

**'Tis a Gift to be Simple:  
Homelessness, Health Care Reform,  
and the Single Payer Solution**

**National Health Care for the Homeless Council**

**National Coalition for the Homeless**

**May 1994**

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# FOREWORD

The following analysis of the American Health Security Act's impact on homeless persons is published jointly by the National Health Care for the Homeless Council and the National Coalition for the Homeless in order to inform and stimulate discussion about national health care reform. *Life and Death on the Streets: Health Care Reform and Homelessness*, a companion paper analyzing the Clinton plan, was published by our organizations in December 1993.

Our organizations encourage homeless people and their allies to become involved in the issues discussed here, because effective health reform is essential to the eradication of homelessness. We particularly encourage advocates to monitor and influence developments at the *State* level, where reforms will be implemented under any national reform that emerges. Regrettably, reforms already under way in various States often neglect important health care concerns of poor and homeless people.

Both the National Health Care for the Homeless Council and the National Coalition for the Homeless have endorsed the American Health Security Act as the reform proposal holding the most promise for poor and homeless people.

We are grateful to the committed and insightful author of this analysis, Jeff Singer, who is Director of Community Relations at Health Care for the Homeless, Inc., in Baltimore. We also thank the several members of our organizations who provided well-informed editorial assistance. Funding for development of this paper came from Comic Relief, Inc., an organization whose support for health care for homeless people has been stalwart and unflagging.

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May 1, 1994 (organizational contact information updated September 2003)

# INTRODUCTION

The American health care system is experiencing striking changes. Millions of citizens are losing access to adequate, appropriate, and affordable health care, even while we spend record proportions of our national income on the health care industry. Complicated managed care arrangements increasingly govern how health care is provided and siphon off health care dollars to insurance company administrators and shareholders. As health care delivery systems become more complex, vulnerable citizens lose access to services which maintain or promote health.

Meanwhile, homelessness continues to increase. The persistence of homelessness is closely related to the lack of accessible, affordable, and adequate health care—homelessness and health are a tangled dynamic. “Homelessness causes some illnesses and exacerbates and perpetuates others by seriously complicating efforts to treat disease and reduce disability.”<sup>i</sup> If we are to effectively intervene in the forces which produce and maintain homelessness, it is essential to reform health care in a way which best serves poor and homeless persons.

Participation of homeless persons and homeless service providers in the national debate concerning health care reform is vitally important. Their insight, experience, and energy are crucial to ensuring that poor and homeless people are not left out of the new world of health care.

At least six major health care reform proposals are before Congress. Currently, only two proposals considered by Congress provide universal access to health care, and are thus entitled to serious consideration by advocates for homeless persons. The effect of the Clinton health care reform plan, H.R. 3600, on homelessness has been exhaustively detailed by the National Coalition for the Homeless and the National Health Care for the Homeless Council.<sup>ii</sup> This paper provides a briefer analysis of the impact of another proposal which promises universal access—the American Health Security Act, H.R. 1200/ 3960/S. 491, which proposes a single payer mechanism to finance health care.

# WHY IS SINGLE PAYER REFORM THE BEST OPTION FOR HOMELESS PEOPLE?

1. It promotes a single system of health care for all Americans, severing the relationship between wealth and health care. This is especially significant for homeless people because homelessness is fundamentally a problem of inequality. Access to housing, food, education and other goods is generally determined by one's wealth. A single payer plan ensures that everyone has the same sort of health insurance.
2. The savings it generates could be redirected into social spending. The single payer approach eliminates the role of insurance companies in health care. The funds that would otherwise pay for administrative costs and for the profits of stock holders can be redirected to the provision of health care and other social welfare programs. This, along with effective cost containment, is the reason that the American Health Security Act (H.R. 1200/3960) has the most realistic financial underpinning of any proposed health care reform. Because it will not rob other social welfare programs (as the Clinton plan proposes) to pay for health care, the needs of homeless persons are less likely to suffer if the single payer plan is adopted.
3. The written guarantee of the right to choose one's health care provider permits the flexibility required by especially vulnerable people. This is one of the most important aspects of this proposal for homeless health care. Managed care is, for the most part, a barrier to health care for homeless persons and an administrative nightmare for Health Care for the Homeless programs. Because homeless people are usually mobile—moving from one part of town to another, or from one jurisdiction to another—locking them into managed care programs hinders ready access to appropriate health care providers. It also eliminates the ability of Health Care for the Homeless programs to receive compensation for the provision of services to many of their clients.

This is especially true for the most vulnerable of the homeless population—e.g., children, teens without parents, the mentally ill—who may be enrolled in managed care arrangements and who are unable to obtain appropriate and timely medical care (or to readily disenroll). By guaranteeing free choice of provider, the American Health Security Act helps assure that homeless persons can see sensitive providers and that these providers will always be paid for the services which they deliver.

4. The American Health Security Act contains a number of provisions which enhance reimbursements to health care providers for the services which they deliver to vulnerable persons. Homeless persons more frequently suffer from complex medical conditions and require ancillary services. By augmenting payments to providers who see a large number of poor and homeless persons, it becomes more likely that agencies—such as Health Care for the Homeless programs—which choose to serve vulnerable populations will survive.

