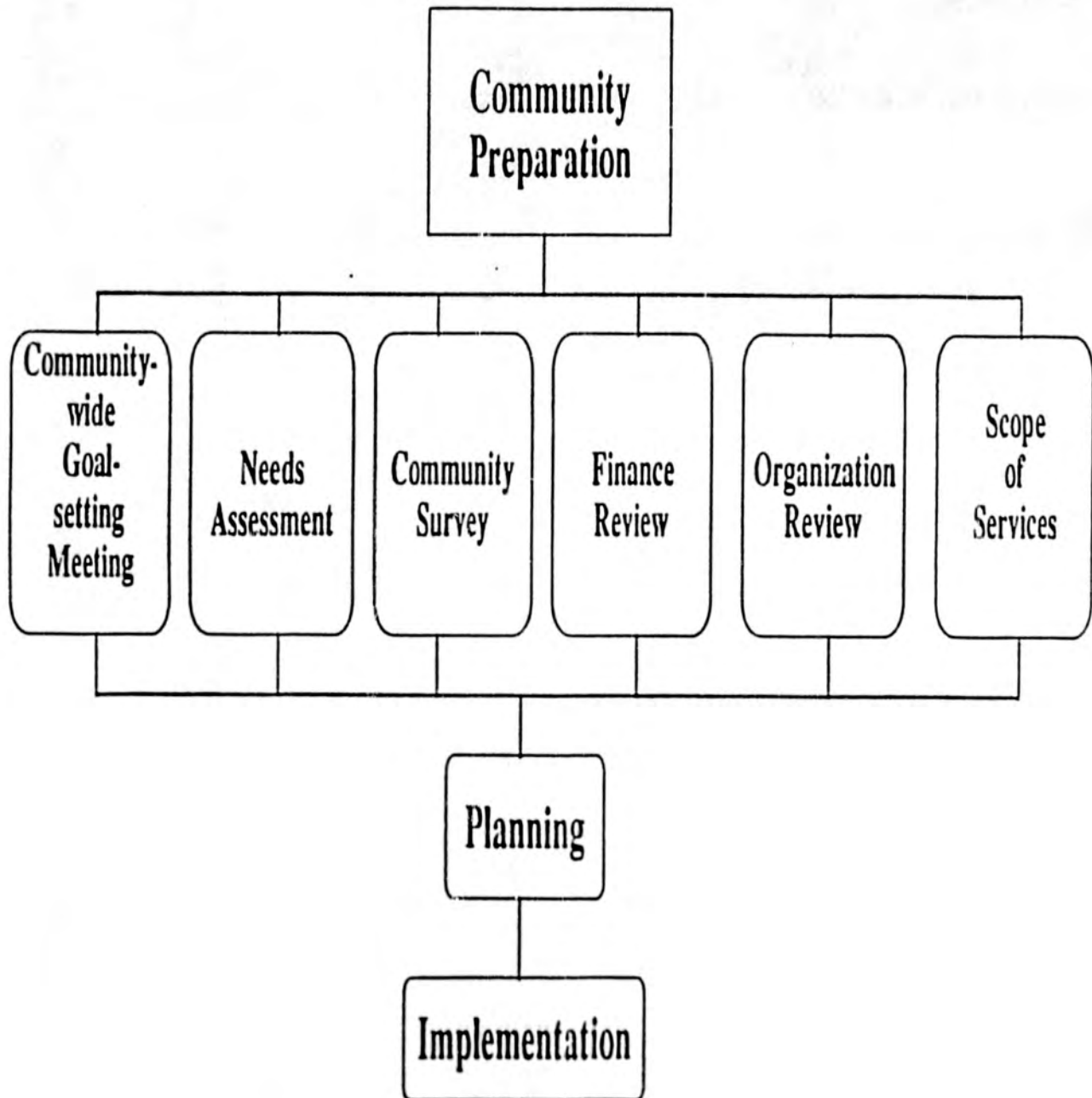
REGIONAL ECONOMIC ISSUES

The leadership in this project ^{Stems} from a recognition of the following issues:

- 1) Surveys of local entrepreneurs show the cost of employee insurance high on the list of barriers to business development.
- 2) Local governments are faced with either reducing direct government services or raising taxes to meet the rising costs of public employee insurance benefits.
- 3) Annually millions of dollars in insurance premiums which could be used locally are exported (estimated in excess of \$25 million) to Outside based insurance companies.
- 4) A significant percent of health care to local residents is provided outside of the area, leaving local facilities operating inefficiently at levels substantially under capacity.
- 5) The health care costs of the uninsured are, in part, passed on to public agencies, employers, and all citizens.

Figure 1

CHSD Phases



Council: Studies ways to pay for plan

Continued from page 1

thing," council member Rich Underkofler said.

Among the possible mechanisms the funding committee is looking at to pay for the plan are: tax subsidies, such as sales tax, property tax, severance tax, income tax, and so-called "sin" taxes; block grants from the state; private foundation funding; premiums, including subsidized premiums for the poor; and "cost containment" measures to lower the prices people pay for medical care.

A benefit design committee is discussing what services should be covered, ranging from pre-natal care to prescription drugs to optional vision and dental care.

The committee has also talked about "deductibles," the amount patients pay before insurance kicks in, ranging from \$100 to \$1,000; making the deductible lower for preventive care procedures, like dental exams; and paying a greater percentage of costs for people who use borough doctors.

The committee has suggested requiring residents to live in the borough a year before becoming eligible for the plan and using things like property ownership, driver's license and voter registration to prove that residency.

A health services delivery committee is looking at ways to coordinate health and social services so all factors contributing to an illness or injury, for instance, alcoholism or domestic violence, are addressed, rather than just the medical ailment.

An implementation committee is looking at whether

'I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them.'

—Stan Steadman,
executive director
of the Economic Development District

to implement the plan in partnership with an insurance company or in-house, how to avoid overloading it with high claims initially, how to market the plan, what kind of data system would be needed and other issues.

The organizational structure committee is looking at what kind of governmental body should be set up to run a borough health plan.

The committees will further refine their ideas by the next council meeting, Golden said.

A group of experts who have been invited to an October conference will tell them whether the concepts they've proposed seem workable, Steadman said.

"We set up the conference as a way to obtain outside peer review of what we were doing, so we weren't operating in a vacuum," he said.

In the next few months, the council will also be hiring an actuary, a person whose work is to calculate risks and premiums for insurance, to put some numbers to the concepts it's coming up with.

"People keep saying 'how much will this cost,' and we can't answer that until we come up with a plan and have an actuary determine rates," Steadman said.

Underkofler remarked at

the last council meeting that he had heard some physicians are apprehensive about what the council is doing.

Dr. James Zirul said it's true some doctors are nervous because organizations that have sprung up in the Lower 48 to control costs — like preferred provider organizations and health maintenance organizations — have buried physicians in paperwork, compromised patient care and made it difficult for doctors to pay their overhead costs. Zirul is one of several health care providers on the council.

What the council is trying to do here is very different from approaches that have been tried elsewhere, he said, and no one knows yet whether it will work.

Steadman said the project manager for the council was in Homer this week meeting with physicians there. Council representatives have had meetings with doctors on the staff of the three hospitals within the borough, he said.

"What we're telling them is we're striving for a better system to provide health care and we recognize that they are a key, integral part to that being accomplished, and we're looking for their input to be sure their interests are represented."

Some doctors are hopeful that the council can come

up with something better than the system now in place.

Dr. Lynn Carlson, who operates a family practice clinic in Nikiski, said many of his patients fall into that category of people who are neither able to afford insurance nor eligible for Medicaid. He is hoping the council may be able to find a better way to provide care to them.

"I'm thinking that a locally run health system would be better than a federally run" system, Carlson said.

"I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them," Steadman said.

It's too early to know yet bottom line things like how much such a plan could cost people in premiums and taxes, what they would get in benefits and how it would affect the medical establishment.

The council's timeline calls for it to go before borough voters at the October 1993 municipal election. It would have to receive Borough Assembly scrutiny before it could even be placed on the ballot.

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KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL
WORK PROGRAM

(for prior track consult revised draft of March 23, 1992)

July - Education Committee and Steering Committee approved survey.

July - Kenai Peninsula Health Care Survey Pilot Testing

July 13 - Full Council Workshop. Dr. Bruce Amundson CHSD Model presentation. Dave Ford, plan organizational alternatives. Council initiates the work of health care plan development. Issues development groups organize around five key areas: Funding, Benefits Design, Implementation and Plan Management, Organizational Structure and Health Services Delivery.

Issues development groups meet to prepare draft issues statements.

August 7 - Full Council Meeting. Standing committees report as well as issues development groups. Decision on alternate date for fall conference which has become more of a fall workshop. The potential still exists for a full conference in the spring.

September 11 - Full Council Meeting. Discuss final drafts of issues statements for inclusion in the work shop packet material. Other operations issues. Approve form of a "Request for Proposal" for a third party consultant to assist with the demographic, coverage, actuarial, financial and management components of the health insurance plan. The RFP Selection Committee is the Steering Committee.

The scope of the consultant's services should include these tasks:

Design a model "community based" health insurance program based on issues development resolves by the council through their "expert" advisors in the October work shop. Specifics should include but are not limited to:

- Prediction of annual expenses of the program
- Classification of program expenses to be retained or deferred by excess insurance or a reserve fund
- Allocation of expenses between various sources of revenue

October 8 - PFP Selection Committee review proposals and select with approval of the Steering Committee.

Kenai Peninsula Borough

Health Care Advisory Council

Kenai Peninsula Borough Economic Development District, Inc. 110 S. Willow St., Suite 106 Kenai, Alaska 99611 (907) 283-3335 Fax: (907) 283-3913

KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL

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Margaret French
Homer

Dr. Jon Godfrey, DC
Homer

Jerry Near
Soldotna

Dr. Vickey Hodnik, DDS
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Dr. John Kobylarz, DDS
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Mike Pate
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Mike Lockwood
Soldotna

Dr. James Zirul, DO
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Ken Hepner
Sterling

Robert Roth
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Linda Hutchings
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Judy Charpentier
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Ray Zagorski
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Emery Thibodeau
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Jim Heim
Soldotna

Karen Moore
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Jon McMichael
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George Carnahan
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Burt Anderson
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Ross Kendall
Nikiski

James Krasnansky
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Rich Underkofler
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Health Care

on the

Kenai Peninsula

A COMMUNITY SURVEY

NOTE: This survey is conducted by the Kenai Peninsula Borough Health Care Advisory Council as part of an evaluation of medical care within our borough. This survey invites you to have an impact on medical care in your community. Please return the completed survey as soon as possible.

The survey asks you to answer questions about "your community." Consider all of the Kenai Peninsula to be your community, unless a particular question says otherwise. Do not consider areas outside the Peninsula to be part of your community.

1. List the age and circle the sex of the members of your household including yourself.

M=male F=female

	AGE	SEX	AGE	SEX	AGE	SEX
First, yourself:	_____	M F	_____	M F	_____	M F
	_____	M F	_____	M F	_____	M F
	_____	M F	_____	M F	_____	M F
	_____	M F	_____	M F	_____	M F

List any others in margin

In the following questions, the term "household" will mean all the people you have just listed. If questions are individualized, answer for yourself.

2. Have members of your household *ever* been hospitalized (stayed in hospital overnight) in any of the following Kenai Peninsula Borough Hospitals? *Circle all that apply.*

- a) Seward
- b) Soldotna
- c) Homer
- d) None of these

3. How many times have members of your household been hospitalized (overnight stay) during the **past two years** in each of the following places? *Do not count hospitalizations occurring before you lived in this community.*

List number, or put a zero when none:

- a) Seward _____
 - b) Soldotna _____
 - c) Homer _____
 - d) Anchorage _____
 - e) Other _____
- Where? _____

4. If you were to be hospitalized tomorrow, where would you go? _____

5. If household members were hospitalized outside of the Kenal Peninsula Borough during the *past two years*, why were non-Peninsula hospitals used? Please indicate whether each of the following were reasons for non-local hospital use:

Circle 1 or 2 for each reason:

	YES, A REASON	NOT A REASON
a) Services not provided locally	1	2
b) Quality of services better elsewhere	1	2
c) Services cheaper elsewhere	1	2
d) Referred by local physician	1	2
e) Referred by non-local physician	1	2
f) Non-local hospital easier to get to	1	2
g) More privacy at non-local hospital	1	2
h) College student away at school	1	2
i) If Other, please specify:		

6. How would you rate the hospital you named in Question 4 in each of the following categories? Circle one answer for each category:

	EXCELLENT	GOOD	FAIR	POOR	
a) Overall quality of care	1	2	3	4	Don't know
b) Physician care	1	2	3	4	Don't know
c) Nursing care	1	2	3	4	Don't know
d) Reasonableness of charges	1	2	3	4	Don't know
e) Staff concern/compassion	1	2	3	4	Don't know
f) Building cleanliness/condition	1	2	3	4	Don't know
g) Emergency room care	1	2	3	4	Don't know
h) Food services	1	2	3	4	Don't know
i) Billing and financial services	1	2	3	4	Don't know
j) Outpatient services (lab, x-ray, physical therapy, etc.)	1	2	3	4	Don't know
k) Patient Input into care program	1	2	3	4	Don't know

7. How do you feel about the number of different types of health services (physical therapy, x-ray, etc.) provided by Kenai Peninsula Borough Hospitals? *Circle one answer.*

- 1) SHOULD INCREASE
- 2) STAY ABOUT THE SAME
- 3) SHOULD DECREASE
- 4) DON'T KNOW WHAT SERVICES ARE AVAILABLE

8. If you were hospitalized tomorrow, who do you think would pay for the majority of the bill? *Circle one answer.*

- 1) SELF-PAY
- 2) MEDICARE (Includes supplemental policy) (OVER AGE 65)
- 3) MEDICAID (PUBLIC ASSISTANCE)
- 4) FISHERMAN'S FUND
- 5) PRIVATE INSURANCE (including employer plans)
- 6) ALASKA NATIVE HEALTH
- 7) VA
- 8) OTHER - please specify: _____

9. If you selected #5 in question 8, what is your total out-of-pocket monthly premium payment for everyone in your household (not including deductibles)? \$ _____

10. Do you feel that you have adequate, satisfactory health insurance? *Circle one answer.*

- 1) YES
- 2) NO

11. *If no, why not? Circle one answer.*

- 1) CAN'T AFFORD IT
 - 2) CAN'T GET INSURANCE DUE TO HEALTH PROBLEMS
 - 3) SELF-INSURE (pay your own bills)
12. Do you feel that physicians and hospitals on the Peninsula would help you arrange a payment schedule for medical bills if needed?
- 1) YES
 - 2) NO
 - 3) DON'T KNOW

13. How important is it that all three Peninsula Hospitals remain open? *Circle one answer.*

- 1) VERY IMPORTANT
- 2) SOMEWHAT IMPORTANT
- 3) NOT IMPORTANT

14. How many medical care visits have members of your household made during the **past year** in each of the following places? *Do not count hospital inpatient visits or visits occurring before you lived in this community. If you saw both a physician and a nurse, midwife or physician assistant in the same visit, count it as a physician visit. List a number on each line.*

	Physician Visits	Visits to Nurse Practitioners, Public Health Nurses, Midwives, and Physician Assistants.
a) Kenai-N. Kenai	_____	_____
b) Soldotna-Sterling-Kasilof-Ninilchik	_____	_____
c) Homer-Anchor Point-Seldovia	_____	_____
d) Seward-Moose Pass	_____	_____
e) Anchorage	_____	_____
f) Seattle	_____	_____
g) Other	_____	_____
If other, where?	_____	_____

15. During the **past year**, did members of your household visit a non-physician health care provider (dentist, nurse practitioner, chiropractor, etc.) outside of the Peninsula?

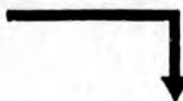
- 1) YES
2) NO



16. If yes, what types of non-local providers were seen?

17. Did household members visit *physicians* in places other than the Kenai Peninsula during the past two years?

- 1) YES; if so, please go to 18 and 19.
- 2) NO



18. Why did household members visit physicians outside the community? For each reason, circle 1 or 2:

	Yes, a reason	Not a reason
a) Services/specially not provided locally	1	2
b) Quality of services better elsewhere	1	2
c) Services cheaper elsewhere	1	2
d) Referred by local physician	1	2
e) Referred by non-local physician	1	2
f) Takes too long to get appointment with local physician	1	2
g) Non-local providers easier to get to	1	2
h) More privacy with non-local providers	1	2
i) Wait in office to see local physician too long	1	2
j) Other—why? _____		

19. Please list the physician specialties seen outside your community, (cardiologist, gynecologist, etc.):

20. How would you rate each of the following aspects of the overall physician care provided in your community? *Circle one answer for each category.*

	EXCELLENT	GOOD	FAIR	POOR	
a) Quality of medical treatment	1	2	3	4	Don't know
b) Concern/compassion for patient	1	2	3	4	Don't know
c) Reasonableness of charges	1	2	3	4	Don't know
d) Competence of support staffs	1	2	3	4	Don't know
e) Night and weekend care availability	1	2	3	4	Don't know
f) Ability to get appointment quickly	1	2	3	4	Don't know
g) Ability to see MD promptly at scheduled hour	1	2	3	4	Don't know

21. Do you have a personal physician who you expect to care for most of your medical care needs? *Circle one answer.*

1) YES

2) NO



22. **If yes, where do you see your personal physician?**

Circle one answer.

- 1) Kenai-N. Kenai
- 2) Soldotna-Sterling-Kasilof-Ninilchik
- 3) Homer-Anchor Point-Seldovia
- 4) Seward-Moose Pass
- 5) Anchorage
- 6) Seattle
- 7) Other

23. How satisfied are you with the care you get from your personal physician? *Circle one answer.*

- 1) VERY SATISFIED
- 2) SOMEWHAT SATISFIED
- 3) INDIFFERENT
- 4) SOMEWHAT DISSATISFIED
- 5) VERY DISSATISFIED

24. How satisfied are you with each of the following aspects of health care in your community? *Circle one answer in each row:*

	Very Satisfied	Somewhat Satisfied	Indifferent	Somewhat Dissatisfied	Very Dissatisfied	
a) Hospital	1	2	3	4	5	Don't know
b) Emergency room	1	2	3	4	5	Don't know
c) Physicians	1	2	3	4	5	Don't know
d) Public health services	1	2	3	4	5	Don't know
e) Dental services	1	2	3	4	5	Don't know
f) Pharmacy services	1	2	3	4	5	Don't know
g) Eye Care services	1	2	3	4	5	Don't know
h) Ambulance service	1	2	3	4	5	Don't know
i) Counseling/mental health	1	2	3	4	5	Don't know
j) Drug/alcohol treatment	1	2	3	4	5	Don't know
k) Hospice care	1	2	3	4	5	Don't know
l) Nursing home care	1	2	3	4	5	Don't know
m) Chiropractic care	1	2	3	4	5	Don't know
n) Homeopath/Naturopath	1	2	3	4	5	Don't know
o) Midwives/Nurse practitioners	1	2	3	4	5	Don't know
p) Physical/occupational therapy	1	2	3	4	5	Don't know
q) Home health services	1	2	3	4	5	Don't know
r) Village Health Clinic	1	2	3	4	5	Don't know
s) Outpatient surgery	1	2	3	4	5	Don't know

25. Where would you seek care for each of the following health care needs?

Circle one place in each row, and complete blank if other location:

a) Cancer treatment	Soldotna	Homer	Seward	Anchorage	Seattle	_____
b) Broken arm	Soldotna	Homer	Seward	Anchorage	Seattle	_____
c) Pregnancy/delivery	Soldotna	Homer	Seward	Anchorage	Seattle	_____
d) Pneumonia hospitalization	Soldotna	Homer	Seward	Anchorage	Seattle	_____
e) Knee surgery	Soldotna	Homer	Seward	Anchorage	Seattle	_____

26. How do you rate your knowledge of the health services that are available in your community? *Circle one answer.*

- | | |
|--------------|---------|
| 1) EXCELLENT | 3) FAIR |
| 2) GOOD | 4) POOR |

We're almost done! The following few questions are of a more personal nature, but are equally important to our survey (and, of course, will be kept strictly confidential). Please answer them and then mail the survey today!

