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State of New Jersey
DEPARTMENT OF HUMAN SERVICES

DREW ALTMAN
Commissioner

CAPITAL PLACE ONE
222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

June 27, 1989

Honorable Louis Sullivan, M.D.
Secretary, Department of Health
and Human Services
Humphrey Building
200 Independence Avenue, S.W.
Room 638G
Washington, D.C. 20201

Dear Secretary Sullivan:

Enclosed are four documents you requested last evening:

- The American Public Welfare Association (APWA) Access to Health Care Report;
- my remarks delivered at the November 22, 1988 press availability in Washington, D.C.;
- the APWA press release, with my quote noted on Page 2;
- and a memorandum outlining my position on these issues and describing my role in the APWA project.

As you will see, my role in this effort was highly circumscribed. As the record clearly demonstrates, I strongly support the President's approach to the problem of the uninsured and always have.

Sincerely,

Drew Altman
Commissioner

DA:bcd
Enclosures

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
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222 SOUTH WARREN STREET
TRENTON, NEW JERSEY 08625

DREW ALTMAN
Commissioner

June 27, 1989

Honorable Louis Sullivan, M.D.
Secretary
Department of Health & Human Services
Humphrey Building, Room 638G
Washington, D.C. 20201

Dear Secretary Sullivan:

I am writing at your request to clarify my views on mandated employer health insurance and the nature of my involvement in the American Public Welfare Association report on this matter, Access to Health Care. At the outset, however, let me state that I could not more strongly support the President's position on this issue. I have long been uncomfortable with proposals to mandate employer health insurance coverage, favoring instead strategies to incrementally expand Medicaid, to allow for a "buy-in" to medicaid coverage, and generally, to deal with the problem of the uninsured incrementally and within the context of our country's pluralistic health care system. It would be a mistake, and given the current federal budget deficit, impossible to address this problem in any other way. Indeed, I have put these ideas into practice through major programs I developed while at the Robert Wood Johnson Foundation, and as Commissioner of the New Jersey Department of Human Services.

My principle objection to proposals to mandate employer insurance is that they run a very real risk of negatively affecting both employment and economic development in ways that will hurt the very people such proposals are designed to help. These are positions I maintained as a participant in the American Public Welfare Association project.

During 1988, I participated as one of nineteen members of the APWA's Matter of Commitment Project. This APWA initiative provided a forum for state and local officials from across the country to debate and produce reports on welfare reform, access to health care and other human services issues. Seven members of the Matter of Commitment Steering Committee represented

republican administrations from New Hampshire, Rhode Island, Florida, Oklahoma, Delaware, Missouri, and, of course, New Jersey. As with most such efforts by national organizations, the conclusions drawn represent the consensus of the majority of participants. The report was adopted unanimously by all the states.

The APWA report on access to health care called for expanded medicaid coverage and a medicaid buy-in, while also calling for mandated employer health coverage. Thus, it combined the major elements of the health insurance proposals being put forward at the time by President Bush and Governor Dukakis. My own involvement with the report dealt with Medicaid issues rather than mandated insurance, since as Commissioner of Human Services I am involved primarily with public assistance issues. In fact, during the life of the project I attended one meeting.

In October of 1988, I was asked by the APWA to participate in a press conference to discuss the Access to Health Care report. I immediately declined this invitation, indicating that I did not support all of the report's recommendations and that I felt strongly that to release the report prior to the election ran the risk of politicizing what had been a non-partisan initiative.

After the election, I was again asked to participate in a press conference to discuss this report. I accepted on the condition that my role be limited to handling the technical task of outlining the nature and scope of the problem. This I did in what were very brief and informal remarks (enclosed).

It would be both inaccurate and most unfortunate if my participation in this project conveyed the message that I support mandating employer health insurance or hold positions on this matter that are in any sense inconsistent with the President's. It was in large part because my views fit so well with the President's that I welcomed your invitation to serve the Administration as HCFA Administrator.

In fact, over the years I have developed and implemented several major programs that embody the Presidents approach to this problem. For example, while at the Robert Wood Johnson Foundation I designed and implemented major national demonstration programs to support private sector and state and local government efforts to develop insurance options for the uninsured. These included the program for Prepaid Managed Health Care, a $16 million, 11 site effort to bring the principles of

market competition to state medicaid programs (this program was formally co-sponsored by the Reagan Administration); the program for Health Care for the Uninsured, a $6 million effort to support diverse state, local and private solutions; and the Community programs for Affordable Care, a $20 million effort to support non-government initiatives to make health care more affordable for all. This latter program was co-sponsored by the American Hospital Association, Blue Cross/Blue Shield, and the American Medical Association, and heavily involved representatives of the Business Roundtable in its implementation. I believe it is fair to say that these programs rank today as among the major private initiatives in the past decade to deal with this important problem.

Finally, as Commissioner of Human Services in New Jersey I developed the Garden State Health Plan, a major proposal to put in place in our state the first federally qualified, state sponsored HMO for medicaid. As part of this plan, I developed a proposal to use the Garden State Health Plan to implement the President's idea of allowing a buy-in to medicaid coverage. It was my hope in doing this that New Jersey could play a major role in helping the President implement his buy-in concept.

In sum, it is not simply the case that my views on this issue (as on all other major health care issues) are consistent with those of the President. Rather, I have been out front for many years in advocating for and in implementing these very same positions. It is hard for me to imagine a circumstance where my own personal views could more closely fit those of a President or an Administration. I hope this helps to clarify this matter.

Sincerely,

Drew Altman
Commissioner

DA:pm
Enclosure

- message today is to APWA outline problem. What is

- ~~HERE TODAY TO TALK ABOUT~~ THE MOST SERIOUS PROBLEM FACING OUR HEALTH CARE SYSTEM, AND WHAT TO DO ABOUT IT.

- WHEN DISCUSS THESE THINGS IN WASH. TEND TO DO SO IN STATISTICAL TERMS .... BUT VISIT NICU, SCHOOL, WELF. OFFICE AND YOU'LL SEE FIRST HAND WHAT MEANS TO HAVE 37 MILL. AMERICANS W/O HEALTH INS.

  - SEE BABIES BORN TOO SOON AND TOO SMALL, BECAUSE LACK PRENATAL CARE.

  - SEE KIDS LONG TERM DEVELOPMENTAL & PHYSICAL DISABILITIES

  - KIDS WHO ARE FAILING IN SCHOOL; FAILING IN LIFE; BEGINNING DROP BY WAYSIDE.

cite NGA parade project

- WE KNOW, FROM STUDY AFTER STUDY, THAT WHEN COMES GETTING THE HEALTH CARE PPLE NEED, BEING WITHOUT HEALTH INSURANCE BIGGEST DISEASE OF ALL.

  - STUDIES SHOW PPLE W/O HEALTH INSURANCE SEE DOC./GO HOSP. MUCH LESS .... (38 % less physic care 46 % " hosp ")

  - WORST OF ALL IS TO BE POOR AND UNINSURED, BECAUSE POOR SICKER (2X AS LIKELY BE BAD HEALTH AS NON POOR).

  - AND TODAY, ONE OUT OF EVERY 3 POOR KIDS LACK HEALTH INSURANCE COVERAGE. . . . so problem worst where want it least.

- WE KNOW HEALTH INS. WORKS, NOT JUST FROM STUDIES BUT FROM EXPERIENCE.

  - POOR COV. MEDICAID SEE DOC/GO HOSP AT LEAST AS OFTEN NON-POOR ... AN AMAZING ACHIEVEMENT ... BUT LESS 50% POOR HAVE MEDICAID COV. ... DOWN FROM 64% 10 YRS. AGO.

- THERE ARE 37 MILL AM. WITHOUT HEALTH INSURANCE COVERAGE ... THAT NUMBER RISES TO ABOUT 56 MILL WHEN ADD THE UNDER-INSURED TO EQUATION.

  - CONTRARY TO PUBLIC PERCEPTIONS ... ABOUT 75% ARE WORKING, OR DEPENDENTS OF WAGE EARNERS.

- OF GREAT CONCERN IS FACT THAT THE #'S OF UNINSURED ARE INCREASING.

  - # UNINSURED INC. BY MILL. EVERY YR. SINCE '79.

  - BETWEEN 82-86, # AMB. VISITS FOR POOR DECLINED 30%.