- 5.** The rich benefit package available in the American Health Security Act—superior to the benefits offered by any other bill—is quite important to homeless persons and advocates. Homeless people are likely to experience a greater frequency and severity of health problems than are others, requiring more and more intensive care. The availability of addictions treatment and mental health services is crucial. And the inclusion of long-term care and ancillary services (including medical appliances, prescriptions, and case management) is essential.
- 6.** The simplicity of the financing structure of the American Health Security Act is another feature of importance to homeless persons. All other proposed reforms will require the poor to apply for subsidies to pay out-of-pocket costs (premiums, copayments, and deductibles.) Many homeless people who are now eligible for social welfare programs (including Medical Assistance) never receive these benefits because of the difficulty of negotiating complex bureaucracies and producing documents to verify income and identity. Every other health care reform measure in Congress would maintain such requirements.
- 7.** The American Health Security Act is the only reform plan which dedicates monies for public health and community health initiatives (including health care for the homeless programs). Every other bill would require that advocates continue to fight yearly for appropriations. H.R. 1200/3960, however, mandates that a portion of the national health budget be set aside for poor and homeless people.
- 8.** The financing mechanisms of the American Health Security Act, with respect to individual contributions, are the most progressive of all the plans being considered by Congress. This is especially important for homeless persons, one-third of whom are employed. Already earning too little to afford housing, homeless persons cannot easily afford further mandates to pay for health insurance. H.R. 1200/3960 limits liability to 2.1 percent of earned income; by comparison, the President’s Bill sets a limit of 3.9 percent. For low- wage workers like homeless persons, the eligibility for the Earned Income Tax Credit generally means that no cash contribution will actually be required.
- 9.** The American Health Security Act guarantees universal coverage no later than one year after its passage. No other bill specifies as favorable a time frame for universal coverage; most bills specify no time frame.

# THE SINGLE PAYER APPROACH:AN OVERVIEW

The single payer approach to health care reform entails the elimination of the private health insurance market and the utilization of the resulting savings to finance health care for the currently uninsured and for the medically underserved. The federal government becomes the “single payer” of all medical bills; the tie between personal wealth and ability to pay for health care is eliminated. As a consequence, the single payer approach also severs the link between employment and health care, and limits the ability of insurers and accountants to mediate the patient/provider relationship.

The American Health Security Act (H.R. 1200/H.R. 3960/S. 491),<sup>iii</sup> introduced by Representatives Jim McDermott (D-WA), John Conyers (D-MI), George Miller (D-CA) and by Senator Paul Wellstone (D-MN), would create a single payer health care financing system in the United States. National standards for health insurance and for health care would be established by the federal government through an American Health Security Standards Board, but programs would be administered by States. The American Health Security Act has the following major characteristics:

1. All legal residents of the U.S. are entitled to participate.<sup>iv</sup>
2. All participants are guaranteed a comprehensive set of health care services.<sup>v</sup>
3. Out-of-pocket payments (for premiums, deductibles, or copayments) are eliminated for preventive, primary, emergency, acute, long-term, and pharmacologic services.<sup>vi</sup>
4. Health care providers are paid by State Health Security Programs for the provision of all covered services.<sup>vii</sup>
5. Health care is financed primarily by taxes on payrolls and by “sin” taxes on tobacco and handguns.<sup>viii</sup>
6. A national budget for health care expenditures is established, and grows only at the same rate as the growth of the gross domestic product.<sup>ix</sup>
7. Every individual is guaranteed the right to utilize the provider of her/his choice. Traditional fee-for-service arrangements are thus preserved to the extent that they are available—i.e., neither the government nor an employer can mandate individual participation in a managed care arrangement.<sup>x</sup>
8. Measures are included to increase capacity to assist the medically underserved.<sup>xi</sup>

Fundamentally, the single payer approach to health care reform focuses on changing the way we pay for health care, making it affordable for everyone. Since almost no one will directly purchase health insurance or health care, almost everyone will be able to afford the same high-quality health care. This removes one of the most important barriers to health care for homeless

people; but affordability alone is not the sole reason that health care is unavailable to homeless people. In the following sections, the American Health Security Act's impact on other significant barriers to health care for homeless persons will be discussed.

# EVALUATING THE AMERICAN HEALTH SECURITY ACT

The National Health Care for the Homeless Council has outlined three principles by which health care reform's impact on homeless people may be measured:

- universal coverage must apply to all people equally;
- access to care should be assured to the medically underserved by building primary care capacity (including innovative delivery systems such as outreach, and by developing equitable financing mechanisms); and
- comprehensive benefits must include enhanced services for special populations.

Below, the American Health Security Act will be examined in light of these principles in order that its impact upon homelessness might be evaluated.

## Universal Coverage

### *Who Is Covered*

The American Health Security Act guarantees coverage to all citizens and other legal residents of the U.S. The bill authorizes the extension of coverage (by the American Health Security Standards Board or by a State Program) to others in the U.S. for any of four reasons:

1. to provide coverage to foreign nationals traveling in the U.S. if their own country provides health services to U.S. citizens;<sup>xii</sup>
2. to preserve the public health of communities (e.g., extending coverage to undocumented persons with tuberculosis);<sup>xiii</sup>
3. to compensate States for financing burdens of caring for uncovered persons;<sup>xiv</sup> and
4. “to prevent adverse financial and medical consequences of uncompensated care.”<sup>xv</sup> (This last clause is quite open-ended, providing the legal justification for a broad expansion of coverage to all persons in the U.S., including homeless persons.)

In contrast to the Clinton plan—which explicitly excludes prisoners, undocumented persons, Medicare recipients, and employees of large corporations—the American Health Security Act provides coverage to:

- all currently uninsured persons;
- all current Medicaid recipients;<sup>xvi</sup>
- all current Medicare recipients;<sup>xvii</sup>

- all federal employees;<sup>xviii</sup> and
- all citizens and legal residents who now have private insurance.

