File

HOUSE COMMITTEE REPORT

. (11)
Date Referred: April 9, 1990 FURTHER REFERRALS:

Date of Committee Action: 4/28/90

The FINANCE Committee considered: HB 581

HOUSE BILL NO. 581 UNIVERSAL HEALTH CARE TASK FORCE

"An Act creating a universal health care task force; and providing for an effective date."

RECOMMENDATIONS:
[✓] be replaced with CS HB 581 (FIN) [ ] the same title [✓] a new title
[ ] have attached amendment(s)
[ ] do pass
[ ] do not pass
[✓] no recommendation
[ ] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: ______ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[✓] fiscal impact DHSS
[ ] zero fiscal note
[ ] zero with analysis

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s)
[ ] zero fiscal note(s)
[ ] zero fn/analysis

SIGNING DO PASS:
Ian Brown Brown
Koponen
Ulmer

SIGNING:
(Check approp. column)

	Do Not Pass	No Rec	Amend
Hoffman		+	
Larson	[illegible] 1-10 No rec. 2		
D. Barnes Barnes		X	
Dick Shultz Shultz	X		
Phillips		✓	
Rieger		✓	
Kay Wallis Wallis		✓	

Larson
CU Chairman's Signature
Hoffman

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION : CS HB 581 (FIN)
PUBLISH DATE :

FISCAL NOTE

REQUEST:

Revision Date:
Title : "An Act creating a universal health care task force & providing for an effective date."
Sponsor : by the HESS Committee
Requestor : by the House Finance Committee

Agency Affected : DHSS
BRU : Administrative Services
Components : Planning and Development

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	73.3	105.9				
TRAVEL	17.5	26.5				
CONTRACTUAL	87.8	7.1				
SUPPLIES	0.9	0.5				
EQUIPMENT	-0-	-0-				
LAND & STRUCTURES	-0-	-0-				
GRANTS, CLAIMS	-0-	-0-				
MISCELLANEOUS	-0-	-0-				
TOTAL OPERATING	179.5	140.0	-0-	-0-	-0-	-0-

CAPITAL	0	0	0	0	0	0

REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	179.5	140.0				
FEDERAL FUNDS						
OTHER						
TOTAL	179.5	140.0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY	3	3				

ANALYSIS : (Attach a separate page if necessary)

See attached assumptions and calculation analysis.
No fiscal impact in FY 1990.

Prepared by : House Finance Committee
Phone : 465-3727
Division : Co-Chairman Ron Larson
Date :
Approved by Commissioner : Co-Chairman Lyman Hoffman
Date :
Agency :

Distribution (by preparer) :
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

CSHB 581 (FIN)
FISCAL NOTE CALCULATIONS AND ASSUMPTIONS April 27, 1990

PERSONNEL			FY 91	FY 92
RAIII	20 months	= $ 84,740	$ 33,896	$ 50,844
RA II	16 months	= 54,912	24,024	30,888
CTIII	18 months	= 39,564	15,386	24,178
Total personnel		$179,216	$ 73,306	$105,910

TRAVEL	FY 91	FY 92
Task Force travel:		
8 meetings, 5 members, 3 days per diem	$ 10,500	17,500
Evenings will be public meeting & discussion		
Next day is education/work session		
Avg. fare $400; per diem $90; misc. $30		
Total per meeting, per member $550		
Staff travel for research and meetings:	7,000	9,000
Total travel	$17,500	$26,500

CONTRACTUAL	FY 91	FY 92
Printing		-0-
3 X $5,000 for expert testimony & task force education	14,000	-0-
Advertizing (display ads)	3,500	6,500
Telephone long distance calls	350	650
Office Space	-0-	-0-
Employer survey (phone)	20,000	
Characteristics survey (phone, interview and observation)	50,000	
Total contractual	$87,850	$ 7,150

SUPPLIES	FY 91	FY 92
Paper goods, office supplies	$ 600	450
Reference books	300	
Total supplies	$ 900	$ 450

EQUIPMENT	FY 91	FY 92
Personal Computer	-0-	-0-

TOTAL FOR PROJECT	$179,556	$140,010

Assumptions:

1. Written work of the task force in providing program description and supportive documentation will be provided by legislative research agency, including any report printing.

2. Teleconferencing of public meetings will be provided at no cost through the legislative network or other comparable arrangement.

3. Reimbursement for services of those appointed by the Governor will be limited to travel and per diem.

4. Advisory committee members will provide funding for travel and other costs for their participation from their respective budgets.

5. Office space to be provided within existing legislative offices or by other donated arrangement.

6. Computer used for staff research work will be donated.

Original sponsor(s): HESS Committee

IN THE HOUSE BY THE FINANCE COMMITTEE

CS FOR HOUSE BILL NO. 581 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act creating the Universal Health Care Task Force; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS. The legislature finds that

(1) over 50,000 residents of the state cannot afford to pay their medical bills, are not covered by a group health insurance plan, do not qualify for public assistance programs, and cannot afford to pay individual health insurance premiums; a vast majority of the uninsured are either employed or are dependents of employed state residents;

(2) many state residents with high risk, preexisting health conditions are unable to obtain health insurance and must deplete their personal resources in order to obtain care;

(3) many state residents do not receive certain kinds of critical care due to exclusions in their health insurance policies;

(4) the health insurance coverage for many state residents does not cover costly illnesses or injuries causing catastrophic financial consequences to them and their families;

(5) due to the lack of health insurance coverage, many state residents do not obtain necessary preventive care, and this leads to dramatically higher remedial care and an additional incidence of disease and illness in the state;

(6) the cost of providing health care to those who are unable to pay is shifted to those who are taxpayers or participants in a health insurance plan;

(7) it would enhance the ability of Alaska businesses to remain competitive if they had better access to affordable health care coverage for their employees;

(8) the Governor's Interim Commission on Health Care recommended that "a state working group should explore and develop health insurance plans for medically uninsured Alaskans";

(9) every state resident should be guaranteed a basic level of health care regardless of income and should not become financially destitute before obtaining health care; access to health care should be universal, including those state residents with preexisting health conditions;

(10) the issues of medical indigency and universal health care are complicated, complex issues requiring review by an authoritative group for a certain period of time.

