John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

June 30, 1988

TO: Interested Parties

FROM: Deborah Curtis, Staff, Special Select Commission on Access to Health Care

SUBJECT: Symposiums on Access to Health Care

The Special Select Commission on Access to Health Care has contracted with Lewin/ICF, a health policy consulting firm in Washington, D.C. to assist the Commission in developing a plan for addressing problems of access to care in Maine. Lewin/ICF will be conducting several symposiums over the next several months as part of its contract. Interested parties are welcome to attend.

The schedule for the remaining symposiums is the following:

Tuesday, July, 19, 1988:	Insurance Mechanisms to Address Access to Care
Wednesday, September 7, 1988:	Financing Strategies for Addressing Access to Care
Thursday, September 29, 1988:	Design of a Basic Plan to Address Access to Health Care in Maine
Tuesday, November 29, 1988:	Discussion of the Components of the Commission's Plan

All seminars will be held in Room 427 of the State House, from 9:30 a.m. to 4:00 p.m.

bb

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

SCHEDULE OF SEMINARS

June 28	Problems of Access to Care and Service Delivery Strategies to Address the Problems
July 19	Insurance Strategies to Address Problems of Access
September 7	Financing Increased Access to Care
September 29	Design of a Basic Plan for Addressing Access to Care in Maine
November 29	Components of the Commission's Plan

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

June 28, 1988

AGENDA

9:30 - 10:00	Introductions
10:00 - 12:00	Who Lacks Access to Health Care? -- United States -- Maine -- Other States
12:00 - 12:30	What Impact Do Access Barriers Have? -- Health Status -- Health Care Costs
12:30 - 1:30	Lunch
1:30 - 3:30	What Health Services Delivery Strategies Can Address the Problem?
3:30 - 4:00	Next Steps

WHO LACKS ACCESS TO HEALTH CARE?

Population Group	Estimated Numbers* (millions)
II. Uninsured	37
A. Employed	26
1. Low Income	19
2. Middle-High Income	7
B. Self-employed	3
C. Non-Workers	8

* Source: Current Population Survey data analyzed by the Employee Benefit Research Institute, 1986.

WHO LACKS ACCESS TO HEALTH CARE?

Population Group	Estimated Numbers* (millions)
I. Insured	165
A. Low Income Publicly Insured	17
Groups with special access problems:	
-- Pregnant women	
-- Children with special needs	
-- Elderly	
-- Mentally ill/substance abusers	
B. Low Income Privately Insured	10
C. High/Medium Income	138

* Source: Current Population Survey data analyzed by the Employee Benefit Research Institute, 1986.

WHO LACKS ACCESS TO HEALTH CARE IN MAINE?

POPULATION GROUP	ESTIMATED NUMBERS*	EXTENT	CAUSE OF ACCESS PROBLEMS		
			FINANCIAL	DELIVERY SYSTEM	OTHER
I. Insured	1.0m				
A. Low income publicly insured Groups with special access problems: • Rural pregnant women. • Children eligible but not enrolled in Medicaid. • Elderly	136,000 (14%)	Medium	<u>Medicaid</u> Administration. Fee levels. Benefit levels/ coverage. Operational problems with "spenddown." <u>Medicare</u> Few preventive benefits. Deductibles/co-pay. Prescriptions.	Special needs not met by <u>medical</u> system (e.g., nutrition). Providers not available. Limited hours/long waits. Limited care management. Providers reluctant to deal with difficult cases. Geographic. Malpractice costs limit availability of providers.	Racial/cultural/language barriers. Transportation. Patients not linked to system. Patient behavior.

WHO LACKS ACCESS TO HEALTH CARE IN MAINE?

POPULATION GROUP	ESTIMATED NUMBERS	EXTENT	CAUSE OF ACCESS PROBLEMS		
			FINANCIAL	DELIVERY SYSTEM	OTHER
B. Low income privately insured • Part-time/ seasonal workers • Pregnant women	200,000 (20%)	Medium	Restricted benefits. High cost sharing relative to income. Employer contributions too low. Preexisting condition. Catastrophic.	Geographic Fragmented system not addressing multi-problem people/families. Limited hours/lost wages. Limited care management. Little prevention. Limited choice of providers. Malpractice costs limit availability of providers.	Racial/cultural/language barriers. Transportation. Patients not linked to system. Not easily identified/reached. Patient behavior.
C. High/Medium Income	664,000 (66%)	Low	Preexisting condition. Catastrophic. Loss of insurance due to disability.	Geographic. Fragmented system. Limited hours/cost of time. Malpractice costs limit availability of providers.	Patient behavior.

WHO LACKS ACCESS TO HEALTH CARE IN MAINE?

		EXTENT	CAUSE OF ACCESS PROBLEMS		
POPULATION GROUP	**ESTIMATED NUMBERS**		**FINANCIAL**	**DELIVERY SYSTEM**	**OTHER**
II. Uninsured (continued)					
2. Middle-High Income	31,000 (38%)	Low			
• Employed in firms that <u>don't</u> provide coverage.			Individual coverage not available. Medically underwritten out.	See above.	Patient behavior.
• Employed in firms that <u>do</u> provide coverage.			Dependent premiums too high. Elect no coverage. Medically under-written out.	See above.	Patient behavior.

WHO LACKS ACCESS TO HEALTH CARE IN MAINE?

POPULATION GROUP	ESTIMATED NUMBERS	EXTENT	CAUSE OF ACCESS PROBLEMS		
			FINANCIAL	DELIVERY SYSTEM	OTHER
II. Uninsured	132,000 (13%)				
A. Employed and dependents	83,000 (63%)				
1. Low Income	52,000 (62%)	High	Individual coverage not available/too expensive/medically underwritten out.	Geographic Special services not available/ coordinated. - medical - non-medical Limited hours/lost wages. Malpractice liability limits providers.	Racial/cultural/language barriers. Transportation. Patient behavior.
• Employed in firms that <u>don't</u> provide coverage.			Part-time excluded. Dependents excluded/ premium too high. Long waiting period. Elect no coverage: -- Premium cost -- Benefits too shallow/not attractive -- Other Preexisting conditions. High cost-sharing. Medically underwritten out.	See above.	See above.
• Employed in firms that <u>do</u> provide coverage.					