  - ONE THIRD OF POOR CHILDREN DID NOT SEE DOCTOR IN '86.

- MOST DISTRESSING OF ALL ... IN 1986 1 MILL. AM. REPORTED TRIED GET CARE ... <u>AND WERE ACTUALLY TURNED AWAY FOR FIN. REASONS</u>.

- WHERE DO THESE PPLE GO? FOR TOO MANY SIMPLY IS NO SAFETY NET ... 1/3 LARGEST CITIES HAVE NO PUBL. INSTIT. /T ALL OFFERING FREE CARE.

- OUR PROPOSALS RECOGNIZE THAT THERE ARE SUBGROUPS WHOSE PROBLEMS CAN BE HANDLED DIFF. -- THE WORKING UNINSURED ... THOSE WHO ARE UNEMPLOYED & UNINSURED.

- THEY ATTEMPT TO PIECE TOGETHER SOLUTIONS THAT TARGET THESE SUBGROUPS AND WHICH TOGETHER WOULD BRING HEALTH INS. TO ALMOST ALL AMERICANS.

- THEY ARE AS NON-PARTISAN AS CAN BE ... INCORPORATING ELEMENTS CONSISTENT WITH BOTH PRES. CANDIDATES HEALTH INS. PROPOSALS. • Do not all support every rec.. • Cost high! • get discussion started

- LAST POINT. WE'VE FOLLOWED UP OUR WELF. REF. PROJECT WITH THIS ONE BECAUSE KNOW FROM OUR WORK HAVE DEAL PROBLEMS FACING POOR CHILDREN COMPREHENSIVELY.

  - POOR DON'T HAVE HEALTH PROB. ONE DAY, ~~WELF. DEP.~~ an unemployment PROBLEM OR A HOUSING PROBLEM THE NEXT ...THEY EXP. ALL OF THESE SIMULTANEOUSLY.

  - DEAL ONLY WITH ONE, AND DIKE LIKELY SPRING LEAK SOME PLACE ELSE.

- SO FOR US, THIS IS A LOGICAL NEXT STEP IN WORK BEGAN WITH MATTER OF COMMITMENT PROJECT.

- Hope report simply gets ball rolling fresh debate.

- THANK YOU.

ugtil J.

AMERICAN PUBLIC WELFARE ASSOCIATION
news

FOR IMMEDIATE RELEASE

For more information:
Kathy Patterson
Jane Horvath 202/682-0100

APWA Recommends Comprehensive Health Coverage

Washington D.C.--Nov. 22, 1988--The nation's cabinet-level state human service commissioners are recommending comprehensive health coverage through a restructured Medicaid program and employer-sponsored health insurance in order to assure access to health care for poor children and their families.

"Access to health care for the poor, and poor children in particular, has actually *deteriorated* in the last few years," states a report released today by the American Public Welfare Association. The 28-page report, entitled *Access*, recommends employer-sponsored health insurance for all workers and their families, with state or regional insurance pools providing coverage for small employers, and Medicaid coverage for all non-working individuals and dependents with incomes up to 200 percent of the federal

poverty line, with graduated premiums for those with incomes over 75 percent of poverty.

"Health care is critical to strong, stable, self-sufficient families," the report states. "It is critical for children to grow and thrive. National policy must assure access to health care for America's poor families and children."

Stephen Heintz, commissioner of the Connecticut Department of Income Maintenance and chair of APWA's "Matter of Commitment" project, said access to health care is prerequisite for families to be self-sufficient. "Today, poor families seeking to leave the welfare rolls face a disincentive in the eventual loss of Medicaid benefits. And too often they secure a job that does not provide insurance or sufficient wages to purchase coverage."

Drew Altman, commissioner of the New Jersey Department of Human Services, said the lack of adequate health care today "has severe, life-long impact. Lack of prenatal care leads to low birthweight babies and the risk of severe complications, as well as physical, developmental and learning disabilities." He cited surveys that show that lack of access to health care for poor families and children is a growing problem.

The chair of APWA's Access to Health Care Task Force, Barbara Matula, director of North Carolina's Division of Medical Assistance, outlined the APWA recommendations. "While others have proposed either a broadened Medicaid

program or mandated employer coverage, we believe both strategies are necessary to meet today's health care needs," she said. "Our proposals promote effective administration, because they are based on existing programs and services. They reflect the kind of public-private partnerships necessary to assure access to health care."

Heintz noted that the recommendations are directed particularly at the new administration and the new Congress. He acknowledged that elements of the APWA plan were included in legislation proposed in the 100th Congress, and said statements made by President-Elect George Bush during the presidential campaign offer encouragement that health care needs of the poor will be a priority for the new administration.

Release of the health care report marks the second phase of APWA's Matter of Commitment project, a 3-year effort to address childhood poverty. The project's first report, *One Child in Four*, led the national policy debate that resulted in major welfare reform enacted by the 100th Congress.

The American Public Welfare Association is a nonprofit bipartisan organization representing the 50 state human service departments, local public welfare agencies, and individuals concerned with social welfare policy and practice.

Additional copies of *Access* and *One Child in Four* are available for $3 from APWA, 810 First Street N.E., Suite 500, Washington D.C. 20002-4205.

ACCESS

. . . to health care for America's poor families and children is a human necessity, and an economic one. Health care is critical to strong, stable, self-sufficient families. It is critical for children to grow and thrive. National policy must assure access to health care for America's poor families and children. What follows are recommendations to provide access to basic health care coverage for all Americans.

Investing in Poor Families and Their Children: A Matter of Commitment

A policy development project of

The American Public Welfare Association
The National Council of State Human Service Administrators

Final Report Part I: *One Child in Four*
Final Report Part II: *Access*

Stephen Heintz, Commissioner
Connecticut Department of Income Maintenance
Chair, Matter of Commitment Steering Committee

October 1988
Washington, D.C.

ter of Commitment
teering Committee

DREW ALTMAN
Commissioner
New Jersey Department of Human Services

CHARLES M. ATKINS
Commissioner
Massachusetts Department of Public Welfare

BARBARA BLUM
President
Foundation for Child Development

NANCY BORDELEAU
Director
Rhode Island Department of Human Services

PETER BREEN
President
American Public Welfare Association

GREGORY L. COLER
Secretary
Florida Department of Health and Rehabilitative Services

WALTER CREDLE
Assistant Director
Virginia Beach, Virginia, Department of Social Services

ROBERT FULTON
Secretary of Social Services
Office of the Governor of Oklahoma

SANDRA GARDEBRING
Commissioner
Minnesota Department of Human Services

CHARLES E. HAYWARD
Secretary
Delaware Department of Services for Children, Youth, and Their Families

STEPHEN HEINTZ
Commissioner
Connecticut Department of Income Maintenance

DANIEL C. HUDGINS
Director
Durham County, North Carolina, Department of Social Services

RUTH MASSINGA
Secretary
Maryland Department of Human Resources

MARY M. MONGAN
Commissioner
New Hampshire Department of Health and Human Services

CESAR A. PERALES
Commissioner
New York State Department of Social Services

MICHAEL V. REAGEN
Director
Missouri Department of Social Services

LINDA REIVITZ
Director of Research
Marian Franciscan Services

JULE SUGARMAN
Secretary
Washington State Department of Social and Health Services

JOHN WHITE, JR.
Secretary
Pennsylvania Department of Public Welfare

Staff

BEVERLY YANICH
Project Director

KATHLEEN PATTERSON
Public Information Director

The American Public Welfare Association is a 58-year-old nonprofit, bipartisan association of agencies and individuals concerned with social welfare policy and practice. The Association's National Council of State Human Service Administrators represents the state cabinet-level officials charged with administering programs on behalf of low-income individuals and families.

Contents

Executive Summary

One out of every six American children has no health insurance, public or private. One child in four is born into poverty. Among poor children, one in three lacks health care coverage. Access to health care for the poor, and poor children in particular, has actually *deteriorated* in the last few years. Today in America poverty and poor health go hand in hand.

In January 1986, human service commissioners undertook a major review of public commitments to the nation's poor, a review demanded by the devastating statistics on childhood poverty. In November 1986, we released *One Child in Four*, a proposal for comprehensive reform of the nation's welfare system. By strengthening families and promoting self-sufficiency, we believe that poverty can be substantially reduced among American children and families.