* Sec. 2. PURPOSE. The purpose of the Universal Health Care Task Force created by this Act, is to

(1) design a cost-efficient program that allows access to health care, through insurance or other means, to all state residents, and that provides a basic level of health care services;

(2) define the best strategy for implementing a universal health care program, including consideration of the redistribution of existing funds spent on health care in the state in order to provide for a more rational and equitable health care system.

* Sec. 3. UNIVERSAL HEALTH CARE TASK FORCE. (a) The Universal Health Care Task Force is created in the Department of Health and Social Services. The task force is composed of five individuals appointed by the governor with a significant and demonstrated expertise or interest in health care. As a nonvoting technical advisory committee to assist the task force, the governor shall also assign one representative each from the Department of Health and Social Services, the division of insurance, the division of

retirement and benefits, and the Office of the Governor, and the presiding officer of each house of the legislature shall assign a member from that house.

(b) The members of the task force are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180.

(c) The task force shall select a chair and a vice-chair from among the members of the task force.

* Sec. 4. DUTIES OF THE TASK FORCE. The task force shall

(1) solicit advice and information from health care consumer groups, the insurance industry, health care providers including the State Medical Association, the Alaska Psychiatric Association, the Alaska Psychological Association, the Alaska Mental Health Board, the State Health Association, the Alaska Pharmaceutical Association, the Alaska Public Health Association, the Alaska Dental Association, the Alaska Academy of Physicians Assistants, the Alaska Nurses Association, the United States Department of Veterans Affairs, the United States Department of Defense, the Civilian Health and Medical Program of the Uniformed Services, public employee unions, representatives of the medically indigent, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, public relations experts, the public, and the technical advisory committee created in sec. 3 of this Act;

(2) analyze all the relevant information necessary to recommend a program of universal health coverage, including 1990 census data and the study done in 1954 for the United States Department of the Interior by Thomas Parran, titled "Alaska Health: A Survey Report";

(3) update the information in the "Alaska Comprehensive Health Care Financing Study" done by the Battelle Human Affairs Research Center in

1982;

(4) make an accurate estimate of the number of people who are unable to receive necessary health care services in the state, which patients are generating unpaid medical bills, which state residents are uninsured or lack adequate insurance, which health care providers are providing uncompensated care, who is paying for the cost of uncompensated care, and the total cost of uncompensated care in the state;

(5) identify those health care services necessary to achieve an acceptable minimum level of health care for all state residents and to examine those health care services that provide the most care for the most people at the least cost, including prevention services; the Oregon Basic Health Services Act shall be examined by the task force;

(6) recommend ways to coordinate services between nonprofit health care providers, profit making health care providers, the state division of public health, the United States Department of Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in order to achieve a more efficient and effective health care delivery system;

(7) consider possible delivery systems for a universal health care program, including using a single, comprehensive statewide system or changing existing health care services to yield an integrated system of health care coverage; options that shall be considered include

(A) expanding the use of private health insurance to provide coverage to the uninsured and underinsured;

(B) continuing or reinstating government programs, including the Medicaid medically needy option or the catastrophic illness program, if private insurance is not the best way to provide coverage;

(C) sponsoring the pooling of small employers into a single organized health care purchasing group;

(D) mandating coverage in the workplace for employers with a certain threshold number of employees;

(E) mandating a minimum basic level of health services to be included in a health insurance plan, with a special emphasis on important preventive services and children's health services;

(F) requiring that health care programs include residents who are unable to obtain insurance due to a high risk or a preexisting medical condition;

(G) requiring that health care programs include coverage for costly medical services that have a catastrophic financial impact on patients and their families, including making the state the payor of last resort before a family becomes destitute;

(H) requiring that the University of Alaska provide health coverage for all students;

(I) combining the workers' compensation system with a universal health care program;

(J) establishing or lengthening the time for continuation or conversion of health insurance coverage after a state resident leaves employment;

(K) using the unemployment insurance program to also cover health care services for the unemployed;

(L) examining the ability of the state to self-insure under a universal health care program;

(M) making charity care a requirement as part of the licensing or certificate of need process;

(N) having special programs designed to ensure that children have adequate health coverage, such as the child health care programs established in Minnesota;

(8) consider a means of financing a universal health care

program including the following:

(A) the use of a payroll tax for full or partial financing of a small employer insurance pool;

(B) a Medicaid waiver requesting a block grant from the federal government to subsidize a universal state program;

(C) using the permanent fund dividend program to finance coverage for some residents;

(D) using reasonable deductibles and co-payments to discourage frivolous use of health programs;

(E) using the unemployment tax to cover the costs of insurance for the unemployed or uninsured;

(F) a Medicaid buy-in for the medically uninsured;

(G) streamlining coverage so that families are not covered under two separate insurance programs;

(9) pursue financial support from other sources, including private foundations like the Robert Wood Johnson Foundation, for the work of the task force and for implementation of a universal health care program;

(10) coordinate with the community health planning efforts described in Senate Bill 326 of the Sixteenth Alaska State Legislature;

(11) solicit actuarial data and other technical information and assistance from the health care insurer providing coverage to the state;

(12) utilize information provided by the Health Care Cost Containment Task Force established by the Sixteenth Alaska State Legislature.

* Sec. 5. REPORT. The task force shall, by March 1, 1992, provide a preliminary report, and by June 30, 1992, provide a final report to the legislature and the governor that recommends a program for providing universal health care, including recommendations for implementing the program in phases in an expeditious, yet orderly manner.

* Sec. 6. This Act is repealed June 30, 1992.

* Sec. 7. This Act takes effect February 1, 1991.

Attachment 1
4/18/90
HB581

Amendment #1 By Rieger

To: CSHB581 (HESS)

Page 2, Lines 17-19 Delete all material after "residents," and replace with "and that provides a basic level of health care services.

Page 2, Line 22, after "provide for a" insert "more"

Page 2, Lines 23-24. Delete all material after "system" add "."