WHO LACKS ACCESS TO HEALTH CARE IN MAINE?

POPULATION GROUP	ESTIMATED NUMBERS	EXTENT	CAUSE OF ACCESS PROBLEMS		
			FINANCIAL	DELIVERY SYSTEM	OTHER
II. Uninsured (continued)					
B. Self-employed*	27,000 (33%)	Medium	Individual coverage not available/too expensive. Absence of 100% tax deduction for corporations.		
C. Nonworkers: Chronically Transitionally Out of Work Force Groups with special access problems: • Homeless • Chronically ill • Mentally ill/ substance abusers • AIDS • Pregnant women • Children	49,000 (37%)	High	Administrative/ categorical barriers to public insurance. Medicaid "spend-down." Eligibility process for Medicaid. Unable to afford individual coverage. Unable to afford continuation of coverage.	Too fragmented to cope with multiple needs. Inpatient care available, community-based not. Geography. Medical system mind-set not geared for (e.g., prescribing bed rest for homeless). Providers not trained for. Provider burn-out.	Health care not perceived as greatest need. Not linked to system/invisible/distrustful. No clear responsibility for care/ refusal to treat. Lack transportation/child care. Perceived in categories by others/ needs oversimplified. Temporary nature of special initiatives. Patient behavior.

* Self-employed are a subset of the employed uninsured. The numbers are part of the 83,000 employed uninsured.

HOW DO MAINE'S PROBLEMS COMPARE TO OTHER AREAS?

	Estimated Percent of Population			
Population Group	Maine	U.S.	D.C.	Pennsylvania
I. Insured	86.8%	82.0%	79.3%	91.4%
A. Low Income Publicly Insured	14.0	10.2	32.4	19.5
B. Low Income Privately Insured	20.0	6.0		6.6
C. High/Medium Income	66.0	83.8	67.6	73.8
II. Uninsured	13.2	18.0	20.7	8.6
A. Employed and Dependents	43.0	70.0	56.2	67.0
B. Self-employed	20.0	8.0	N/A	N/A
C. Non-workers	37.0	22.0	43.8	33.0

WHAT DIFFERENCE DOES LACK OF ACCESS TO CARE MAKE?
HEALTH STATUS

- Women who receive late or no prenatal care are at greater risk of having low weight births.

- Lack of primary care can result in more serious conditions often requiring hospitalization:

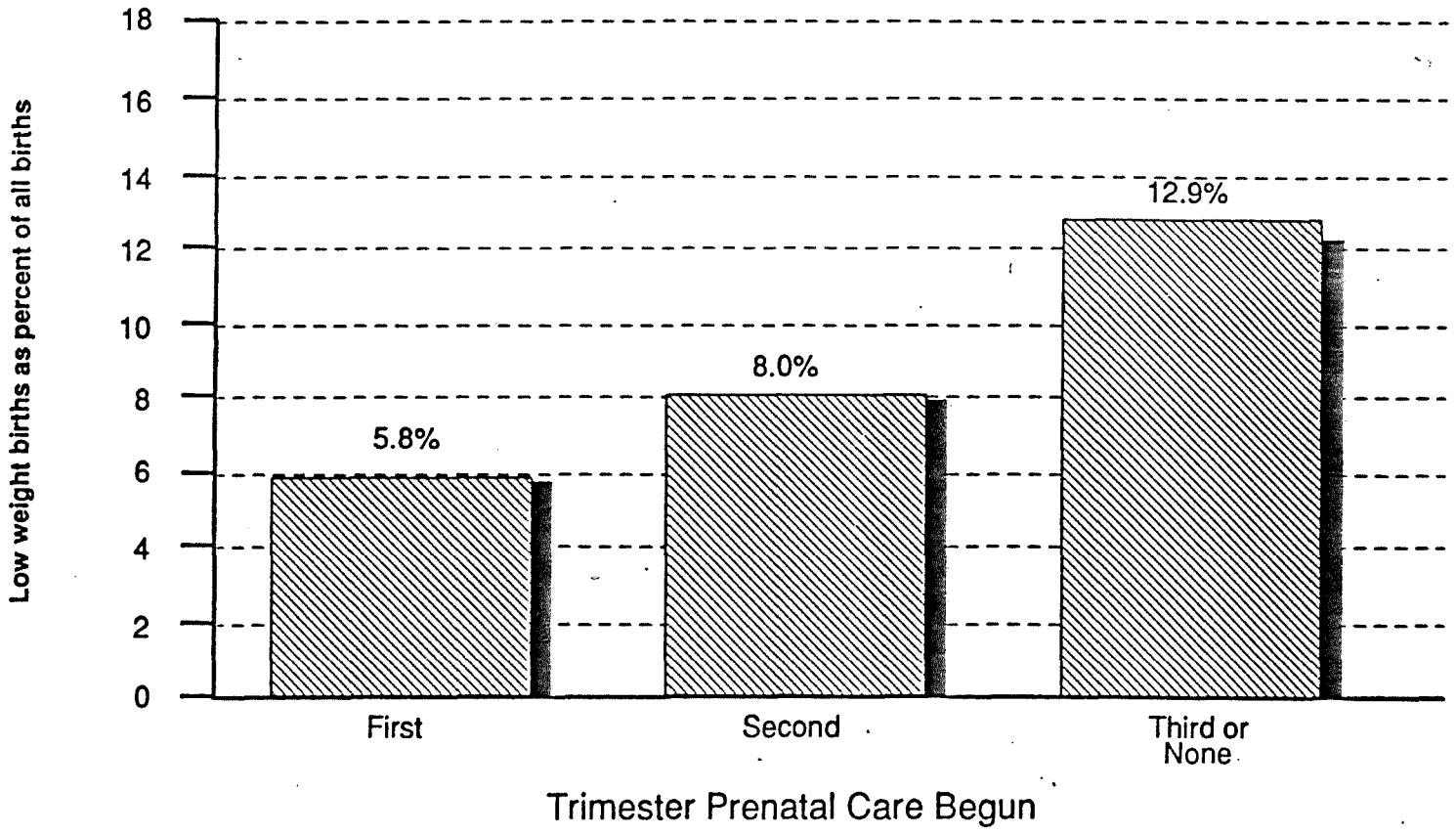
  -- Hospitalization for bronchitis is significantly higher among low income persons than high income persons.