27. What is your zip code? _____

28. Approximately how far do you live from your local Hospital and how long does it take you to get there?

_____miles _____minutes

29. How long have you lived in this community?

_____years

30. Which of the following best describes your yearly total household income? *Circle one answer.*

- | | |
|------------------------|-------------------------|
| 1) less than \$5,000 | 4) \$15,000 - \$ 24,999 |
| 2) \$ 5,000 - \$ 9,999 | 5) \$25,000 - \$49,999 |
| 3) \$10,000 - \$14,999 | 6) \$50,000 or more |

31. Which of the following best describes your racial or ethnic identification? *Circle one answer.*

- | | |
|---|------------------------------|
| 1) BLACK | 4) WHITE |
| 2) CHICANO OR HISPANIC | 5) ASIAN OR PACIFIC ISLANDER |
| 3) NATIVE AMERICAN (American Indian, Eskimo, Aleut) | |
| 6) OTHER (Please specify): _____ | |

32. What is your marital status? *Circle one answer.*

- | | |
|------------|--------------------------|
| 1) SINGLE | 3) SEPARATED OR DIVORCED |
| 2) MARRIED | 4) WIDOWED |

-
36. How would you rate your health on a scale from 1 to 10, with 1 being very poor and 10 being excellent? *Circle one answer.*

1 2 3 4 5 6 7 8 9 10

37. If you travel outside of the Kenai Peninsula for medical care, how often do you shop for consumer goods (household, medications, automotive products, etc.) on the same trip? *Circle one answer.*

- 1) ALWAYS
- 2) OCCASIONALLY
- 3) NEVER
- 4) DOES NOT APPLY

38. Would you be willing to pay local taxes to support a Kenai Peninsula Borough Health Care Plan that would subsidize your care from local providers for all the residents in the community? *Circle one answer.*

- 1) YES
- 2) NO

39. If you answered YES to question 38, which form of taxation would you prefer? *Circle one answer.*

- 1) PROPERTY TAX
- 2) SALES TAX
- 3) SEVERANCE TAX ON RESOURCES (FISH, TIMBER, COAL, ETC.)
- 4) OTHER (*Please specify*)

40. What do you feel is the most important health care problem in your community?

**KENAI PENINSULA BOROUGH
HEALTH CARE ADVISORY COUNCIL
Revised Survey Instrument Time Line**

- | | |
|------------|---|
| May 18-22 | Draft # 1 survey instrument |
| May 26 | Send draft with meeting packet for full council review June 4 |
| June 4 | Review, amend by full council; draft #2 |
| June 23 | Education Committee consider and approve:
-Amended survey instrument
-Amended time line for survey work
-Instrument distribution, tabulation and analysis
-Pilot testing plan |
| July | Pilot testing of survey instrument:
July 1-6 Mail test survey with cover letter to health care providers, others
July 6 Seward General Hospital Board of Directors (7:00 PM)
July 23 Central Peninsula Hospital Service Area Board (5:30 PM)
South Peninsula Hospital Service Area Board (6:00 PM)
July 29 Kenai Chamber of Commerce (Noon)
Final survey instrument, begin survey publicity
Publicity activities:
*Radio talk shows in Homer, Seward and Kenai-Soldotna
*Media release to local papers
*Radio PSA's - 30 second sound bite
*Newspaper guest editorials: Dr. Bruce Amundson and committee members |
| Aug 1-14 | Develop alternative sources for data base from which to construct sampling frame |
| Aug 17-27 | Sampling frame construction by Idaho State University, transport survey to Alaska for bulk mail. |
| Aug 28 | Surveys in mail, continue publicity |
| Sept 24 | Close out receipt of surveys for data entry purposes |
| Sept 24-31 | Data entry (estimated 1,000 surveys) |
| Oct 1-14 | Data analysis and preparation of draft report |
| Oct 15 | Final Report |
| Oct 16-17 | Health Care Work Shop |

General Information

Purpose - A workshop for the Kenai Peninsula Borough Health Care Advisory Council, Health care service providers, local government officials and citizens to further define a health care plan for Kenai Peninsula Borough residents.

Invited Experts - Dr. John Coombs, Vice President, Medical Affairs, Tacoma General Hospital; Cindy Rice, Sound Care Manager, Kitsap Physicians Service, Bremerton, Washington; Dennis P. Degross, Health Planner, Community Health Services Development Project, University of Alaska, Fairbanks; Jack Brandt, NCAS Northwest, Seattle; Dr. Bruce Amundson, Private Rural Health Consultant, Seattle; Amy Hagopian, Associate Director, University of Washington, Department of Family Medicine, Seattle; David Ford, Private Health Benefits Consultant, Seattle; Cheryl Schott, Executive Director, Group Health Cooperative of Puget Sound, Seattle.

Transportation - ERA, SouthCentral Air, and Markair Express all serve Kenai from Anchorage and Homer. Currently Alaska Airlines (with ERA Commuter) and Markair (with Markair Express) offer roundtrip Seattle/Kenai fares of \$380 if tickets are purchased prior to Sept. 30 (Saturday night stay).

Housing & Workshop Site - The workshop housing and site is the Kenai Merit Inn, 260 South Willow, Kenai, AK; telephone is 907-283-6131; Fax is 907-283-6090. When making reservations say you are attending the HCAC Workshop for a special \$55 rate; single or double occupancy.

Sponsors - Kenai Peninsula Borough Health Care Advisory Council through Kenai Peninsula Borough Economic Development District; funding support from Community Health Services Project Development Grant.

Conference Agenda

Friday, October 16, 1992

3:00PM - 5:00PM	Welcome and Introduction of HCAC Project - Stan Steadman, HCAC Chair; Local and National Significance of Plan- Dr. Bruce Amundson, Project Consultant
5:30PM - 7:00PM	Reception (included in registration)
7:00PM - 9:00PM	Public Forum: Community Health Care Plan and Survey Results- Stan Steadman; Bruce Amundson; and Amy Hagopian, University of Washington (no fee to attend)

Saturday, October 17, 1992

8:00AM-9:30AM	Continental Breakfast; Presentation of HCAC Plan Draft & Development Team Reports on Funding, Benefits Design, Implementation & Management, Delivery of Health Services, Organizational Structure
10:00AM-2:00PM	Breakout Sessions for Plan Development teams to work with faculty experts. Lunch break will vary with group needs (box lunch provided)
2:00PM-5:00PM	Report of teams and draft plan refinements; wrap-up; next moves: political action, schedule of community forums, publicity, work assignments

Registration

Name _____

Title _____

Company _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Fax _____

Payment Information

Registration fee is \$25.00, which includes reception, continental breakfast, and box lunch. Pay by check (payable to EDD) if registering by mail, check or cash if registering at the door. Conference attendance will be limited, so make reservations. Send registration to:

EDD
110 So. Willow St., Suite 106
Kenai, Alaska, 99611
Tel. (907)283-3335; Fax (907)283-3913

Early Arrivals

A tour beginning at 9:00 AM on Friday, October 16th, of the Kenai-Soldotna area will be available for out-of-towners arriving early. Please check the box if interested.

Early Arrival Tour ☐

See you on the Kenai!

Kenai Peninsula Borough

Health Care Advisory Council

Kenai Peninsula Borough Economic Development District, Inc. 110 S. Willow St., Suite 106 Kenai, Alaska 99611 (907) 283-3335 Fax: (907) 283-3913

KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL

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Jim Heim
Soldotna

Bonnie Heimbuch
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Kenai Peninsula Borough Economic Development District (Alaska) Health Plan Development Project

OVERVIEW

The Kenai Peninsula Borough, Alaska is located south of Anchorage, encompassing over 25,000 square miles with a population of over 40,000 people. In November, 1991, the Borough Assembly passed a resolution establishing the 30 member Health Care Advisory Council and requesting the Kenai Peninsula Borough Economic Development District (EDD) to administer the work of the Council. Since January, 1992, the Council has been aggressively pursuing a course to accomplish its mission:

SUBMIT A REPORT TO THE BOROUGH ASSEMBLY MAKING FINDINGS AND RECOMMENDATIONS AS TO OPTIONS FOR THE ESTABLISHMENT OF A BOROUGH-WIDE INSURANCE PROGRAM WHICH WOULD MAKE AFFORDABLE HEALTH INSURANCE AVAILABLE TO ALL RESIDENTS AND THEREBY INCREASE ACCESS AND UTILIZATION OF THE LOCAL HEALTH CARE SYSTEM.

Kenai Peninsula Borough residents are concerned about the accessibility and rising costs of health care. This concern is particularly acute for low income residents and the many workers in high risk, seasonal, small business occupations. The expectation that the state or federal governments will act to establish a program to meet the needs of those who cannot afford insurance is not being realized as lawmakers continued to be mired in debate between competing interests.

Over the past several months the Council's members have worked in committees and sub-committees defining elements of the proposed plan to be revealed in a workshop on October 16-17, 1992, in Kenai, Alaska. The day and a half workshop provides an opportunity for in-depth discussion of plan elements as reviewed by chosen experts in the area of funding, delivery of health services, benefits design, organization of structure, and implementation and management.

REGIONAL ECONOMIC ISSUES

The leadership in this project ^{stems} from a recognition of the following issues:

- 1) Surveys of local entrepreneurs show the cost of employee insurance high on the list of barriers to business development.
- 2) Local governments are faced with either reducing direct government services or raising taxes to meet the rising costs of public employee insurance benefits.
- 3) Annually millions of dollars in insurance premiums which could be used locally are exported (estimated in excess of \$25 million) to Outside based insurance companies.
- 4) A significant percent of health care to local residents is provided outside of the area, leaving local facilities operating in efficiently at levels substantially under capacity.
- 5) The health care costs of the uninsured are, in part, passed on to public agencies, employers, and all citizens.

APPROACH

In conjunction with a \$47,000 grant received from the state funded Community Health Services Development Project (CHSD), the Council has implemented the CHSD Model developed by the WAMI Rural Health Research Center (see attachment) in the analysis and development of a borough-wide health care plan. The following four phases are envisioned by the model and have been implemented by the Council:

1) Preparation - A core group of community and health system leaders brought the request for official sanction and participation in the project to the Borough Assembly. In November, 1991, the Assembly established the 30 member Health Care Advisory Council, requested the Borough Mayor to select Council members, and requested the EDD to service as the project administrator. Since January, 1992, the Council has been discharging its responsibilities under the leadership of three committees: steering, planning, and education. Through the EDD, a consultant project manager, Kathy Scott, and a project advisor, Dr. Bruce Amundson, were hired.

2) Analysis - Identification and discussion of the concerns of Council members, analysis of existing health data, and investigation of innovative health care systems across the United States and Canada occupied the first several months of the Council's efforts. In mid-summer, 1991, the Council undertook preparation of a borough-wide, random community survey evaluating the health care system within the borough with the assistance of the Institute of Rural Health Studies, Idaho State University, and the University of Washington School of Medicine. Also, the Council surveyed Alaska and Seattle, Washington, hospitals to determine the location and type of care provided outside of the local area to Kenai Peninsula Borough residents. Both surveys were still in progress as of September, 1992.

3) Planning/Development - By mid-summer, 1992, the Council turned its focus to developing the specifics of a health care plan. Five issue groups were organized to work on various plan elements: funding, benefit design, implementation and plan management, organizational structure, and health services delivery. The work of these groups will be revealed in a workshop, October 16-17, in Kenai. At that time an invited panel of experts will assist with plan refinements. Then, with a draft plan in place, an actuarial firm will be hired to determine costs and prices.

4) Implementation - This phase will begin when the Council feels confident in proceeding with public review of a draft plan. According to the schedule under which the council is working, the draft will go to public review prior to a fall, 1993, referendum election on whether necessary public powers should be adopted to enable full plan implementation.

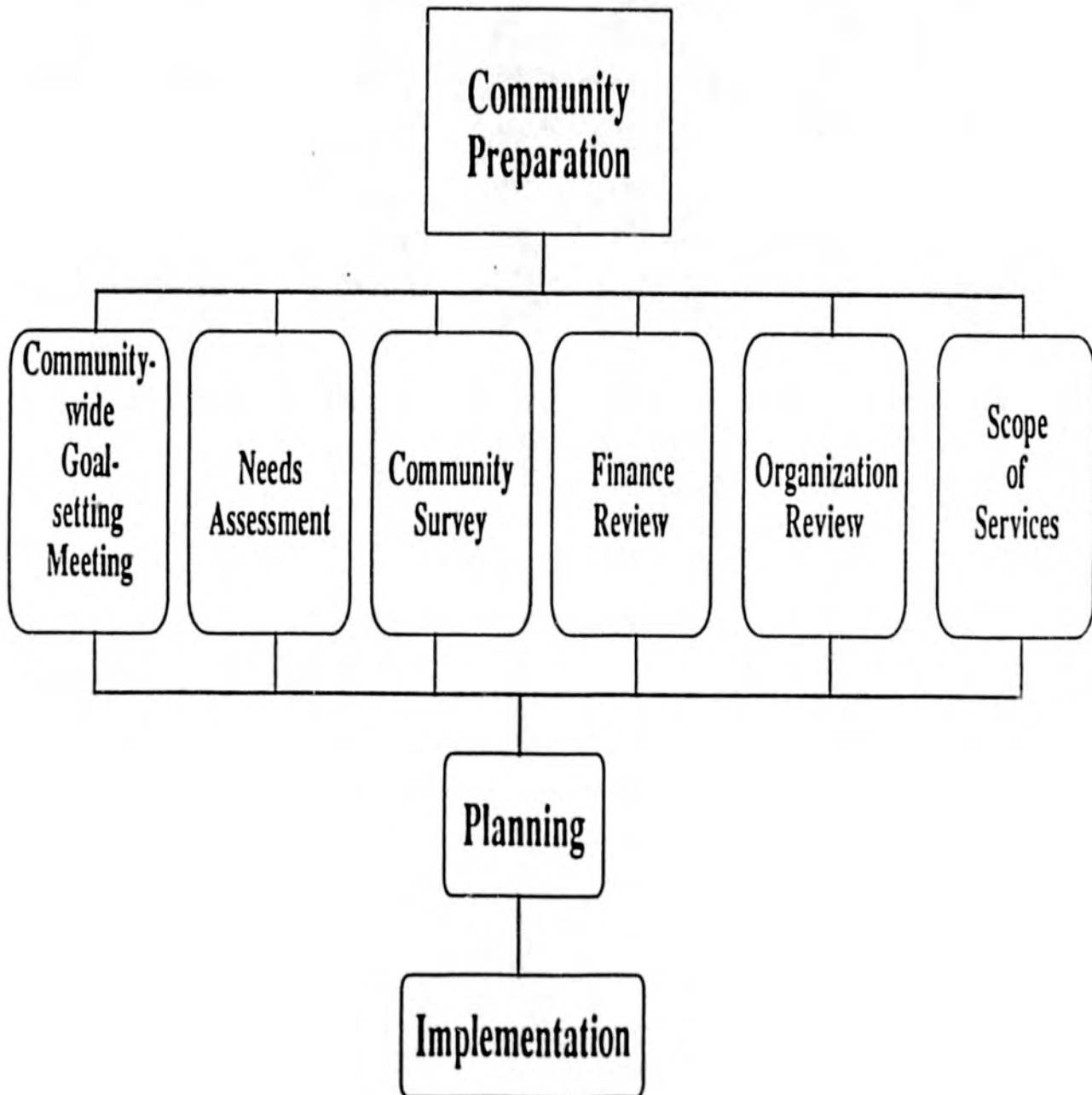
VISION

Many of the basic resources to accomplish this project are available locally (i.e. leadership, public involvement, data). However, the Council will look to participation of other agencies, organizations, and foundations for resources beneficial to project accomplishment.

The presentation of this concept at state and national conferences has sparked keen interest. The inclusion of all jurisdiction residents in a locally administered plan and the linking of health costs to economic development objectives are unique, and the success of this project is seen as having far reaching importance in dealing with this critical issue.

Figure 1

CHSD Phases



Health care panel wins award for innovation

By CATHY DOWD
Peninsula Clarion

8/13/92

The Kenai Peninsula Borough Health Care Advisory Council, which is in the midst of coming up with a possible boroughwide health plan, has garnered an "innovation award" for the borough Economic Development District, EDD Executive Director Stan Steadman said.

As administrator of the health council, the EDD has won a National Innovation Award from the National Association for Development Organizations.

The award not only provides recognition of the council's work, it also may help it gather financial support, Steadman said.

"I think it gives us visibility," he said. "With that kind of recognition, it strengthens our position in seeking grants, in seeking participation in the program from federal, state and private funding sources."

The 30-member health council was established last winter by the Borough Assembly to investigate the feasibility of a boroughwide health program.

The idea is that by pulling borough residents into one large insurance pool, the borough may be able to make health care more affordable for all residents.

The EDD also sees the council as a way to keep insurance and health care dollars in the community.

The council spent much of first half of the year educating itself about factors driving the cost of care and the cost of health insurance and looking at plans other states have adopted to try to deal with the problem.

It is now beginning to visualize what a borough health plan might look like. Five committees are coming up with ideas for benefits, funding, organizational structure, implementation and delivery of health services.

They met last week to talk about what they've come up with, but won't have firm recommendations until a Sept. 11 meeting, said Bonnie Golden, administrative assistant to Borough Mayor Don Gilman.

"This is still brainstorming, looking at alternatives, looking at the pros and cons of every-

See COUNCIL, page 16

Council: Studies ways to pay for plan

Continued from page 1

thing," council member Rich Underkofler said.

Among the possible mechanisms the funding committee is looking at to pay for the plan are: tax subsidies, such as sales tax, property tax, severance tax, income tax, and so-called "sin" taxes; block grants from the state; private foundation funding; premiums, including subsidized premiums for the poor; and "cost containment" measures to lower the prices people pay for medical care.

A benefit design committee is discussing what services should be covered, ranging from pre-natal care to prescription drugs to optional vision and dental care.

The committee has also talked about "deductibles," the amount patients pay before insurance kicks in, ranging from \$100 to \$1,000; making the deductible lower for preventive care procedures, like dental exams; and paying a greater percentage of costs for people who use borough doctors.

The committee has suggested requiring residents to live in the borough a year before becoming eligible for the plan and using things like property ownership, driver's license and voter registration to prove that residency.

A health services delivery committee is looking at ways to coordinate health and social services so all factors contributing to an illness or injury, for instance, alcoholism or domestic violence, are addressed, rather than just the medical ailment.

An implementation committee is looking at whether

'I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them.'