Technical

Page 3, Line 3, after "benefits," insert "a member selected by"

Page 3, Line 3, after "representatives," insert "a member selected by"

Page 3, Line 8, delete "governor" and replace with "task force"

+ Page 4, Line 29 through Page 5, Line 3: Delete all material and re-letter accordingly

+ Page 6, Lines 10-14: Delete all material and re-letter accordingly

Page 4, Lines 26-28: Delete all material and re-letter accordingly

Am#2

presiding ~~member~~ officer of ~~ea~~ each house of the Legislature shall assign a member from that house.

page 2, line 28: after "care." insert "The governor shall consider, to the greatest extent possible, making appointments that represent a broad cross section of Alaskans interested in health care."

HEALTH CARE COALITION
OF
ALASKA

March 16, 1990

REC'D MAR 19 1990

Jim

Honorable Johnny Ellis
Chairman
Health, Education and Social Services Committee
Alaska State Legislature
P.O. Box V (MS3100)
Juneau, Alaska 99811

Dear Representative Ellis:

On behalf of the health care industry in this state, I commend you and your colleagues for recognizing and responding to the need for a universal health care task force. I believe this to be the most significant piece of health legislation this session.

The entire issue of cost and access is impacted by the medically indigent, native health delivery system, veterans care, CHAMPUS, Medicare, Medicaid, military delivery system, the public and the private sector. There are no easy answers to our current dilemma, but unless we pull ALL the players into the game, we will never find a solution.

I have two requests that I sincerely ask you to consider. The first request is to consider adding health industry members to the task force. Apart from providing the educational expertise, I believe they would be objective and honest in their assessments. But most importantly, it would be helpful for them to participate in any final resolutions. Secondly, I have enclosed an overview of what many believe is the problem facing society today. I realize how busy you are, but I strongly urge you to read this document. Hopefully it summarizes the need, and possibly the direction you might consider for the Task Force.

Again, thank you for recognizing the urgent need for this kind of a group. You might suggest to Senator Kelly that his cost containment group might be best served through this task force.

Sincerely,

Ray Schalow
Chairman

ALASKA ACADEMY OF PHYSICIANS ASSISTANTS • ALASKA PHARMACEUTICAL ASSOCIATION • ALASKA PUBLIC HEALTH ASSOCIATION
ALASKA STATE MEDICAL ASSOCIATION • HEALTH ASSOCIATION OF ALASKA • ALASKA NATIVE HEALTH BOARD • ALASKA NURSES ASSOCIATION • ALASKA DENTAL SOCIETY
working together . . . caring together
4107 Laurel Street Anchorage, AK 99508 (907) 562-2662 Fax 561-2063

Alaska State Medical Association
4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

Dr. John Kitzhaber, an Oregon physician and current president of the Oregon State Senate offers a clear and cogent presentation on the issue of uncompensated care in America. I have taken the liberty of paraphrasing his comments and urge you to read them thoroughly. It speaks to an issue that we in the health industry are just now beginning to understand, and it points out the need for greater dialogue between provider and legislator in order to address a critical social problem.

Let me begin by stating to you that unequivocally the most serious threat facing the health industry today is uncompensated care. If left unresolved, it will erode the health of our society and in turn will lead to an erosion of the clinical autonomy of physicians and other providers. It will also undermine some of the very principles on which our health care system has been built and will lead to increased regulation of the practice of medicine and probably to a government controlled health care delivery system.

To understand the threat and challenge it poses, we must first consider the evolution of our American health care system. Our health care system was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer. We were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered and the cost was merely shifted to someone who could pay through an incremental increase in their bill or in their insurance premium.

This policy was no accident, but was the result of conscious decisions in both the public and private sector. In the public sector, we enacted Medicare and Medicaid in 1986 extending coverage to the poor and the elderly. At the same time, we had a rapid expansion of private policies funded primarily through employment. This rapid growth of third-party insurance coverage led to the belief that health care for the poor in this country was free, when in fact it being subsidized primarily by the government and by the business community. We created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they wanted or needed. Physicians could practice pure medicine, viewing their patients primarily from their health needs without concerning themselves over income. But this system also led to, and encouraged utilization. It led to the deeply held social belief in this country that health care is a right. That resulted, understandably, in a dramatic increase in expenditures. The amount we spent on health care grew from $75 billion in 1980 to nearly $500 billion in 1988 and it still continues to grow. An more telling, is the growth of health care expenditure as a percent of the Gross National Product. We spent 7.4 cents on the dollar in 1970 and we spend about 12 cents today. If this rate continues, by the turn of the century we will be spending 20 percent of the Gross National Product on health care, and by about 2020, we will be spending 40 cents out of every dollar on health care.

This, of course, will not happen. It makes a great deal of sense in terms of a social policy, but makes little sense in terms of an economic policy. No single set of expenditures can grow at a rate faster than the growth of the Gross National Product.

The prosperity we have enjoyed in the lst 20 years has allowed us to absorb these rapid increases and has masked the underlying fallacy of the way we finance health care in this country. A number of factors occurred that have brought our ideal health care system into collision with economic realities. New medical technologies were being developed and being used because there was no financial restraint on the system, and at a tremendous cost. Secondly, the population was aging. There has been a significant increase in the elderly as a percent of the population, and they use more health care services. They have a larger incidence of chronic diseases, both of which increase the financial strain on the system. These factors brought the people who had been traditionally subsidizing the cost of health care for the poor, the business community and the government, to a position where they had to reevaluate their willingness to continue to do that. The economic stagnation that we experienced at the beginning of this decade could no longer absorb the rapid increases in the cost of health care. Our annual productivity growth was 3% a year in the sixties and seventies, but fell to half a percent a year by 1979, and was actually negative in the early eighties.

Our federal budget deficit increased from about $73 to $211 billion in five years. We liquidated all our foreign assets and became the largest debtor nation in the world. The government in the first part of this decade recognized that they could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit or making deep cuts in other domestic programs. At the same time, this country entered the world market. We began recognizing that we were not competing just among ourselves like the auto industry once did, but were competing with mainland China, West Germany, Japan, etc. They realized that cutting costs, particularly labor-related costs, had to be done in order to remain competitive with cheap labor industries abroad. They couldn't pass the cost of health care on to their consumers and still remain competitive; particularly when American business has to carry the cost of health care on the books as necessary expense and are competing with countries that do not carry health care as a cost, because they have nationalized health care programs.