  -- Low income populations are more likely than higher income populations to be hospitalized for conditions resulting from uncontrolled diabetes and hypertension.

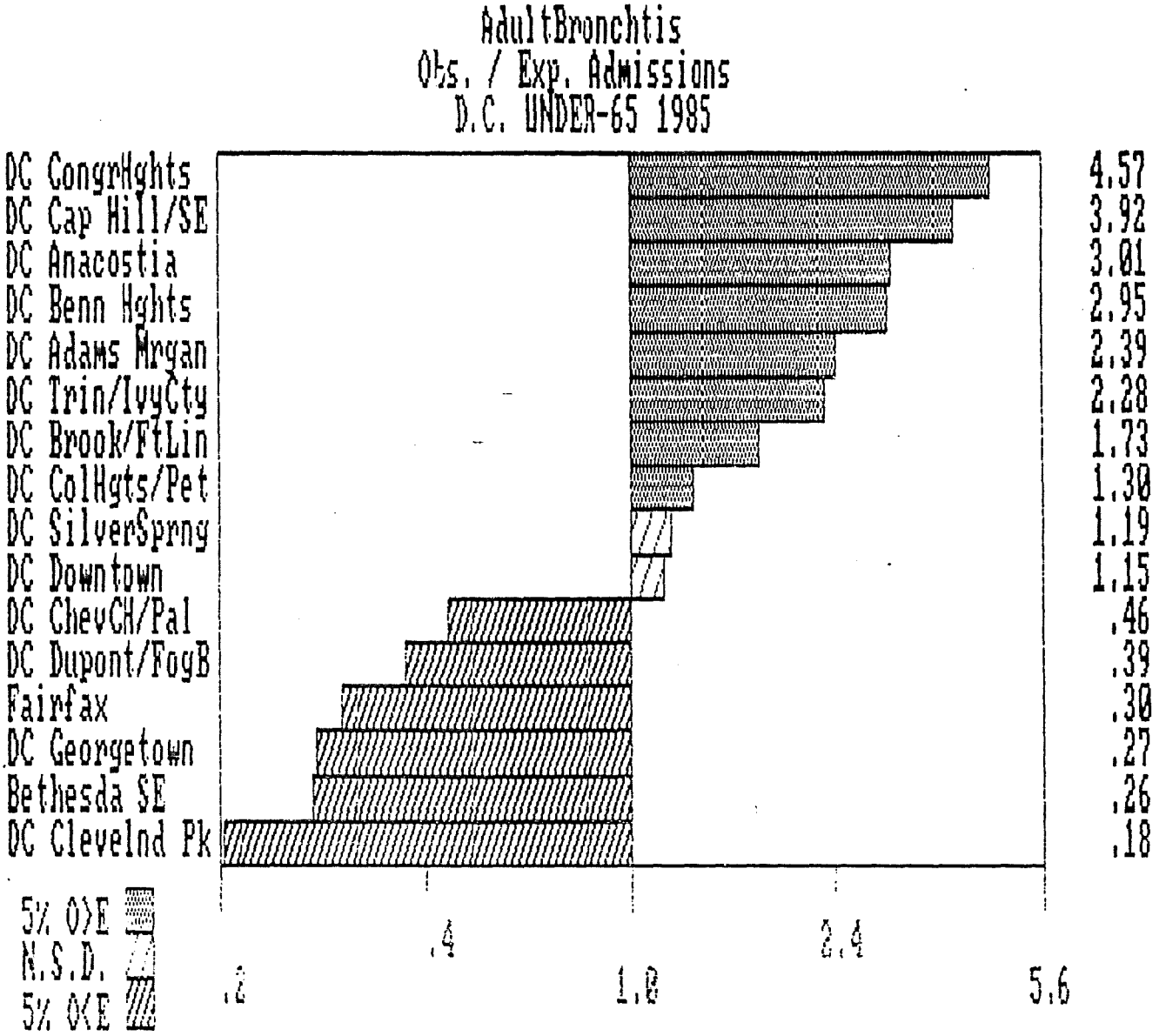
  -- Advanced stages of cancer, such as invasive cervical cancer, are more common among low income populations than higher income populations.

Women Who Receive Late Prenatal Care Are At Higher Risk of Having Low Birth Weight Births

(Pennsylvania, Total Population)



Source: Data runs by Lewin and Associates with data provided by State Health Data Center; data taken from birth certificates for births to Pennsylvania residents, 1986.