The 100th Congress has taken the first steps toward comprehensive welfare reform, changing what has traditionally been an income maintenance program into a system that promotes individual and family self-sufficiency.

In *One Child in Four* we said that other efforts would be needed, including new national policies to assure access to health care for all Americans. The American Public Welfare Association's Matter of Commitment Steering Committee established the Access to Health Care Task Force to study this issue. This report represents the work of the Task Force.

For families to be strong and self-sufficient, for children to grow and thrive, they must have access to health care services. Today, however, an estimated 37 million Americans have no health insurance to cover their medical bills. They lack regular access to health care when it is needed. Although Medicaid provides coverage to certain of the poorest families, many other Americans have neither insurance through their workplace nor access to the protection offered by Medicaid.

Human service commissioners bear a special responsibility to the nation's poor. We are charged with providing services and income assistance. We administer Medicaid programs for individuals poor enough to qualify for its benefits.

We understand the links between poverty, welfare, and access to health care. Today poor families seeking to leave the welfare rolls for employment face a disincentive in the eventual loss of Medicaid benefits. Too many cannot secure employer-sponsored insurance as they enter the workforce, nor can they afford to purchase coverage from the low wages they earn. Many former recipients are forced to leave their jobs and return to welfare in order to meet the health care needs of their children.

This report of the American Public Welfare Association recommends two major strategies to assure financial access to primary health care services for poor uninsured children, families, and individuals:

RECOMMENDATIONS

I. For Workers and Their Families

A. We recommend employer-sponsored health insurance for all employed individuals and their families to cover (at a minimum) hospital and physician services; prenatal, well-baby and well-child care; diagnostic and screening tests. We recommend phasing in prescription drugs, dental services for children, and eye care as services in the minimum package at a later date. Very small employers (perhaps six or fewer employees) would be exempted.

B. We recommend the establishment of state or regional insurance pools to

allow small businesses to offer health insurance at rates equal to those paid by large firms.

II. For Nonworking Individuals and Families

A. We recommend restructuring Medicaid to cover all non-working individuals and dependents with family incomes up to 75 percent of poverty and family assets under $12,000 (excluding the home and other noncountable resources). This group should receive benefits currently covered in a state's Medicaid plan. This recommendation essentially eliminates categorical requirements for Medicaid coverage.

B. For those whose income is at, or above, 75 percent of poverty or whose assets exceed $12,000, we recommend that state Medicaid programs provide a minimum benefit package equal to the employer's basic coverage. For those with incomes from 75 to 200 percent of poverty, states would charge an income-based premium for the minimum benefit package.

These recommendations are incremental because they build on existing programs and methods, and comprehensive because they provide financial access for all of those currently uninsured. Like welfare reform, these proposals are critical *investments* in the future health and well-being of our citizens, our economy, and our nation. ■

Poverty, Children, and Health

The most disturbing findings of the 1986 National Access Survey involve the deterioration in access to medical care among the nation's poor, minority, and uninsured citizens.... These changes are real and have a serious impact on the segments of the American population least able to take advantage of the various new forms of health care delivery, or to pay for the care they so evidently need.

—Access to Health Care in the United States: Results of a 1986 Survey,
the Robert Wood Johnson Foundation

One out of every six American children today has no health insurance, public or private. Among poor children, one in three lacks health care coverage. From 1980 to 1985 health insurance coverage for poor children under the age of three declined *by 34.9 percent* according to a recent Children's Defense Fund study. For these children there is no preventive health care; no well-child visits to the pediatrician. There is no access to health care at all until the most dire emergency, and then children are treated as "charity patients" if they are treated at all.

Clearly poverty and poor health go hand in hand. As the American Public Welfare Association reported two years ago, one child in four is born poor in America today. The data on relative poverty by age group are disturbing, to say the least. That children have become the most economically disadvantaged segment of the population says more about the country's values than any other measurable index.

- The U.S. currently ranks 19th in infant mortality among the industrialized nations. In too many of our cities the infant mortality rate rivals that of Third World nations.
- A half million American children suffer from the effects of malnutrition.
- More than a third of the nation's homeless population consists of families with children.

Consequences

Lack of adequate health care early in life has severe, lifelong impact. The pregnant American woman who cannot afford prenatal care is more likely than a counterpart receiving care to give birth to a premature or low birthweight baby. She may suffer severe complications herself. Infants born into poverty are twice as likely as their nonpoor counterparts to suffer low birthweight. These newborns face a significantly greater risk of infant death. If they survive the first year of life, they face a greater risk of physical, developmental, and learning disabilities.

Children who begin life ill or disabled suffer in other ways. They cannot learn well in school. They are vulnerable to lifelong economic dependency. They risk long-term dependence on their families, on other private resources, and, ultimately, on public institutions. Today too many American children start life with disabilities that compound, and are compounded by, poverty.

The knowledge that many of the health problems facing poor children can be avoided deepens the tragedy. Inadequate prenatal care, low birthweight, and infant and child mortality are, in large measure, preventable. The issue has less to do with medical science, and has everything to do with the social and economic costs we are willing to bear. Current policies do provide public dollars to pay the substantial costs and consequences of inadequate health care when it results in disease and disability. Yet we have not invested the resources necessary to assure that children begin life healthy and that families remain healthy.

We have a health care system that *can* provide for the health of all of the nation's families. We must assure that families have access to that system.

With Medicaid, the public health program for the very poorest Americans, progress has been made in improving the health of poor children and their families. But children of the working poor and those whose parents are seeking to become independent of the welfare system have not had access to Medicaid. For all its gains, Medicaid has not solved the problem of *financial access* to preventive and acute health care services for all poor children. There are significant gaps in the health care safety net that demand attention.

Access to health care turns on the key issue of access to affordable health insurance, and *affordability* is a major barrier

Inadequate prenatal care, low birthweight, and infant and child mortality are, in large measure, preventable. The issue has less to do with medical science, and has everything to do with the social and economic costs we are willing to bear.

for low-income families and individuals. While most U.S. citizens with health insurance receive health care coverage through employer-based benefit plans, and the very poorest are covered by Medicaid, a significant percentage of the population under age 65 has either no insurance, or inadequate insurance.

The Uninsured

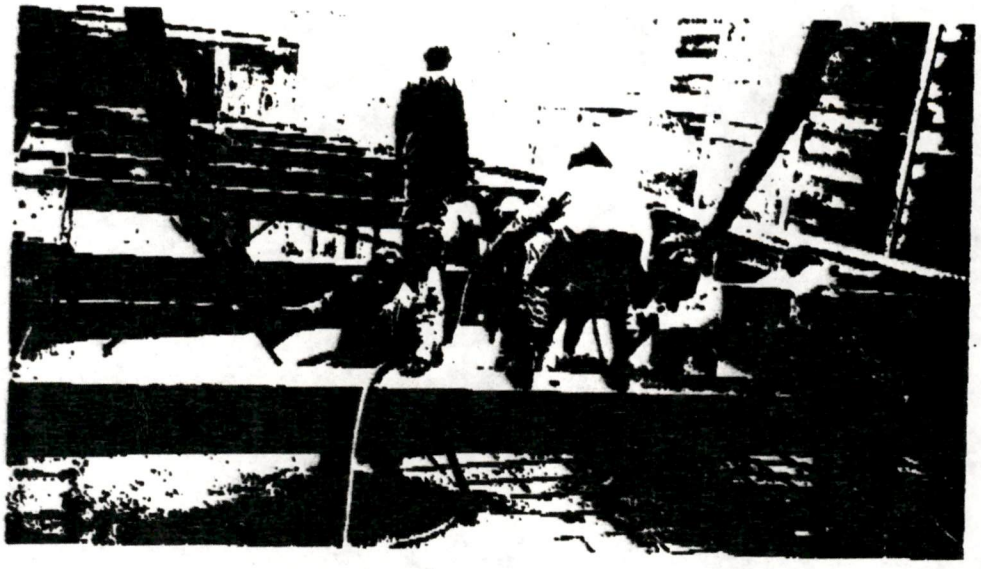
There is general agreement that 37 million children and nonelderly adults lacked any health insurance coverage for all or part of the year in 1985. That is fully 15 percent of the population, and the number has grown by a million each year since 1979. Almost 20 percent of all children under 18 had no health insurance in 1985, a 16 percent increase since 1982.