—Stan Steadman,
executive director
of the Economic Development District

to implement the plan in partnership with an insurance company or in-house, how to avoid overloading it with high claims initially, how to market the plan, what kind of data system would be needed and other issues.

The organizational structure committee is looking at what kind of governmental body should be set up to run a borough health plan.

The committees will further refine their ideas by the next council meeting, Golden said.

A group of experts who have been invited to an October conference will tell them whether the concepts they've proposed seem workable, Steadman said.

"We set up the conference as a way to obtain outside peer review of what we were doing, so we weren't operating in a vacuum," he said.

In the next few months, the council will also be hiring an actuary, a person whose work is to calculate risks and premiums for insurance, to put some numbers to the concepts it's coming up with.

"People keep saying 'how much will this cost,' and we can't answer that until we come up with a plan and have an actuary determine rates," Steadman said.

Underkofler remarked at

the last council meeting that he had heard some physicians are apprehensive about what the council is doing.

Dr. James Zirul said it's true some doctors are nervous because organizations that have sprung up in the Lower 48 to control costs — like preferred provider organizations and health maintenance organizations — have buried physicians in paperwork, compromised patient care and made it difficult for doctors to pay their overhead costs. Zirul is one of several health care providers on the council.

What the council is trying to do here is very different from approaches that have been tried elsewhere, he said, and no one knows yet whether it will work.

Steadman said the project manager for the council was in Homer this week meeting with physicians there. Council representatives have had meetings with doctors on the staff of the three hospitals within the borough, he said.

"What we're telling them is we're striving for a better system to provide health care and we recognize that they are a key, integral part to that being accomplished, and we're looking for their input to be sure their interests are represented."

Some doctors are hopeful that the council can come

up with something better than the system now in place.

Dr. Lynn Carlson, who operates a family practice clinic in Nikiski, said many of his patients fall into that category of people who are neither able to afford insurance nor eligible for Medicaid. He is hoping the council may be able to find a better way to provide care to them.

"I'm thinking that a locally run health system would be better than a federally run" system, Carlson said.

"I think everybody that's aware that this is taking place is very interested in where it's going and what the outcome's going to be and how it's going to affect them," Steadman said.

It's too early to know yet bottom line things like how much such a plan could cost people in premiums and taxes, what they would get in benefits and how it would affect the medical establishment.

The council's timeline calls for it to go before borough voters at the October 1993 municipal election. It would have to receive Borough Assembly scrutiny before it could even be placed on the ballot.

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KENAI PENINSULA BOROUGH HEALTH CARE ADVISORY COUNCIL
WORK PROGRAM

(for prior track consult revised draft of March 23, 1992)

July - Education Committee and Steering Committee approved survey.

July - Kenai Peninsula Health Care Survey Pilot Testing

July 13 - Full Council Workshop. Dr. Bruce Amundson CHSD Model presentation. Dave Ford, plan organizational alternatives. Council initiates the work of health care plan development. Issues development groups organize around five key areas: Funding, Benefits Design, Implementation and Plan Management, Organizational Structure and Health Services Delivery.

Issues development groups meet to prepare draft issues statements.

August 7 - Full Council Meeting. Standing committees report as well as issues development groups. Decision on alternate date for fall conference which has become more of a fall workshop. The potential still exists for a full conference in the spring.

September 11 - Full Council Meeting. Discuss final drafts of issues statements for inclusion in the work shop packet material. Other operations issues. Approve form of a "Request for Proposal" for a third party consultant to assist with the demographic, coverage, actuarial, financial and management components of the health insurance plan. The RFP Selection Committee is the Steering Committee.

The scope of the consultant's services should include these tasks:

Design a model "community based" health insurance program based on issues development resolves by the council through their "expert" advisors in the October work shop. Specifics should include but are not limited to:

- Prediction of annual expenses of the program
- Classification of program expenses to be retained or deferred by excess insurance or a reserve fund
- Allocation of expenses between various sources of revenue

October 8 - RFP Selection Committee review proposals and select with approval of the Steering Committee.

October 16-17 - Full Council Work Shop with "faculty" experts to refine elements of the proposed health care plan. (See work shop outline for detail).

November 6 - Full Council or Steering Committee consider and approve interim report of Health Care Advisory Council in preparation for presentation to the Borough Assembly at their November 17 Meeting. Extension of time from Borough Assembly for life of Health Care Advisory Council occurs at same meeting.

- Secure remainder of funding needed for the project. Potential sources of additional funding may be: the Borough hospitals, a grant from the American Hospital Association, a grant from the Kellogg Foundation, another state grant, etc.

Authorize consultant to proceed.

1993

February 4 - Due date for the first draft of the consultant's report.

Revisit the assumptions. Adjust demographics, coverage, services and/or allocation of program expenses between the various sources of operating revenue (as appropriate) to make the cost consistent with what residents should be willing to pay for the health insurance program.

Introduction of state and local legislation necessary to amend existing laws to give KPB explicit authority (or exemption from existing law) to implement a community based health insurance program subject to the approval of a majority of the borough's voters.

April 1 - Due date for second draft of consultant's report. Give policy guides as appropriate for final revisions to the report.

May 6 - Submit final report to the Borough Assembly making findings and recommendations for the establishment of a Borough-wide insurance program which would make affordable health insurance available to all residents and thereby increase access to and utilization of the local health care system.

June 1 - Assembly introduces an ordinance which would provide the Borough with authority to implement the program subject to approval of the voters at the October regular election.

October 7 - Voters decide whether to approve or reject a proposition to enable implementation of the program.

October 23, 1992

MIDWIFERY CARE IS A VIABLE OPTION

I. Midwifery in Alaska

A. Midwives Association of Alaska

1. Membership
2. Registry requirements (fashioned after N.M. licensing requirements)
3. Direct-entry Midwives -- combination of apprenticeship and academics (degree programs available)
4. Affiliation with national association -- the Midwives Alliance of North America

II. National Focus on Midwifery

A. Carnegie-Sponsored meetings { ACNM: American College of Midwives MANA: Midwives Alliance of N. America Consumers

1. Decisions:
 - a. Nursing not necessary prerequisite to midwifery
 - b. Core competency more important than specific pathways of learning
 - c. National testing standards adopted

B. Credentialing in other states

C. Reimbursements in other states.

III. Comments

A. Financial Access to System

1. Medicaid -- licensing should make a difference
2. Private insurance -- approximately 60% pay currently -- will improve with licensing

B. Quality of Care

1. Social support of woman and her family
2. Education
3. Continuity of care throughout
4. Midwives spend approximately 50-60 hours with a woman for prenatal, labor and delivery, postnatal care and education which translates into:
 - a. improved infant and maternal health
 - b. improved mother and baby relationship
 - c. breast feeding success
 - d. less abandonment and neglect

C. Cost Effectiveness

1. A cost comparison was done in the six areas of the state where members of the registry of the Midwives Association of Alaska practice; that is Juneau, Soldotna, Fairbanks, Palmer, Anchorage and Cordova. Their fees were compared with the combined fees of doctors (family practice and obstetricians averaged) and hospitals for perinatal care including a normal vaginal delivery without complications or interventions when the mother spends 24 hours or less in the hospital.
2. The average cost of midwifery care was **\$1,850.00**. The average cost for doctor/hospital care was **\$4,100.00**.
3. Please note additional enclosures including FACT SHEETS prepared by the Midwives Association of Washington State for additional information.

IV. Summary

Midwifery care is a viable option for low-risk women. Low income women are presently denied this option of choice which would potentially translate into savings of many health care dollars.

Thank you for the opportunity of addressing this task force.

Dollars and Sense: Midwifery Care Is Cost-Effective Care

Midwifery Fact Sheet

- Professional fees of midwives are lower than those of physicians: in 1988 they averaged \$1450, while physician charges for comparable care averaged \$2100.¹ Additionally, midwifery fees have not increased at the same rate as physician fees in recent years.
- Midwives use fewer expensive technologies to provide safe care. Consequently, patient charges, including length of hospital stay, are significantly lower. Comparisons of midwifery care and physician care, including one study of the same population of patients in the same hospital,² have shown that midwives have equally good outcomes, while using fewer interventions.^{3,4}
- Midwifery care is preventive care. Midwives spend time to provide education, information and social support to their clients. All of these factors have been cited as significant contributors to reducing adverse outcomes, especially prematurity and low birthweight.^{5,6}
- Midwives have far fewer malpractice claims filed against them than do physicians. In a survey conducted by the American College of Nurse-Midwives, 9.6% of nurse-midwives said they had been named in a suit.⁷ The American College of Obstetricians and Gynecologists' national survey of 1985 revealed that 73% of obstetricians had been sued at least once.⁸
- Because midwives are sued less frequently than physicians, their malpractice insurance premiums cost less. In 1987 the average premium for a physician delivering babies was \$37,000; for a midwife, malpractice insurance cost \$3,500.⁹ This difference greatly contributes to the lower cost of midwifery care.
- Midwives offer a choice of birth setting. Out-of-hospital births, either at home or in a licensed birth center, offer the low-risk, healthy woman a safe option at considerable savings. The cost of an out-of-hospital birth is 50% to 70% less than a hospital birth.¹ Recognizing these substantial savings in health dollars, several private health insurance plans now encourage midwife-attended out-of-hospital birth by reimbursing 100% of these charges, while hospital delivery is reimbursed at 80%.¹⁰ Similarly, the state's Medicaid program reimburses for delivery in a licensed birth center.¹¹

- References**
1. State of Washington, Department of Licensing. *An Assessment of Childbirth Outcomes in Washington: Report to the Legislature*. Olympia, WA, 1987.
 2. Beal, M.W. Nurse-midwifery intrapartum management. *Journal of Nurse-Midwifery*, 1984, 29, 13-19.
 3. Haire, D. Improving the outcome of pregnancy through increased utilization of midwives. *Journal of Nurse-Midwifery*, 1981, 26, 5-8.



Midwives' Association of Washington State
2425 16th Avenue South #300
Seattle, Washington 98144 or (206) 548-5766

Published by the Midwives' Association of Washington State, the professional organization of Certified Nurse-Midwives and Licensed Midwives in Washington State. 7/90

Birth Outside the Hospital

Midwifery Fact Sheet

Trends in birth setting ● In 1940, 50% of births in this country took place at home, with a doctor or midwife in attendance. By 1960, birth had been moved almost exclusively into the hospital. During the 1970's, a notable increase in out-of-hospital births signaled a new debate among consumers and health professionals on the appropriate place for labor and birth.

Today, approximately 1% of American families choose to give birth outside the hospital; in Washington State, this proportion is about 2.5%. These families choose home birth, or delivery in a free-standing birth center (not a hospital facility) licensed by Washington State's Department of Health. The majority of out-of-hospital births, in Washington as well as throughout the United States, are attended by midwives.

Reasons for out-of-hospital birth ● Why do families choose out-of-hospital birth? A number of consistent themes emerge from the literature including:

- increased control over the childbirth experience;
- avoidance of unnecessary medical routines and interventions;
- continuous care by a known and supportive birth attendant;
- labor and delivery among loved ones and in familiar surroundings;
- avoidance of the high cost of hospitalization.

Safety: What the Studies Say ● For most people concerned with childbirth, a central issue is safety. What do we know about the relative risks of childbirth in various settings? Studies reporting outcomes from well-organized out-of-hospital birth practices, both in the U.S. and abroad, show very low rates of adverse outcomes for mothers and infants. Holland, for example, where 35% of deliveries take place in the home, has one of the lowest perinatal mortality rates in the world. There is no evidence that birth in the hospital is safest for women at low medical risk.^{1,2}

Some early reports on outcomes of out-of-hospital births were misleading because they compared hospital and non-hospital births without determining whether these births were planned and/or attended by a qualified person. In other words, late miscarriages, premature births, taxi cab deliveries, and other unexpected out-of-hospital births were included in the outcome data.^{3,4}

Other studies which considered these factors found that the neonatal mortality rates of the planned out-of-hospital births with a qualified attendant averaged 4/1000, below the national rate, while for the unplanned groups the rates averaged 97/1000.^{5,6,7}

In controlled studies, those births planned to occur outside the hospital with midwives in attendance were associated with lower rates of obstetrical interventions than births planned to occur in the hospital with physicians and other care providers. In some studies, planned out-of-hospital births also had lower rates of complications than the hospital births.^{8,9,10}



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Several authors have estimated that the probability of an emergent complication arising during an out-of-hospital labor, in a well-screened, healthy population of women, in which the loss of time in transit to a hospital could increase the risk of an adverse outcome, would be less than 1 in 1,000.^{1,11,12}

Midwifery Practice Ensures Safety

Midwives attending out-of-hospital births ensure optimum safety for their clients by:

- Accepting into care only women who have no pre-existing medical conditions, who want to have natural labor and birth (without medical interventions or pain medication) and who are experiencing a normal pregnancy;
- Providing comprehensive prenatal care that includes on-going screening for complications, education, support and personal attention;
- Ensuring continuous, one-to-one care during labor, carefully monitoring the progress of labor, and maternal/fetal condition;
- Maintaining the skills and equipment needed for treating emergent and unexpected conditions, such as hemorrhage or neonatal resuscitation;
- Establishing consultation and referral relationships with obstetricians and pediatricians who can provide hospital treatment if indicated.

In summary, an out-of-hospital birth that is planned, with a well-trained attendant, is a safe, satisfying, and economical choice.

- References**
1. Sagov, S.E. & Brodsky, A. The issue of safety. In Sagov, S. et al, *Home Birth: A Practitioner's Guide to Birth Outside the Hospital*. Rockville, MD: Aspen Systems Corporation, 1984.
 2. Campbell, R. & MacFarlane, A. Place of delivery: a review. *British Journal of Obstetrics and Gynecology*, 1986, 93, 675-683.
 3. Aubrey, R.H., The American College of Obstetricians and Gynecologists: Standards for Safe Childbearing. In Stewart, D. & Stewart, L. (eds), *Twenty-first Century Obstetrics Now*, Chapel Hill, N.C. NAPSAC, 1977.
 4. "Health Department Data Shows Danger of Home Births", news release. Chicago, The American College of Obstetricians and Gynecologists, January 4, 1978.
 5. Burnett, C.A., Jones, J.A., Rooks, J., et al, Home delivery and neonatal mortality in North Carolina. *Journal of the American Medical Association*, 1980, 24, 2741-2745.
 6. Hinds, M.W., Beergeisen, G.H., and Allen, D.T. Neonatal outcome in planned vs. unplanned out-of-hospital births in Kentucky. *Journal of the American Medical Association*, 1985, 11, 1578-1582.
 7. Schramm, W.F., Barnes, D.E. & Blakewell, J. Neonatal mortality in Missouri home births, 1978-84. *American Journal of Public Health*, 1987, 77, 930-935.
 8. Feldman, E., Hurst, M. Outcomes and procedures in low risk birth: a comparison of hospital and birth center settings. *Birth*, 1987, 14, 18-24.
 9. Mehl, L., Peterson, G.H., Whitt, M., and Hawes, W.E. Outcomes of elective home births: a series of 1,146 cases. *The Journal of Reproductive Medicine*, 1977, 19, 281-290.
 10. Scupholme, A., McLeod, A.G. and Robertson, E.G. A birth center affiliated with a tertiary care center: Comparison of outcome. *Obstetrics and Gynecology*, 1986, 67, 598-603.
 11. Hoff, G.A., and Schneiderman, L.J. Having babies at home: Is it safe? Is it ethical? *Hastings Center Report*, December, 1985, 19-27.
 12. Kloosterman, G.J. The organization of obstetrics in the Netherlands. *Nederlands Tijdschrift voor Geneeskunde*, 1978, 122, 1161-1171.

What do international experts say about midwifery?

"...I came to see that midwifery wasn't just a way of substituting cheaper obstetrical care for the poor and deprived...I discovered that the countries with the lowest infant mortality rates in the world also had medical care systems in which the whole of normal obstetrical practice was carried on by midwives."

George A. Silver, M.D.
Professor Emeritus of Public Health, Yale University

Source: *The Next Fifty Years of Nurse-Midwifery Education*, Maternity Center Association, New York, 1983, page 66.

"...there is evidence that a strong independent midwifery profession is an important counterbalance to the obstetrical profession in preventing excessive interventions in the normal birth process. Consequently, it is perhaps not surprising that in the U.S. one finds the highest obstetrical intervention rates as well as a serious problem with malpractice suits. The European experience and our data strongly support the urgent need for the introduction of widespread, independent midwifery practice in the United States as a most important counterbalance to the present situation."

Marsden G. Wagner, M.D.
Maternal and Child Health Officer for the European Region, World Health Organization

Source: "Infant Mortality in Europe: Implications for the United States: Statement to the National Commission to Prevent Infant Mortality", *Journal of Public Health Policy*, Winter 1988:473-484.

"Midwifery provides a balance between the family and medical perspectives on birth. To negotiate and balance the different meanings and perspectives of birth within the health care system, it is essential for midwives to have a legitimate and powerful role within the system. Midwifery should be powerful enough to influence both the nature and delivery of services. This, I believe, would greatly enhance maternity care, which ultimately is the crux of the matter...the safe, loving and skilled care of women, their babies and their families at one of the most important points of life...birth."

Lesley Page
Director of Midwifery, Oxfordshire, England

Source: "The midwife's role in modern health care" in *The Midwife Challenge*, Sheila Kitzinger, ed. Pandora: London, 1988, page 259-260.

"The midwife must be able to advise the expectant mother, give her moral support, to make her enthusiastic for a natural childbirth, and above all, to supervise her in such a way that all minor and major abnormalities are recognized or at least suspected as early as possible. I am convinced that she is able to do this as well as a doctor, and very often better...Without the presence and acceptance of the midwife obstetrics becomes aggressive, technologic, and inhuman."

G. J. Kloosterman, M.D.
Former President, International Federation of Obstetricians and Gynecologists

Source: "The Midwife: Her Task and Responsibility in a Technologic World" in *The Five Standards for Safe Childbearing*, David Stewart, ed. NAPSAC International: Marble Hill, Missouri, 1981, pages 157-158.

Midwives' Association of Washington State
2425 16th Avenue South #300
Seattle, Washington 98144 or (206) 548-5766

Published by the Midwives' Association of
Washington State, the professional organization
of Certified Nurse-Midwives and Licensed
Midwives in Washington State. 7/90



Crisis in Maternity Care: The Problem

Midwifery Fact Sheet

- *The United States presently ties for last place in infant mortality rates among all industrialized countries in the world.*

Low birthweight (and prematurity) is the leading cause of infant death, and the single largest contributor to death in the neonatal period (birth to 28 days). Since 1980, there has been no reduction in the incidence of low birthweight in the United States.

- *The United States stands alone among 75 industrialized and developing countries in its failure to ensure basic health and social services needed during pregnancy, childbirth and infancy.*

The most effective prenatal interventions have been shown to be social, not medical. Programs that provide all women with assistance in nutrition and lifestyle changes, and that provide personal attention improve the health of mothers and babies.

- *Maternity care costs have increased at an alarming rate, partly due to increased use of expensive technologies and surgical procedures.*

An uncomplicated physician-attended delivery in a Seattle area hospital now costs \$5000; with interventions, this cost is driven much higher. Nearly one-fourth of all births are cesarean sections (which cost two to three times more than vaginal births). This rate is two times higher than the maximum rate considered acceptable according to World Health Organization recommendations. It is estimated that in 1986, this excess in cesarean births cost the United States over 1 billion dollars.