AdultBronchtis
Obs. / Exp. Admissions
D.C. UNDER-65 1985
DC CongrHghts
DC Cap Hill/SE
DC Anacostia
DC Benn Hghts
DC Adams Mrgan
DC Trin/IvyCty
DC Brook/FtLin
DC ColHgts/Pet
DC SilverSprng
DC Downtown
DC ChevCH/Pal
DC Dupont/FogB
Fairfax
DC Georgetown
Bethesda SE
DC Clevelnd Pk
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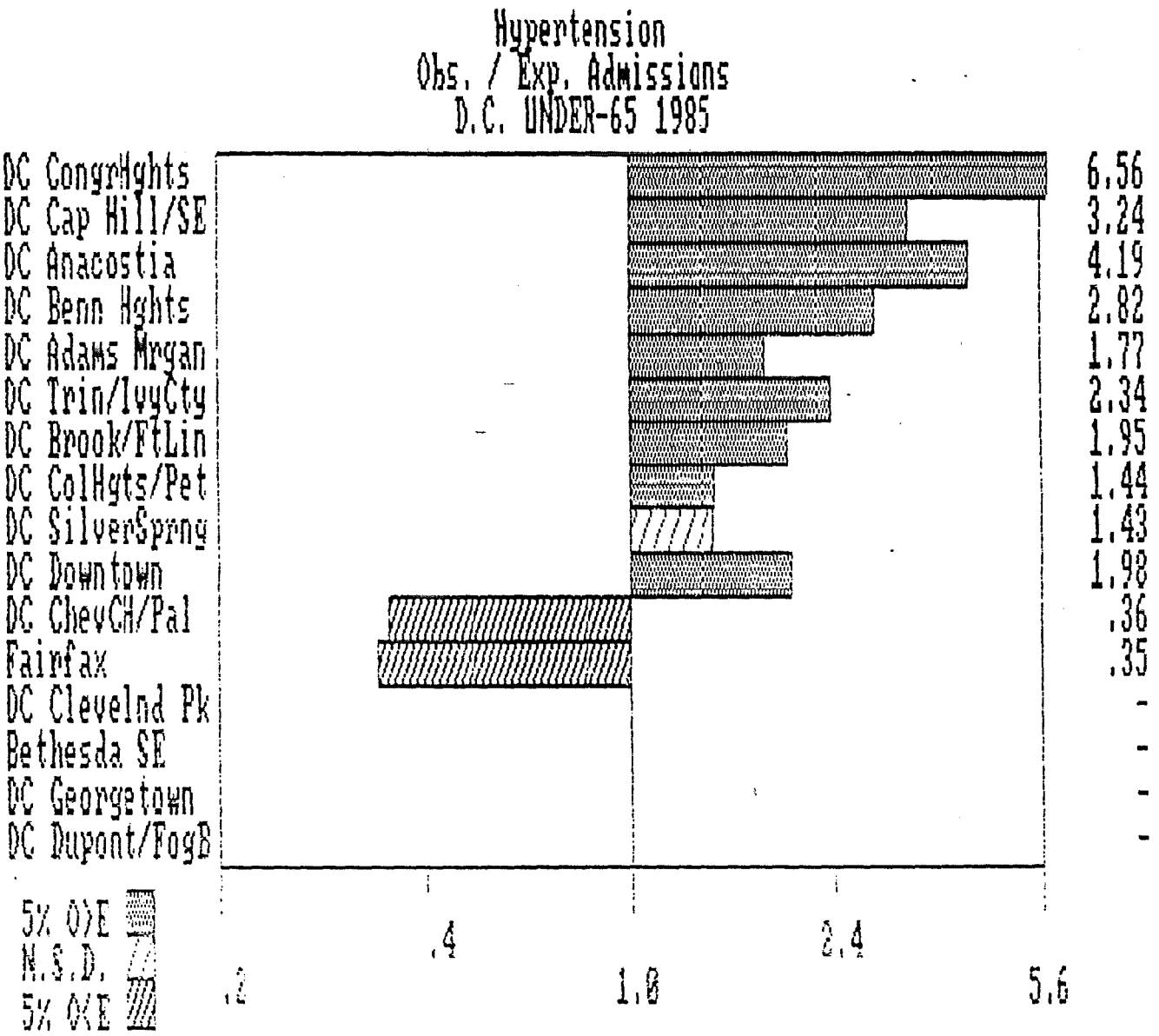
Hypertension
Obs. / Exp. Admissions
D.C. UNDER-65 1985
DC CongrHghts
DC Cap Hill/SE
DC Anacostia
DC Benn Hghts
DC Adams Mrgan
DC Trin/IvyCty
DC Brook/FtLin
DC ColHgts/Pet
DC SilverSprng
DC Downtown
DC ChevCH/Pal
Fairfax
DC Clevelnd Pk
Bethesda SE
DC Georgetown
DC Dupont/FogB
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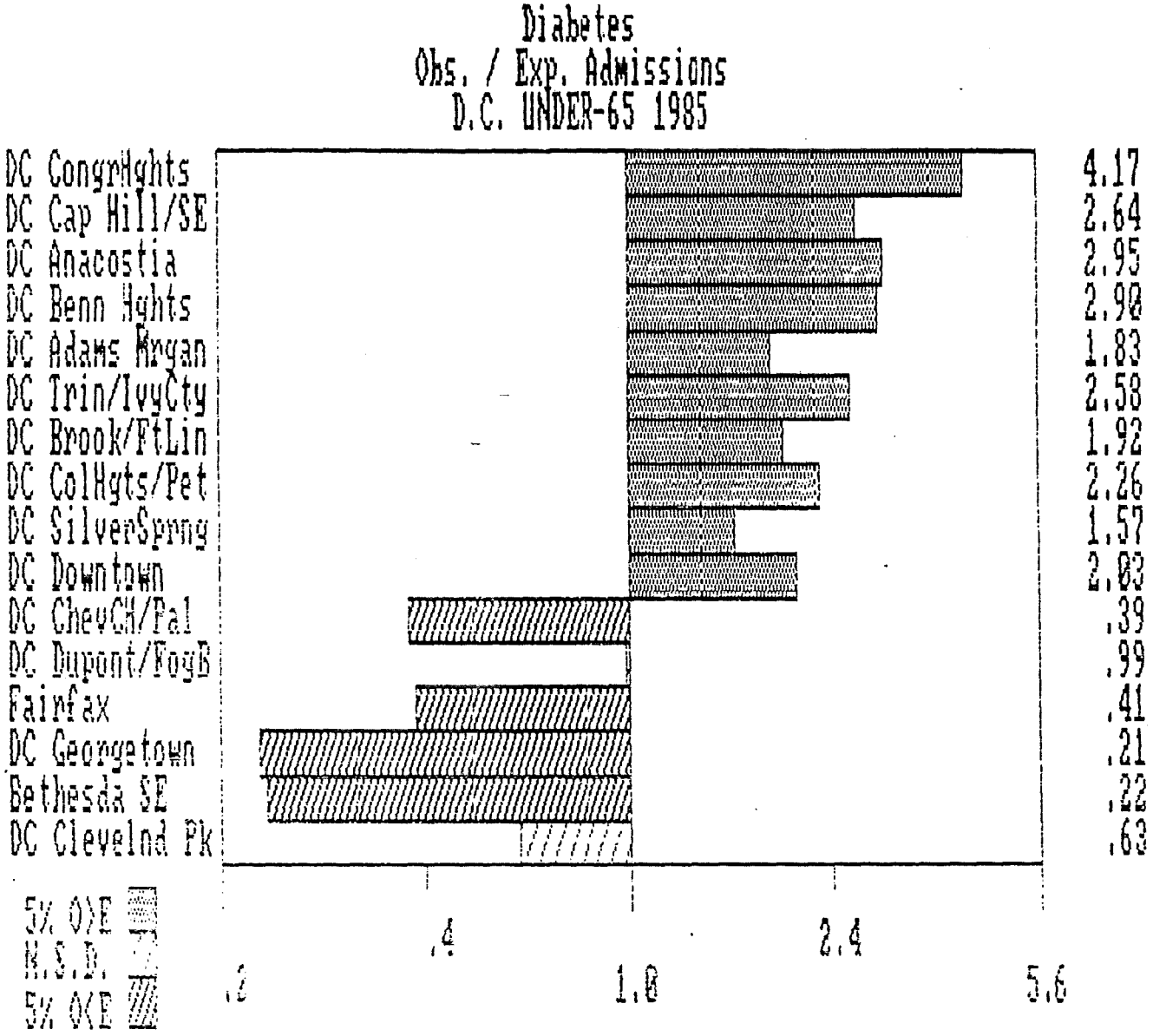
Diabetes
Obs. / Exp. Admissions
D.C. UNDER-65 1985
DC CongrHghts
DC Cap Hill/SE
DC Anacostia
DC Benn Hghts
DC Adams Mrgan
DC Trin/IvyCty
DC Brook/FtLin
DC ColHgts/Pet
DC SilverSprng
DC Downtown
DC ChevCH/Pal
DC Dupont/FogB
Fairfax
DC Georgetown
Bethesda SE
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WHAT DIFFERENCE DOES LACK OF ACCESS TO CARE MAKE?
HEALTH CARE COSTS