When the underinsured are added—those individuals whose terms of coverage such as deductibles and copayments preclude access to care when it is needed—the number jumps to 56 million, almost a quarter of the American population.

In actual numbers, and as a percentage of the workforce, the number of workers without health insurance is increasing.

The sheer magnitude of the problem drives the need to address broader access to health care coverage. In actual numbers, and as a percentage of the workforce, the number of workers without health insurance is increasing. Though it is commonly believed that most of those without insurance are unemployed, that is not the case. In 1985 almost 75 percent of the uninsured were either employed, or dependents of wage earners. From 1982 to 1985 the number of workers without insurance rose from 13.9 million to 17 million, an increase of 22.5 percent.

The increase in uninsured workers is generally a result of changes in the economy and the types of jobs being created. The service sector, with historically low rates of employer-sponsored health coverage, is growing at a rate four times faster than other sectors. The Joint Economic Committee of Congress has documented that employment growth is occurring in low-wage, parttime jobs that rarely provide health insurance to the workers who fill them.



The Health Care Marketplace

These workforce changes are juxtaposed against a health care industry in which rapidly escalating costs have rendered health services and individual insurance coverage financially out of reach of many workers.

Many individuals and families pursue care through emergency rooms and outpatient clinics because they do not have a primary care physician. These "medically indigent" individuals are those most acutely affected by health industry economics and lack of coverage. They also experience more frequent acute care needs and hospitalization. They have no affordable alternative, and this leads to episodic, crisis-oriented care for the patient, at great cost to individual hospitals and to society.

Health care industry economics are adversely affecting uncompensated or charity care, the traditional avenue to acute care service for the medically

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CHICAGO—Iris Moore is chewing bubble gum and singing along with a song on the radio as she sits beside a tiny incubator in the intensive care nursery at Mt. Sinai Hospital, where sick babies are hooked up to tubes and wires and machines that help them breathe.

One of the infants belongs to her.

At 17, Iris is the oldest of five children in her family. Her mother is on welfare and her father unemployed. Dr. Ann West, a second-year resident at Mt. Sinai, remembers the sinking feeling that came over her when she delivered Iris' baby at about 11 p.m. July 21.

"I felt sad," West recalls. "You don't know how babies like this will do."

The baby, named Tina, was born too soon, 15 weeks premature. She weighed only 710 grams, slightly more than a pound and a half. Premature deliveries are often the result of adolescent pregnancies and are all too common at Mt. Sinai, a teaching hospital in the impoverished West Side neighborhood of North Lawndale.

From the moment Tina Moore was born, her future was in jeopardy.

She depended on a whoosh of oxygen from a tube just so she could take her first breath. Medical complications resulting from her prematurity may leave her with respiratory difficulties, a susceptibility to Sudden Infant Death Syndrome and learning disabilities that might not be revealed until she is ready for school.

But she is vulnerable to much more.

Unless someone or something intervenes during the little girl's life, there is good reason to believe that Tina Moore will be condemned to repeat the same vicious cycle that took hold of her mother, her grandmother, and her great-grandmother, by having a baby during—or perhaps even before—her teens.

—The Chicago Tribune

LOS ANGELES—Bryan Redfield gets up from a kitchen chair slowly, awkwardly using his arms to help maneuver his partially immobilized lower limbs, the result of a horribly broken pelvis suffered in a car crash.

He struggles into the living room of his tiny West Hollywood, Calif., apartment and reaches for a plastic shopping bag stuffed nearly full with hospital and doctor bills.

The bills are a result of the Dec. 6, 1986, accident in which Redfield's car was broadsided by a drunken, uninsured driver. Redfield suffered such massive internal injuries that he needed more than 100 units of blood, spent seven months in three hospitals, and is only now learning how to walk again.

Rummaging through the bag with a slight, ironic smile, he finds what he is looking for: a single yellow sheet sent by one of the hospitals. It says:

"This is to notify you that you still have an outstanding balance of $165,737.41. As a convenience to you, payment of the balance can be made by cash payment, check, or by use of your Visa or Mastercard."

There is little Redfield can do except laugh. A sporadically employed actor before the accident, Redfield was earning less than the $2,900 annual minimum to qualify for Screen Actors Guild health insurance. The tavern where he tended bar offered coverage to its workers only if they paid for it themselves. But Redfield, 36 and otherwise healthy, could not afford the $90 monthly premium.

He is a classic example of someone who has fallen through the cracks of the American health-care delivery system.

—Los Angeles Times

indigent. The health care industry as a whole, hit by rapidly rising costs and externally induced cost containment and competition, is less willing to provide uncompensated care.

The volatile health insurance market is also a factor. Commercial insurers face increasing competition among themselves and with corporations that find it less expensive to insure their own workers. In the battle to keep premiums down, insurers are demanding higher coinsurance payments and deductibles for the insured. While this helps control hospital utilization, higher deductibles and coinsurance payments make it difficult, if not impossible, for individuals with low incomes to obtain coverage and make use of that coverage.

To remain competitive, insurers guard against "cost-shifting," the traditional practice of charging paying patients more in order to subsidize the cost of uncompensated care. Government programs, particularly Medicare, also guard against cost-shifting to keep costs down. In doing so, government and commercial carriers are responding to demands of taxpayers and the business community to reduce government deficits and the costs of health care.

The prohibition on cost-shifting, leaner reimbursements overall, and increased demands for uncompensated care are adversely affecting health care providers. Uncompensated care costs are large and growing: from $3.5 billion in 1980 to $7 billion in 1986. This burden falls on public and nonprofit institutions.

As a result, many hospitals where indigent individuals have traditionally received care have not survived. Today one-third of the nation's hundred largest cities have no public institutions offering free care, according to the American Hospital Association (AHA). The public must depend instead on nonprofit hospitals for uncompensated care. Institutions still offering such care have taken steps to reduce the amount of uncompensated care they provide. The AHA reports that one in every seven hospitals adopted specific limits on the amount of uncompensated care they provided by 1983. Without a paying patient pool, a hospital cannot survive.

To a considerable extent health insurance coverage in this country is a matter of luck. Those fortunate enough to be employed by large, unionized, manufacturing firms are also likely to be fortunate enough to have good health insurance coverage. Those who have modest incomes, live in the South and West or in rural areas, and those who are black or minority group members are more likely to bear the personal and economic effects of lack of insurance and the consequent financial barriers to health care.

—Karen Davis, chairman, Department of Health Policy and Management, Johns Hopkins School of Hygiene and Public Health, in congressional testimony, July 25, 1988

Jackie Flanagan, cloth cutter in a Baltimore rag factory, makes only $3.50 an hour, and wonders if work is worth the trouble. The monthly take-home pay, about $506, is only $25 more than she received from welfare.

She started the job last December. Five lively youngsters, ages 3 to 11, were driving her stir crazy, and the characters on the afternoon soap operas had become more familiar than real life.

"I watched those stories so much that I dreamed about them," said Jackie, 33, a round-faced woman who speaks almost in a whisper.

Her routine now is to rise at 5:30, lay out the children's clothes, wash and dress the littlest ones. Then she makes lunches before leaving the children with the next-door neighbor.

The subway takes her downtown. From there, she catches either the No. 23 or the No. 15 bus. Both go down Franklintown Road, and it is a short walk to the factory. At 8 a.m., she starts slicing rags from a bolt of cloth.

"I enjoy the work," she said, her voice betraying her uncertainty. "The people are nice. They let you go on break when you feel like it."

Pleasant or not, the job is hard on her budget. She pays her neighbor $50 a week for baby-sitting. She also pays $8.50 a week in carfare.

Worse yet, the job offers no health insurance. Because she is no longer on Medicaid, the state will soon take away her Medicaid card. Every flu and cough the children catch will mean less money for groceries.

"Marcia, the 3-year-old, has asthma," she said, the worry clear on her face. "I didn't know working would end up costing me money. Mentally, I want to keep working. Financially, I don't know if I can."

—Los Angeles Times

For the employed insured, these industry trends mean higher out-of-pocket expenses, reduced benefits, and increasingly limited access to care. For the medically indigent outside an employer group, there are fewer care alternatives as more facilities deny care or close down completely.