- *In 1988, 13% of women giving birth in our state did not receive adequate prenatal care.*

Early and continuous prenatal care reduces the incidence of complicated births, particularly low birthweight: for every \$1 invested in preventive prenatal care, more than \$3 can be saved in expensive curative care. Today, at least half of Washington's 39 counties are considered "distressed areas" because too many women are receiving inadequate prenatal care. Yet, while the need increases, there has been a sharp decline in physicians providing obstetric care, particularly to poor women.



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Midwifery Care: Part of the Solution

- Professional midwifery care in the United States has been associated with reduced rates of low birthweight and neonatal mortality.

This is true not only in "low risk" populations, but also among low income women who, as a group, are at higher risk for these problems.^{1,6}

- Midwives provide quality prenatal care that is especially effective for women who are at risk for having a low birthweight infant because of social and economic factors.

Since midwives provide more time, education and personal care, these clients are more likely to keep their prenatal appointments, follow recommendations and feel more satisfied with the care they receive.^{4,7}

- Women cared for by midwives have lower rates of obstetrical interventions, with no compromise in maternal or infant outcomes.

A variety of studies have shown that midwifery care can reduce the cesarean section rate, the need for analgesia and anesthesia during labor, the use of episiotomy and the length of hospital stay.^{3,8,9}

- Midwives can provide accessible care to underserved populations.

Training opportunities available in Washington have contributed significantly to the steady increase of midwives in the state over the past ten years. These midwives report that the majority of their clients are low income women.¹⁰ The Midwives' Association of Washington State is committed to assisting in the placement of midwives in underserved communities.

- References
1. Browne, H. & Isaacs, G. The Fronder Nursing Service. *American Journal of Obstetrics and Gynecology*, 1976, 124, 14-17.
 2. Levy, B.S., et al. Reducing neonatal mortality rate with nurse-midwives. *American Journal of Obstetrics and Gynecology*, 1971, 109, 50-58.
 3. Haite, D. Improving the outcome of pregnancy through increased utilization of midwives. *Journal of Nurse-Midwifery*, 1981, 26, 5-8.
 4. Institute of Medicine, Div. of Health Promotion and Disease Prevention, Committee to Study Low Birthweight. *Preventing Low Birthweight: Summary*, Washington, D.C: National Academy Press, 1985.
 5. Sullivan, D. & Weiss, R. *Labor Pains: Modern Midwives and Home Birth*. New Haven, CT: Yale University Press, 1988.
 6. Starzyk, P. *Alternative Delivery Services in Washington State: Trends and Current Practice*. Health Data Unit, Department of Social and Health Services, Olympia, WA, 1987.
 7. Slome, C., et al. Effectiveness of CNM's: A prospective evaluation study. *American Journal of Obstetrics and Gynecology*, 1976, 124, 177-182.
 8. Beal, M.W. Nurse-midwifery intrapartum management. *Jour. of Nurse-Midwifery*, 1984, 29, 13.
 9. Brucker, M.C. & Muellner, M. Nurse-midwifery care of adolescents. *Journal of Nurse-Midwifery*, 1985, 30: 277-279.
 10. Baird, J.E. A Demographic Study of Washington State Licensed Midwives. Unpublished Master's Thesis, University of Washington, Seattle, WA, 1987.

Landmark Decision for British Homebirth & Midwifery

by Marjorie Tew

Marjorie Tew was an academic in the field of research statistics at Nottingham University when she stumbled into the subject of safety in childbirth. In 1975, she was teaching students at the university's medical school how much they could find out about various diseases from the available official statistics, and she assigned a group of them to look at how increased hospitalization of birth had affected infant and maternal mortality. She was very surprised to discover, as a result of these epidemiological exercises, that the relevant statistics did not seem to support the widely accepted hypothesis that the institutionalization of birth was responsible for the decline in infant and maternal mortality. Once she had written up her discovery, she was dismayed to find that medical journals were not interested in publishing her work. Finally, in 1977, her first article was published, and she began to receive support from the many British midwives and doctors who were aware of the problems caused by overuse of technology in childbirth. Her book, *Safer Childbirth? A Critical History of Maternity Care*, was published by Chapman and Hall in 1990.

Safer Childbirth? made a powerful case that Britain's move to total hospitalization of birth had not been made on scientific grounds and that the previous system of maternity care that allowed women to have options about the kind of maternity care they received was, in fact, safer.

Now it appears that policy planners in Britain have looked at the evidence presented by Marjorie Tew and others and have decided there is merit to her argument. Here are her reactions to the newly issued Report on Maternity Services made by the Health Committee of the House of Commons. — IMG

This non-party Committee, made up of eleven Members of Parliament with Chairman Nicholas Winterton MP (Member of Parliament), took a year to make an in-depth survey of the current British Maternity Services. Its enquiry, instigated by one of its members, Audrey Wise MP, was begun in February 1991 by giving an open, widely advertised invitation to all concerned, whether as providers or users of the service, to make written submissions describing their views and it received around 450 of these, many long and detailed. In addition it was made aware of relevant books and articles already published. Besides digesting this written

evidence, the Committee had the advice of six expert advisors, but whereas in all previous official inquiries, the dominant expert advisors had been obstetricians or uncritical supporters of the obstetrician's philosophy that childbirth is a pathological condition, the dangers of which can be avoided only by obstetric management, this time only two of the six advisors were obstetricians, while two were midwives, one was a paediatrician and one a general practitioner.

In March 1992 the Committee produced a lengthy report (1) of its findings, ending with a list of its 34 conclusions and 66 recommendations. Many of these are relevant only

The Report deserves to stand as a landmark in the history of maternity care world wide.

material, the Committee called many representatives of professional bodies and consumer organizations to give oral evidence at the House of Commons and to answer the questions raised by the Committee members. It broadened its understanding of the problems by visiting a sample of maternity hospitals and clinics, not only in the United Kingdom, but also in Sweden and Holland, countries noted for the high quality and good results of their maternity service and, in the case of Holland, for its uniqueness in providing for over 30 percent of births to take place in the mother's home and for independent midwives to take sole responsibility for the delivery of over 40 percent of babies whether in hospital or at home. To assist in evaluating the accumu-

lating evidence, the Committee had the advice of six expert advisors, but whereas in all previous official inquiries, the dominant expert advisors had been obstetricians or uncritical supporters of the obstetrician's philosophy that childbirth is a pathological condition, the dangers of which can be avoided only by obstetric management, this time only two of the six advisors were obstetricians, while two were midwives, one was a paediatrician and one a general practitioner.

The Report of a Parliamentary Committee does not have the force of law, but government departments are usually influenced by its recommendations. If the implementation of any of the recommendations of this Committee would require a change in the

law there is a good chance that appropriate legislation would in due course be put before Parliament and, if approved, enacted. Most of the recommendations for change, however, would be more likely to affect policies and administrative arrangements at central and local levels and would be subjects for discussion and agreement between all the parties concerned.

The relative strengths of these bodies in arguing their case in the light of the Committee's recommendations will determine the extent to which the changes will be implemented. The Report deserves to stand as a landmark in the history of maternity care world wide.

For the first time in any such inquiry, paramount importance has been given to organizing the maternity service so that it best serves the physical and psychological needs of the mother and baby. The human interests of the service receivers are given precedence over the professional interests of the service providers, except in the respects where the evidence has clearly shown that these are not in conflict.

Given this changed attitude, as will be obvious from the extracted material that follows, the Report's main recommendations strike at the heart of the official policy of the Department of Health, which since 1970 has been to provide for all births to take place in consultant obstetric hospitals, of which the larger hospitals equipped with more facilities for technological interventions have been progressively favored. But it has never been illegal to give birth in any other place, in particular in the mother's home. Nevertheless, as a result of professional persuasion or, through a variety of tactics, of keeping birthing mothers from realizing that they did have a choice, 96 percent of all births in England and Wales in 1989 took place in obstetric hospitals, with less than 2 percent in small maternity units and only 1 percent at home. If the recommended changes are to be implemented, there will have to be revolutionary changes in the provisions for maternity care, with revolutionary implications for the current providers of care, unfavorable for those whose professional interests are best promoted by the existing

system, favorable for those whose professional interests have been demoted by the existing system. As would be expected, these latter have welcomed the Report with great enthusiasm, as have the consumer groups who have campaigned for reform, but there has not yet been time for the medical establishment to express its considered reaction and to indicate what steps they may take to facilitate or obstruct the implementation of the recommendations.

On a personal note, I am gratified that the evidence assembled in my book *Safer Childbirth? A Critical History of Maternity Care* (2), together with that put forward in my written submission and oral testimony, carried some weight in influencing the Committee's deliberations and conclusions.

References

1. House of Commons, Session 1991-92, Health Committee (Chairman Nicholas Winterton), Second Report, Maternity Services, Volume 1, published on March 4, 1992, HMSO, London.
2. Tew, Marjorie. (1990) *Safer Childbirth? A Critical History of Maternity Care*. Chapman and Hall, London.

Selected Conclusions and Recommendations with Universal Relevance

from a Report on Britain's Maternity Services by the House of Commons Health Committee

On the basis of what we have heard, this Committee must draw the conclusion that the policy of encouragement all women to give birth in hospitals cannot be justified on grounds of safety. (paragraph 33)

Given the absence of conclusive evidence, it is no longer acceptable that the pattern of maternity care provision should be driven by presumptions about the applicability of a medical model of care based on unproven assertions. (paragraph 33)

We conclude that there is a strong desire among women for the provision of continuity of care throughout pregnancy and childbirth and that

the majority of them regard midwives as the group best placed and equipped to provide this. (paragraph 49)

We conclude that the choices of a home birth or birth in small maternity units are options which have been substantially withdrawn from the majority of women in this country. For most women, there is no choice. This does not appear to be in accordance with their wishes. (paragraph 86)

We conclude until such time as there is more detailed and accurate research about such interventions as epidurals, episiotomies, cesarean sections, electronic fetal monitoring, instrumental delivery and induction of labor, women need to be given a choice on the basis of existing information rather than having to undergo such interventions as routine. (paragraph 96)

The evidence we have received suggests that the importance of continuity of care needs underlining very heavily for the professionals who are involved in delivering the maternity services of the National Health Service. Many still demonstrate an insufficient awareness of its prominence among the criteria which women use to judge the quality of the care they have received. Nor have they yet done nearly enough to respond in practical terms to the call by women to be involved as full partners in the decisions made about their care. (paragraph 191)

We believe that the discussions we have heard about the case of providing continuity of care and the enabling of women to control their own pregnancies and deliveries have been far too heavily influenced by territorial disputes between the professionals concerned for control of the women whom they are supposed to be helping. (paragraph 191)

We are persuaded that the present imposition of a rigid pattern of frequent antenatal is not grounded in any good scientific base, and there is no evidence that such a pattern is medically necessary. The identified needs of women for information and support during pregnancy can be met

The Birth Gazette

more effectively than happens at present. There is widespread agreement that this requires a more flexible system which is based in the community, not in the hospital. The present system of shared care between hospitals and the community should, by and large, be abandoned. Hospitals are not the appropriate place to care for healthy women. (paragraph 208)

We conclude that there is an established need for the professionals involved in the maternity services to address the issue of providing women with a wider choice of place of birth and to consider ways of organizing services to support that choice. More immediately there is a need to establish ways of providing a choice of a less medicalized pattern of intrapartum care, whatever the setting. (paragraph 230)

We are not persuaded by the evidence we have received that the current organization of the maternity services for intrapartum care has yet succeeded in resolving the conflicts between different philosophies of care. In the oral evidence presented to us there was a clear indication of the potential for a damaging demarcation dispute between the professional groups over how labor should be supervised. (paragraph 232)

We conclude that there is universal agreement between all involved in maternity care that an increase in the level of breast-feeding is desirable. (paragraph 255)

We recommend that geographically-based follow-up of intensive care survivors, especially VLBW (Very Low Birth Weight) infants, should be regionally organized and supervised by Regional Perinatal Advisory Committees. The results should be made widely available so that the outcome of intensive care is clearly known. (paragraph 290)

We recommend that the policy of closing small rural maternity units on presumptive grounds of safety should be abandoned forthwith. We recommend that in considering any appeal against the closure of such a unit, the Secretary of State should

make a presumption against closure unless the case is overwhelming, since we believe that there is a shift in attitude towards maternity care which can only be met by maintaining such units as a realistically available option. (paragraph 312)

We recommend that a hospital delivery unit should: afford privacy; look like a normal room rather than be reminiscent of an operating theatre; enable refreshments to be available for the woman and her partner or companions; ensure the feasibility of the woman being "in control" of her labor. All case notes should contain the woman's wishes for her labor; enable the woman to take up those positions in which she is most comfortable; enable the woman to have with her a midwife she has been able to form a relationship with during her pregnancy. (paragraph 328)

We recommend that the Department of Health vigorously pursue the establishment of best practice models of team midwifery care. (paragraph 339)

We recommend that the Department of Health take steps to impress upon all GP (general practitioners) their duty to facilitate the wishes of women, especially in their choice of place of birth and their right to midwifery only care. (paragraph 349)

We recommend that it be a duty placed upon all GP practices to have in place arrangements for women to have home confinement with GP cover or midwife-only cover if they so desire. (paragraph 349)

We recommend that, in the area of postnatal care above all others, attention must be turned away from a medical model of care to a woman-centered approach which takes full account of their social needs. (paragraph 383)

We recommend that Ministers, when considering the resources of the maternity services, give urgent attention to filling gaps in our knowledge of the true costs of the current pattern pattern of delivery of maternity care. (paragraph 420)

We recommend that the funding for the MRC (Medical Research Council) should be sufficient to support a full research program relevant to the maternity services. (paragraph 425)

We recommend that all maternity services be obliged to publish figures relating to operative intervention and stillbirth and neonatal mortality rates over the previous five years, and to make these figures available to women booking with that service. (paragraph 435)

We recommend as a matter of priority, that the Department of Health funds the establishment of extensive pilot schemes in the establishment of midwife-managed maternity units within or adjacent to acute hospitals. We further recommend funding of an extensive program of establishing small team midwifery care using community-based clinics. (paragraph 440)



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Florida Celebrates Passage of Midwifery Act!

By Jackie Casanova

This year, supporters of direct entry midwifery in Florida have a major reason for celebration with the passage of the Midwifery Practice Act. Florida is now in a position to share its experience and to offer hope to midwifery supporters in other states where there is no direct entry training and licensure.

On March 12, Florida legislators passed a law which sets guidelines for the training and licensing of midwives. This law even provides Medicaid reimbursement to licensed midwives for prenatal and postpartum care and says that any hospital receiving public funds must also provide clinical experience to midwifery students.

There was a strong grassroots movement that brought the needs of the family the legislative attention it deserved. In 1990, the Florida Senate Health Care Committee mandated a study on the issue of midwifery in response to consumer demands for safe birth options with midwives in settings other than hospitals. Other public concerns were lack of access to care of pregnant mothers, de-

creasing numbers of practitioners providing maternity care and the high rate of cesarean sections in the state.

The study concluded that it was safe and cost effective to train and license midwives to meet these needs and also recommended that Medicaid pay for care provided by a licensed midwife.

Many people who have been waiting in the wings to open schools or to enter them are now working to get the ball rolling — again! Other states pushing for similar legislation should be aware of what supporters of midwifery in Florida learned the hard way: sunset review can mean losing everything. This isn't the first time Florida has been in a position to regulate direct entry midwifery.

In 1982, Florida took a progressive step by passing the Midwifery Practice Act (F.S. 467), which allowed midwives to become licensed after a three year program of academic and clinical training. Two Florida schools opened their doors in January of 1984. However, on the last day of the 1984 legislative session, when the law was up for sunset review, it was

politically sabotaged by a physician legislator. He added an amendment which restricted applicants for state licensure to only those who were currently enrolled in the schools.

It has now been ten years since the original legislation came to pass. What we have learned in Florida is that if you aren't politically savvy, the rug can be pulled out from under you. An article in *The Birth Gazette* (Volume 6, Number 3) on Sharon Wells gives a detailed history of the women and work that created the first direct entry schools in Florida. Now, ten years later, we are about to re-create the wheel — hopefully for the last time. When the current legislation comes up for review in the year 2002, it is probable that Florida will be leading the nation by example in providing a full range of safe, affordable birthing options to our families.

Jackie Casanova has been a supporter of licensed midwifery since attending her first birth at a birth center eight years ago. At the time, she was in her final semester of Public Relations at the University of Florida's College of Journalism and published a feature story and photos on the birth. Since then she has published many stories related to midwifery, which she plans to compile in a public relations handbook for achieving direct entry midwifery state by state.

Becoming a Midwife in the Nineties

Shortages in maternity care exist in rural counties and inner cities alike. And midwives are the obvious, and acknowledged, solution to the crisis.

Rahima Baldwin

The acceptance of midwives and the demand for midwifery care are increasing at such a dramatic pace that the nineties promises to be an especially exciting time for aspiring and practicing midwives. Just as no one could have foreseen how rapidly the Berlin Wall would come down or the Communist bloc would disintegrate, so five years ago, no one could have predicted how different the attitude toward midwifery would be today.

Suddenly, in the past two years, the United States has witnessed a growing recognition that more trained midwives are needed to meet the burgeoning need for cost-effective maternity care. Lowering the infant mortality rate has finally become a national priority; at the same time, however, malpractice insurance rates have created a doctor shortage in obstetrics, and skyrocketing fees have placed maternity care beyond the reach of families without insurance. Shortages in maternity care exist in rural counties and inner cities alike. And midwives are the obvious, and acknowledged, solution to the crisis.

To meet the challenge, midwifery

groups such as the American College of Nurse-Midwives (ACNM) and the Midwives' Alliance of North America (MANA) have undergone internal changes and have begun communicating in a series of meetings sponsored by the Carnegie Foundation. Here, certified nurse-midwives (CNMs), direct-entry midwives, and consumers have been exploring together the need for—and the implications of—training thousands of new midwives.

What Is a Midwife?

Among the most promising developments emerging from the Carnegie-sponsored meetings is a new consensus on what it means to be a midwife. In this regard, two historic shifts in attitude have occurred. One resulted in a mutual agreement that a degree in nursing is not necessarily a prerequisite for being a good midwife. The second led to an agreement that "core competencies" are more important than "pathways of learning." This means that a woman may be considered a midwife by a broad segment of society (legislatures and insurance companies, for

example if she can demonstrate certain knowledge, skills, and abilities regardless of where she learned them—whether in school or through apprenticeship with another midwife.

It was a triumphant moment for midwifery when, on June 9, 1991, the Interorganizational Work-Group on Midwifery issued a statement signed by all the delegates—six chosen by the ACNM, six by MANA, and six consumer advocates—acknowl-

edging that a "professional midwife" could be prepared for practice "through a variety of educational routes that have been approved by the American College of Nurse-Midwives (ACNM) or the Midwives' Alliance of North America (MANA)" and that she "practices in accord with MANA or ACNM standards."

A third historic change occurred at a meeting held in September 1991. Here, the Interorganizational Work-Group accepted a statement on "The

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Grand Midwife," recommending that any midwife in the United States who practiced under local regulation prior to 1965 be allowed to return to practice if she so desires, and that all midwifery training programs utilize the expertise and knowledge of these Grand Midwives. No longer written off as "granny midwives," these direct-entry practitioners are finally approaching the recognition they deserve from the nation's major midwifery organizations.

