American Public Health Association
Working for a Healthier World
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July 27, 2006

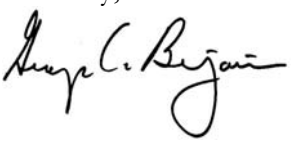
Patricia A. Maryland, DrPH
Chair
Citizens' Health Care Working Group
7201 Wisconsin Avenue
Suite 575
Bethesda, MD 20814

Dear Dr. Maryland:

On behalf of the American Public Health Association (APHA), the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States, please accept the attached document as comments to the Interim Recommendations of the Citizens' Health Care Working Group.

Thank you for your attention to and leadership on this important public health issue. We look forward to working with the Citizens' Health Care Working Group as it moves its recommendations forward. If you have questions, or for additional information, please contact me or have your staff contact Courtney Perlino at (202) 777-2436 or courtney.perlino@apha.org.

Sincerely,



Georges C. Benjamin, MD, FACP
Executive Director

The American Public Health Association (APHA) is the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

For over 130 years, APHA has been in the forefront of numerous efforts to prevent disease and promote health. Since 1950, APHA has vigorously supported and promoted the concept of universal health care throughout the United States. APHA is committed to the policy that all individuals in the United States deserve unencumbered access to quality health care services, regardless of race, gender, financial status and/or geographical location. We share your views that, with approximately 46 million Americans who are uninsured, the approach to increasing the access of Americans to affordable health care needs to be multifaceted in nature—addressing both the public and private sectors and the rising costs of prescription drugs, while implementing measures to make the health system operate in a more efficient and effective manner.

APHA was an original supporter of the Health Care that Works for All Americans Act for a number of reasons. First, the bill established a working group that would provide an open debate for Americans from a variety of backgrounds and experiences within the U.S. health care system to come together and examine the best ways to ensure quality, affordable health care for all Americans. Second, after convening hearings across the country to involve broad public participation, the working group was charged with providing Congress with recommendations on how to best address issues surrounding health care coverage and quality in the U.S. At this point, as the final proposed recommendations from the Citizens' Health Care Working Group are guaranteed hearings, APHA stresses the need for the Working Group to provide more specifics and clarity to its Interim Recommendations, so Congress will have the best guidance possible in terms of which direction to move in to provide health care for all Americans.

Recommendation #1: Guarantee financial protection against very high health care costs.
APHA agrees with the Citizens' Health Care Working Group Interim Recommendations that there is a need to adequately protect all Americans facing catastrophic health care costs, while ensuring the high quality and appropriate utilization of services and fair distribution of the financial burden of that care. However, a requirement that all Americans have coverage against high out-of-pocket costs cannot occur without a requirement for these individuals to have basic health coverage, including coverage for preventive services. Catastrophic coverage needs to incorporate an expanded definition of catastrophic health care that includes the coverage of persons faced with long-term as well as extended acute care costs. Ultimately, individuals need to be adequately protected against the financial devastation of extended acute and long-term health costs, which is especially needed by persons of all ages with chronic disabilities and diseases, and HIV/AIDS.

A free-standing catastrophic health insurance coverage policy is inadequate, as there is limited coverage for preventive services, and no coverage for such essential, yet costly services as outpatient prescription drugs, eyeglasses, hearing aids, dental care, unskilled home care, and most nursing-home care. For some of these services, costs are rising rapidly; and all of these services would most efficiently and effectively be provided by a single, unified program rather than leaving beneficiaries to their own complementary insurance. In this vein, APHA is especially concerned with the illustration that is being used as it a) is a free-standing requirement for coverage against high out-of-pocket costs and b) is highlighting what currently exists in the private sector, which is ineffective. APHA is cognizant of the need for risk adjustment and reinsurance mechanisms that

consider the particular issues presented by high-risk populations. However, we stress that the highlighted design, although used an example, leads individuals in the wrong direction.

If there is a requirement for catastrophic health care coverage, APHA iterates that individuals with household incomes under 200% FPL should not be unduly burdened financially. It is ultimately questionable whether individuals, especially parents with children, in this income bracket would be able to pay their premiums and deductibles for this coverage while continuing to meet their basic needs, especially if they live in areas with higher costs of living. Ultimately, the subsidies for this income bracket will have to be substantial, and for people below 100% FPL, would have to cover the full cost of such coverage.

Although this recommendation would offer protection to Americans who are currently uninsured or underinsured against high health care costs, APHA reiterates these individuals need more than catastrophic coverage to fully protect themselves from financially devastating costs associated with their health care. They need basic health care coverage as well, which will protect them against the potentially crippling costs associated with visiting a physician or dentist, and prescription drugs.

Recommendation #2: Supported integrated community health networks
APHA supports this recommendation. Federally Qualified Health Centers, community health centers, migrant health centers, health care for the homeless programs, public housing primary care programs and school-based health centers and other safety net providers provide needed high-quality, family-oriented, culturally and linguistically competent primary and preventive care to millions of poor and near-poor Americans, many of whom are uninsured. Although these networks at the community level need to be integrated and expanded, a stable funding stream for these entities is needed so they have the ability to provide needed care. So, it would make sense, in this recommendation, to stress that the Medicaid program needs to continue to be adequately funded, as it is a primary financier of safety-net providers. Without needed Medicaid dollars, these public health providers, with only grant and other funding sources upon which to rely, would not be able to sustain their viability. This reality is shown by the studies that have concluded that Medicaid contributes to approximately one-third of health center operating revenue, and is the largest source of revenue for community mental health providers. In the case of school health centers, Medicaid financing positively correlates with the availability of health services available to students.