Unfortunately, a significant number of homeless persons are undocumented residents and would be ineligible for participation unless coverage is expanded. As noted above, the American Health Security Act provides for the expansion of insurance coverage to prevent the consequences of uncompensated care, a broad legal justification for the extension of coverage. Should this bill be adopted, advocates for special populations would be required to forcefully seek the optional expansion of eligibility described above at federal and State levels.

Another provision of particular interest to homeless advocates is that children and adolescents are individually covered—the bill has no age or family status requirements. This feature, in concert with the guarantee that every individual is entitled to choose practitioners for covered services,<sup>xix</sup> should positively impact upon health care delivery to homeless children and youth on the streets. Currently, many of the young people encountered by Health Care for the Homeless providers are enrolled in their parents’ managed care plans, even if they are not residing with their parent. It is often impossible to secure timely and appropriate treatment from these plans, given the special needs of homeless children and youth. The American Health Security Act, however, assures that children and youth can’t be locked into the managed care programs in which their parents might have enrolled.

By eliminating the relationship between employment and health insurance, the American Health Security Act effectively severs the link between wealth and insurance status. This constitutes a major conceptual transformation—while still not enshrining equal health care as a right, it does offer equal health insurance as a right. Consequently, a set of barriers for homeless people is abolished. Not only is a lack of income no longer a hindrance to securing insurance, but the need to prove identity, residence and income is also limited, an advantage for homeless persons who frequently do not have the documents by which identity is established in this society.

The Veterans Administration health services and the Indian Health Service are maintained as separate programs in the American Health Security Act, funded by Congressional appropriations.<sup>xx</sup> These exceptions recognize national commitments to veterans and treaty obligations to Native American nations.

### ***How Is Coverage Obtained***

The American Health Security Act mandates that in order to receive federal funds, each State and the District of Columbia must submit plans for a State Health Security Program.<sup>xxi</sup> Each program must include the creation of a State Health Security Board to oversee the State Health Security Program, including providing mechanisms for enrollment.<sup>xxii</sup> These must incorporate automatic enrollment at birth or immigration, and the availability of applications at local Social Security Administration offices, at social service locations, at outreach sites (this would seem to include homeless health clinics, shelters, and soup kitchens),<sup>xxiii</sup> and at other accessible

locations. The bill does not specify the procedures or documents required to enroll, but does mandate that each enrolled individual is to be issued a health security card.

Enrollment takes place at the State level; consequently, a person is guaranteed coverage so long as s/he remains in the State in which s/he enrolled. If a person moves to another State, the waiting period to enroll in that State's Program cannot be longer than three months.<sup>xxiv</sup> The State of origin must continue paying for services to a holder of a State health security card for the duration of any waiting period.<sup>xxv</sup> States are permitted to negotiate "cross-border" arrangements with adjacent States to promote continuity of coverage.<sup>xxvi</sup> These provisions guarantee portability of coverage unmatched by any other health reform proposal.

Because the link between employment and health insurance has been abolished, changes in employment status are irrelevant to insurance coverage. No one can lose her insurance because she is laid off or finds a new job. This has important implications for welfare reform, because the loss of Medical Assistance is an important disincentive for relinquishing welfare benefits and entering the job market. H.R. 1200 removes this disincentive.

## **Assuring Access to Care**

Access to health insurance is a necessary, but not sufficient, condition for effective health care reform. Health care delivery systems and services must be accessible and affordable. Two broad categories of concerns relating to health care access are explored below: financial barriers and infrastructure development. Outreach, an additional and essential access issue for homeless people, is addressed on page X below.

### ***Financial Barriers***

The American Health Security Act eliminates many financial barriers to the utilization of health insurance. The most important provision is the abolition of out-of-pocket payments for all covered benefits. Deductibles, coinsurance, and copayments for covered services are forbidden by law,<sup>xxvii</sup> and providers are prohibited from imposing a charge for any covered service.<sup>xxviii</sup> Elimination of all out-of-pocket costs, especially copayments at the time of service, is critical to assuring access for impoverished people.

All those who work and pay taxes (including homeless persons) would be required by the American Health Security Act to pay an additional 2.1 percent of their income. The recent expansion of the Earned Income Tax Credit will, however, limit the amount that the very poor would pay; indeed, it is likely that most poor people will pay nothing.

Certain other financial barriers, especially the cost of transportation, are not necessarily eliminated by the American Health Security Act, although financial incentives which could

defray a portion of these costs are available to providers of services to the medically underserved.<sup>xxxix</sup> These incentives are discussed below under Enhanced Payment Provisions.

### *Infrastructure Development*

The foundation of access to health care for vulnerable populations is adequate funding of the programs which serve these populations. The American Health Security Act provides for a national health security budget to be established annually, based on health expenditures of the prior year plus the growth of the gross domestic product and/or the growth of the population.<sup>xxx</sup> The funds devoted toward this budget are termed the American Health Security Trust. It is this Trust which finances health care for all, including federal grants for special purposes.

The very existence of Health Care for the Homeless<sup>xxxi</sup> programs and other population-based (e.g., migrant worker) and disease-specific (e.g., HIV) health care programs is grounded in the recognition that the extraordinary life and health situations of our most vulnerable citizens require extraordinary interventions. The 30 year history of Migrant and Community Health Centers<sup>xxxii</sup> and the ten year history of Health Care for the Homeless programs demonstrate the effect of accessible and appropriate services and methodologies (e.g., extensive outreach programs and integrated case management) in improving health.