What about women who choose not to take the registry exams—specifically, those who prefer to be granted the title "midwife" by the community of women whom they serve, or those who think of themselves as "traditional midwives" and have no desire to work within the confines of the current healthcare system? Many participants at MANA's October 1991 conference expressed the conviction that these women's rights to be called a midwife and to practice the art of midwifery need to be safeguarded while their sister midwives are moving toward greater acceptance as "professional midwives."

Participants emphasized, moreover, that MANA is an organization for all midwives, whether they call

themselves certified nurse-midwives, direct-entry midwives, community midwives, Christian midwives, shamanic midwives, or anything else. It is the right of birthing women to choose who will serve them, with disclosure statements forming the basis of informed choice.

Educational Developments

In response to the national demand for more trained midwives, numerous organizations are both creating new educational options and expanding on those already in existence. The ACNM has added a community-based training program for nurses who want to become CNMs. The Community-based Nurse-Midwifery Education Program (CNEP), which allows nurses to do their midwifery training through a two-year program while remaining in their own communities, hopes to train 10,000 nurse-midwives by the year 2000. This past year alone, the program has enrolled as many students as the other 27 nurse-midwifery training programs combined. The key is that nurses may do most of their coursework at home through "modules" and their clinical work with a "preceptor"—a local nurse-midwife prac-

In response to the national demand for more trained midwives, numerous organizations are both creating new educational options and expanding on those already in existence.

ticing in a hospital or birth center—thus enabling many women with families or job obligations to complete their training and receive certification.

The ACNM is also exploring accreditation and certification standards for direct-entry professional midwifery programs, and investigating ways to help foreign-trained midwives become certified to practice in the United States. In addition, the organization voted to add a module on homebirth to each nurse-midwifery training program.

MANA has been wrestling with educational issues as well. It has stood firmly for the validity of the apprenticeship model, and has been probing the question of which core competencies are truly central to midwifery. In addition, the National Registry Board, which MANA mandated in 1989, has developed an exam to test entry-level midwifery knowledge. The exam is being given throughout the country, and any midwife who passes it may call herself a "North American Registry Board Licensed Midwife."

Direct-entry training programs, which have been in existence for a number of years, are actively seeking recognition through junior colleges, college accreditation programs, and the ACNM. The Seattle Midwifery School, for example, having trained direct-entry midwives for many years, was approved by the ACNM Division of Accreditation to offer a nurse-midwifery pathway in affiliation with a local university. And a program developed by the New Mexico Midwives Association and the Northern New Mexico Midwifery Center has been recognized by the New Mexico Commission of Higher Education as a degree-grant-

ing institution now known as the National College of Midwifery. The college offers associate, bachelor's, master's, and doctorate degrees in midwifery. In addition, a Midwifery Education Accreditation Council has been formed, with the goal of establishing an accreditation body for direct-entry midwifery educational programs so that they can receive national recognition just as nursing programs now do.

Each state has its own regulations regarding the practice of midwifery. As a result, the nation remains a checkerboard of opportunity and repression. On the positive side, licensed direct-entry midwives in New Mexico and Washington can now receive Medicaid reimbursement for their services. Furthermore, legislation decriminalizing midwifery and establishing various guidelines for its practice is pending in many states.

On the downside, Illinois has declared pregnancy a "condition," implying that unlicensed direct-entry midwives who "treat it" are committing a criminal offense. Cases against midwives are pending in Georgia, California, and other states. Moreover, direct-entry midwives in most states are not eligible for reimbursement by insurance companies, which adds further constraints to the challenge of earning a living as a direct-entry midwife.

Amid today's rapidly changing conditions, it is impossible to predict what the future will bring. One thing is for sure: the country needs midwives. Clearly, midwifery has "grown up" over the past 20 years, as evidenced in both the increasing professionalism of direct-entry midwives and the acceptance of certified nurse-midwives into hospitals, where they are getting excellent results, even in high-risk populations. Midwives are becoming more assertive about sharing their knowledge, and more politically savvy. In addition, midwives are being called upon to serve as primary healthcare providers for pregnant women.

While the options for midwifery training and practice are likely to increase dramatically over the next five years, the path toward full acceptance of midwifery may involve setbacks—simply because old ideas, institutions, and special-interest groups are notoriously resistant to change. Even so, the decade of the nineties promises to be an exciting time to be working toward better births for all women.

For More Information

Midwifery Organizations
American College of Nurse-Midwives
1522 K Street NW, Suite 1000

Community-based Nurse-Midwifery Education Program
PO Box 528
Hyden, KY 41749

Midwives' Alliance of North America
PO Box 1121
Bristol, VA 24203

Seattle Midwifery School
2524 16th Avenue South
Seattle, WA 98144
206-322-8834

Additional Resources

For information on the National Registry Exam, write to North American Registry of Midwives, PO Box 13, Linn, WV 26364.

For information on the National College of Midwifery, the Midwifery Education Accreditation Council, or the National Coalition of Midwifery Educators, contact Elizabeth Gilmore, National College of Midwifery, Drawer 555, Taos, NM 87571.

For a discussion of the legislative regulations in each state, along with useful addresses, request a copy of *Midwifery and the Law* (\$19.95) from *Mothering*, PO Box 1690, Santa Fe, NM 87504.

For a list of direct-entry midwifery training programs, state midwifery organizations, and midwifery journals, request a copy of the seven-page pamphlet *Becoming a Midwife* (\$1 in cash) from Informed Homebirth, PO Box 3675, Ann Arbor, MI 48106.

For more information on midwifery, see the following articles in past issues of *Mothering*: "Mothering Interviews the Taos Midwives," no. 20; "Midwives United: The Midwives Alliance of North America," no. 24; "Confessions of a Restrained Midwife," no. 27; "Midwife," no. 33; and "The History of Midwifery in the United States," no. 34.

Rahima Baldwin is a practicing midwife and codirector of the Garden of Life Birth Center. She is founder of Informed Homebirth, an author, and mother of Seth (13), Faith (16), and Jasmine (12). Rahima lives with her husband, Agay Dancy, and their children in Ann Arbor, Michigan.

Health Resources and Access Task Force

October 23, 1992

Submitted by: Gordon A. Anderson, CEBS
Manager, Benefits and Annuitant Affairs
Alyeska Pipeline Service Company
Anchorage, Alaska

Senator Jim Duncan, Representative Johnny Ellis, and task force members. I am Gordon Anderson, Manager, Benefits and Annuitant Affairs for Alyeska Pipeline Service Company. I am pleased to be able to speak to you today.

Alyeska is a company with our entire operations located in this great state. We have approximately 1,300 employees working and living in remote and urban areas, participating in and supporting each community. Our employees and their families use the health care system available in Alaska and are supported by benefits plans which the company provides. At present, we anticipate 1992 claim payments of \$4.2 million.

As you are aware, we have been asked to comment upon several items dealing with problems created by the health care system, recommendations we might have for reforming the system and lastly how the Task Force's guiding principles support or conflict with our view of health care reform.

First let me comment upon the current system and how it impacts our organization.

Health care costs have skyrocketed over the past 20 years, much faster than the general rate of inflation. We have all contributed to some degree in this cost escalation through fee-for-service plans and state mandated coverage's. The current system is a well meaning process for providing health care coverage which has gotten out of control. Though state mandated coverages in Alaska are minimal, the costs of health care in this state are higher than the national average as acknowledged by the interim report of the Task Force. This has an impact on public and private employers as well as on employees.

Alyeska has always shared the cost of coverage with employees. This means that increasing prices affect the company's and employees' finances. Our premium for employee and family coverage was \$98.00 in 1979 and is \$448.36 today, approximately five times the 1979 rate. Because we are "insured" and have the means to pay, we are affected in the cost transfer mechanism whereby hospitals and other providers reallocate the cost of uninsured care

to patients with coverage. Health care costs represent a larger portion of our employee overall expenses than previously and are of great concern to our employees. Alyeska has attempted to react to changing events and we have since 1989 had a program of managed care . This has stemmed temporarily the rate of coverage increases.

Second, I will briefly outline the recommendations I would propose for health care reform. These are similar to many proposals which have already been discussed. It is the implementation of these items which require tough political and ethical decisions by all who are involved in the management or delivery of health care.

Overall a combination of governmental programs and private sector programs should be developed to coordinate the allocation of resources to health care. This is more suitable to the culture of this country than purely governmental programs.

Under this system the uninsured and underinsured could be covered by a modified Medicare/Medicaid system of basic and catastrophic care. The uninsured suffer virtually no access and the underinsured suffer exposure to catastrophic loss. The conflicting and confusing regulations from multiple federal and state agencies should be simplified to decrease confusion and paperwork. Individuals should be able to buy into a health care program whether it be government or private. However, this solution for the governmental portion will not be easy in Alaska given the projected state deficit predicted by a recent paper issued by the Institute of Social and Economic Research.

- Market based reforms are preferable to universally mandated or administered government coverage. Governmental systems tend to bureaucratize the process, generate excess controls and stifle innovation. The market system is not without risk but it does encourage innovation and allows employers who cover the majority of insured persons, the flexibility of tailoring plans to fit the financial strength of each company.
- Small employers should be allowed access to controlled pools wherein their employee base combines with other small employers to form a larger premium base over which claim risk is spread and coverage can be obtained at reasonable cost.

Health Resources and Access Task Force
Page 3

- Legislation inhibiting managed care should be reasonable, uninfluenced by special interest groups and limited in order to allow non provider interaction with the hospital/physician providers.
- Facilitate the development of community coalitions of health care consumers for the analysis of health care costs, the utilization of resources including sophisticated technology within each community and the dissemination of pricing information to the consumer. The utilization of technology resources may involve the creation of satellite facilities for immediate care which refer patients to an acute care facility .
- Facilitate "Outcomes" research to determine the relationship between the level of health care or treatment and the quality of the result.
- Revise the medical malpractice system via Tort reform. Alaska has recently taken some steps in this direction but more needs to be done.
- Integrate the worker's compensation provisions of care into the overall system of non work related health care.

Lastly, in answer to the question, "do the guiding principles of the Task Force support or conflict with our recommendations for change", I offer these comments.

Access	-	Individuals should have access to basic health care for early detection and treatment. The private sector may differ on the level of primary care and coverage for catastrophic and terminal illness.
Financing	-	The desire to have individuals wherein possible share in the cost of coverage is consistent with our philosophy practiced with our own employees. The private sector may differ on how the state should collect revenues to finance governmental coverage's.
Cost Containment General	-	We find no disagreement with the committee's basic approach. Simplicity where possible will reduce cost and improve the application of care.

NFIB Alaska

National Federation of
Independent Business

PRESENTATION

TO

HEALTH RESOURCES AND ACCESS TASK FORCE

AUGUST 25, 1992

PROBLEMS AND SUGGESTIONS FOR REFORM
OF THE HEALTH CARE SYSTEM

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The Guardian of
Small Business

Chairman, members of the Committee, my name is Resa Jerrel, and I am the State Director for the National Federation of Independent Business - NFIB/Alaska. On behalf of our 4,730 small business owners, I appreciate the opportunity to share with you some of the problems small business owners face in attempting to obtain and retain health insurance coverage and to offer some solutions.

Since the early 1980's NFIB Foundation surveys have revealed that small business owners consider the cost and availability of health insurance a serious problem. Surveys were conducted in 1990 and 1992 and again, business owners characterized health insurance as their number one problem.

Further surveys also have found that small business owners want to offer health insurance as a fringe benefit out of both a sense of family obligation and competitive necessity.

PROBLEMS

* Cost/Profitability

The ability of the small business owner to provide insurance is influenced by the high costs of premiums and profitability of the business. I have given to staff a very interesting research paper that shows there is a direct tie between business profitability and a business providing employee health insurance. Exhibit 1 shows the data creates an almost stair-like pattern. The graph shows that as the income of a business rises the propensity for small employers to provide employee health insurance rises as well.

For many small business the skyrocketing annual premium increases, small profit margins and restricted cash flow all contribute to the increasing difficulty small business owners have in purchasing health insurance. If the cost of purchasing or continuing to provide health insurance continues increasing, small business owners will be forced to increase employee contributions, cut benefits, or in some cases drop coverage altogether.

Small business are most severely impacted by:

- * Adverse selection
- * Demographics of the work force
- * Higher employee turnover resulting in unpredictable participation rates
- * Lack of expertise and clout in purchasing plans

By virtue of their size, small businesses have very little access to cost containment mechanisms available to large firms such as

self-insurance. Being unable to obtain the benefits of self-insurance they must:

- * Comply with expensive state mandates
- * Pay state premium taxes
- * Shoulder a larger portion of the carrier's administrative expenses

Under the present tax structure only 25 percent of health insurance premiums are deductible. I know you can not do anything about the Federal tax structure. I would encourage you to recommend to the Legislature that they pass a Resolution asking Congress to raise the deduction from 25 to 100 percent. Raising the tax deduction will encourage many uninsured self-employed to purchase health insurance not only for themselves, but for their many employees.

SMALL BUSINESS MARKET REFORM

Last week I gave to staff detailed suggestions from National NFIB and the Healthcare Equity Action League. Briefly those documents state that effective small market health insurance reform should include:

- * Lower the cost of health care coverage by eliminating state health insurance benefit mandates and allowing the insurance industry to develop affordable basic benefit packages.

- * Permitting small business to form health insurance purchasing groups.

- * Restricting the preexisting condition limitation.
- * Instituting the use of rating bands.
- * Guaranteeing the issuance of health insurance policies.
- * Guaranteeing renewal of health Insurance policies.
- * Establishing risk pools.
- * Promoting managed care and utilization review.
- * Educating health care consumers.
- * Reforming medical malpractice laws.
- * Simplifying health insurance administrative costs.

Thank you for the opportunity to outline some of the

problems small businesses face and offer some solutions.
NFIB/Alaska has supported and will continue to support any
legislation that will help make voluntary, privately administered
health insurance more available and affordable for small
businesses.

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NFIB VIEW ON SMALL MARKET REFORM

Since the early 1980's small business owners have been saying that the cost and availability of health insurance are serious problems. Today, health insurance ranks twice as high as the second most important concern of small business, which is federal taxation of business income. The most critical obstacle they face in obtaining health insurance is cost or affordability.

Small business owners demand reform of a health insurance system that is broken and out of control. They want a return to free market principles to ensure the availability, affordability, renewability and portability of health insurance for themselves and their employees. The changes needed to bring this about are part of a proposed package referred to as small market health insurance reform. Some elements of this package will increase cost, others will reduce them. Taken as a whole it will make health insurance more affordable for small business.

NFIB believes that effective small market health insurance reform should include:

* Preempting state health insurance benefit mandates and allowing the insurance industry to develop affordable basic benefit packages.

Currently all states mandate that certain types of treatments are covered by insurance policies. Combined nationwide, there are over 900 state mandates. These mandates cumulatively can raise the cost of health insurance by more than 30 percent. According to the National Center for Policy Analysis, as many as 8.5 million Americans have been priced out of the health insurance market by costly mandates. All of these are in smaller businesses that cannot afford to self-insure.

The key to finding affordable insurance is creating competitive low-cost basic policies that can be marketed nationally so that newer or less profitable firms can afford to purchase a minimum level of coverage for their employees.

Problems Addressed: Accessibility and affordability.

* Permitting small business to form health insurance purchasing groups.

Allowing small firms to band together to self-insure

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The Guardian of
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has proven to be a very effective way of providing affordable and manageable health care coverage. Purchasing groups reduce the administrative and medical costs of providing health insurance through economies of scale and risk sharing. Purchasing groups will bring the cost of coverage to a level that more Main Street firms can afford.

Problems Addressed: Accessibility and affordability.

* Enacting legislation to permit self-employed business owners (sole proprietors, partnerships or S-corporations) to deduct the full cost of the purchase of health insurance (100% deductibility).

The self-employed business owner should have the same tax deduction for health insurance as do big businesses. Increasing the deduction for health insurance premiums for the self-employed from 25 to 100 percent will level this playing field and enable many of the 4.8 million uninsured self-employed to purchase health insurance not only for themselves, but for their nearly five million employees.

Problems Addressed: Affordability

* Restricting the Preexisting Condition Limitation.

Pre-existing condition clauses typically exclude certain health conditions from being covered and reimbursed through insurance from a period of six months to as long as two years. Pre-existing condition restrictions should not be used if a person has previously been insured. This will enable employees with medical conditions to change jobs without fear of losing their health insurance.

Problems Addressed: Accessibility and portability

* Instituting Use of Rating Bands

Current insurance industry rating practices have resulted in serious price fluctuations for small businesses. Carefully crafted rating bands will enable small firms to predict future premium costs. These bands should allow for a 20 percent variance between blocks of business and not more than 1.5 times the lowest premium for the first three years within the business block.

Problems Addressed: Affordability and stability

* Guaranteeing the Issuance of Health Insurance Policies

Insurers often seek to insure the healthiest groups of individuals and drop coverage for those requesting reimbursement for high medical costs. Adverse selection

must be addressed by guaranteeing small business access to affordable health insurance. The insurance industry should be required to issue a policy to any business that wants to obtain coverage.

Problems Addressed: Accessibility

* Guaranteeing Renewal of Health Insurance Policies

Insurance companies should not be permitted to cancel a policy unless the policy holder is grossly negligent in paying premiums or is engaged in fraudulent activities. Limiting the variation in premium increases and prohibiting increased rates or cancellation based on health status will significantly stabilize the health insurance market for small firms.

Problems Addressed: Accessibility and affordability

* Establishing Risk Pools

High risk individuals, while making up a small percent of the population, can drive up health insurance costs for everyone. The cost of providing coverage for this group must be spread through risk pooling.

Problems Addressed: Accessibility, affordability and stability

* Promoting Managed Care and Utilization Review

The use of coordinated care systems can lead to lower costs and better quality care. Managed care and utilization review foster competition which are clear means by which to control costs. State anti-managed care provisions must be preempted.

Problems Addressed: Cost containment, quality of care, and affordability

* Educating Healthcare Consumers

Consumer information and education would instill personal accountability in the system and reduce deceptive or aggressive rating practices and defensive medicine. Beneficiaries should be given information on provider fees, treatment protocols and quality of care. Patients must be encouraged to question providers' fees and practices and should be able to select and refuse treatment. Cost sharing through higher deductibles and copayments will force a patient to assess the cost and medical necessity of each visit.

Problems Addressed: Cost containment, quality of care, and affordability

* Reforming Medical Malpractice Laws

Effective medical malpractice tort reform, which includes the elimination of the collateral source rule, uniform statute of limitations, caps on damages, as well as the use of practice guidelines as a defense would reduce not only malpractice premiums and doctors' fees but would curb the expensive practice of defensive medicine.

Problems Addressed: Affordability, cost containment, and accessibility

* Simplifying Health Insurance Administrative Costs

Paperwork reduction must be a part of any healthcare reform. Developing uniform claims for both private and public payers and establishing electronic data interchange (i.e. electronic billing, enrollment, and purchasing) will significantly reduce the cost of administering health insurance.

Problems Addressed: Affordability

* Conducting Outcomes Research

Research must be conducted on the effectiveness of new technologies and drugs, the results of which must be shared with patients to allow them to knowingly participate in their medical treatment.

Problems Addressed: Affordability, cost containment, and quality of care

* Summation

The health insurance market cannot remain dysfunctional. Implementation of these reforms will help bring predictability and competition to the market which will significantly drive down the cost of providing health insurance and thereby give access to insurance for many of the uninsured.