- Delayed, deferred, and episodic care may be increasing hospital costs.

  -- Low birth weight deliveries are more expensive than normal deliveries.

  -- Many hospitalizations are avoidable or preventable had the patient received appropriate primary care.

- Care provided in inappropriate settings may be increasing health care costs.

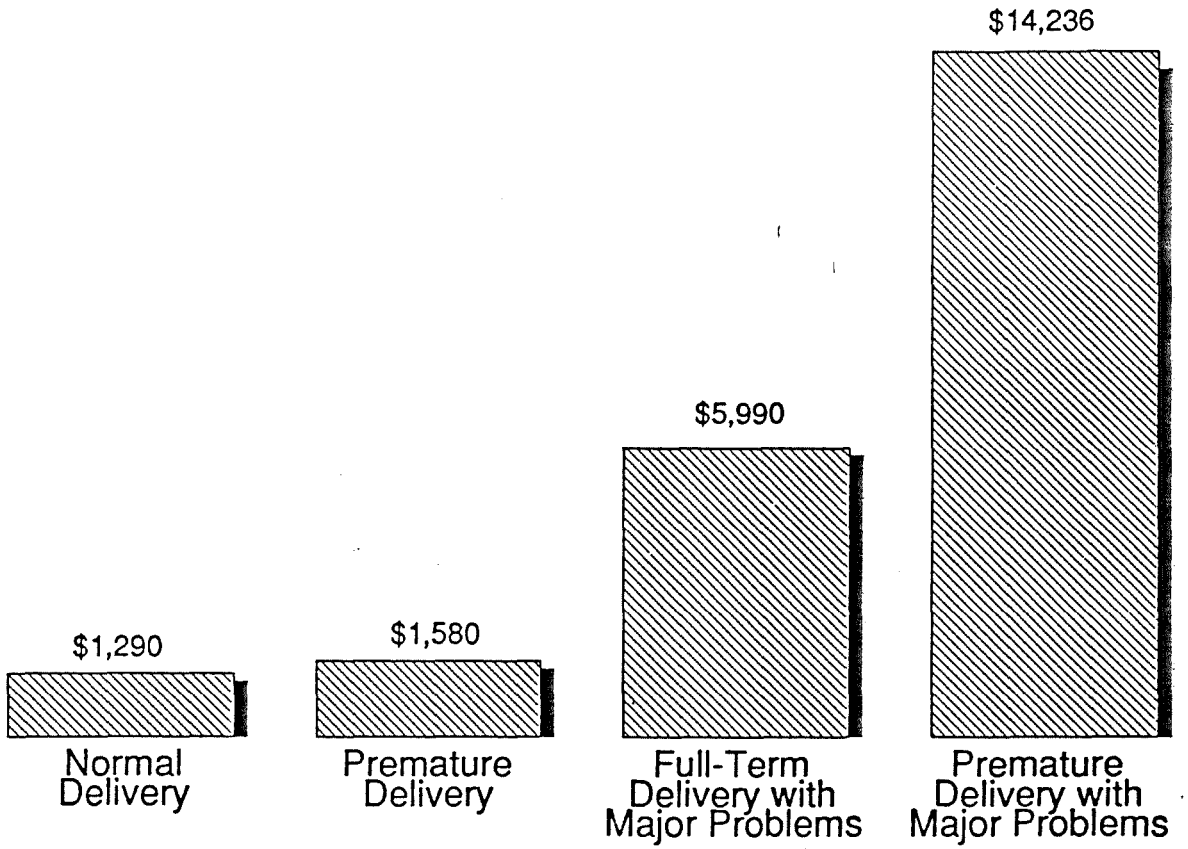
  -- The medically indigent are heavily dependent upon hospital-based sources of care (e.g., use of emergency rooms for primary care).