Some states have already taken action to assist hospitals with heavy uncompensated care caseloads, including increased Medicaid reimbursements to affected hospitals, mandated surcharges on hospital payments from private insurers, and the establishment of revenue pools to supplement payments to hospitals.

The fiscal strain indigent care places on workers, employers, providers, and government points to the need for a national policy that addresses the issue of more equitable financial access to health care, with costs of coverage distributed more equitably throughout society. Business spokesmen who have testified before Congress in recent months point to the *inequity* in the current health care marketplace. Businesses providing workers with health care coverage are, in fact, subsidizing businesses that do not provide such care through taxes that ultimately pay the bill for indigent care.

Health care costs and lack of insurance coverage result in a significant segment of the U.S. population living at risk of health emergencies without the ability to pay for care. The lack of coverage among both the employed, and the unemployed, threatens the ability of American families to be self-sufficient.

Action to Address Poverty and Health Care

In November 1986, the American Public Welfare Association called for national action to reduce poverty among families with children through strengthening families and promoting their self-sufficiency. The report, *One Child in Four*, called for sweeping reform of the

nation's welfare system, reform the 100th Congress has initiated.

The goals of welfare reform also require reform of the health care financing system. Today poverty, poor health, and welfare dependency are joined in a perverse way. Because entry-level jobs often provide few health care benefits, and wages too low to purchase insurance, many parents are hesitant to enter the workforce. The availability of Medicaid has inhibited many parents from leaving welfare for jobs. Economic independence is thus blocked by the prohibitive costs of health insurance and health care.

APWA's *One Child in Four* called for review and recommendations on the issue of access to health care for poor families with children. The APWA Matter of Commitment Steering Committee established the Access to Health Care Task Force to study this issue.

The human service administrators from across the country serving on the task force concluded very quickly that the biggest single barrier to access to health care for poor families is *financial*; the lack of health insurance coupled with the lack of resources to purchase coverage or pay out-of-pocket for health care. The task force also recognized that issues related to access to health care include quality of care and health care delivery systems. Because a source of payment for health care is central to all other issues, however, this report focuses on financial access to health care.

The task force acknowledged that the current health care financing system limits access to care and can be improved. Therefore the recommendations that follow are both *incremental* because they build on existing programs and

methods, and *comprehensive* because they provide financial access for all of those currently uninsured.

Access to a continuum of long-term care services, and financing for those services, is also a critical concern, and that issue will be the subject of a companion report to be published in 1989.

We firmly believe that this nation must find a way to make financial access to basic health care services available to all citizens, regardless of economic status. Individuals and families have a responsibility to pursue self-sufficiency through employment. That responsibility should not be undercut by the very real fear of unmet health care needs. ■

Individuals and families have a responsibility to pursue self-sufficiency through employment. That responsibility should not be undercut by the very real fear of unmet health care needs.

Recommendations:

Access to Health Care for Poor Families and Children

Human service administrators approach the issue of access to health care for an obvious reason: we provide health care services for the poorest among the uninsured. But the systems we administer do not provide for all of those in need. The working poor and those striving to be independent of the welfare system need policies and programs that assure their access to health care.

It is incumbent upon us as human service administrators, together with our colleagues in health care and the private business sector, to propose alternatives so that families do not face the stark choice between taking a low-wage job without health insurance and remaining on welfare in order to ensure the availability of health care for their children. We must also assure that workers, who are otherwise self-sufficient, are not reduced to economic dependence or medical indigence by their lack of health insurance. This is a matter of equity for families and individuals. It is also an economic necessity. The nation needs a healthy, productive workforce. On the following pages we propose policies to provide financial access to health services so that no member of society is denied basic care when care is needed.

These recommendations derive from principles articulated in *One Child in Four* that stress the mutual responsibilities of individuals, government, and the private sector:

- The individual has a responsibility to obtain health coverage when it is available and affordable and to seek out health care as needed. Parents have a responsibility to obtain coverage for their children and to seek appropriate providers and services when needed.
- Society has an obligation to ensure that all citizens have access to health care. The public sector has a responsibility to provide assistance to those who cannot afford health care, and the private sector has the obligation to provide health care coverage for employees.

As we stated in *One Child in Four*, we seek policies that reflect a social insurance model. We called for a new Family Living Standard (FLS)—a nationally mandated, state-specific standard for cash assistance based on a uniform methodology for calculating actual living costs. Cash benefits would replace AFDC, food stamps, and low-income home energy assistance for eligible families with children. FLS benefits would meet the difference between a family's income—wages, child support, stipends and so forth—and the local FLS. A study of the Family Living Standard is included in welfare reform legislation enacted this year by Congress.

Similarly, we believe health care benefits should eventually reflect a Family Health Standard, a formula that takes into account local health service and insurance costs, and their differences across the country. Measured in conjunction with the FLS, the Family Health Standard would be used to set eligibility and income levels for the basic health benefit package. The Family Health Standard would help direct further health care policy development. We recommend that the congressionally mandated study of the Family Living Standard include the Family Health Standard approach. Until the FLS methodology is implemented, we propose that the policies we recommend use the federal poverty level as an interim determinant of need.

In addition to the two overarching principles outlined above, the Health Care Task Force developed guidelines to evaluate alternative health care policies and formulate our recommendations. We urge other individuals and organizations to use them as well. The APWA "family health guidelines" include:

- *Equity*. Families in similar economic and health circumstances should be treated in the same way.

It is incumbent upon us as human service administrators, together with our colleagues in health care and the private business sector, to propose alternatives so that families do not face the stark choice between taking a low-wage job without health insurance and remaining on welfare. The nation needs a healthy, productive workforce.

oday, companies like ours pay for ealth care twice—once for our own nployees and then again, via taxes nd inflated health insurance remiums, for the employees of ose businesses who don't provide nefits for their own people.... ermitting companies to skimp on nployee and retiree benefits like sic pensions and adequate medical surance in order to gain mpetitive advantages is simply ot sound public policy. If this is e beginning of a trend, our nation in deep trouble—and now is the me to put a stop to it.

-Robert L. Crandall, chairman and esident, American Airlines, Inc., in ngressional testimony, June 24, 1987.

- *Benefit coverage*. Individuals and families should be covered by a basic benefit package including primary and preventive health care.
- *Work incentives*. Health care coverage should be an incentive for families to obtain employment and leave public assistance.
- *Economic impact*. Policies should minimize any adverse economic impact on business that might lead to the loss of jobs as a result of increased insurance costs.
- *Broad but differentiated coverage*. Health care benefits should be available for everyone. At the same time, providing coverage to diverse groups may call for diverse methods.
- *Effective administration*. Policy and program alternatives should be conducive to effective and efficient operation, including links with other social and health programs.
- *Economic efficiency*. Serious consideration must be given to cost control elements of any policy or program alternative, particularly by emphasizing managed care systems.

To assure financial access to primary health care services for poor uninsured families and individuals, we recommend:

- Employer-sponsored health insurance for all employed individuals and their families with a basic package including hospital and physician services; prenatal, well-baby and well-child care; and diagnostic and screening tests. We propose as later additions to this basic package prescription drugs, dental services for children, and eye care. For small businesses, coverage would be provided through regional insurance pools offering premium rates equal to those available to large firms.
- Restructured Medicaid programs to cover all nonworking individuals and dependents with family incomes up to a percentage of the FLS/FHS (75 percent of poverty as an interim measure), and family assets not in excess of $12,000 (excluding the home and other noncountable resources.) For the unemployed with incomes between 75 and 200 percent of poverty or whose assets exceed $12,000, the state would provide a minimum benefit package equal to the employer's basic plan. States would charge income-related sliding scale premiums for those with incomes between 75 and 200 percent of poverty. The uninsured with family incomes equal to or exceeding 200 percent of poverty could buy into the program by paying the full premium costs.

These policies recognize that different populations—the employed and the unemployed—require different solutions. The two policies complement each other by providing broad but differentiated coverage for all the uninsured and underinsured. The combination of approaches would provide work incentives for people leaving cash assistance because they will be assured workplace coverage. The programs permit and encourage effective administration by using existing program structures. The proposals address efficiency, job loss, equity, and benefit coverage comparability among and between programs.

These policies should be implemented in a manner that does not discriminate against individuals based on the state of their health. To equitably manage the inclusion of persons with chronic conditions in insurance pools, for example, the government should monitor that inclusion to prevent a preponderance of high-risk individuals in one pool ("adverse selection"). Similarly, programs should avoid "skimming," the selection of only those at very low risk of health problems.