The National Federation of Independent Business is the nation's largest small business advocacy organization, representing more than 550,000 small and independent business owners nation-wide.

HEALTHCARE EQUITY ACTION LEAGUE

EMPLOYERS UNITED FOR REFORM

The Healthcare Equity Action League: Its Recommendations and Membership

The Healthcare Equity Action League (HEAL) seeks to reform the nation's health care system so Americans can obtain health insurance, afford to pay for it and not lose it when they need it most. HEAL looks to accomplish its goals by building on the best of the current health care system and making those aspects accessible and affordable to people currently left out. It does not favor scrapping the current system for unworkable, costly government-imposed controls.

HEAL is a large and diverse group. More than 400 companies and organizations representing 1 million employers and 35 million employees are members of HEAL. They are small and large businesses, corporations, associations, health care providers and insurers. They are united around a set of proposals for which there is already a broad consensus — proposals that can and should be enacted now.

The positive steps HEAL is proposing would reform the health care system while maintaining its basic structure. These practical steps would help make the best of the private health care system available and affordable to more Americans and keep it available to those who are in danger of becoming uninsured.

In addition, HEAL's proposals have broad, bipartisan political support and could be enacted now to bring quick relief to the problem of health care accessibility and cost. They include the following:

- Significantly lower the cost of health care coverage by eliminating more than 1,000 state rules mandating many specific and costly provisions. These provisions, which in some cases require businesses to pay for hair transplants, acupuncture and in vitro fertilization, inflate the cost of coverage.
- Pre-empt state laws that restrict managed care health plans. This would allow the insurer to monitor costs, treatments and practices to assure better care and further reduce premium costs.
- Allow small businesses to deduct 100 percent of their health insurance premiums. Currently, incorporated businesses may deduct 100 percent, but many small business owners and the self-employed are only allowed a 25 percent deduction. By changing the tax code to allow full deductibility for all businesses, smaller companies would have an incentive to obtain or expand health insurance.

- Reform insurance underwriting to prohibit the denial of claims for pre-existing conditions once an individual has been covered or when an employee changes jobs or files claims.

This proposal also would provide for "portable" coverage that would enable employees to maintain eligibility, even when they change jobs. This would enable working Americans to make career decisions based on factors other than the availability of health care benefits.

- Reform medical malpractice laws to reduce the use of costly and unnecessary tests and treatments ordered to avert malpractice claims.
- Empower consumers and encourage personal responsibility. Patients need timely, reliable information on fees, physician practices and protocols as well as treatments and their outcomes in order to be effective participants in their own health care — and to stimulate a market-driven health care system. Wellness education also is needed to help contain future health care costs.
- Bring health care costs under control by pursuing innovative purchasing and managed care techniques. Health care providers must be part of the solution to escalating health care costs.

HEAL was formed to combat the idea that the nation's health care problems can only be solved by totally restructuring the system. HEAL rejects national health insurance and so-called "play or pay" mandated coverage programs as proposed solutions.

For example, under the "play or pay" option, all employers would be forced to provide health insurance to employees or pay a tax. HEAL contends that the tax increase needed to finance either of these plans would place unreasonable financial burdens on taxpayers and small business, possibly costing employees their jobs or driving small firms out of business.

In addition, HEAL believes the resulting system would not improve the quality of health care. Instead, it's quite likely a national health insurance program administered by a federal bureaucracy would diminish the quality of care by having the government decide how much health care patients can receive and when they can receive it.

Instead, HEAL proposes a better way — one that is attainable, preserves jobs, delivers quality care and provides life-long security of coverage at a reasonable cost.

The NFIB Foundation

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Independent Business

TAXES BASED ON THE INABILITY TO PAY: ANOTHER EFFECT OF "PLAY OR PAY"

Mandatory employer provision of employee health insurance is a tax levied on those least able to pay. Whether the tax is direct ("pay" option) or indirect ("play" option) depends on an employer's choice. But in either case, the effect is the same -- a large, new tax liability that must be paid principally by those who can least afford to do so. That is true whether one assumes the new tax burden falls on employees through lower wages and fewer employment opportunities, or on employers who will forego earnings to pay it. Unfortunately, the negative redistribution effects of "play or pay" have gone largely unnoticed in the current debate, mocking the re-distribution concerns lying at the political heart of the vigorous debate over the so-called middle income tax cut and various other issues.

It is well-known that working Americans without employer sponsored health insurance usually fall near the bottom of the income scale. If one believes that these low income Americans would effectively pay the full cost of their health insurance under "play or pay," as do most economists, then the proposal is by definition regressive. The reason is that the proposal for all intents and purposes levys a substantial tax increase (\$2,000 - \$3,000 a year) almost exclusively on the working poor and near-poor. However, if one believes that employers will absorb the increase by reducing their income, as do many social activists, then regressivity may not be an issue.

The following paragraphs demonstrate that one's belief about who ultimately pays the cost of a "play or pay" health insurance program is irrelevant to the regressivity discussion. They show that even if employers do absorb program costs, or even a fraction of their costs, "play or pay" remains a highly regressive approach to resolution of the health insurance coverage problem.

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Business Profitability and Employee Health Insurance

A direct tie exists between business profitability and the provision of employee health insurance. Owners who take more out of their businesses in the form of salary, earnings, draw, etc., are more likely to provide employee health insurance, while those who take out less income are less likely to do so. In fact, a 1989 survey conducted by The NFIB Foundation found that over 90 percent of those taking more than \$70,000 out of the business in the prior year provided employee health insurance.¹ Just a third of those who took \$20,000 or less out of the business did so.

Exhibit 1 presents the direct relationship between income from the business and provision of employee health insurance. The data create an almost stair-like pattern. As business income rises in \$10,000 increments, the propensity for small employers to provide employee health insurance rises as well. In other words, where businesses are relatively profitable, small business owners tend to provide health insurance as an employee benefit. Where businesses are marginally profitable, small business owners tend not to.

"Play or pay" demands that all employers not currently providing employee health insurance make a significant financial contribution to the health care costs of their employees. But who is not now providing health insurance? Those drawing comparatively little from the business are the ones usually not providing the benefit. Therefore, if one believes that employers will bear the cost of a "play or pay" program, the burden absorbed by employers primarily will fall on the group least able to afford it. Under these circumstances, the financing system of "play or pay" is regressive.

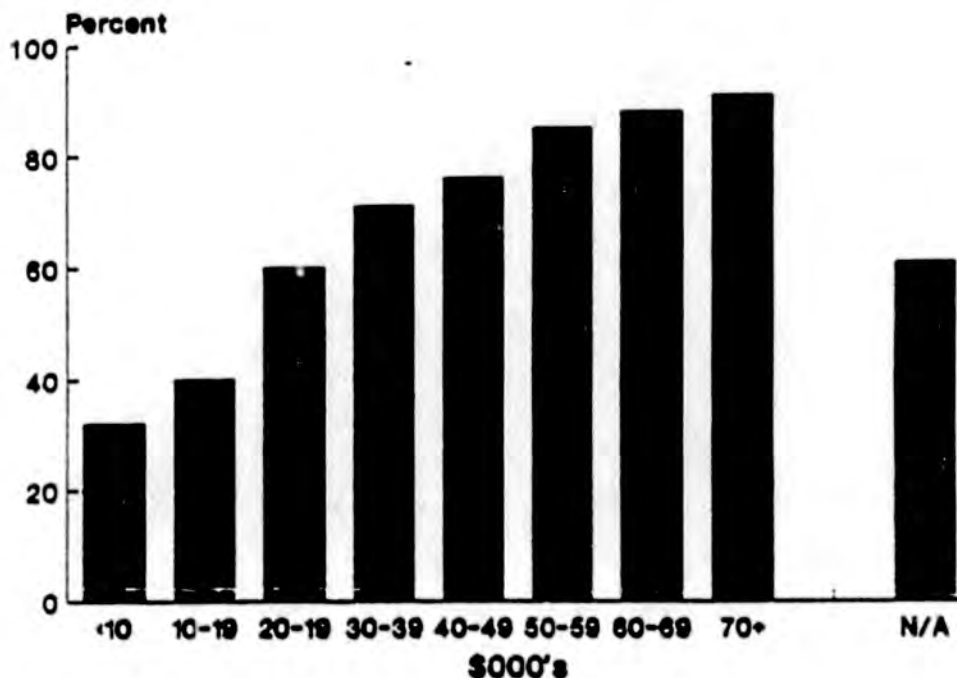
Critical observers might question the validity of the self-reported income figures used to make the association found on Exhibit 1. They might also wonder about the bar on Exhibit 1 labeled "N/A," noting that only 61 percent of the "N/A" group provided employee health insurance. Those observers could reasonably ask how large this group of respondents was and where did its members fall on the "take-out" scale. The short answers to these two questions are that a check within the survey indicates that the income data are reliable and that the "N/A" group reflected the distribution of the income data across the reporting population. The following section addresses those data reliability questions. Readers not wishing to review these data nuances should skip the section and proceed to the section on owner income and business size.

¹Hall, Charles P., and Kudor, John M., *Small Business and Health Care: Results of a Survey*, The NFIB Foundation: Washington, D.C., 1990.

Check on the Reliability of Income Data

The income question ("About how much did you take out [salary, draw, earnings, etc.] of your business last year?") appeared at the very end of the survey. It provided respondents possible answers in \$10,000 increments up to \$70,000. In addition, the query offered a "Prefer Not To Answer" option. These broad ranges were designed to provide respondents with a degree of comfort in reporting a private matter that narrower ranges or actual dollars figures would not have. As it was, 19 percent chose the "Prefer Not To Answer" option and five percent left the question blank.

Exhibit 1
SMALL BUSINESS OWNER "TAKE-OUT" AND THE
PROPENSITY TO PROVIDE EMPLOYEE HEALTH INSURANCE

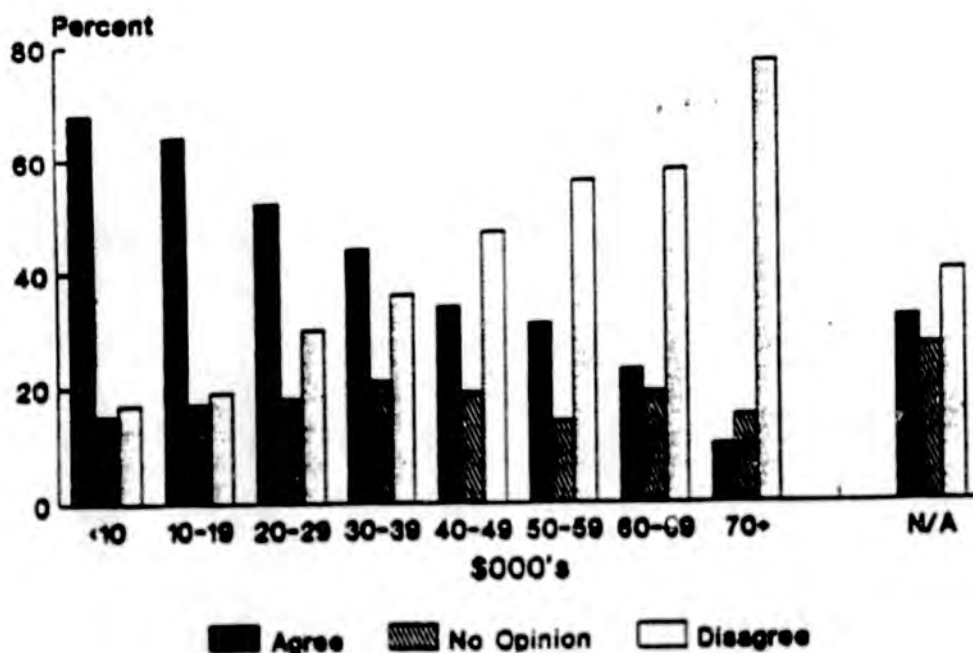


A check on the income inquiry was included earlier in the survey. It was designed to uncover similar, though not identical, data, and to provide a comparative point for the income question. The check query posed the following proposition, "I could earn more working for someone else than in this business." Respondents could answer on a five point scale ranging from "Strongly Agree" to "Strongly Disagree." Factors such as personal opportunity costs, newness of the business, etc., would affect agreement or disagreement with the proposition. However, financial success of the business should be the most prominent factor in the assessment.

Note the close relationship exhibited on Exhibit 2 between the belief that an owner could earn more elsewhere and low take-out, i.e., earnings. More than 2/3's of those reporting take-out of \$10,000 or less agreed that they could earn more elsewhere. At the other end of the scale, over 3/4's of those reporting take-out of \$70,000 or more did not believe they could earn more elsewhere. The chart's bars are, in fact, almost symmetrically positioned. As income rises, the percent disagreeing rises and the percent agreeing falls. As income falls, the opposite occurs. The correlation between the answers to both questions is very high. Moreover, the point where more begin to disagree with the proposition than agree with it comes at \$40,000, just about the point of median family income for a family headed by someone with above average education and in their 40's. As a result, the data are mutually reinforcing and suggest reasonable reporting accuracy.

Twenty-four (24) percent of survey respondents failed to answer the "take-out," i.e., income, question. This group conceivably could be loaded with owners doing very well, yet providing employee health insurance infrequently. On the other hand, it could be loaded with those who are not doing well, yet offering insurance far in excess of their means. One way to address the issue is to cross-reference (cross-tab) the check question with the 24 percent who didn't answer the income question. If a comparatively large percentage of the non-respondents disagreed with the notion that

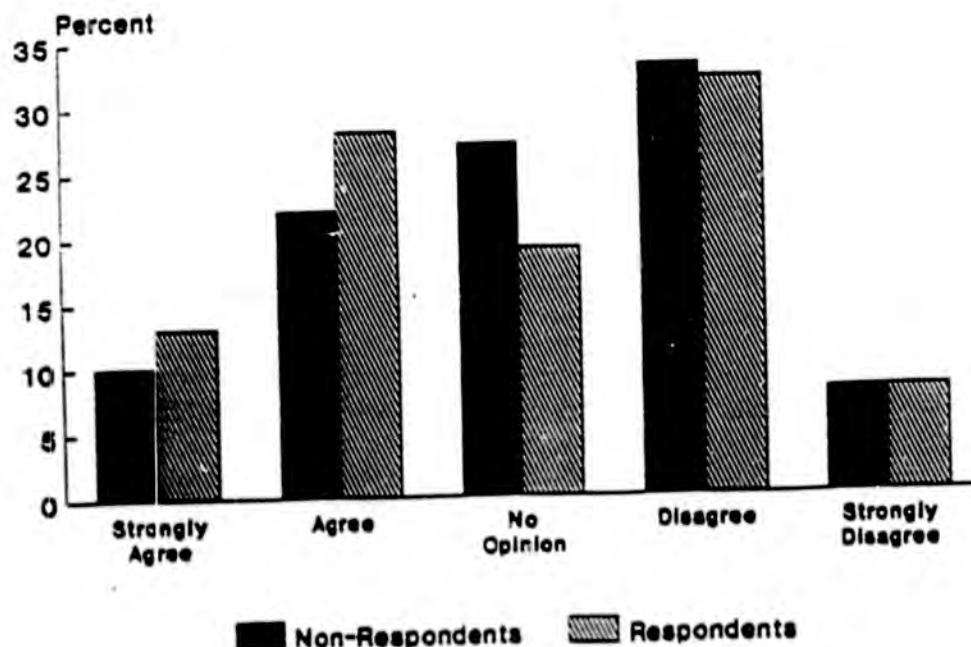
Exhibit 2
 AGREEMENT WITH THE PROPOSITION THAT "I COULD EARN
 MORE WORKING FOR SOMEONE ELSE THAN IN THIS
 BUSINESS BY REPORTED 1989 BUSINESS TAKE-OUT



they could earn more elsewhere, then we might conclude the group is heavily (and disproportionately) populated by those doing well. The opposite would also be true.

Exhibit 3 demonstrates remarkably little difference as measured by the check question between those who answered the income question and those who did not. The two populations are the same for all intents and purposes. The small difference that did exist suggested that non-respondents do somewhat better than respondents. At the same time, non-respondents did not offer insurance as often as did respondents (63 percent versus 60 percent). The cumulative effect is to modestly reduce the slope of the increases in insurance provision as take-out rises. In other words, small business owners with relatively low take-outs are somewhat more likely to provide employee health insurance than the data on Exhibit 1 suggest. The opposite is also true. Yet, the fundamental relationship is unchanged. Those doing comparatively well exhibit a high propensity to provide employee health insurance, while those with doing comparatively poorly exhibit a high propensity to provide none.

Exhibit 3
RESPONDENT AND NON-RESPONDENT TO THE INCOME SURVEY QUESTION
BY AGREEMENT/DISAGREEMENT WITH THE PROPOSITION THAT THEY
COULD EARN MORE WORKING ELSEWHERE



Owner Income and Business Size

W. David Helms, President of the Alpha Foundation, a Washington-based health research and consulting organization, observed that the health insurance coverage "problem is with the very small employer, or the micro-employer," i.e., businesses with less than 10 employees.² He noted that half of the employed uninsured could be found in firms of less than 10 employees and another 18 percent in firms of 10-24. How does this phenomenon relate to an employer's financial capacity to provide employee health insurance benefits?

The smallest employers not only are the ones who least often provide employee health insurance, they are also the ones who take least out of their firms. Examine exhibit 4. It presents owner take-out by size of firm. Note the employee size of business Helms identified as the "problem." Forty-five percent of those who owned firms with 1-4 employees reported taking-out less than \$20,000 in 1988. That percentage falls almost by half when moving to the next largest size classification, i.e., the 5-9 employee group. Still almost one in four took less than \$20,000 out of their businesses. The percentage of those who took out less than that amount falls rapidly as the businesses size increases. The opposite occurs as well. Relatively few owners of businesses employing 1-4 people took \$60,000 or more out of the business. The same is true of those owning businesses with 5-9 employees, but the percentage rises along with firm size.

The data presented in Exhibit 4 provide corroborating evidence of the blatantly regressive nature of the "play or pay" proposal under the assumption that employers ultimately absorb the cost. We already know that the proposal is regressive if the employee ultimately absorbs the cost. But, if "play or pay" is also regressive when the employer absorbs the cost, shouldn't those people sensitive to the concerns of the less-fortunate be appalled at the scheme? It would seem so. Yet, many are not. How can that inconsistency be resolved?

A Regressive Tax or a Simple Premium?

An argument can be made for "play or pay" recognizing that the financing mechanism is regressive. The argument runs that those paying the bills, i.e., the formerly uninsured, effectively are also those receiving the benefits. Thus, the tax is really not a tax at all. It is merely a premium paid for health insurance, and good social policy requires that everyone have health insurance. Regressivity is not an issue under these circumstances.

²W. David Helms, "Experiments with Incentives for the Smallest Employers," *Rescuing American Health Care: Market Rx's*, The NFIB Foundation: Washington, 1991, p. 50.

Exhibit 4
OWNER TAKE-OUT BY EMPLOYEE SIZE OF BUSINESS

Employee Size of Bus	% of Total Population	Income from Business			
		<\$20	\$20-39	\$40-59	\$60+
1-4	52	45	36	12	7
5-9	23	24	40	23	14
10-19	13	15	38	25	22
20-49	8	10	24	26	40
50+	4	4	15	16	65

Population totals from SBA data, 1991

That argument is supported by the nearly five million people who purchase non-group health insurance with under \$15,000 in annual income, or the nearly ten million who purchase it with less than \$30,000.³ This group manages to purchase health insurance on modest incomes. Others can as well. Add tax credits for the very poor and some real progress can be made on the non-coverage problem.