The business community now became interested in cost containment in order to remain competitive. The government became interested in cost containment to balance the budget. The object of business and government was simply to reduce the exposure to the cost shift, and to reduce their funding and subsidy of the cost to care for the poor. The subsidy was not taken out of the system, it was merely shifted on to individuals and providers. How did they do it?

In 1983, the federal government enacted the DR'G`s, which is a prospective reimbursement system that shifted economic risk on to providers. They began requiring first-day hospital deductible for Medicare, increases in the Part B monthly Medicare premium. This shifted costs on to the individuals. With Medicaid, the program for the poor, they cut their match rate and shifted that to the states. The first thing the states did was cut provider reimbursement rates, so that now we get 45 to 50 cents on the dollar for taking care of someone on welfare. That pushed costs and responsibility to the individuals. We have had 800,000 women and children squeezed off Medicaid in the last ten years. That program, which used to cover 65 percent of the poor, now covers less than 38 percent of the poor.

The private sector reacted exactly in the same way with an increased involvement in HMO's, PPO`s, and other prospective managed care plans that put the providers at risk. They increased co-payments and deductible for their employees then shifted costs on to individuals. The important thing to remember is that cost containment reflected absolutely no social policy beyond cutting costs for the government and the business community. There was recognition that the amount of health care that could be spent on the poor was limited. There was no consideration of the implications of those decisions on access to health care. They reduced the funding in the system, but didn't reduce what the public expected from the system.

Today we find ourselves in a situation of transition. We are still ostensibly committed to the principle of universal access; but now the system is driven by economic factors, not by the social factors that drove it in the Sixties and Seventies. Providers are now at economic risk, and we are losing our ability to cost shift.

Our ability to deliver on the concept of universal access has depended on cost shifting and the willingness of business and government to subsidize the cost of care for the poor. But what we are seeing today, while we are still supposedly committed to universal access, is a progressive shifting of the responsibility to pick up that cost. Remember that between 1965 and 1980 that subsidy was borne by government and business which spread it out over taxpayers in general. So society was paying for the social responsibility to have universal access in this country.

Because of the cost containment measures that have occurred, the subsidy has now been shifted to providers. Physicians have far less ability to absorb this shift and what formerly was subsidized care for the poor is now showing up as uncompensated care. As physicians reach a point where they can't absorb additional uncompensated care and still pay the bills, they push the costs on to individuals. So today, if you don't have insurance coverage or money, you are increasingly likely to lose access to the health car system - either because the provider won't take in any additional indigent patients, or you delay treatment because you are afraid you can't afford it.

This has changed how we finance health care in this country. Our health care system now has a bifurcated financing mechanism. On one side is the public system, which is Medicare and Medicaid; and on the other side is the private system which is mostly employment based policies and some individual policies. There has always been a little gap in between where some people slip through the cracks. But as long as government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and has really contained only society's truly downtrodden.

Today as those two-third party payers are trying to escape from the subsidy, we`ve seen a reduction in government expenditures, co-payments and deductible in Medicare and increases for Medicaid eligibility, so people spill of the public side into that gap. As competition in the world market increases, we shift from a manufacturing to a service based economy with large numbers of low paid, non-unionized workers without health insurance coverage, and as premium rates continue to climb, people spill off the private side into that gap. Today that gap is no longer narrow, it has 37 to 40 million Americans in it. They are no longer just society's downtrodden. Seventy percent of those people are working full time or part time or are dependents of someone who is working. But it's those in that gap that are generating 75 percent of the uncompensated care. Why should we be concerned about this? Because there are some serious consequences in the shifting of responsibility to pay for the care of the poor, and there are some social and professional consequences that affect providers.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. Since market systems were not designed to foster social responsibility, it shouldn't be surprising that no one is competing for the poor. Public health clinics are closing and we are seeing patient dumping from hospital to hospital, physician to hospital and between physicians. There are treatment delays and a growing number of people in the gap.

That leads to the second consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two-thirds of those mothers do not receive adequate prenatal care. Forty percent of the poor in America are children and only one-third of them are covered by Medicaid, the other two-thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in pertussis and pediatric nutritional problems. There is case after case of people actually dying because of lack of access to the system. People are dying from strokes because they couldn't get in to get their blood pressure medication refilled. People are dying of heart failure and having MI's because of lack of routine checkups. People are dying of perforated ulcers because of treatment delays.

The third consequence is that we are mortgaging our own future. Remember, that 40 percent of the poor in this country are children, and two-thirds of them are in the gap. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we're expecting to fuel the economy and pay for a growing retired population. How are we going to do that in the face of $170 billion owed to foreign governments and nearly a three trillion dollar national debt; a ten trillion dollars unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security and federal pensions, most of which are automatically indexed and have no income eligibility requirements. What we're asking these people to do is be more productive than any other generation. We are asking them to do something that we have all refused to do, and that is recognize that increases in personal consumption have to be balanced with increases in productivity.

In the last ten years, American workers have averaged a $3200 increase per capita in personal consumption and only $950 of that has been paid for by increases in what each one produces. The remaining $2200 has been paid for by cuts in domestic spending and investment and by foreign debt. We are asking this group of people to be more productive than anyone in the history of this country, and probably take a reduction in their standard of living. Having asked them that, we are crippling them going in by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is health and well educated. This is a very, very serious implication.