  -- The medically indigent are often hospitalized for conditions that can be treated in outpatient settings.

- Encourage efficiency by incorporating utilization control and case management into systems of care for the medically indigent.

Delayed, Deferred, and Episodic Care May Be Increasing Costs By Generating Adverse Outcomes That Are More Expensive to Treat

Adverse Effects of Low Birth Weight:
Average Amounts Approved by Medical Assistance



Source: Data run by Lewin and Associates with data provided by Department of Public Welfare of 10,000 Medical Assistance Recpients, 1984

What Health Services Delivery Strategies Can Address the Problem?

Population Group	Estimated Numbers	Service Delivery Strategies		
		Private	Private/Public	Public
I. Insured A. Low income publicly insured * Pregnant women * Elderly	1.0m (87%) 136,000 (14%)	***Build Capacity*** Medical society efforts. Restructured outpatient departments. ***Facilitate Use*** Hospitals reach out: • Transportation • Prenatal education	***Build Capacity*** Hospital/primary care center. Rural networks for physicians, hospitals, etc. Physician "circuit riding." ***Facilitate Use*** Subsidy of volunteer programs. ***Special Populations*** Malpractice solutions.	***Build Capacity*** Primary care centers. Public hospitals. Service contingent health professions training. ***Facilitate Use*** Family health workers. Transportation. Emergency systems. ***Special Populations*** Targeted programs for high-risk.

* Reference groups to test adequacy of our solutions.

What Health Services Delivery Strategies Can Address the Problem?

Population Group	Estimated Numbers	Service Delivery Strategies		
		Private	Private/Public	Public
I. Insured (cont.) B. Low income privately insured * Children	200,000 (20%)	*Build Capacity* Voluntary sliding fee scales. Private care or share. Accept assignment. *Facilitate Use* Waive cost-sharing. Voluntary health promotion.	*Build Capacity* Specialty society sponsors. State-subsidized programs. *Facilitate Use* Voluntary agencies/ churches help locate/serve with public health nurse. Insurance companies require health promotion.	*Build Capacity* Primary care center. Public hospitals Public agencies accept insurance. Mandated sliding fee scale. *Facilitate Use* Family health workers/case finder. Public clearing house.
C. High/medium Income * Pre-existing conditions	664,000 (66%)	Patient buys care management.	Subsidized care management. Alcohol and drug capacity (sliding scale).	

* Reference groups to test adequacy of our solutions.

What Health Services Delivery Strategies Can Address the Problem?

Population Group	Estimated Numbers	Service Delivery Strategies		
		Private	Private/Public	Public
II. Uninsured A. Employed 1. Low income • Employed in firms that <u>don't</u> offer insurance.	132,000 (13%) 83,000 (63%) 52,000 (62%)	***Build Capacity*** Medical society on-call. Free clinics. Providers offer insurance-like package to employer or employee.	***Build Capacity*** Inducements to physicians. Reorganized outpatient departments. ***Facilitate Use*** Translators. Workplace health promotion. Hospitals/physician triage.	***Build Capacity*** Primary care centers. Public hospitals. NPs/PAs triage, write vouchers. Mandate provider acceptance as condition of licensure/ reimbursement. ***Facilitate Use*** Evening/weekend primary care. Care managers/ advocates. Translator

What Health Services Delivery Strategies Can Address the Problem?

		Service Delivery Strategies		
Population Group	**Estimated Numbers**	**Private**	**Private/Public**	**Public**
I. Uninsured (cont.) • Employed in firms that do offer insurance		See above.	See above.	See above.

What Health Services Delivery Strategies Can Address the Problem?

		Service Delivery Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
2. Middle-High Income • Employed in firms that <u>don't</u> offer insurance.	31,000 (38%)	***<u>Build Capacity</u>*** Providers offer insurance-like package to employer or employee. ***<u>Facilitate Use</u>*** Voluntary health promotion. Employee assistance programs.	***<u>Facilitate Use</u>*** See above.	***<u>Build Capacity</u>*** Primary care centers. Public hospitals.
• Employed in firms that <u>do</u> offer insurance.			See above.	

What Health Services Delivery Strategies Can Address the Problem?

Population Group	Estimated Numbers	Service Delivery Strategies		
		Private	Private/Public	Public
B. Self-employed * Medically underwritten out	27,000 (33%)	Hospital manages care.	Subsidized care manager.	
C. Nonworkers * Homeless * AIDS * Chronically mentally ill/ substance abusers	49,000 (37%)	***Facilitate Use*** Voluntary outreach (e.g., churches, shelters with volunteer physicians).	***Facilitate Use*** Health promotion. Reward providers who serve. Health professions training. Subsidized community-based care. ***Special Populations*** Circuit-riders to special needs.	***Build Capacity*** Primary care centers. Public hospitals. Service-contingent health professions training. Programs for alcohol, drug abuse, mental health. Multi-year funding.

* Reference groups to test adequacy of our solutions.

What Health Services Delivery Strategies Can Address the Problem?

Population Group	Estimated Numbers	Service Delivery Strategies		
		Private	Private/Public	Public
C. Nonworkers ✳ Homeless ✳ AIDS ✳ Chronically mentally ill/ substance abusers	49,000 (37%)			*Facilitate Use* Health connected to higher priority services. Family health workers. Care managers. Link to social and other services. Transportation. *Special Populations* Targeted programs for high-risk.

✳ Reference groups to test adequacy of our solutions.