Homeless health care programs have learned important lessons which must be incorporated into health care delivery to people caught in the cycle of homelessness. Most important is the need for a public financial commitment to primary and preventive care which literally “starts where the client is,” physically (on the streets, in abandoned buildings, under bridges, at shelters and soup kitchens) as well as psychologically. Historically, public health agencies and nonprofit community-based primary health care centers have been the locus of such activities. These agencies, however, have long been grossly underfunded.

The American Health Security Act makes a financial commitment to develop the public and primary health care delivery systems. This is accomplished through two methods: enhanced payments for services and grants dedicated to the public health and primary care infrastructure.

### *Enhanced Payment Provisions*

Several mechanisms in the American Health Security Act to provide enhanced payments for the medically underserved.

First, coverage may be extended to undocumented persons.<sup>xxxiii</sup> This would permit health care providers to be reimbursed for treating undocumented persons in just the same manner as they are paid for treating other persons, reducing instances of “uncompensated care.” Thus, the financial resources of health care providers could more accurately reflect the numbers of clients served.

Secondly, federal support for State health care budgets is adjusted for conditions such as “social, environmental, or geographic conditions affecting health status,”<sup>xxxiv</sup> thus theoretically making available a larger State budget—and greater payments to providers—in especially-impacted States. This means that the numbers of poor and homeless people in a State would be considered when the State’s budget for health care services is determined.

Thirdly, payments to providers of capitated services to the medically underserved are given an adjustment for “special health needs, including a disproportionate number of medically underserved individuals.”<sup>xxxv</sup> This means that the amount of money given to a health maintenance organization (HMO) for each member will be calculated to reflect the costs of treating homeless people, who are generally sicker than the remainder of the population (HMOs and similar managed care arrangements will survive in the single payer environment).

A fourth funding mechanism offers additional funds to community-based primary health care facilities (which include Federally Qualified Health Centers<sup>xxxvi</sup> and other public and private nonprofit recipients of Public Health Service Act funds) in recognition of their special circumstances. Special payments are made available in three categories:

- for those without Health Security cards (“an additional amount . . . to cover the costs incurred by a provider which serves persons not covered by this Act”);<sup>xxxvii</sup>
- to cover “the reasonable costs” of case management, transportation services, and translation services;<sup>xxxviii</sup> and
- an additional payment for health professional education programs.<sup>xxxix</sup>

Finally, section 620 of the American Health Security Act, “Payment Incentives for Medically Underserved Areas,” mandates the American Health Security Standards Board to establish payment methodologies and other incentives to foster the provision of health care services in medically underserved areas, “particularly in rural and inner- city underserved areas.”

It is essential to note that the amount of the payments referenced above is not set by the bill, and will no doubt become a field of battle between supporters of realistic payments and those who wish to curtail public spending.

The American Health Security Act provides significant mechanisms to nurture the primary health care delivery system. Unfortunately, the monetary value of the adjustments and additional payments discussed above is not specified in the bill. Consequently, it is difficult to evaluate the adequacy of these mechanisms. Certainly the adoption of this bill would require advocates for homeless health care to mobilize nationally and at the State level to influence the financial value of the adjustments and additional payments available to primary care providers.

### *Grants for Direct Health Care Delivery*

Title VII of the bill is dedicated to the promotion of primary health care, including enhancement of the capacity of programs which assist the medically underserved. It creates a number of new grants to encourage services to such populations.

**Section 711** provides funds to the Public Health Service to pay States for maternal and child health, preventive health, community mental health, chemical addictions services, and HIV/AIDS services. These grants may not replace, but must supplement, existing programs (at a base line of FY93 funding) and are limited to a minimum of 0.1 percent and a maximum of 0.14 percent of the American Health Security Trust’s annual expenditures. See Table 1.

**Table 1**  
**AMERICAN HEALTH SECURITY ACT SET-ASIDES**  
**SUPPLEMENTING CURRENT FUNDING FOR PUBLIC HEALTH ACTIVITIES<sup>xl</sup>**

(in millions of dollars)

<b>Fiscal Year</b>	1997	1998	1999	2000	2001	2002	2003
<b>Minimum</b>	\$630	\$939	\$995	\$1,052	\$1,110	\$1,171	\$1,235
<b>Maximum</b>	\$882	\$1,315	\$1,393	\$1,473	\$1,554	\$1,639	\$1,729

**Section 712** provides funds to public and nonprofit entities to plan, develop, and operate primary care centers (which are defined as homeless, migrant, and community health centers). These grants must supplement existing programs (at a base line of FY93 funding) and are limited to a minimum of 0.06 percent and a maximum of 0.1 percent of the American Health Security Trust’s annual expenditures. See Table 2.

**Table 2**

**AMERICAN HEALTH SECURITY ACT SET-ASIDES  
SUPPLEMENTING CURRENT FUNDING FOR  
PRIMARY CARE PROGRAMS<sup>xli</sup>**

(in millions of dollars)

<b>Fiscal Year</b>	1997	1998	1999	2000	2001	2002	2003
<b>AHSA Minimum Set-Aside</b>	\$378	\$563	\$597	\$631	\$666	\$703	\$741
<b>AHSA Maximum Set-Aside</b>	\$630	\$939	\$995	\$1,052	\$1,110	\$1,171	\$1,235
<b>Clinton Bill<sup>xlii</sup> Authorizations</b>	\$900	\$1,000	\$800	\$400	\$0	\$0	\$0

Additional Sections of the American Health Security Act provide appropriations for the education of health professionals (Sec. 703) and for primary care and outcomes research. Table 3 shows the total percentages of the American Health Security Trust Fund (beyond provider reimbursements) which are dedicated to primary health concerns.