There are also some disturbing professional implications. The first is the growing problem of uncompensated care that is catching physicians and providers between what society expects from our health care system, and economic realities. When the government and the business community move to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals, and they could do so without publicly or explicitly abandoning the idea of universal access, because they shifted that subsidy on to the providers. But when physicians move to limit their exposure to this for exactly the same reasons, they have to deny access to individuals. When a physician reaches a point where he or she cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring. That puts physicians in direct conflict not only their professional ethics, but with social expectations for the health care system. It casts them in a very unfavorable light as many people still view physicians as they were in the halcyon days of the 1960's or 1970's, when the economy was booming and incomes were rising. Most physicians do not understand the relationship between cost shifting and subsidizing care for the poor, and they don't understand the implications of taking cost shifting away from providers. The thought that a wealthy profession would be denying access to the poor is unacceptable to them. It puts them in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react and they are going to say: If physicians are not going to take care of the poor voluntarily, we are going to force you to do that. There are a lot of ways that are designed to force physicians to assume the responsibility for taking care of the poor, but they ignore the fact that society, while paying lip serve to universal access, has made a decision to limit the amount of money that they're going to spend on it. When someone convinces corporate America that a government sponsored health care program will put them in a better position in terms of competition in the world market; then we will be looking at a nationalized health care program. But in the short run, we are looking at increased regulation, reduction, and erosion in physician clinical autonomy.

What can we do about this problem? To solve this crisis in uncompensated care, we have got to start by accepting three very hard realities. The first reality is that resources are limited and that's a difficult reality. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars. As we said, we have a national debt approaching three trillion dollars that must be reduced. We have a huge defense budget that has been traditionally hard to pare down, and we spend $450 billion a year on Medicare, Social Security and other federal pensions. At the same time, we are cutting aid to education, we are also cutting investments in road, sewers, and infrastructure; and civilian research and development. All of those things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut, but at the same time, we want to reduce government spending. We want good road and schools, safe streets, criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, clean water; and we want to do all that, of course, with lower taxes and higher wages.

Obviously that doesn't work. There is a finite amount of money that this country can invest in health care versus the other things we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality. The rich are always going to have access to more health care than the poor. That's all right if what the poor get is adequate and if they're all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis of income, not necessarily on need or merit. We readily accept that in most instances. We don't expect public housing to look like the Ritz and we don't expect food stamps to be redeemed in very expensive restaurants. But because of our system, our concept of universal access, we take for granted that the poor should have access to all the health care services that are available to the rich.

This is the only part of our system that operates on this open-ended economic principle. What we've done is reject a multi-tiered system based on income. But actually we already have that kind of a system in place. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available near home. They have had consultations and elective surgeries that the poor have not had access to. We would all agree that everyone should have a right to prenatal care. You may argue whether or not the public should pay for a face lift electively for everybody on welfare, but it becomes much more difficult when you are trying to balance a transplant versus prenatal care.

What we need is a better definition of adequate health care to address that question. If we know resources are limited, if we know people with high incomes can buy more health care than people of lower incomes, and if we know that society can't buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get, that means the definition of adequate health care.

That brings us to the last reality, the inevitability of rationing. This is very difficult for physicians and providers to come to terms with. But when you define adequate health care, you also define what's more than adequate. That lads to the basis for explicit rationing of health care. I suggest that rationing already exists in our system. We ration by income and transportation barriers. But more importantly, we ration through a lack of any policy to guide how we spend our health care dollars. We ration inadvertently by legislative decision. If we have a limited amount of money in the health care budget and you spend it on one thing, it`s not available to be spent on something else.

Consider how we are doing this today. We spend almost $2000 per capita on health care in America. That is more than any other country in the world and yet our wellness as measured by morbidity and mortality statistics is not significantly higher than in England, which spends half as much, or even Singapore which spends a fourth as much. Why is that? Because we have no policy to guide how we spend our health care dollars. We are spending huge sums on some and none on others. We spend more per capita than any country in the world, yet 37 million Americans have no coverage and many of them are losing access to the system. We spend three billion dollars a year on neonatal intensive care while we're denying prenatal care to hundreds of thousands. We spend $50 billion a year on people in the last six months of their lives, while we are closing pediatric clinics. That's like having someone in charge of a truck fleet for your corporation who adopts a policy that he won't change the oil in the trucks until the blocks melt. You certainly wouldn't hire that guy to work for you. But that's exactly how we spend health care dollars in this country. We don't spend it on prenatal care, we spend it on neonatal intensive care. We don't treat hypertension, we treat people who have stroked out. We are rationing by default. It's guided by no social policy and it's not equitable. We are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly as opposed to explicitly is because we don`t want to come to grips with our own limits.

To solve this problem of uncompensated care with of the ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system that is based on the three realities that we've just discussed: limited resources, acceptance of the fact that the rich will always be able to buy more health care than the poor, and that we`re going to have to ration. We have to recommit ourselves to universal access, but not universal access for everyone to everything. Universal access for everyone to an adequate level of health care. This will put our system back on a sound economic foundation, and means we are going to have a three tiered system of delivery in this country. We already have a non-defined sort of implicit multi-tiered system. But this would mean a government sponsored tier for the poor. It would mean a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services. It`s at that bottom tier that we have to come to grips with rationing.

The government has a responsibility to pay for the poor, not for the elderly. The government should pay for the poor regardless of age and there is no reason Lee Iacocca needs Medicare. We should put an income eligibility requirement on it.

It`s the bottom tier that we have to come to grips with rationing. It's this tier that we have to set the socially acceptable minimum level of health care for this country, and how do we get there? I suspect there are three elements to resolving this. We must have a clear social policy and we need to define adequate health. Then we need a universal insurance system to insure that people get access to that care. The social policy we had in the Sixties, Seventies, and Eighties, was universal access. One of the reasons we are in trouble today is because we were able to cover everybody for almost everything. But unless you define what it is you`re covering people for, you still have an open-ended system that we can't afford. Politically it's far more difficult to deal with the question of adequate health care than to design and politically adopt a position to deal with the universal insurance coverage question.

We must have a clear social policy because we need a framework to guide how we spend those health care dollars in a way that is efficient and equitable. We must make an attempt to recognize our limits and adopt such a policy. Should we discontinue funding for heart, bone marrow and liver transplants for people on welfare or should we take that money and extend it out to buy preventive and prenatal services for a far larger group of people who have been in the gap? The question is not whether transplants have merit. The question is not whether, in the short run, we could find some additional money to buy a few more transplants for people on public assistance. The issue is, does it make more sense and is it a better use of public dollars if we we're going to spend more on health care to buy high tech services for a group of people who already had access to virtually everything in the private sector; or should we extend services to a larger number of people who currently do not have access to any health care whatsoever. Should universal access to adequate health care be the first priority for spending additional dollars?