Recommendation #3: Promote efforts to improve quality of care and efficiency.
APHA agrees with this recommendation. In fact, APHA's 14 Points on Universal Health Care Toward a National Health Program for the United States calls for incentives and safeguards to assure effective and efficient organization of services and high-quality care, and education of consumers about their health rights and responsibilities. We agree that the utilization of health information technologies and electronic medical record systems constitute a step in the right direction, as long as the privacy rights of patients are upheld. However, ultimately, a focus on evidence-based medicine, using the best available science to protect the public's health, is needed. Evidence-based medicine will lead the health system to rely more on health education, disease prevention and health promotion versus treating disease.

Recommendation #4: Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.
APHA agrees with this recommendation. Palliative care, including hospice care, is currently under-utilized in this country. This is reality despite the fact that hospice care has been shown to be

associated with greater family satisfaction, fewer patient/family unmet needs and with improvements in pain assessment and management. With an aging population, this is the time to develop more effective interventions for improving advance health care planning and end-of life care, as the proportion of deaths associated with chronic terminal illness will increase. Therefore, APHA endorses and supports the promotion of advance planning for end-of-life care through public and professional education by health care providers, public health professionals, government entities and/or community coalitions. Ultimately, the public needs to be educated on hospice and palliative care—and health care providers, public health professionals and government entities have to have a stake in that educational effort.

It is vital that payment incentives change for end-of-life services, which currently are slanted towards care provided in hospitals and nursing homes. Financial barriers to third party payment for early and comprehensive hospice and palliative care need to be eliminated. This includes, in the very least, the elimination of Medicare's requirement that such care may only be reimbursed when efforts to cure have been terminated.

Recommendation #5: It should be public policy that all Americans have affordable health care.

Although APHA agrees with the spirit of this recommendation, more specifics and clarity need to be added to this recommendation in order to make it different from the status quo. Currently, this recommendation reflects the current debate on health care, in which individuals prefer a wide range of solutions, ranging from single-payer to tax credits to health savings accounts. Without additional analysis of what options would work best to ensure that all Americans have affordable health care, it is regrettable that this recommendation would do little to move the debate forward.

Ultimately, in order to assure universal coverage for everyone in the United States, APHA calls for an organized system for defining health needs and for marshalling resources to meet them. APHA supports the view that every place in our country should have an official focal point of leadership and responsibility to monitor, maintain and assure the effectiveness of such a system. This system should offer comprehensive benefits, including health maintenance, preventive, diagnostic, therapeutic and rehabilitative services for all types of illnesses and health conditions. This should include the support and expansion of disease prevention measures including screening, education and counseling in ambulatory settings including hospitals, neighborhood health centers, outpatient departments and homes to promote healthy lifestyles and behaviors. These services must be provided through primary care teams of physicians, dentists, nurses and allied health professionals who are linked with specialty consultative personnel, hospital, nursing home, home health care and all other necessary services to meet the patient's total health needs. Also, attention in the delivery of care should reflect the needs of all populations including those confronting geographical, physical, cultural, language and other non-financial barriers to service.

To ensure that all individuals are able to access this care, financial barriers need to be eliminated. Ultimately, financing of such coverage should depend on an individual's ability to pay. This includes financing by a combination of federal social insurance and general tax revenues. Ultimately, the organization and administration of health care should be through publicly-accountable mechanisms to assure maximum responsiveness to public needs, with a major role for federal, state and local government health agencies.

In this system, it is essential that there be fair payment to providers using mechanisms that encourage appropriate treatment by providers and appropriate utilization by consumers.

This includes payment to providers for care for professional and institutional services to define population groups in a per capita basis; annually negotiated rates for institutional providers and choice of repayment or fee-for-service payment for professional providers; and incentives for providers to adopt patterns of organization and payment aimed at achieving more effective and efficient services, particularly those embracing prevention of illness, accessibility and continuity of care.

APHA would like additional information on the statement, found on p. 18 under "How will we pay for health care for all Americans?" that reads "The opinion polls we examined, the community meetings we held, and the web-based surveys and comments we received, all showed large majorities of people willing to make additional financial investments in the service of expanding the protection against the high costs of illness and the expansion of access to quality care." Specifically, is there data that outlines what percent of the "large majorities" have incomes under 200% FPL? 100% FPL? If there is no data, a qualifying statement is needed that these populations, especially as health care is not factored into computing the poverty line, may not be able to make these additional financial investments.

Recommendation #6: Define a 'core' benefit package for all Americans.

APHA is pleased that this recommendation takes into consideration that the set of core health services should include health maintenance, preventive, diagnostic, therapeutic and rehabilitative services for all types of illnesses and health conditions. These include, of course, disease prevention measures including screening, education and counseling in ambulatory settings, and physical, mental and dental health services. However, APHA believes that the call to establish an independent, non-partisan, private-public group needs to be more specific in terms of where it would best be housed, who will appoint members to serve on the group, etc.