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

July 19, 1988

AGENDA

9:30 - 9:45	Introductions
9:45 - 10:15	Review of Service Delivery Strategies
10:15 - 10:30	Who Are the Uninsured in Maine?
10:30 - 10:45	Break
10:45 - 12:30	What Insurance Strategies Can Address the Problem?
12:30 - 1:30	Lunch
1:30 - 2:45	How Do Proposals to Address the Problem Compare?
2:45 - 3:00	Break
3:00 - 3:30	What Should Be the Minimum Benefits/Services?
3:30 - 4:30	What Questions Should We Be Asking?

REVIEW OF SERVICE DELIVERY STRATEGIES

BUILD CAPACITY

- Assure adequate numbers and types of health providers, e.g., primary care centers, hospitals, physicians placed through service contingent programs.

- Encourage existing providers to treat uninsured and newly insured, e.g., rural physician networks.

- Assure low income persons access to needed services not covered by insurance, e.g., preventive care, mental health.

- Assure availability of affordable care to low income persons, e.g., sliding fee scales.

FACILITATE USE

- Encourage appropriate and timely use of health providers, e.g., outreach, referral links.

- Facilitate greater awareness of need for and availability of services, e.g., health education, public clearinghouse.

- Facilitate greater access to services, e.g., transportation, evening and weekend hours, translator.

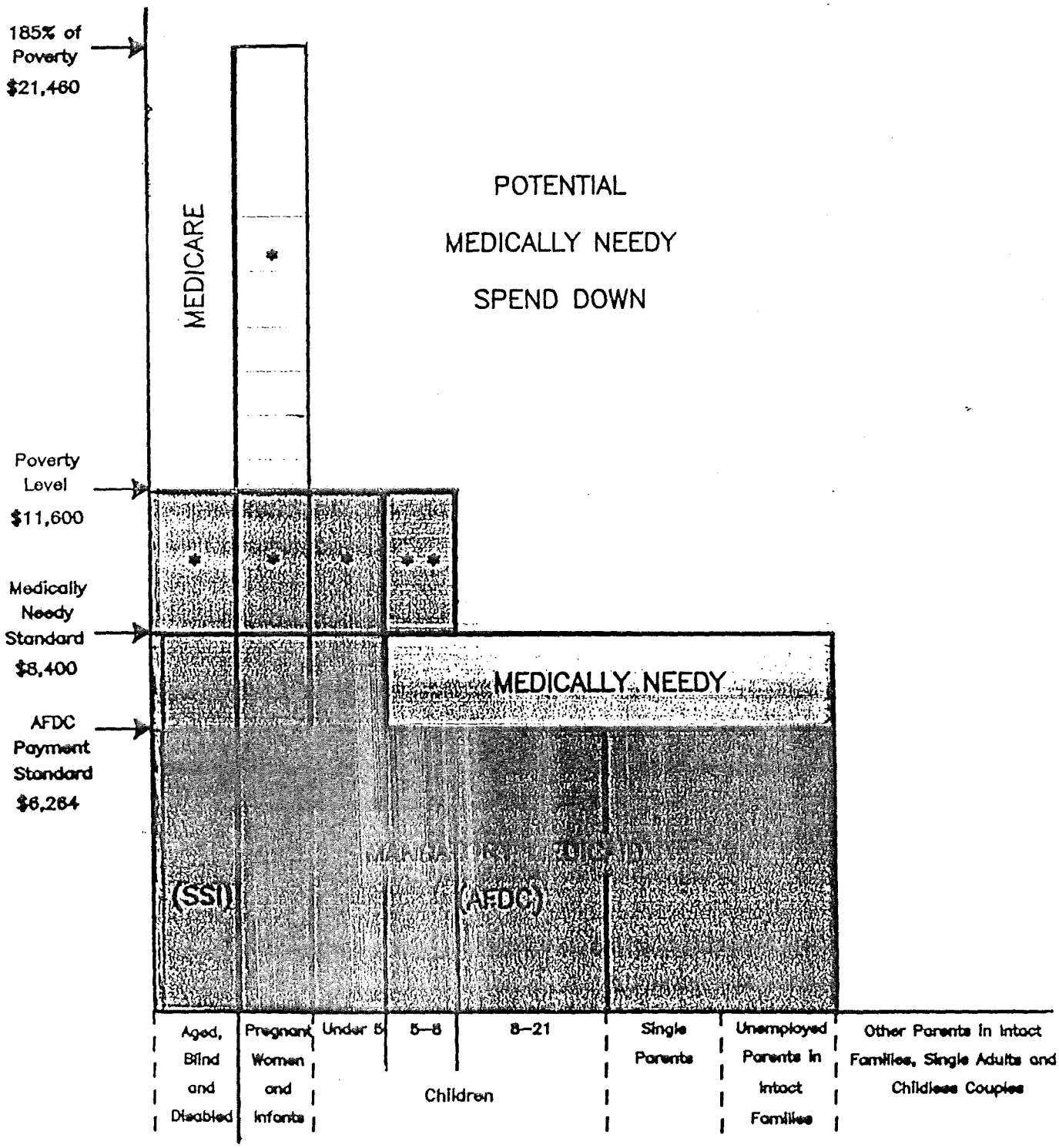
SPECIAL POPULATIONS

- Establish special programs for high-risk populations.

- Find solutions to access barriers created by high malpractice costs.

MEDICAID AND THE POOR IN MAINE

(Income Levels for a Family of Four in 1988)



* Effective October 1, 1988.

* * Children age 5–8 below poverty (optional).

Note: This is a simplified representation of eligibility. Income thresholds are net of allowable deductions including child care expenses, work related expenses, and certain work incentive disregards. Assets also enter into eligibility.

WHAT INSURANCE APPROACHES ALREADY EXIST IN MAINE?

- Medicaid

  -- AFDC income eligibility threshold is set at 54 percent of the poverty level.

  -- Aged, blind, and disabled persons and children under five below poverty are eligible.

  -- Pregnant women and infants below 185 percent of poverty ($21,460) are eligible.