Once we get a definition of adequate health care and array our health care services on a priority basis, we are changing, in a very fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus. It goes like this: You have one heart and three potential recipients. Do you give that heart to the 17-year-old unwed mother of three on welfare or do you give it to a 40-year-old corporate executive? This raises the kind of imponderable ethical and moral question that society, almost by definition, can't resolve on an individual basis. But when you develop a definition of adequate, and array your health care services in a priority order, you shift that debate from the individual focus to a social focus. You are no longer debating which service should be given or denied to which individual, you are debating which priority funding should be given to each service, given the reality of limited resources. Society has made the decision to limit the amount of money it's spending on health care. Society needs to make the decisions on how to spend that money. That takes physicians out of the squeeze and they can now continue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. A group of dedicated providers and health experts should break down every dollar spent on health care. A list should be made of the number of people getting the service and the cost; the number of people not getting the service and the economic as well as health implications of not giving them that service; and the cost to extend the service to cover everybody in giving them that service; and then the cost to extend the service to cover everybody in the unmet need population. Arrange this list in a tentative priority order and begin presenting it at town hall meetings where citizens are actually getting involved in working through the trade-offs and choices that are necessary to set up a priority list of health care choices. Bring this information together and generate a final list that will be submitted to the legislature. Once the health care resources are arrayed in that kind of a list, you ;have to integrate it with the budget process. You must, then, require that the funding go to the first item on your priority list for everyone in the population for whom the state has responsibility. You go down and fund the second, third, etc., until you run out of money.

What that does is, put accountability in the system. If our state legislature decided to cut $20 million out of our health care budget, it would not be an abstract accounting exercise. It would mean the deletion of very specific services for very specific individuals off the bottom of the priority list and then the debate becomes far more focused. If you want to come in and refund the transplant program, it's very clear that you either have to knock something else off your priority list - you have to make a choice, a clinical choice and a political choice between those two health services, or you have to rob another program, or raise more money.

The final point with this type of system is that, if it's done on the basis of sound clinical grounds, you can actually save money in the system. A study done in California suggested that the cost of treating a low birth weight infant was $28,000 up to six figures. The study suggested that if you provided that care to all the indigent women who needed it, you could save $22 million a year in your health care system. That's money that can be used to add services on your priority list. It could be used to raise provider reimbursement levels to a reasonable point where people are not trying to avoid dealing with that population.

What is the role of physicians in resolving this problem? The most significant role they plan is to come to grips with their own limits. They have got to recognize that health care resources in America are in fact limited. How can we expect the public to accept the limits or expect state legislatures to recognize the limits if physicians are not willing to recognize them themselves. We are inviting all of the ominous consequences that uncompensated care is bringing our way. We have to do that as a first item and express that publicly, physicians must discuss it with each other and with their patients.

Secondly, professional organizations need to adopt a policy. a statement on how to expend limited health care dollars. Something that says the first priority is to extend the basic level of health care coverage, and then we can fight about the budget. But to do that, we have to get involved in the definition of "adequate". Physicians are really the only group in this country that have the qualifications to provide sound clinical input to the state legislature. We need to say, yes, we are going to have to ration health care in this country. It's inappropriate and unethical for physicians to do it, society needs to do it. If the legislature is going to ration health care, then offer a list of clinically wise priorities. This makes sense in terms of marginal costs and marginal benefits. We have to provide that input and then support the legislative decisions that make responsible resource allocation decisions. We have to do that publicly, in our community and at the legislative level.

Uncompensated care requires a partnership solution between public policy makers at the state legislative level and leadership in the medical community. If left unresolved, the problem of uncompensated care is going to result in an erosion in our social commitment to universal access, a deterioration of health for a growing number of Americans with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system. This will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We cannot accept this outcome as in the final analysis, physicians are patient advocates.

I hope this will assist your understanding concerning the health care industries dilemma and crystallize societies dilemma as well.

Sincerely,

Ray Schalow
Executive Director

AB581

MEDICAL INDIGENCY **ProjectNotes**

National Conference of State Legislatures Vol. 1, No. 2 February 1990

HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;" and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was $600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately $2,400 per person. 1990 health spending is expected to reach $661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- o A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- o Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- o Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.[1]
- o Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- o The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- o Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- o Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.[2] Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.[3]
- Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

FINANCING INSURANCE COVERAGE

> *"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace."* John C. Goodman and Gerald L. Musgrave, Freedom of Choice in Health Insurance, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

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[1] Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

[2] Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in Hunger Action Forum, Vol. 2, No. 8, August 1989.

[3] Paula Braveman, MD, et al., *"Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," The Western Journal of Medicine,* 1988 December: 149: 708-11.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (**HB 1034**) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (**1989 Georgia Laws, p. 1749, HR 162**). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (**1989 Indiana Acts, P.L. 327, SEA 385**) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (**HB 1127**). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of **North Carolina** either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be $1.4 billion, but institute officials contend that the net cost would be much lower -- about $700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In **Washington** state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of $3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g, "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care, and eliminate unnecessary procedures."

> *"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do no offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs."* Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more copayments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.

FYI

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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina, and Wisconsin. The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

MEDICAL INDIGENCY ProjectNotes

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

National Conference
of State Legislatures
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FINANCING HEALTH CARE FOR ALASKA'S UNINSURED AND UNDERINSURED

A Technical Assistance Program
for the Alaska State Legislature

March 30 - 31, 1990

Health Care Financing Project
Medical Indigency Project

Health Services Program
Human Services Department

National Conference of State Legislatures
1050 17th St., Suite 2100
Denver, CO 80265
303/623-7800

TABLE OF CONTENTS

Colorado

Massachusetts

AHCCCS

The Arizona Health Care
Cost Containment System

ARIZONA'S
HEALTH
CARE
PROGRAM
FOR
THE
INDIGENT

Overview

TABLE OF CONTENTS

The Arizona Health Care Cost Containment System is now in its eighth year as a Medicaid demonstration project, and changes in the health care industry promise to make it yet another year of challenges. AHCCCS has already demonstrated that it costs less than traditional Medicaid in other states -- an independent study by SRI International, a nationally known research organization, shows a substantial cost savings (see Page 20) -- and that the partnership between the public and private sectors is working.