**Table 3**

**INFRASTRUCTURE SPENDING AS PERCENTAGE OF  
AMERICAN HEALTH SECURITY TRUST FUND**

<b>Health Professional Education</b>	0.04 – 0.06%
<b>Public Health Grants</b>	0.10 – 0.14%
<b>Primary Care Center Grants</b>	0.06 – 0.10%
<b>Health Outcomes Research Grants</b>	0.01 – 0.02%

Table 4 indicates the total grant funds provided in the American Health Security Act to promote primary care and other programs to assist the medically underserved. While significantly less than the new programs proposed by the Clinton Bill, the American Health Security Act mandates these grants as appropriations rather than as authorizations as in the Clinton Bill.

**Table 4**

**TOTAL FUNDING OF PROGRAMS  
FOR MEDICALLY UNDERSERVED**

(in millions of dollars)

<b>Fiscal Year</b>	1997	1998	1999	2000
<b>AHSA Minimum<sup>xliii</sup> Set-Asides</b>	\$1323	\$1972	\$2090	\$2209
<b>AHSA Maximum<sup>xliv</sup> Set-Asides</b>	\$2016	\$3005	\$3184	\$3336
<b>Clinton Bill<sup>xlv</sup> Authorizations</b>	\$3830	\$4205	\$4055	\$3655

## **Health Care Benefits Under the American Health Security Act**

### *What Services Are Available*

The American Health Security Act offers a relatively comprehensive set of benefits, including preventive, primary, acute and long-term care services. These are available to any beneficiary provided that they are “medically necessary and appropriate for the maintenance of health or for the diagnosis, treatment, or rehabilitation of a health condition.”<sup>xlvi</sup> Unfortunately, some of the significant terms in this Act are not defined, including “medically necessary and appropriate.”

More specifically, as defined in the Act, benefits include:

**Hospital services** Inpatient, outpatient, and emergency;

**Professional services** By practitioners authorized under State law;

**Community-based primary health care services** Ambulatory health services furnished by a rural clinic, FQHC, school-based clinic, or a public/nonprofit grantee of the Public Health Service (and thus includes Section 340 Health Care for the Homeless grantees);

**Preventive services** Basic immunizations, prenatal and well-baby care to the age of one, well-child care until the age of 18, mammography and other routine cancer screenings, routine dental

exams and prophylaxis, physical exams, family planning services, routine eye exams and corrective devices, and hearing aids;

**Long-term and chronic care** Including nursing facilities, home health services, home and community-based long-term care services, hospice care, and care coordination;

**Prescription drugs**, biologicals, insulin, and medical foods;

**Mental health services** Including care coordination;

**Chemical addiction treatment** Including care coordination;

**Diagnostic tests**; and

**“Other items and services”** Outpatient rehabilitative therapies, durable medical equipment, home dialysis, emergency ambulance service, prosthetic devices, and other medical or health care items or services as specified by the American Health Security Standards Board.

The availability of many of these services is extremely important in effective intervention to end homelessness. This bill not only covers these services, but establishes an entitlement to them “when medically necessary and appropriate” —and this could have far-reaching consequences.

These benefits include mental health services (it is estimated that one-third of single homeless adults suffer from severe mental illness)<sup>xlvii</sup> and chemical addictions treatment (the National Institute of Alcohol Abuse and Alcoholism estimates that 50 percent of the homeless adult population is dependent upon alcohol or drugs).<sup>xlviii</sup> While the guarantee of these services is crucial to homeless persons, the limits which the Act specifies are inadequate (see **Conditions of Coverage** below).

Important benefits provided by the bill, often not available to homeless persons at present, should be emphasized. These are:

- **Routine physical examinations** which are essential for adequate primary and preventive health care—and which are frequently necessary to secure employment;
- **Vision services** including eyeglasses and contact lenses;
- **Diagnostic tests** to which many homeless health care providers do not have ready access;
- **Hearing aids** rarely covered by existing public insurance programs;
- **Ambulance services** which in some jurisdictions are now billed to the unfortunate patient, who is then harassed by collection agencies;
- A relatively full range of **preventive services**; and

- **Routine dental exams** and prophylaxis.

Notably absent from this list—and important to homeless persons—are dental services beyond routine exams, such as fillings and prostheses.

Especially noteworthy is the coverage of prescriptions and medical foods. Eligible medications are those determined by an Advisory Committee on Prescriptions (appointed by the American Health Security Standards Board) to be “necessary for the maintenance or restoration of health or employability or self- management.”<sup>xlix</sup> Significantly, the prohibition against all out-of-pocket payments including copayments and deductibles applies to prescriptions as well. Most existing insurance policies and all other proposed health care reform legislation require out-of-pocket payments; these have the effect of denying important medications to those unable to afford them. Of additional import is the coverage of medical foods, unavailable in most existing benefit packages and especially vital to those with HIV-related and alcohol-related conditions.