If that argument were to be made, no reason exists for small employers, those most effected by "play or pay," to be included in the process. Conventional wisdom holds that small employers bring group economies to their uninsured employees if nothing else. There is some truth to that argument. But we also know small business owners already pay substantially more for the same coverage than do larger insured units. The participation of the small employer, therefore, serves to raise the premium for the low-income insured by requiring the employee's participation in a small rather than a large group. It would be much simpler, fairer and cheaper to fashion large purchasing groups, by-passing small employers, and eliminating the need for a "play or pay" scheme.

Conclusion

Most economists argue that employee benefits are paid by employees in the form of lower wages and less employment. That means health insurance provided under "pay or play" would be financed by the people that would receive coverage. Thus, the working poor and near-poor would receive the benefit, but they also would pay the bill. A strong argument can be made for that position -- those who

³Helms, *op cit.*

receive benefits should pay for them. Yet, it is precisely because the poor and near-poor usually cannot pay for their insurance given other financial demands that a coverage problem exists.

Adding a significant financial burden to the working poor and near-poor bothers many people. But even if employers ultimately bore the cost of health insurance, nothing would change. A serious regressivity problem would remain. Small employers who do not provide employee health insurance are also the ones who take comparatively little out of their businesses. They, too, are often part of the working poor or near-poor. To tax them to provide the health insurance for other members of the working poor or near-poor makes no more sense than simply requiring the poor to purchase insurance. In fact, it makes less sense because the marginal employer would usually have to absorb the costs of more than one person/family, making the tax all that more severe.

Most "play or pay" proposals do incorporate tax credits or subsidies of a similar nature. Those credits are intended to ameliorate some of the most egregious regressivity inherent in the "play or pay" approach. But, to increase the credits sufficiently to eliminate, or nearly eliminate, regressivity abandons "play or pay" as an approach. To purge the credits puts an extreme burden on the working poor or near-poor whether they be employees or employers. Thus, the inclusion of credits in "play or pay" legislation primarily functions to acknowledge and underscore its liabilities.

"Play or pay" is an ill-devised approach to the health insurance coverage problem. The plan proposes a huge new tax. And, the huge new tax would be apportioned on the inability to pay. There are better ways to finance health care.

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FINANCIAL DIVERSIFIED SERVICES INC.

FAX TRANSMITTAL COVER SHEET

NAME OF SENDER A.L. TAMAGNI, SR.

DATE January 13, 1992

TIME 2:10 PM

NAME OF RECEIVER Ms. Risa Jerrell

COMPANY Nat'l Federation of Independant Business

CITY & STATE Juneau, Alaska

FAX # (907) 789-3433

COMMENTS:



FINANCIAL DIVERSIFIED SERVICES, INC.
Annuities and General Insurance

A. L. TAMAGNI SR.

Phone: 907-562-3938
Fax: 907-562-1366
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1205 East International Airport Road
Suite 205
Anchorage, Alaska 99518

These are in
addition to the letter
for review

NUMBER OF PAGES TRANSMITTING INCLUDING COVER 3

TRANSMITTING FROM (907) 562-1366 TRANSMITTED BY Amey Tamagni

IF YOU DO NOT RECEIVE ALL THE PAGES, PLEASE CONTACT THIS OFFICE AS
SOON AS POSSIBLE.

Alaskan's For Liability Reform

January 13, 1992

Ms. Risa Jerrell
Nat'l Federation of Independant Business
9159 Skywood Lane
Juneau, AK 99801

Dear Ms. Jerrell:

I am enclosing herein the pertinent data in regards to the Insurance Commissioner's report for the year 1990, which outlines the amount of funds collected by the State of Alaska on the Sale of Insurance from within the State. The rates are broken out on the Premium Tax Rates page, and the amounts are on the second page, Revenue Appropriations and Expenditures for 1940-1990.

The amount of funds to run the Division of Insurance for the period of 1990 was 1.9 million dollars, yet the legislature saw fit to charge consumers who bought insurance taxes in excess of 22 million dollars, in addition to Agents, Brokers, and carrier fees in excess of 2.1 million dollars.

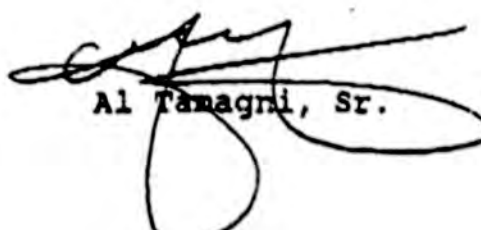
The premium taxes are a sales tax under the rhetorical phrase of Premium Taxes.

The legislature chose to exempt themselves and all other state employees from this action with passage of 21.209.210(I), which pertains to all State employee benefits under Statute 39.30.

I believe that it would be a good position for the State Chamber to ask for equal treatment.

In the event you may have any questions on this, feel free to call me at any time.

Very Truly Yours,



Al Tanagni, Sr.

PREMIUM TAXES

The taxation on Health Insurance Policies by the State of Alaska is divided into 2 categorizes:

All Domestic and Foreign Insurers (Alaska Statutes 21.09.210(b)(1) - 2.7%. This is calculated by taking Total Premiums paid minus dividends and refunds equals the amount taxes times 2.7%. Regular Insurance Companies

Hospital and Medical Services Corp (Alaska Statutes 21.09.210(b)(2) - 6%. This is calculated by taking total premiums minus claims paid equals the amount taxes times 6%, Blue Cross.

WHAT IS A PREMIUM TAX

A premium tax is a tax collected from the purchasers of Insurance by Insurance Companies and paid to the State of Alaska. It should be more rightfully know as an Insurance Sales Tax.

STATE EMPLOYEES

In legislation introduced in the 1988-1989 Legislative Session Jim Duncan from Juneau Added Sections to Alaska Statutes 21.09.210 (i) on exhibit A-2 which excluded taxes on premiums purchased on contracts by the State under Chapter 39.80 Insurance and Supplemental Employee Benefits, which includes all participating legislators etc.

As a result of this action State Employees, legislators and certain vendors under 39.80.090 (7), (8) (9) (10) (11) (12) that purchased insurance and additional coverages, were exempt from this tax.

The question is one of fairness to all, should there be a sales tax on Health, Disability and Life Insurance. If the answer is no then everyone should be exempt. If the answer is yes, then there should be no exceptions.

Chapter 27. Pay Plan for State Employees.

Section

11. Salary schedule

Sec. 39.27.011. Salary schedule. (a) The following monthly basic salary schedule is approved as the pay plan for classified and partially exempt employees in the executive branch of the state government who are not members of a collective bargaining unit established under the authority of the Public Employment Relations Act and employees of the legislature under AS 24.10 and AS 24.20:

Range No.	Step A	Step B	Step C	Step D	Step E	Step F
05	1504	1546	1591	1635	1683	1728
06	1591	1636	1683	1728	1778	1830
07	1683	1728	1778	1830	1887	1946
08	1778	1830	1887	1946	2001	2064
09	1887	1946	2001	2064	2131	2191
10	2001	2064	2131	2191	2258	2327
11	2131	2191	2258	2327	2405	2480
12	2258	2327	2405	2480	2565	2652
13	2405	2480	2565	2652	2746	2845
14	2565	2652	2746	2845	2945	3057
15	2745	2845	2945	3057	3166	3276
16	2945	3057	3166	3276	3394	3516
17	3166	3276	3394	3516	3637	3762
18	3394	3516	3637	3762	3885	4032
19	3637	3762	3885	4032	4155	4310
20	3885	4032	4155	4310	4442	4605
21	4155	4310	4442	4605	4750	4921
22	4442	4605	4750	4921	5084	5270
23	4750	4921	5084	5270	5446	5650
24	5084	5270	5446	5650	5841	6039
25	5446	5650	5841	6039	6262	6497
26	5650	5841	6039	6262	6497	6731
27	5841	6039	6262	6497	6731	6987
28	6039	6262	6497	6731	6987	7230
29	6262	6497	6731	6987	7230	7485
30	6497	6731	6987	7230	7485	7749

(b) (Repealed, § 38 ch 3 SLA 1980.)

(c) If a state officer or employee is appointed a deputy department head or a division director and, at the time of appointment, the officer or employee is receiving a salary higher than that set for the position to which appointment has been made, the officer or employee is entitled to continue receiving the higher salary. This subsection does not

apply to the salary of a person appointed to a position of deputy department head or a division director.

(d) The commissioner of administration shall adopt the regulations required under AS 22.05.140(d), AS 22.07.090(c), AS 22.10.15, AS 22.15.220(e). The regulations relate to the internal management of state agencies and their adoption is not subject to the Administrative Procedure Act (AS 44.62). The regulations shall be published in the Alaska Administrative Register and Code for informational purposes. (§ 12 ch 148 SLA 1976; am § 1 ch 92 SLA 1977; am §§ 1, 10 SLA 1978; am §§ 1, 16, 30, 31, 38 ch 3 SLA 1980; am § 1 ch 50 SLA 1982; am § 1 ch 83 SLA 1983; am § 4 ch 87 SLA 1985; am § 7 ch SLA 1987; am § 1 ch 46 SLA 1990; am §§ 9, 10 ch 19 SLA 1991.)

Cross references. — For applicability of the salary schedule in (a) of this section to employees of the judicial and legislative branches, and to employees of the executive branch not otherwise covered by this section, see § 2, ch 46, SLA 1990 and § 11, ch. 19, SLA 1991 in the Temporary and Special Acts, for compensation of certain employees of the University of Alaska, see § 3, ch 46, SLA 1990 and § 18, ch. 19, SLA 1991 in the Temporary and Special Acts.

Effect of amendments. — The 1991 amendment, effective May 11, 1990, rewrites subsection (a).

The 1991 amendment, effective June 7, 1991, rewrites subsection (a) and adds subsection (d).

Editor's notice. — Section 4, ch. 46, SLA 1990 provides: "This Act is retroactive to January 1, 1990."

Section 13, ch. 10, SLA 1991 provides: "This Act is retroactive to January 1, 1991."

Chapter 30. Insurance and Supplemental Employee Benefits.

Article

2. Group Life and Health Insurance (§ 39.30.090 — 39.30.095)

4. Supplemental Employee Retirement Withdrawal from Social Security (§ 39.30.150, 39.30.153, 39.30.160, 39.30.162)

Article 2. Group Life and Health Insurance.

Section

90. Procurement of group insurance

96. Group health and life benefits fund

Section

96. (Repealed)

Sec. 39.30.090. Procurement of group insurance. (a) The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.25.168, AS 22.26.090, AS 39.35.535 or former AS 39.37.145, employees of other participating governmental units, or persons entitled to coverage under AS 23.15.136, subject to the following conditions:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance,

surgical expense insurance, dental expense insurance, audiovisual insurance, or other medical care insurance.

(2) Each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration.

(3) A governmental unit may participate under a group policy if (A) its governing body adopts a resolution authorizing participation, and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing.

(4) The Department of Administration shall comply with the dual choice requirements of AS 21.86.310, and shall obtain the insurance policy from any insurer authorized to transact business in the state under AS 21.09 and AS 21.90, or from a health maintenance organization authorized to operate in this state under AS 21.86.

(5) The Department of Administration shall make available bid specifications for desired insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available on or before July 1, 1965, and at least once every succeeding five years. The lowest responsible bid submitted by an insurance carrier with adequate servicing facilities shall govern selection of a carrier under this section.

(6) If the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees.

(7) A person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit.

(8) A person electing to have insurance under (7) of this subsection shall pay the cost of this insurance.

(9) For each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the permanent part-time employee shall contribute the other one-half.

(10) A person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section. The level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age,

survivors, and disability insurance program. A person electing insurance under this paragraph shall pay the cost of the insurance. The commissioner of administration shall adopt regulations implementing this paragraph.

(11) A person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care insurance for that person and eligible dependents under this section. A person who elects insurance under this paragraph shall pay the cost of the insurance premium. The commissioner of administration shall adopt regulations to implement this paragraph.

(12) Each licensee holding a current operating agreement for a vending facility under AS 23.15.010 — 23.15.210 shall be covered by the group policy that applies to governmental units other than the state.

(b) In this section

(1) "eligible employee" means

(A) an employee who has served in permanent full-time or part-time employment with the same governmental unit for 30 days or more, except an emergency or temporary employee; and

(B) an elected or appointed official of a governmental unit, effective upon taking the oath of office;

(2) "governmental unit" means the state, a municipality, school district, or other political subdivision of the state, and the North Pacific Fishery Management Council;

(3) "insurance", "insurance carrier" and "insurance policy" include health care services, health care service contractors and contracts and health maintenance organizations. (AS 1, 2 ch 161 SLA 1955; am § 1 ch 168 SLA 1959; am § 1, 2 ch 105 SLA 1965; am § 1 ch 70 SLA 1968; am § 66 ch 69 SLA 1970; am § 1 ch 123 SLA 1970; am § 1 ch 159 SLA 1972; am § 1, 2 ch 46 SLA 1973; am § 13, 14 ch 47 SLA 1974; am § 2, 3 ch 27 SLA 1976; am § 2 ch 86 SLA 1977; am § 39 ch 177 SLA 1978; am § 1 ch 65 SLA 1979; am § 1 ch 62 SLA 1981; am § 37 ch 137 SLA 1983; am § 1 ch 46 SLA 1984; am § 13, 14 ch 8 SLA 1986; am § 2 ch 38 SLA 1990; am § 2, 3 ch 95 SLA 1990).

Effect of amendments. — The first amendment inserted "or persons entitled to coverage under AS 23.15.136" in the introductory paragraph of subsection (a) and added paragraph (b)(12).

The second 1990 amendment, effective June 8, 1990, added the provisions relating to AS 21.86 in paragraph (a)(4) and added "and health maintenance organizations" at the end of paragraph (b)(3).

Sec. 39.30.095. Group health and life benefits fund. (a) The commissioner of administration shall establish the group health and life benefits fund as a special account in the general fund to provide for group life and health insurance under AS 39.30.090 and 39.30.160. The commissioner shall maintain accounts and records for the fund. The fund consists of employer contributions, employee contributions,

of insurance in this state may be suspended by the director if the annual statement has not been filed by March 1.

(f) In addition to the requirements of (a) of this section, a domestic insurer shall file its annual statement with the National Association of Insurance Commissioners by the due date established by the association, and shall pay the applicable filing fee. An insurer that fails to comply with this subsection is subject to the penalties specified in (e) of this section, calculated from the filing and fee due date established by the National Association of Insurance Commissioners. (§ 1 ch 120 SLA 1986; am § 1 ch 149 SLA 1984; am § 7 ch 26 SLA 1985; am §§ 17, 18 ch 50 SLA 1990)

Effect of amendments. — The 1990 present third sentence in subsection (a) amendment, effective May 16, 1990, rewrites the second sentence and adds the

Sec. 21.09.205. Quarterly statement. (a) The director may require an insurer to file quarterly financial statements. If required, the statements must follow for a given quarter the reporting format specified in the quarterly financial statement blank form and instructions most recently approved by the National Association of Insurance Commissioners.

(b) A quarterly financial statement, if required, is due 60 days after the end of the quarter to which it applies.

(c) An insurer shall pay to the division \$100 for each day the insurer fails to file the quarterly statement in the form required or within the time established in (b) of this section. (§ 19 ch 60 SLA 1990)

Sec. 21.09.210. Tax. (a) Each authorized insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall file with the director, before March 2 in each year, a report of all insurance business written or contracted in the state (with proper proportionate allocation of premium for the property, subjects, or risks in the state insured under policies or contracts covering property, subjects, or risks located or resident in more than one state) during the preceding year ending December 31. The report must show

- (1) the amounts paid policyholders on losses;
- (2) the total direct premium income including policy membership and other fees, premiums paid by application of dividends, refunds, savings coupon, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance whether designated a premium or otherwise;
- (3) the amounts paid policyholders as returned premiums;

(4) the amounts paid policyholders as dividends.

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons, and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director annually before April 1, and is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 per cent;

(2) for hospital and medical service corporations, six per cent of their gross premiums less claims paid.

(c) [Repealed, § 48 ch 29 SLA 1987.]

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, before April 1 of each year, pay to the director a tax of three-quarters of one per cent on its gross underwriting profit. The gross underwriting profit is computed by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance), on wet marine and transportation insurance contracts, the net losses paid (i.e., gross losses paid, less salvage and recoveries on reinsurance ceded) during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit shall not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts.

(e) Payment to the director by an insurer of the tax upon its premiums required by this section shall be in lieu of all other taxes imposed by the state upon premiums, franchise, privilege, or other taxes measured by income of the insurer commencing with the taxable year beginning January 1, 1967.

(f) The state hereby preempts the field of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses, and fees upon insurers and their general agents, agents, and representatives as such; and on the intangible property of insurers or agents; and all political subdivisions of agencies in the state, including home rule boroughs or cities, are prohibited from imposing or levying upon insurers, or upon their general agents,

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agents, and representatives as such, any tax, license, or fee. However, that this subsection shall not be construed as prohibiting the imposition by political subdivisions of taxes upon real and tangible personal property of insurers and their general agents, agents, and representatives.

(g) The director may suspend or revoke the certificate of authority of an insurer that fails to pay its taxes as required under this section.

(h) The provisions of this section do not apply to title insurance companies. A premium tax on title insurance companies shall be levied in accordance with the provisions of AS 21.66.110.

(i) Premiums paid by the state for insurance policies and contracts purchased under the provisions of AS 29.30 are exempt from taxation under this section. An insurer may not include the tax imposed under this section in a premium charged on an insurance policy or contract purchased by the state under the provisions of AS 29.30. An insurer may claim the exemption on forms provided by the division of insurance. (1 ch 120 SLA 1966; am § 29 ch 137 SLA 1962; am § 1 ch 118 SLA 1966; am § 41 ch 14 SLA 1967; am §§ 1, 48 ch 29 SLA 1967; am § 1 ch 23 SLA 1989)

Effect of amendments. — The first 1967 amendment, effective May 30, 1967, deleted "except as provided in AS 21.66.200(c)" preceding "is computed at the rate" near the introductory language of subsection (b).

The second 1967 amendment in subsection (c) inserted "that may filed with the director, before July 1, 1967, for approval to organize" and "not more than" preceding "five years" and added "or until June 30, 1967, whichever occurs first" at the end of the subsection and repealed subsection (c), July 1, 1969.

The 1969 amendment, effective May 9,

1969, in subsection (i), added the present second sentence and substituted "An insurer may claim the exemption" for "Claims for exemption shall be made" at the beginning of the last sentence.

Editor's notes. — Section 2, ch. 118, SLA 1966 provides that the tax rules in (b) of this section, as amended by § 1, ch. 118, SLA 1966, apply "to the tax due by April 1, 1967 for the tax year beginning January 1, 1966 and to the tax due for subsequent tax years."

Section 2, ch. 23, SLA 1969 provides that this section is retroactive to January 1, 1969.

NOTES TO DECISIONS

Constitutionality. — Subsection (b), prior to the 1966 amendment of this section, violated the equal protection clauses of both the Alaska and federal constitutions because it imposed a higher tax on foreign insurance companies than on domestic insurance companies, a discrimination which lacked any legitimate state purpose. *Principal Mut. Life Ins. Co. v. State, Div. of Ins.*, 756 P.2d 1073 (Alaska 1988).