  -- Medically Needy standard is set at 72 percent of the poverty level.

- Blue Cross/Blue Shield Non-Group Plans

- Risk Pool

WHO ARE THE UNINSURED IN MAINE?

- 13.2 percent (93,000) of Maine's population age 18-64 is uninsured.

- Three-quarters of the uninsured have been uninsured 12 months or longer.

- 63 percent of the uninsured are employed and 71 percent are employed full-time.

- One-third of the uninsured are self-employed.

- Two-thirds of the uninsured have incomes below $15,000.

- Over 40 percent of the uninsured report that they cannot afford to purchase insurance. Another 11 percent report they lack insurance because their firm doesn't offer it.

- From 1982 to 1985 the proportion of uninsured increased by 1.2 percent while the unemployment rate decreased by 5.1 percent.

Source: "Health Insurance Coverage in Maine: An Analysis of the Problem, Its Effects and Potential Solutions." Human Services Development Institute, University of Southern Maine, 1986.

WHAT INSURANCE STRATEGIES CAN ADDRESS THE PROBLEM?

MEDICAID EXPANSION

- **Raise medically needy income standard to 133 percent of the AFDC payment standard for all family sizes.**
- **Extend Medicaid eligibility to children between 5 and 8 to the poverty level.**
- **Raise AFDC payment standard.**
- **Raise provider fees.**

EMPLOYMENT-BASED INSURANCE

- **Mandate health benefits.**
- **Tax incentives for employer-based insurance.**
- **Robert Wood Johnson-type demonstrations.**
  - -- **Create pooling arrangements.**
  - -- **Negotiate provider discounts.**

INDIVIDUAL OPTIONS

- **Catastrophic plan.**
- **Insurer cross subsidy of individual plans.**

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
I. Insured A. Low income publicly insured ✳ Pregnant women ✳ Elderly	1.0m (87%) 136,000 (14%)		Uncompensated care pool (care or share)	Raise provider fees. Adopt all-inclusive fee for Medicaid. Extend dental and prescription drug benefits to all Medically Needy. Extend Medicaid to children between 5 and 8 up to poverty.

✳ Reference groups to test adequacy of our solutions.

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
I. Insured (cont.) B. Low income privately insured ✳ Children	200,000 (20%)	Expand HMO options to overcome access barriers due to co-pays and deductibles.	Mandate benefits.	Medicaid secondary to private insurance for excluded services.
C. High/medium income ✳ Pre-existing conditions	664,000 (66%)			High-risk pool. Catastrophic insurance plan.

✳ Reference groups to test adequacy of our solutions.

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
II. Uninsured A. Employed 1. Low income • Employed in firms that <u>don't</u> offer insurance.	132,000 (13%) 83,000 (63%) 52,000 (62%)	*<u>Employer-based</u>* Create pooling arrangements (METS). *<u>Individual Options</u>* Limited benefit plan. Insurer cross-subsidy for individual plans.	*<u>Employer-based</u>* Tax-incentives. Mandate insurance. Subsidize insurance for small employers. Subsidize dependent coverage. *<u>Individual Options</u>* Subsidize individual plans. Regulatory mandates on Blues. Uncompensated care pool (care or share).	*<u>Employer-based</u>* Medicaid buy-in *<u>Individual Options</u>* Raise Medically Needy payment standard to 133 percent of AFDC standard. Medicaid buy-in Drug plans.

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
I. Uninsured (cont.) • Employed in firms that do offer insurance		*Employer-based* HMO options to reduce access barriers due to high cost-sharing. Limited benefit plan. Greater employer premium share.	*Employer-based* Create pools to reduce cost of insurance. Mandate maximum employee premium share. Subsidize insurance premium. Subsidize dependent premium. Subsidize risk pool premium.	*Individual Options* Subsidized high-risk pool. Raise Medically Needy standard to 133 percent of AFDC standard. Medicaid buy-in.

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
2. Middle-High Income • Employed in firms that <u>don't</u> offer insurance.	31,000 (38%)	*<u>Employer-based</u>* See above *<u>Individual Options</u>* Catastrophic plan. Private individual plans.	*<u>Employer-based</u>* Tax incentives. Mandate insurance. *<u>Individual Options</u>* Catastrophic health plan. Risk pools.	
• Employed in firms that <u>do</u> offer insurance.		*<u>Employer-based</u>* HMO options. Catastrophic plan.	*<u>Individual Options</u>* Catastrophic plan. Risk pools.	

What Insurance Strategies Can Address The Problem?

		Insurance Strategies		
Population Group	Estimated Numbers	Private	Private/Public	Public
B. Self-employed ✳ Medically underwritten out	27,000 (33%)	Create pools of self-employed to reduce the cost of insurance.	Subsidize individual plans.	Medicaid buy-in
C. Nonworkers ✳ Homeless ✳ AIDS ✳ Chronically mentally ill/ substance abusers	49,000 (37%)		Subsidize Medigap coverage to low income elderly with incomes above level for Medicaid.	Make Medicare disability more flexible. Presumptive eligibility. Administrative flexibility for public programs.

✳ Reference groups to test adequacy of our solutions.

DO THESE APPROACHES SATISFY THE COMMISSION'S CRITERIA?

	INSURED POOR WITH ACCESS BARRIERS:		EASIER-TO-REACH UNINSURED POOR			DIFFICULT-TO-REACH UNINSURED POOR	
Criteria	Medicaid Improvements	Service Delivery Expansion	Medicaid Expansion	Private Insurance Expansion	Service Delivery Expansion	Private Insurance Expansion	Service Delivery Expansion
• Expand access							
• Assure cost-effective affordable health care							
• Financially broad-based							
• Services on sliding scale							
• Mixed system							
• Assures preventive/primary care							
• Maintain/improve quality							
• Reality-based building							
• Acceptable to health professionals							
• Not negative to business climate							
• Perception of fairness							
• Administrative feasibility							