Recommendation to Meet the Needs of Workers and Their Families: Expansion of Employer-Sponsored Health Care Plans

Most of the U.S. population with insurance has traditionally been covered through employer-sponsored plans. A broad consensus, therefore, already exists that employers have a responsibility to provide coverage. Our proposal for expanded employer-based coverage provides continuity with the current system which will aid implementation and minimize costs.

Mandating employer-sponsored coverage will significantly reduce the problem of lack of insurance since a majority of those now uninsured are employed. Employer-sponsored groups generally benefit from lower premiums, an effect increased with the creation of insurance pools that broaden the community of risk to be covered. While this proposal benefits primarily the uninsured, a mandated basic package will also benefit the low-income underinsured

A broad consensus already exists that employers have a responsibility to provide coverage.

intent of this ommendation is to vide universal erage for workers and r families.

whose policies now preclude access to basic services.

APWA recommends expansion of employer-sponsored health care coverage as follows:

1. Eligibility

The intent of this recommendation is to provide universal coverage for workers and their families. All employees following 28 consecutive days of employment would be covered. This would include self-insured firms. Very small employers (perhaps with six or fewer workers) would be exempted. Employees in such firms would have the option of purchasing coverage in state or regional insurance pools, described below.

2. Coverage

Employees and their dependents will be entitled to a basic benefit package to assure an acceptable level of health and self-sufficiency. The basic package includes:

- inpatient and medically necessary outpatient hospital services
- physician services
- prenatal, well-baby, and well-child care
- diagnostic and screening tests

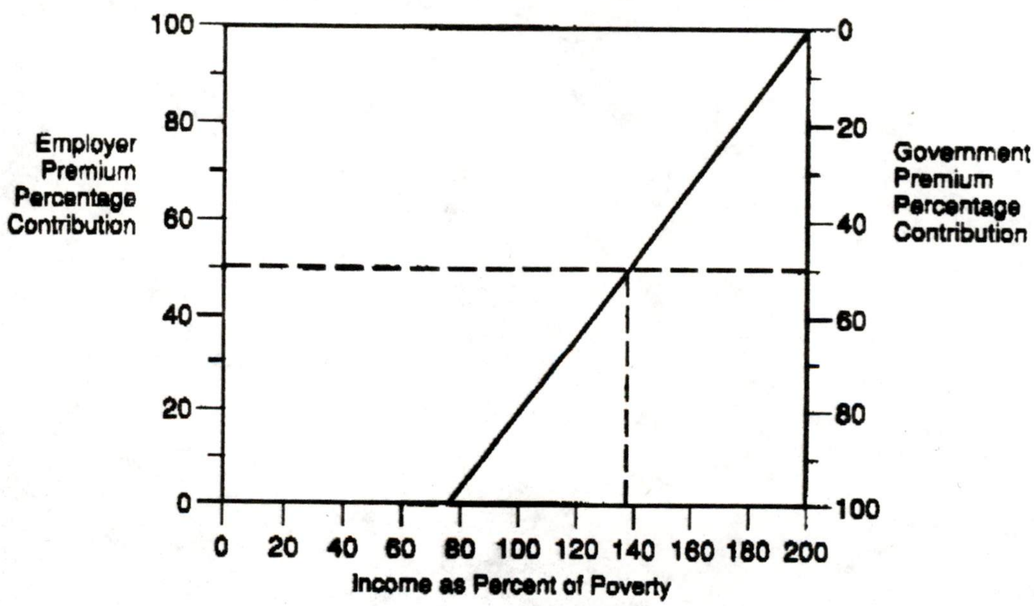
We view this basic package as a starting point to provide services at the core of primary prevention and catastrophic health care. We recommend phasing in other important services over time, specifically:

- prescription drugs
- dental services for children
- eye care

3. Financing

For fulltime employees with family income greater than a percentage of the state specific FLS/FHS (200 percent of poverty as an interim measure) the cost of coverage would be split 80-20 between the employer and employee. For workers earning below 200 percent of poverty, the employee share of the premium would be subsidized in part by the government on an income-based

Government Subsidy for Low-Income Workers



sliding scale (see chart, Government Subsidy for Low-Income Workers). If family income falls below 75 percent of poverty, the government covers the entire employee share of the premium.

For parttime workers with family income at or above 200 percent of poverty, the employer would pay a share of the premium based on hours worked—more for the worker who works more hours to assure that an employer does not have to pay fulltime benefits for parttime workers (see chart, Premiums for Parttime Employees).

This sharing of responsibility for health care costs among the employee, the employer, and government is a public-private partnership consistent with the principle of reciprocal obligations outlined above. For this purpose, a fulltime employee is defined as one who works 20 or more hours a week.

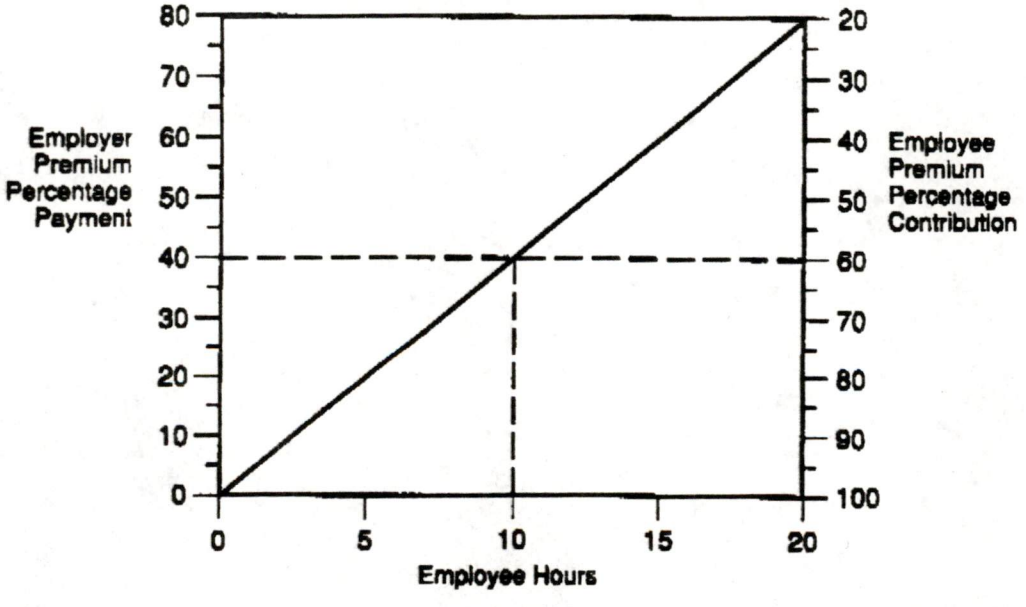
4. Small business

To address the problem of increased costs for small businesses we propose the creation of state or regional insurance pools. Such pools, either privately administered with public oversight or publicly administered, could spread the costs of financial risk among many small employers in an area. It is the intent of this recommendation to facilitate coverage for all workers, and to provide access to state or regional pools to all small businesses for whom pools represent the most efficient means of insuring workers.

The government could assist in the development of pools and facilitate matching small employers with pools. It may be appropriate to develop pools for specific sectors of industry. Careful development and design of pools can also assure efficiency through strong managed-care components. A further option to meet the economic concerns of employers would be the possibility of purchasing Medicaid coverage for workers. To minimize the financial impact on small businesses, we recommend phasing in expanded coverage, and giving consideration to tax breaks and other assistance

This sharing of responsibility for health care costs among the employee, the employer, and government is a public-private partnership.

Premiums for Parttime Employees



All public and private institutions have a role in achieving a society of healthy, productive citizens. There is no more important task for America than a major national investment in the well-being of poor children and in the strength and self-sufficiency of their families.

—*One Child in Four*, APWA, 1986

through individual state economic development programs.

5. Self-employed and other specific worker groups

We propose that self-employed individuals, temporary workers, and intermittent workers have access to the system of regional insurance pools. In addition, self-employed individuals would be allowed to deduct 100 percent of the cost of health insurance as is the case with employers providing group health coverage. Today the self-employed may deduct only 25 percent of their costs.