The purpose of excluding "insurance businesses" from the coverage of AS 43.70.000(a) of the Alaska Business License Act by virtue of the definition in AS 43.70.110(1) is apparently to avoid taxing those businesses twice, since insurers are subject to a premium tax imposed by this section. *Northern Adjudicator, Inc. v. Department of Revenue*, 677 P.2d 365 (Alaska 1984).

Secs. 21.09.220 — 21.09.240 Resident agent's counter signature exception; affidavit requirement (Repealed. § 2 ch 41 SLA 1984)

Sec. 21.09.260. Prohibited acts. An insurer doing business in this state may not make, write, place, or cause to be made, written, or placed in this state a policy, duplicate policy, or contract of insurance of any kind or character, or general or floating policy upon persons or property resident, situated, or located in this state, from or through a broker, agent, general agent, surplus line broker, or person who has not secured a license in this state. An insurer may not pay a commission or any form of remuneration to a person, firm, or organization for the writing or placing of insurance coverage in this state unless that person, firm, or organization holds a license issued by the director. (1 ch 120 SLA 1966; am § 2 ch 29 SLA 1987)

Effect of amendments. — The 1987 amendment inserted "general agent" in the first sentence and made minor punctuation changes throughout the section.

Sec. 21.09.260. Violations — Penalties. An insurer that the director determines, following an appropriate hearing as provided in AS 21.06.170 — 21.06.230, has violated the provisions of AS 21.09.260 is subject to a civil penalty of not more than \$2,500 for each violation. The director may suspend or revoke the license of the insurer for a violation of AS 21.09.260, but violation does not invalidate the insurance contract. (1 ch 120 SLA 1966; am § 1 ch 41 SLA 1984; am § 2 ch 149 SLA 1984)

Sec. 21.09.270. Retaliation. (a) If, under the laws of another state or foreign country, taxes, licenses, and other fees, in the aggregate, and fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Alaska insurers, or upon their agents or representatives, that are in excess of the taxes, licenses, and other fees, in the aggregate, or that are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers, or upon their agents or representatives, of another state or country under the statutes of this state, as long as the laws of the other state or country continue in force or are applied, the same taxes, licenses, and other fees, in the aggregate, or fines, penalties, or deposit requirements or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the director upon the insurers, or upon their agents or representatives, of the other state or country doing business or seeking to do business in this state. A tax, license or other fee or other obligation imposed by a city, county, or other political subdivision or agency of another state or country on Alaska insurers or their agents or representatives shall be considered

ALASKA PREMIUM TAX RATES

ADMITTED (AS 21.09.210) PERCENT

Domestic and Foreign Insurers (AS 21.09.210(b)(1)) 2.7%
(Total Direct Premiums — Dividends/Refunds)

Hospital and Medical Service Corp (AS 21.09.210(b)(2)) 6%
(Gross Premiums — Claims Paid)

Wet Marine and Transportation Insurance (AS 21.09.210(d)) ¾ of 1%
(Gross Underwriting Profit)

Title Insurers (AS 21.66.110) 1%
(Gross Premium)

SURPLUS LINES

Casualty Insurance (AS 21.09.210(b)(1)) 2.7%
(Total Direct Premiums — Dividends/Refunds)

Marine Insurance (Except Wet Marine) (AS 21.34.900(12)) 2.7%
(Total Direct Premiums — Dividends/Refunds)

Wet Marine Insurance (AS 21.34.900(12)) ¾ of 1%
(Gross Premiums — Taxed under AS 21.33.055)

Filing Fee — All Lines (AS 21.34.190) 1%
(Gross — Returned Premiums)

UNAUTHORIZED (AS 21.33.055)

Casualty Insurance 3%
(Gross Premiums)

Marine, Wet Marine & Transportation Insurance ¾ of 1%
(Gross Premiums)

SELF-PROCURED (AS 21.33.061)

All Lines (Except Marine Insurance) 3%
(Gross Premiums)

Marine, Wet Marine & Transportation Insurance ¾ of 1%
(Gross Premiums)

Revenue, Appropriations and Expenditures
Fiscal Years 1940 — 1990

Year	Fees	Taxes	Receipts	Appropriation	Expenditure
1940	4,769	27,274	32,043		
1950	26,620	162,035	188,655		
6/30/60	80,204	857,211	937,415	42,400	
6/30/70	171,114	2,561,761	2,732,875		156,449
6/30/80	536,297	10,435,773	10,972,070		735,816
6/30/81	654,757	10,618,190	11,272,947		862,700
6/30/82	686,689	12,530,175	13,216,864		913,000
6/30/83	801,034	13,842,732	14,643,766	976,000	
6/30/84	833,710	16,172,775	17,006,485	991,600	
6/30/85	876,059	17,504,733	18,380,792		791,000
6/30/86	1,641,244	21,285,325	22,926,569	1,082,000	1,052,674
6/30/87	1,411,122	23,659,248	25,100,370	964,700	933,720
6/30/88	1,763,899	23,847,174*	25,611,073	1,306,300	1,281,651
6/30/89	1,773,062	19,391,389*	21,164,431	1,626,000	1,605,097
6/30/90	<u>2,159,787</u>	22,691,760	24,851,547	1,960,600	1,935,555

*Taxes collected as of 6/30/88 were overstated by a \$1,698,261 refund that was not processed until December 1988. Accordingly, taxes as of 6/30/89 are understated by the amount of the refund. The corrected 6/30/88 tax figure is \$22,148,913 and for 6/30/89, \$21,089,650.

Total Premiums Written
1950-1989
(\$000)

Year	Property & Casualty	Disability	Life	Title	Surplus & Self-Procured	Total
1950	6,732	238	1,104	19	1,575	9,668
1960	20,701	3,605	6,679	357	2,812	34,154
1970	82,045	19,539	21,987	2,001	7,621	113,193
1980	243,067	99,440	75,608	8,064	52,509	478,688
1985	562,034	193,166	117,927	16,283	66,715	956,125
1986	618,059	191,478	132,021	15,915	84,508	1,041,981
1987	588,850	144,444	127,956	11,020	72,652	944,922
1988	568,604	170,598	120,649	10,010	52,353	922,214
1989	601,003	203,154	111,360	13,450	54,874	983,841

WRITTEN COMMENTS

Provided by Individuals

We MUST put more
into preventive health
care, and also reimburse
alternative methods of treat-
ment. We must learn
from other countries, where
health care costs less, is
available to all, where
the illness and death
rates are lower.

If the board could
come up with such a plan,
we would be a pace
setter for the nation.

Martin Ellen Anderson
4020 Primrose
Kenai, Ak 99611

October 25, 1992

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

Dear Task Force:

Our yearly income is between \$60,000 and \$100,000 a year. I have a individual Blue Cross Health Insurance Plan that covers me and my 2 children. I have a \$1,000 deductible per person and pay \$270 bi-monthly. My husband buys his own private health plan from Central States through payroll deductions of \$70 a month; he also has a \$1,000 deductible per each separate medical incident each year. Our concerns are as follows:

1. Every man, woman and child is entitled to health care.
2. For the birth of my first child, I had maternity coverage through my Blue Cross policy. I had an emergency C-section and Blue Cross paid for 80% of the cost. Soon after, however, Blue Cross sent me a letter and said I was no longer covered for maternity benefits. (I still had to pay the same premium.) My second child was also a C-Section and we paid over \$10,000 out of pocket expenses.
3. When we do fulfill our deductibles, and bills are sent in Blue Cross will only pay 80% of what they felt the medical charge should have been.
4. This year we tried to put my husband on my Blue Cross policy and he filled out a detailed

medical history for Blue Cross. They sent back a nice letter saying they would be happy to insure him except for all his "pre-existing conditions". Insurance companies should not be allowed to "exempt" anyone.

5. My family receives excellent, but expensive, medical care, simply because we are lucky enough to afford it. A uninsured woman I know can only afford going to the neighborhood health clinic where she can pay a sliding fee for only the very basic of services. When she or her children need a specialist, because she is uninsured, the doctors will refuse to see her without cash up front. It is humiliating to her to try to BEG for medical care for her family and this makes me furious.

6. Ideally health care reform should mean the extinction of the health insurance industry. The insurance company's goal is profit, not human lives.

7. If the insurance industry is kept, all their "dirty tricks" have to be done away with completely.

8. I would gladly give up my permanent fund check or pay state income taxes for a reformed health care system.

Thank you for your time and consideration.

Sincerely,

Susan Bergerson

Susan Bergerson
2830 Legacy Drive
Anchorage, AK 99516

my concerns -

- Look at everyone responsible for payment of health care. Hosp. is paid by government and insurance. So more is being shifted on the individual for payments of those.
- Defends Patients utilize emergency department more for their primary care. They are usually without insurance. We need to recognize the role, up front and develop a plan for everyone to participate. No matter what system, recognize and plan for those who will not be able to pay.

Insurance companies do penalize subscribers for misuse of the system in reduction of payments. Create incentives as a great motivator for cost controls.

- Transfer duplication of services offered. Should have improved coordination between hospitals. Incorporate the VA. Patient health and primary systems.

- Increase utilization of outpatient services. Allow patients to receive more at home with supportive services.

Look at services needed for the elderly. Allow them to remain in their homes longer.

Christine Harrison
4866 Mills Dr Anchorage 99501

running the health care system. Persons on Medicaid and Medicare
come to the ER for very minor problems such as "I need a blood test
or my stitches removed" or they have a cold or a very tiny laceration. It
feels that problems could be handled more appropriately elsewhere. They say
"Oh that's OK. We got emergency!" It just frustrates me as I know that
being over, I'm paying for it. Some will bring the whole family with
a sufferer - something you or I who know we'd have to pay the bill, and
nurses come in for. It's almost like a social ceiling for them.

Also some demand to have their prescriptions filled "I have no money!"
It seems they have enough for their cigarettes!!

There are people about the paramedics because they have no skills
and a hope in the system. Many are able bodied but have no intention
of finding work. It's too easy just to let someone else take care of the
problem. That these people should have to pay a certain amount every
month for their copays and a set amount up front for each ER visit
or they'll think twice before coming in for trivial things.

Also we are seeing folks coming up here from other states because our
unfavorable benefits are better! These folks are really abusive as they
are veterans of working the system.

We need to quit coding hospital cases and folks that don't want to be.
The health care system has gone way overboard in trying to salvage people
who will never have a good quality of life again. I feel this is largely
due to the lawyers & their litigation-happy ways. Something needs to be
done to curb that.

Except China's system & anyone who has more than 2 children has
to pay a big penalty for each additional child instead of getting paid more for
each child.

Some nations have their own hospital with free care. They should not
also be given Medicaid so they can use the hospitals as that way
the payers are paying for them twice. If they want to carry insurance,
then fine. Then they can choose where they want to go.

All persons on Medicaid should have their premiums & deductibles paid for
so as to help cover their Medicaid benefits.

they are not automatically penalized & have benefits taken away.
In any way at all now they are encouraged to not need a ghost to hold out their
hands & say "Thank you" & to need to just contribute & get it.
It is more self-sufficient! This would raise their self-esteem.

Have frequent of welfare do public service for several hours or weeks so
that they feel more like they are earning it, not just given it.

Many of my co-workers have the same concerns as Sister well.

(Our own health insurance has changed) tremendously since I started working
here in 1980. At first the hospital paid all the premiums. Now, every
year we have to pay more & more & the benefits are less and less.
It is very frustrating!! Also we are told where we have to go & who we
have to see to get the most from our insurance.

Sincerely,

Queenie Scott



ALASKA PHARMACEUTICAL ASSOCIATION

Box 10-1185 Anchorage, Alaska 99510

October 29, 1992

Alaska State Legislature
Health Resources & Access Task Force
State Capitol
Juneau, Alaska 99801-1132

Dear Health Care Task Force:

Thank you for allowing me to speak on behalf of the Alaska Pharmaceutical Association at the September meeting. Tom Hodel and I attended the Kenai Peninsula Borough meeting on October 17th and were impressed with the work being done. We are still not aware of any proposals on how pharmaceuticals should be handled with the health care reform. Tom and I would like to share with your task force the proposal we are recommending locally for prescription coverage and we hope it will be seriously considered. We have worked with many third party prescription billing and believe our recommendations to be most effective in dealing with prescription coverage.

Choice is a primary concern of pharmacists, as it is with physicians. We are definitely OPPOSED to bidding or contracting out. Competition must remain to prevent a "corner on the market" which may ultimately result in increased prices. We feel that with a co-pay, the patient will shop for the lowest price and the best service. If a patient is forced to use a particular pharmacy they may not want to be a part of the program.

We believe a "menu" choice is necessary for prescription coverage. For many, a program without prescription coverage would be worthless. However, we feel that this extra benefit should be "paid" for. Otherwise, the program would probably not sustain the high cost of drugs. A menu also allows those who prefer to pay "out of pocket" to do so. We suggest an added dollar value of \$25.00 to \$50.00 monthly, and/or a separate prescription deductible be added to the premium. If a menu was not set up and prescriptions were included in your program, we feel the tremendous financial impact on your program could be devastating. (A single terminal patient may spend thousands of dollars monthly in prescriptions alone.) Also, it may not be feasible to the program for a policy holder to opt for the prescription benefit at any time during coverage, by paying the extra coverage.

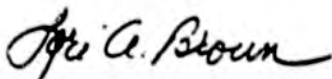
We feel a co-pay is essential. This helps prevent over-utilization which is a major problem with patients receiving their medications "free" such as medicaid patients. We recommend an 80% coverage by plan and 20% coverage by enrollee. This would encourage patients to "shop around" for best price and service. Also, having a 20% co-pay would encourage use of generic brand. We do not believe that a different co-pay should be mandatory for generic. Patients seem to dislike the fact that they are forced to get generic. Patients will opt for generic when 20% is paid because they will save money.

We feel that the following recommendation would be most effective in your plan:

1. Quantities should be limited to a 34 day supply or 100 doses, whichever is greater. This would decrease any waste that may be created if the patients drug is changed or discontinued.
2. The plan should include all medications requiring a prescription and it should include, (but not limit to) insulin, insulin syringes, blood test strips, blood glucose monitoring machines, urine test strips and lancets.
3. Smoking cessation products, such as patches and gum should be a covered item. Though these items are expensive, they will ultimately decrease medical costs. (Some newer programs make the patient pay initially, and if after a year they have not started smoking again, the insurance program will rebate part or all of the cost of their prescription.)
4. Anorexics or anti-obesity products should be excluded.
5. Oral contraceptives and diaphragms should be covered.
6. Durable medical equipment (crutches, commodes, walkers etc.) should be covered but ONLY when ordered on a prescription form by a physician.

We hope that you will seriously consider our proposal when deciding how pharmacy will fit into your proposed program. Thank you and Tom or I will be glad to help you in any way.

Yours truly,



Lori A. Brown
Pharmacist, President AKPHA

Anchorage!

"See Us In a New Light"

Because I need to leave early,
I didn't indicate a desire to
testify. However, if I had I
would have applauded the
Jack Jara's efforts in this regard.
I do have a concern about
the number of witnesses in
Alaska - the difficulty of small
businesses to afford Anchorage
for employees - and the
extreme cost of food than here.
There are other concerns as well.
but I am aware that the Jack
Jara has reviewed the best
plan for health care reform
being circulated by American Assoc.
of Retired Persons. There are some
very good points in the plan.

Betty Carlson

Acting State Director

AARP

Anchorage!  **Convention & Visitors Bureau**

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Box 2871
Sitka, Alaska 99835
October 19, 1992

Senator Jim Duncan
Health Resources and Access Task Force
State Capitol
Juneau, Alaska

Dear Senator Duncan:

I have mulled over the discussion at the recent teleconference here in Sitka, and read the Task Force's Report and write today to give my thoughts.

It would have been well for me to have read your Report before I attended the hearing. I had no idea what issues to raise for I did not know what direction the committee had taken. I know we have awful communications difficulties in Alaska, but in this instance there was a lot of interest in the subject and I think people would have prepared for the hearing had they had access to the Report, and it might have been worth the trouble to get it distributed beforehand. (Putting a copy at the local library and noting in the publicity that it is there might suffice.)

Speaking of publicity, the Sitka AARP did quite a bit of publicity for the hearing.

My concerns about the medical care system have to do with rather small pieces of it. Though there is no doubt we need a global, systemic approach, it is not too late in the planning process to think about pieces of the system, analyze the problem in terms of its parts. Possibly, we can improve the general situation by making small, incremental changes. Such small changes might have a more general effect. Small changes that work would serve to encourage the planners and I submit that concerned people could use some success, some encouragement.

I have followed your work in Juneau a little, as much as I could in the newspapers, and have been impressed with your creativity. If I make no other point today, I would like to encourage you to continue to be creative and innovative. I still think that Alaska with its small population eager to tackle new project, to dream impossible dreams, could set precedent for the country. I am discouraged with the way things go in Juneau but want to send a message from one citizen that I admire and support your efforts.

Oregon has tackled health care problems creatively and I would hope we use what it has learned in our studies.

It looks to me like the way Medicare is administered has had a great effect on raising care costs.

I have had some years experience with home health services and I am stunned with the amount of paperwork medicare demands and how

that eats up nursing time, raising costs.

It seems that the prices for services are in fact set by Medicare. What Medicare will reimburse is what is the charge period. But Medicare reimburses not only for the actual cost of the care but for the cost of doing all that Medicare administrative stuff.

Medicare, and other insurance, seems to structure the business practices of the offices of hospitals and doctors. Billing is done for Medicare and insurance and good accounts receivables practice cannot be carried out.

You must hear all over that patients cannot understand their billings, cannot deal with them like they deal with other payables. I tried to deal with the hospital about bills for my elderly father. I had invoices and payment notices all over my desk and was unable to sort them out and decide what I owed the hospital. Billings are done by encounter, not by patient. I wrote and asked for a statement, showing invoices and payments, saying that we were prepared to pay the balance due immediately. I never got a reply from the hospital. It has been a couple of years now and I can just assume that we don't owe them anything. If it is that difficult to get a statement out, we can imagine the state of the receivables.

These very receivables seem to demand a lot of work. The business office staffs appear to grow before my eyes.

Given the methods used, there is nothing that patients can do to help with billings because they are not allowed. I found this out in an incident at Bartlett in Juneau. I got a little fracture, waited until doctor's offices were open and called for an appointment with an orthopedist. I was refused an appointment because any fracture is an emergency and I must go to the emergency room. I was forced to go to the emergency room. There I was asked to sign an assignment of insurance proceeds to the hospital. I refused to do this, saying that I would pay the charges myself and deal with my insurance myself. (It was a small injury and I don't feel claims should be made for little things and I might have decided not to file.) The hospital said it was the policy to refuse care to anyone who would not sign the assignment! My rejoinder that I would pay cash for the service did not help. I felt at that point that it was not in the interest of the hospital to share its billing with me and about then I really wanted to see it. No one would believe at that point that it was my concern about rising costs that motivated me, but I persevered and signed the assignment but paid the charges for the visit, opting to be reimbursed by the hospital when the insurance paid the hospital. The costs for that little cast were over \$500. Had I gone to a doctor's office, I can't believe it would have cost more than \$100.

I complained to Blue Cross administration in Seattle and learned that Blue Cross is owned by the hospitals in whose interest it is