The program began Oct. 1, 1982, and is now serving almost 290,000 needy Arizonans, mostly mothers, children and elderly persons. Among these are 11,417 people who have qualified for services under the Arizona Long Term Care System, a major new program for the developmentally disabled, elderly and physically disabled that started in January 1989.

BACKGROUND

Before 1982, Arizona was the only state not participating in the federal Medicaid program, which began in the mid-1960s. Since 1864, health care for Arizona's low-income population was provided by the counties through county hospitals and clinics, or through contracted providers.

A statewide county government fiscal crisis in 1980-81, due in part to escalating health care costs and a new law that limited county budget increases, compelled the Legislature to propose a Medicaid demonstration project funded by federal, state and county governments.

In the spring of 1982, AHCCCS was approved as a three-year demonstration project (under Section 1115 of the Social Security Act) by the Health Care Financing Administration, the federal agency that oversees the program. AHCCCS officially began Oct. 1, 1982. HCFA has since given the program repeated extensions to continue operating and receiving federal funds as a demonstration project. In late November 1988, HCFA approved a five-year extension until 1993. Arizona, on the other hand, gave AHCCCS permanent status in 1987.

The goal of the AHCCCS project was to develop and test a new delivery and payment system for providing health care services, facilitate cost containment, improve patient access and, at the same time, encourage quality care and efficient treatment.

The original program design called for a private contractor to serve as the day-to-day administrator. The administrator's responsibilities included enrollment functions, health plan oversight, audit and compliance functions, claims processing, medical quality assurance, and grievance and appeals.

The program was implemented with very little time for planning and development. Virtually every review of the early years of AHCCCS cites an inadequate amount of time for planning.

During its first 18 months the program was beset with a number of administrative and budgetary problems, which resulted with the termination of the private administrator's contract less than halfway through the term. There was a tremendous amount of negative press about the program, resulting in a lack of confidence by elected officials, the medical community and the public at large.

After having received a notice of contract termination from the private administrator in March 1984, the state assumed the administration of the program. A task force was appointed to manage the transition from the private sector to the state.

Within 30 days, the state succcessfully took over the operation. It hired 150 employees, transferred the private administrator's computer software system to state computers, and brought on-line a new computer center.

The AHCCCS program was mobilized to assume a strong, regulatory position. New challenges included:

-- Performing financial and contractual compliance reviews of 19 contracting health plans.

-- Quality control review of the county eligibility systems.

-- Medical quality-of-care audits of the health plans, some of the most thorough medical reviews of any Medicaid program.

-- Increased staffing for the audits, compliance and utilization review functions.

After the state assumed administration of the program, two health plan contracts were terminated due to plan insolvency and another plan with new management was successfully reorganized under the federal bankruptcy statutes. AHCCCS was then, and remains today, the only statewide prepaid Medicaid system in the country.

FUNDING

AHCCCS is funded by a combination of state, county and federal contributions. The chart on Page 5 shows the AHCCCS budgets by revenue source since Fiscal Year 1982-83. Before FY 1988-89, the percentage of funds contributed by the state continued to grow partly because of the addition of the Children's Care Program, which is 100 percent state-funded. Because the counties' contribution is fixed and the federal government's risk-sharing is limited, the State General Fund has absorbed a number of program cost increases. There have been increases in the federal percentage over the past three years, which can be attributed to two factors. First, the AHCCCS Administration has more aggressively pursued more federal matching funds. Second, more federal funds have become available as Congress has expanded federally matched eligibility under Medicaid for more pregnant women and children.

AHCCCS differs from traditional Medicaid programs in that its "match" of federal funds is in the form of capitation payments (fixed rates based on AHCCCS population numbers) rather than being based on services rendered. The state is capitated by the federal government on a prepaid basis per its Section 1115 waiver agreement for the categorically eligible, and therefore it is at financial risk for containing health care costs.

Captitation rates were established according to actuarial estimates and represent 95 percent of the estimated cost of services that would have been provided under a fee-for-service arrangement. The actuarial study, conducted by Actuarial Research Corporation (contracted by HCFA), was based on utilization and cost data obtained from several surrounding states. The

AHCCCS BUDGETS
by fiscal year

(000)

	State	Federal	Other*	Total
1982/83	22,050	37,800	55,300	115,150
1983/84	81,270	57,063	80,457	218,790
1984/85	124,621	66,772	65,272	256,664
1985/86	141,311	70,120	62,912	274,343
1986/87	127,822	87,148	72,162	287,132
1987/88	187,193	111,983	78,050	377,226
1988/89**	245,216	311,402	123,906	680,524
1989/90**	320,293	452,026	159,475	931,794

* Primarily county funds

** Includes long term care

amount paid the state has been based on the estimated number of enrollees in each eligibility category multiplied by the respective capitation rate. Quarterly adjustments are made for the actual number of enrollees. Having established the capitation rate, HCFA then pays the state based on a federal matching rate of about 62 percent of that rate.

The annual county contributions for the acute care portion of the program are fixed by statute at 50 percent of the lesser of what they budgeted or spent on health care in FY 1980-81 which resulted in an annual contribution of $63,073,476. A change was made to Pima County's contribution in 1986 based on a re-evaluation of their 1980-81 indigent health care expenditures by the Auditor General. The only change made to the statutory formula since the inception of the program also reduced Pima County's contribution. That change to the county contribution formula (per Laws 1986, Chapter 380, Section 19) limited the amount of county contributions beginning with FY 1987 to 33 percent of the amount that AHCCCS expended in that county for FY 1984. That change affected only Pima County's contribution, which was reduced by $3,403,130 to $12,737,224.

The chart on Page 7 shows the history of the counties' annual contributions to the acute care AHCCCS program. The chart illustrates that while the AHCCCS program has grown significantly, the county contribution to acute care has actually decreased.