For temporary and intermittent workers, we propose that insurance pools allow employers to pay for coverage based on annual averages for their employees. Such financing arrangements could be made so that these workers pay premiums based on annual or quarterly averages of hours worked, with a government subsidy of those premiums based on averaged incomes.

Recommendation to Meet the Needs of Nonworking Individuals and Families: Extension of Medicaid Eligibility

For nonworking individuals and their families, APWA recommends extending Medicaid eligibility so that those not currently covered receive benefits. There are sound reasons to use Medicaid to cover those who would not be affec' ı by expanding employer-sponsored coverage, including the fact that a delivery system is now in place. Broadening Medicaid coverage can be accomplished without additional administrative structures and administrative funding.

Certain difficulties within Medicaid now, such as low provider participati. could be addressed by this broadened coverage, and specifically the decoupling of eligibility from cash assistance. Provider participation levels could be enhanced as program enrollment increases and providers respond to increased market share potential. Lack of

continuity in coverage and uncertainty about reimbursement has been a disincentive for providers. This proposal provides continuity of coverage for the nonworking population and eliminates the uncertainty about reimbursement.

We propose amending the current Medicaid program to require states to provide Medicaid benefits to all nonworking individuals and families. The amended program would provide for all costs of coverage of individuals and families with incomes up to a particular level of the FLS/FHS (on an interim basis, 75 percent of poverty) with some asset limitations. States would be required to provide to this population all benefits currently included in their Medicaid program. States would also be required to provide a basic package of benefits, and could charge premiums and deductibles to those with incomes at or over 75 percent of poverty.

APWA recommends restructuring the Medicaid program to include nonworking individuals and families as follows:

1. Eligibility

Those eligible would be all nonworking individuals and families who are not otherwise eligible for Medicaid or other third-party coverage. Recent legislation mandates coverage for infants and pregnant women up to 100 percent of poverty, and allows coverage up to 185 percent of poverty. We encourage states to provide this optional coverage. It should also be noted that recent welfare reform legislation extends Medicaid coverage for one year to families leaving welfare due to employment, and we expect this transition benefit to remain in place until the expansion in employer-sponsored coverage takes effect.

Eligibility would be based on simple tests of income and assets rather than categorical requirements of cash assistance programs.

COST-EFFECTIVE PROGRAMS

Program	Benefits for Children	Cost Benefit
Prenatal Care	Reduction in prematurity, low birthweight births, and infant mortality; elimination or reduction of diseases and disorders during pregnancy.	$1 investment can save $3.38 in cost of care for low birthweight infants.
Medicaid	Decreased neonatal and infant mortality, and fewer abnormalities among children receiving EPSDT services.	$1 spent on comprehensive prenatal care added to services for Medicaid recipients has saved $2 in infant's first year; lower health care costs for children receiving EPSDT services.
Childhood Immunization	Dramatic declines in incidence of rubella, mumps, measles, polio, diphtheria, tetanus, and pertussis.	$1 spent on Childhood Immunization Program saves $10 in later.

Source: *Opportunities for Success: Cost Effective Programs for Children Update, 1988*, Select Committee on Children, Youth and Families, U. S. House of Representatives

Eligibility would be based on simple tests of income and assets rather than categorical requirements of cash assistance programs. Individuals and families whose incomes are below the interim measure of 75 percent of poverty and whose resources do not exceed $12,000 (excluding the home and other non-countable resources) would be eligible for Medicaid coverage without premium or deductible obligations. This approach would eliminate current categorical limitations on eligibility for this group.

Individuals and families with income above that measure, or assets in excess of $12,000, would be eligible for a basic benefit package but would be subject to premiums and deductibles on a sliding scale at state option. This coverage would use the Medicaid administrative system.

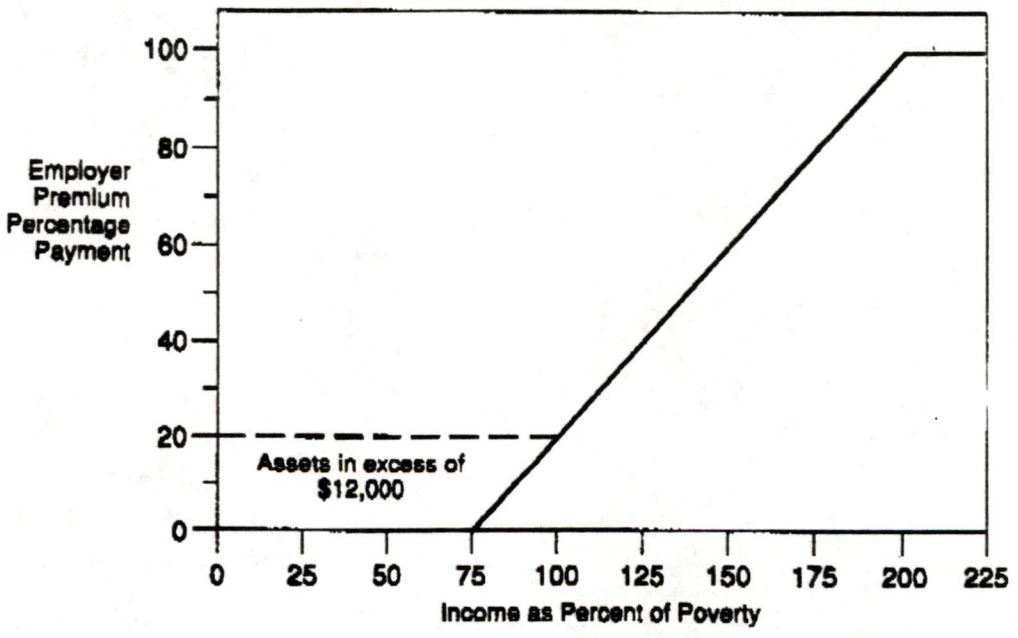
2. Coverage

For those individuals with incomes below the interim measure of 75 percent of poverty, states would provide the same benefits currently provided in their state plans. For those with incomes equal to or above 75 percent of poverty, states must offer at least a basic package of benefits equal to the basic employer-sponsored package. This includes:

- inpatient and medically necessary outpatient hospital services
- physician services
- prenatal, well-baby, and well-child care
- diagnostic and screening tests

As stated above with reference to employer coverage, we recommend

Premium Schedule for Buy-In Coverage



phasing in the following services as part of the basic package over time:

- prescription drugs
- dental services for children
- eye care

3. Financing

Financing would remain the same as current Medicaid funding with federal and state contributions based on the established federal matching rate. Enrollees with incomes at or above the specified level of FLS/FHS (75 percent of poverty as an interim measure) would pay monthly premiums according to a sliding schedule based on income. A household with income equal to or above 200 percent of poverty would be required to pay 100 percent of the average costs of providing the particular package of services for which the client enrolled. Individuals below the income level of 75 percent of poverty with assets in excess of $12,000 would pay 20 percent of the premium costs (see chart on page 24).

States would have the flexibility to set up multiple benefit packages that would meet or exceed the minimum package, and charge higher enrollment fees depending on the benefits included in the particular service package. States could charge deductibles and copayments in order to control service utilization of these expanded coverage packages.

Both of these proposals will, when fully implemented, make access to basic health care a reality for all Americans. These are investment strategies: investments in the well-being of individual Americans, and investments in a strong and productive economy. ■

Conclusion

In 1986 nearly 19 million Americans needed medical care, but for financial reasons had difficulty getting care, according to a nationwide survey by the Robert Wood Johnson Foundation. The same research found that one-third of the nation's poor children had not seen a doctor. The deterioration in access to health care for America's poor families and children demands action—action by the national and state governments and the private sector. Access to health care is critical for the well-being of individuals and families, and critical as well to the economic productivity of the nation.

These recommendations build upon, and are similar to, the proposals of other concerned organizations. While researchers, analysts, and lawmakers have proposed either a broadened Medicaid program, or mandated employer coverage, APWA believes that the only way to equitably address the problems of those lacking health insurance is to implement both proposals. This dual approach will alleviate the problems of the uninsured and underinsured, within a framework that is manageable and equitable for the public and private sectors.