### ***Conditions of Coverage***

The conditions under which a particular service or benefit is available—including how often and for how long it may be receive—can be a significant barrier to its use. In this regard, the American Health Security Act offers less complete guidance than, for example, the Clinton Bill, which frequently specifies these conditions. For example, the American Health Security Act mandates the availability of many preventive services, but does not provide details concerning when or how often these services may be reimbursable. Rather, the American Health Security Standards Board is required to publish a *Guide to Clinical Preventive Services* which establishes a periodicity schedule for coverage.<sup>1</sup> The conditions for coverage of certain services are specified:

**Addictions** Fifteen days of inpatient care and 20 outpatient visits are permitted per year; a utilization review program must approve additional treatment in order for payments to be made.<sup>li</sup> The national Board or State programs may extend these limits, but as defined they are clearly inadequate—for example, the standard residential rehabilitation program is 28 days in length, following inpatient detoxification. Advocates and providers must seek to expand this benefit, particularly to broaden the definition of treatment to include housing and nonmedical approaches, such as long-term residential recovery programs.

**Mental health** Fifteen days of inpatient care and 20 outpatient visits per year are permitted prior to utilization review.<sup>lii</sup> As with addictions services, it is critical to homeless persons that these limits be expanded to permit adequate treatment.

**Home and community-based long-term care services** These are available to adults who are unable to perform two activities of daily living (bathing, eating, dressing, toileting, or transferring in and out of a bed or wheelchair) or who pose a health or safety hazard to self or others (due to cognitive or mental impairment).<sup>liii</sup> Standards for those under the age of 18 are to be specified by the Board. Services are further limited to payments which do not exceed 65

percent of nursing home payments (this is subject to modification by the Board “consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting”).<sup>liv</sup>

**Care coordination** Persons with a serious mental illness, with a history of addiction and severe associated illness or treatment failure, or who are eligible for long-term and chronic care (as defined above) are also entitled to care coordination services, i.e., case management. A care coordinator is defined in the American Health Security Act as an individual or nonprofit or private agency which has the capacity to evaluate and recommend appropriate treatment, but which has no financial interest in treatment decisions. Care coordination, or case management, in the context of health care for homeless people, entails increasing access to health care and supportive services. This is to be distinguished from the “managing of care” by insurance companies, whose objective is to control the delivery of services to patients in order to avoid costs.

The services outlined above are crucial to homeless persons. Conditions which impede their effectiveness (such as time limits for addictions and mental health services) or restrict their availability (such as confining case management to those with “serious mental illness”) will only serve to deny necessary health care to vulnerable populations. Again, advocates must fight for more generous provisions that are more responsive to the real needs of homeless people.

## ***Outreach***

Perhaps the most significant aspect of health care programs which effectively serve homeless people is the emphasis on outreach, that is engaging and even treating people in the places where they live—on sidewalks, in parks and abandoned buildings, under bridges, in forest encampments, and in shelters and soup kitchens. Outreach itself is not a covered service within the American Health Security Act; however, it would appear that several aspects of the Act’s benefit package enhance the prospect of outreach. First, any “medically necessary service” is covered by any authorized provider, without respect to the location of service provision. This means that a physician, nurse, or licensed social worker could be reimbursed for providing services on the street, in a shelter, or anywhere else.

Secondly, the availability of care coordination to the mentally ill, the addicted, or those in need of long-term care suggests that outreach could be covered as a means to “gain access to appropriate ancillary services” or for “evaluating and recommending appropriate services . . .”<sup>lv</sup> Importantly, care coordinators are not required to have professional credentials; consequently, outreach workers typically employed by homeless health care programs who have experience, insight, and engagement skills but not the imprimatur of State licensing authorities, may be performing a reimbursable service.

Thirdly, community-based primary health care facilities, such as Section 340 programs, are eligible to receive special payments to cover the “reasonable costs” of case management and transportation services.

Finally, the appropriation of funds for primary health care delivery explicitly includes monies for Health Care for the Homeless programs, which are mandated to provide outreach services.

The American Health Security Act does not, then, create a new entitlement to outreach, or specifically fund these services. Providers will continue to struggle to pay for the costs associated with outreach (e.g., the time and transportation expenditures) without adequate reimbursement. Advocates for the homeless might promote the creation of a separate category of reimbursable services entitled “outreach,” which might include engagement, treatment, case management, and transportation. This would encourage (and enable) primary care providers and other community-based organizations to provide accessible services to homeless persons.

In sum, the benefits mandated by the American Health Security Act and the conditions under which they are available do afford significant opportunities for homeless health care. In comparison with other bills currently before Congress, the American Health Security Act clearly provides the richest benefit package.<sup>lvi</sup> Nonetheless, it is crucial to advocate for improvements, especially in the areas of addictions treatment, mental health services, and outreach.

## **Fiscal and Administrative Considerations**

Two other sets of issues remain to be discussed with respect to the impact of the American Health Security Act on homelessness: the manner in which health services are financed and the administrative provisions required for implementation.

### ***Financing the Single Payer System***

The American Health Security Act is financed by a mix of federal and State funds. These funds together are a “global budget” for health care expenditures. The federal portion is noteworthy in two respects. First, by divorcing wealth from insurance status, a genuine public commitment to the health of the national community and all of its members is secured. Secondly, additional revenues are generated for health care through a relatively progressive taxation scheme.

All federally-covered health costs are paid by a newly established American Health Security Trust Fund.<sup>lvii</sup> This Fund will include the amounts appropriated for existing federal health expenditures—Medicare, Medicaid, the federal employees health benefit program, CHAMPUS, and Public Health Act programs—and new tax revenues.