We believe these recommendations are viable and feasible. We understand that expanded Medicaid coverage and a broad mandate for employer-sponsored health insurance coverage represent major changes in our national health policy. This progress will not come about without additional costs. The initial costs can be minimized by phasing in the new policies, including the specific basic benefit package. It is important to keep in mind, however, that this nation is already incurring far greater social and economic costs through continued inaction. Today many of our health care costs are being borne inequitably. Companies providing health insurance are subsidizing their competitors who do not provide coverage. And the worst burden, by far, is that borne by individual poor children whose quality of life is diminished because their mothers were unable to obtain needed prenatal care.

Samuel Johnson wrote that "a decent provision for the poor is the true test of a civilization." That is a test we are failing today. We cannot address the needs of the poor without addressing the need for access to health care.

As a society we have historically dealt only with pieces of the health-care puzzle, and not with the puzzle as a whole. It is time to take a comprehensive view of the situation, determine how and where society *should* be investing in health care for our citizens, and take the actions necessary to assure access to health care for all Americans. ■

Access to health care is critical for the well-being of individuals and families, and critical as well to the economic productivity of the nation.

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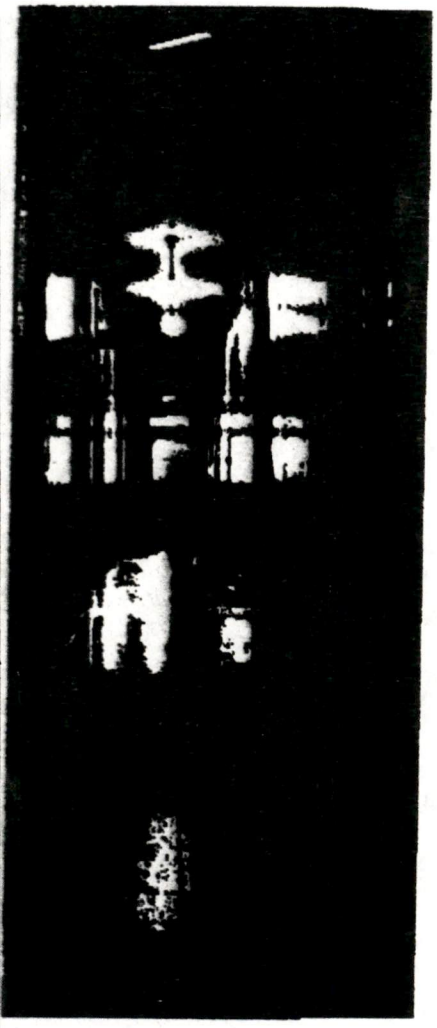

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THE WHITE HOUSE
WASHINGTON

Date: 4-28-99

FOR: Governor Summers

FROM: ANDY CARD Andy

- ☐ Action
- ☐ Your Comment
- ☐ Let's Talk
- ☒ FYI

fyi

note: Bill Roper will push HCFA to follow his recommendations.

fil

THE WHITE HOUSE

WASHINGTON

April 28, 1989

MEMORANDUM FOR ANDREW H. CARD, JR.

FROM: WILLIAM L. ROPER Bill

SUBJECT: Maine Medicaid Issue: Day Habilitation Services

Background

- o The Medicaid law requires that services be essentially medical in nature in order to be eligible for federal matching funds.
  - Under current regulations, habilitation services are eligible for a federal match only when provided in an intermediate care facility for the medically retarded (ICF/MR) or as part of a home and community-based services waiver.

Narrative

- o Maine submitted a state plan amendment proposing to extend the range of facilities in which it provides habilitation services to include skilled nursing and intermediate care facilities.
  - Notwithstanding the fact that the amendment was inconsistent with law and regulations, the Health Care Financing Administration (HCFA) regional office in Boston approved the amendment.
- o The state subsequently proposed amending its state plan to further extend the settings where it provided habilitation services to include the community, that is, outside institutions.
  - Because a HCFA regional office staff member told the state over the phone that its plan already covered individuals in the community, the state did not pursue the amendment process.
    - The original state plan amendment covers only 70 to 80 persons. The follow up amendment, extending habilitation services into the community, covers 600 people.

- HCFA asserts that the state is attempting to shift state costs to the Medicaid program. Much of the services relate to sheltered workshops. A HCFA site visit found one group being provided habilitation services at work stuffing envelopes. This is HCFA's example to show the services, while appropriate, are not the type contemplated by the Medicaid law.

Current status

o HCFA is attempting to correct what it views as a mistake by the Boston regional office.

  - HCFA deferred payment on the community services in its most recent state payment.

  - HCFA has initiated the compliance process to bring the state plan into compliance with state law. This would have the effect of undoing the first state plan amendment on the grounds that it conflicts with the Medicaid statute.

o If every state covered habilitation services outside institutions the federal cost is estimated to be several hundreds of million per year.

Recommendation

I believe the situation can be resolved if the State of Maine agrees to stop making claims for day habilitation services outside ICFs/MR. In return, I believe HCFA would not pursue any further financial penalty against the state.

This agreement, if accomplished, should be kept as quiet as possible, so as not to give other states incentives to seek similar settlements.

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

April 25, 1989

MEMORANDUM FOR BILL ROPER

FROM: ANDY CARD AC/LS

SUBJECT: HCFA

Sen. Cohen has been in touch with the Governor regarding a HCFA waiver for Maine. According to Senator Cohen, they were promised approval of a change to their state medicaid plan and now HCFA is reneging on the promise. More specifically, it concerns services for the developmentally disabled.

I would appreciate your checking into this situation and getting back to me as soon as possible ... The Governor will meet with Cohen Friday.

AC--

HAVE you heard back on this? Or, shall I hound Roper's office?

I hound Bill this afternoon (4/27).
We should hound again 4/28!

Andy

MAKE APPT
GET ANSWER TO HHS FRI A.M.

Document Originally
Attached to
Following Page

ANDY.

FROM SENATOR COHEN, MAINE
FOR GOV. M ⊆ K

HCFA "PROMISED" MAINE APPROVAL OF A CHANGE TO THEIR STATE MEDICAID PLAN... (NOW RENIGGING ON PROMISE)
Re: DAY HABILITATION SERVICES FOR THE DEVELOPMENTALLY DISABLED —
COST $2.5 MILLION
CAN WE HELP?

HHS - Andy Leap call
Kevin Moley

THE WHITE HOUSE
WASHINGTON

Sen. Cohen —

48 hr resol

visit / Ld

I
Andy after you get
answer — Cohen should
be able to come down here
to discuss 48 hr

MEMORANDUM

THE WHITE HOUSE

WASHINGTON

April 25, 1989

MEMORANDUM FOR BILL ROPER

FROM: ANDY CARD AC/LS

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4/28

Andy—

Here is a fact sheet on this matter— I'd be glad to discuss what our options are—

Bill

MAINE'S DAY HABILITATION SERVICES ISSUE

Background

- The Medicaid law requires that services be essentially medical in nature in order to be eligible for federal matching funds.
  - Under current regulations, habilitation services are eligible for a federal match only when provided in an intermediate care facility for the medically retarded (ICF/MR) or as part of a home and community-based services waiver.

Narrative

- Maine submitted a state plan amendment proposing to extend the range of facilities in which it provides habilitation services to include skilled nursing and intermediate care facilities.
  - Notwithstanding the fact that the amendment was inconsistent with law and regulations, the Health Care Financing Administration (HCFA) regional office in Boston approved the amendment.
- The state subsequently proposed amending its state plan to further extend the settings where it provided habilitation services to include the community, that is, outside institutions.
  - Because a HCFA regional office staff member told the state over the phone that its plan already covered individuals in the community, the state did not pursue the amendment process.
    - The original state plan amendment covers only 70 to 80 persons. The follow up amendment, extending habilitation services into the community, covers 600 people.
    - HCFA asserts that the state is attempting to shift state costs to the Medicaid program. Much of the services relate to sheltered workshops. A HCFA site visit found one group being provided habilitation services at work stuffing envelopes. This is HCFA's example to show the services, while appropriate, are not the type contemplated by the Medicaid law.

Current status

- HCFA is attempting to correct what it views as a mistake by the Boston regional office.
  - HCFA deferred payment on the community services in its most recent state payment.
  - HCFA has initiated the compliance process to bring the state plan into compliance with state law. This would have the effect of undoing the first state plan amendment on the grounds that it conflicts with the Medicaid statute.
- If every state covered habilitation services outside institutions the federal cost is estimated to be at least $200 million per year.