The new tax revenues derive from four sources: taxes on employers, on personal income, on tobacco products, and on fire arms and ammunition.

1. **Employer taxes** are as follows:

- 4 percent of payroll for small employers (defined as those with fewer than 75 full-time employees *and* whose average wage is less than \$24,000 per year); and

- 8.4 percent of payroll for other employers.<sup>lviii</sup>

2. An additional **personal income** tax of 2.1 percent is instituted.

3. **Tobacco products** (cigarettes, cigars, pipe tobacco, smokeless tobacco, and cigarette papers) are subjected to additional taxes. For cigarettes, these add \$2.00 to the cost of a pack.

4. **Firearms and ammunition** are subject to a tax equal to 50 percent of the price for which they are sold.

As mentioned above, financing is a collaborative responsibility of federal and State governments.<sup>lix</sup> The federal contribution to each State is determined by a formula which considers each State's revenue capacity (i.e., poorer States would receive a proportionately larger federal contribution). The average federal contribution must equal 86 percent of national health care spending; contributions to individual States can vary between 81 percent and 91 percent depending upon the State's revenue capacity.

The recent Congressional Budget Office analysis<sup>lx</sup> of the financing of the American Health Security Act indicates that it will reduce projected national health care spending by \$225 billion in the year 2004. These savings could conceivably be redirected toward social services, housing, and employment programs which might directly benefit homeless and other indigent people.

### ***Administering the Single Payer System***

The administrative provisions of the American Health Security Act are also of interest. One of the most significant factors contributing to the existing health care crisis is the role of administrative costs. In a national system which expends one trillion dollars per year for health care, it is difficult to imagine that vast segments of the population are unable to secure basic life-preserving services. This may be explained in part because administrative expenses (including billing, marketing, and authorizing services) consume a disproportionate percentage of health care expenditures. While the federal government spends 2.1 percent of Medicare expenditures for administrative overhead, the private insurance sector (which currently accounts for approximately 50 percent of total health expenditures) has overhead costs of 26.3 percent.<sup>lxi</sup>

The establishment of a single-payer system for financing health care eliminates the role of insurance companies, thus minimizing the billing requirements of health care providers. These savings in billing costs can be transferred to an increased quantity and a higher quality of health care services, and permits extending an generous packet of benefits to all Americans. The

benefits of single payer financing may be observed in the following comparison of the U.S. and two countries with single payer systems:

**Table 5**

**COMPARITIVE INTERNATIONAL  
HEALTH CARE SPENDING AND OUTCOMES<sup>ixii</sup>**

	U.S.	Canada (single payer)	Britain (single payer)
<b>Health Care Spending Per Capita</b>	\$1,926	\$1,370	\$711
<b>Health Spending as % of GNP</b>	11%	8.5%	6%
<b>Average Life Expectancy</b>	75 years	77 years	75 years
<b>Infant Mortality per 10,000 births</b>	11 deaths	7 deaths	9 deaths

The American Health Security Act establishes a two-tiered administrative structure. On the federal level, an American Health Security Standards Board is created which is charged with developing policies, procedures and requirements to carry out the Act. These include defining eligibility, enrollment, benefits, provider participation standards, national and State funding levels, methods for determining provider payments, quality assurance, planning, and determining “medical necessity.” Each State is required to develop and implement a Health Security Program which will meet the standards defined by the national Board. A single State agency must be designated to administer the State Health Security Program and to pay health care providers. Additionally, States must establish both State Health Security Advisory Councils and District Health Advisory Councils (covering representing distinct geographic areas within States) which must include a majority of consumers and which carry out assessments of health needs and evaluations of health care delivery.

Each State Health Security Program administers a global health care budget, with a set ceiling for total yearly payments. From this amount, the state programs pay practitioners in one of two ways:

- (1) Payments may be in the form of a fee for each billable covered service. In this case, fee structures are established by the State Health Security Programs, which may use models

developed by the National Board or which may develop their own fee structures, similar to the Medicare Program.

- (2) Payments may be prospective payments negotiated with providers, similar to existing capitated methods such as HMOs use. Community-based primary health care services (such as Health Care for the Homeless programs) may bill on a fee-for-service basis or may negotiate prospective capitated payments.

The role of insurance companies in the administration of health care is eliminated by this structure. Thus the numbers of billing clerks which are required by health care providers is dramatically diminished, as is the number of persons employed in selling health insurance. One percent of the American Health Security Trust fund is designated for workers dislocated by the adoption of this Act.

## **CONCLUSION: WHY WORK FOR A SINGLE PAYER SOLUTION**

The American Health Security Act promises notable advantages for homeless persons.

It approaches universal coverage by guaranteeing insurance to all legal residents, and suggests the potential to expand this coverage to undocumented persons.

It enhances access by significantly increasing public funding for primary health care and for programs which reach the medically underserved.

It offers comprehensive benefits to all, without regard to income or employment status.

The superiority of these provisions of the bill constitutes an important ground for its support by homeless advocates; however, other grounds for support exist. These include the establishment of a right to insurance and a concomitant right to services; the severance of the link between wealth and access to health care, reduction of inequities in the provision of health care; and expansion of the public sector component of health care, rendering the possibility of increased public oversight and participation in health policy creation and implementation.

The American Health Security Act may also be construed as a step toward the decommodification of health—reconceptualizing health care as a public utility available to all, rather than as a commodity available only to those who can afford it. It limits the profits of private providers through the global budgeting and rate-setting provisions, while granting public control over significant aspects of investment. The American Health Security Act does not socialize health care provision, but it does threaten the hegemony of the medical/industrial complex—witness the antipathy of most of those who profit from the current arrangements.

And it is just the opposition of these powerful interests which constitutes the final, and perhaps most compelling, reason that homeless advocates should work toward the adoption of the American Health Security Act. For this bill will not be adopted without the creation of a popular movement to oppose those whose voices are more readily heard by national decision-makers. Creating such a movement entails the mobilization of poor and homeless people in a broad coalition with union members, seniors, people of color, and others whose lack of access to health care is a symbol of their general marginalization.

Working for a single payer solution will, consequently, have benefits beyond the possibility of a vastly improved health care system. It requires a massive educational campaign and a discussion of social structure and function. It will engage all of those with an interest in justice and equality, and may transform the terms in which current struggles are being waged. If the requisite mobilization is achieved, even though the American Health Security Act might lose, the poor and homeless would yet win.

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- <sup>iii</sup> H.R. 1200 (103rd Congress, 1st Session), April 25, 1993; H.R. 3960 (103rd Congress, 2nd Session), March 3, 1994; S.491 (103rd Congress, 1st Session), March 3, 1993. All references in the text will be to H.R. 3960, March 3, 1994 unless otherwise specified.
- <sup>iv</sup> H.R. 3960; Sec. 102(a).
- <sup>v</sup> Title II (entire).
- <sup>vi</sup> H.R. 3960, Sec. 201(b).
- <sup>vii</sup> H.R. 3960, Sec. 405(b)(1)(A).
- <sup>viii</sup> H.R. 396 . Title VIII (entire).
- <sup>ix</sup> H.R. 3960, Sec. 601(b)(2).
- <sup>x</sup> H.R. 3960, Sec. 405(b)(1)(F).
- <sup>xi</sup> H.R. 3960, Sec. 102(c); Sec. 602(d); Sec. 611(a)(2)(K); Sec. 614(b)(2); Sec. 615 (b)(1)(2)(3) and (c)(2); Sec. 620; and Title VII (entire).
- <sup>xii</sup> H.R. 3960, Sec. 102(b)(2).
- <sup>xiii</sup> H.R. 3960, Sec. 102(c)(1)(A).
- <sup>xiv</sup> H.R. 3960 Sec. 102(c)(1)(B).
- <sup>xv</sup> H.R. 3960 Sec. 102(c)(1)(C).
- <sup>xvi</sup> H.R. 3960, Sec. 106(a).
- <sup>xvii</sup> H.R. 3960, Sec. 106(a).
- <sup>xviii</sup> H.R. 3960, Sec. 106(b)(c).
- <sup>xix</sup> H.R. 3960, Sec. 405(b)(1)(F).
- <sup>xx</sup> H.R. 3960, Sec. 106(d).
- <sup>xxi</sup> H.R. 3960, Sec. 405.
- <sup>xxii</sup> H.R. 3960, Sec. 103(a).
- <sup>xxiii</sup> H.R. 3960, Sec. 103(b)(3).
- <sup>xxiv</sup> H.R. 3960, Sec. 103(a)(1).
- <sup>xxv</sup> H.R. 3960, Sec. 103(a)(2).
- <sup>xxvi</sup> H.R. 3960, Sec. 103(b).
- <sup>xxvii</sup> H.R. 3960, Sec. 201(b).
- <sup>xxviii</sup> H.R. 3960, Sec. 201(c).
- <sup>xxix</sup> H.R. 3960, Sec. 612(c)(2); Sec. 614(b)(2); Sec. 615(b)(1),(2),(3), and (c)(2); and Sec. 620.
- <sup>xxx</sup> H.R. 3960, Sec. 601.
- <sup>xxxi</sup> The National Health Care for the Homeless Program was originally created by a private grant program of The Robert Wood Johnson Foundation and The Pew Charitable Trusts in 1984. Nineteen providers in 19 large cities were initially funded. The Stewart B. McKinney Act added Section 340 to the Public Health Services Act, providing Federal grants to providers of Health Care for the Homeless services, beginning in 1987. Currently there are 120 grantees.
- <sup>xxxii</sup> A federally-funded program under Section 330 of the Public Health Services Act, supporting primary health care clinics with consumer-led boards of directors in medically-underserved areas.
- <sup>xxxiii</sup> H.R. 3960, Sec. 102(c).

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- xxxiv H.R. 3960, Sec. 602(c)(1)(B).
- xxxv H.R. 3960, Sec.(c)(2), Sec. 614(b)(2), and Sec. 615(c)(2).
- xxxvi A category of health care providers created by the Omnibus Budget Reconciliation Acts of 1989 and 1990 entitled to bill Medical Assistance and Medicare Programs. These include Migrant Health Centers, Community Health Centers, and Health Care for the Homeless Programs.
- xxxvii H.R. 3960, Sec. 615 (b)(1).
- xxxviii H.R. 3960, Sec. 615(2).
- xxxix H.R. 3960, Sec. 615(b)(3).
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- xliii American Health Security Act (H.R. 3960) spending based on minimum funding requirements.
- xliv American Health Security Act (H.R. 3960), maximum funding permitted.
- xlv Clinton Bill (S.1757, November 20, 1993) figures include Graduate Medical Education, Academic Health Centers, Health Research, Core Public Health Functions, Health Services for the Medically Underserved, Mental Health and Addictions, and School-Based Health Initiatives.
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