It is important to note that the startup of the long term care program in FY 1988-89 increased the counties' contribution to the program. The counties' contribution is to cover the entire local share of the long term care program costs for the elderly and the physically disabled. However, as discussed later, the counties' contribution to long term care was capped

ANNUAL COUNTRY CONTRIBUTIONS TO AHCCCS ACUTE CARE PROGRAM

	FY 84 FY 85 CONTRIBUTION	FY 86 CONTRIBUTION	FY 87 FY 88 FY 89 FY 90 CONTRIBUTION
APACHE	$ 262,476	$ 262,476	$ 262,476
COCHISE	2,161,200	2,161,200	2,161,200
COCONINO	724,956	724,956	724,956
GILA	1,379,280	1,379,280	1,379,280
GRAHAM	523,044	523,044	523,044
GREENLEE	186,108	186,108	186,106
LA PAZ	207,000	207,000	207,000
MARICOPA	32,933,076	32,933,076	32,933,076
MOHAVE	1,207,956	1,207,956	1,207,956
NAVAJO	302,964	302,964	302,964
PIMA	17,378,112	16,140,357	12,737,224
PINAL	2,649,756	2,649,756	2,649,756
SANTA CRUZ	471,288	471,288	471,288
YAVAPAI	1,393,260	1,393,260	1,393,260
YUMA	1,293,000	1,293,000	1,293,000
	$63,073,476	$61,835,721	$58,432,588

according to statute for the first two years of the program. The Legislature must now re-address the counties' funding of Medicaid long term care.

ELIGIBILITY GROUPS

AHCCCS provides services to several different groups of people. These include categoricals and the Medically Needy/Medically Indigent. Categoricals are those people who enter AHCCCS through a program for which federal matching funds are available. Examples are persons who are receiving Aid to Families with Dependant Children (through the Department of Economic Security) or Supplemental Security Income (through the Social Security Administration). Other eligible groups that are defined by Arizona statute only -- such as the Medically Needy/Medically Indigent who come to AHCCCS through the counties -- receive no federal matching funds. A chart showing the income levels for each eligibility group can be found in Appendix A.

Eligibility groups are briefly described below:

1. <u>Categorically eligible</u>

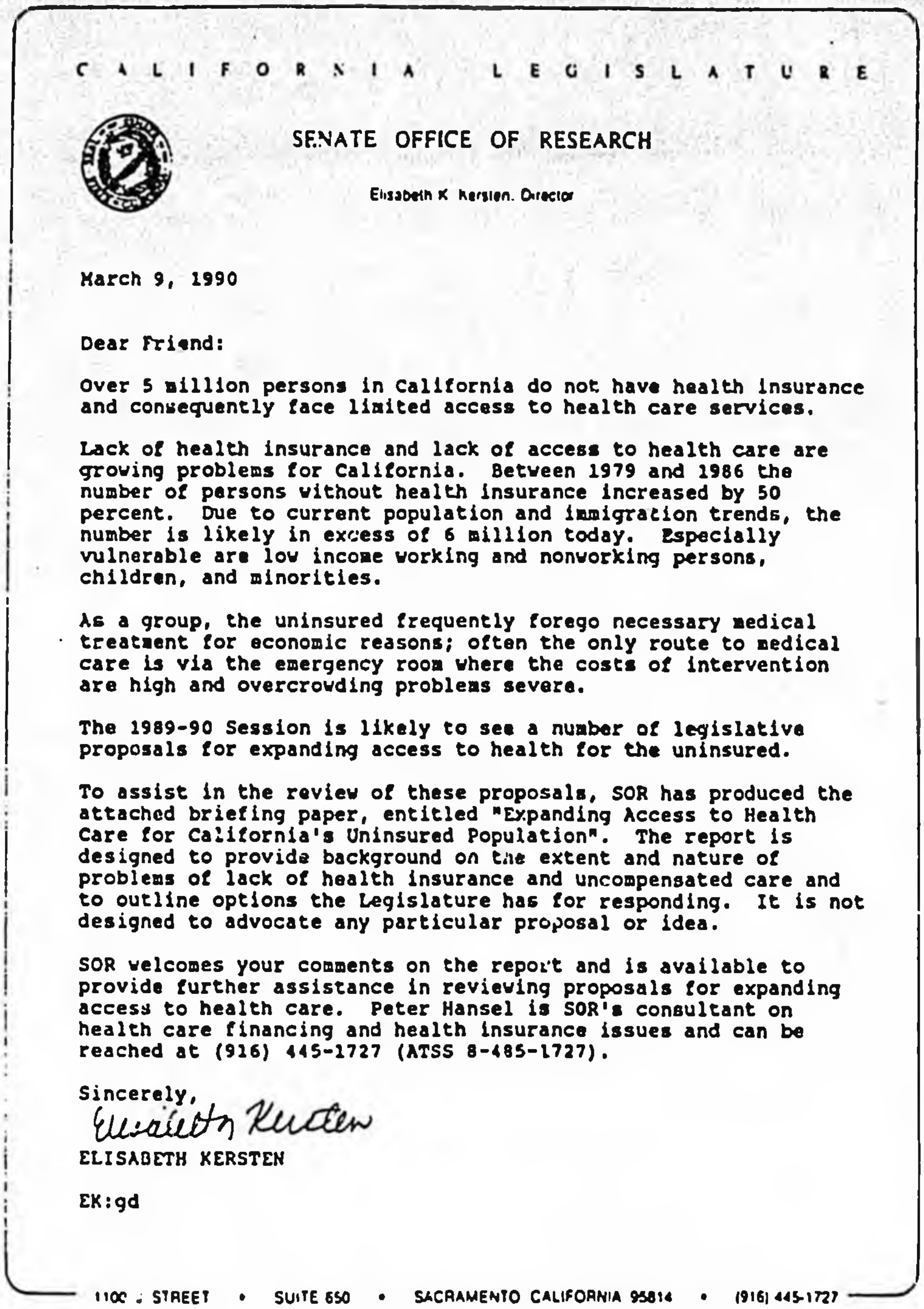
By federal law, these groups must be covered by AHCCCS. A person may qualify for AHCCCS benefits through the Aid to Families with Dependent Children (AFDC) program, through the AFDC-related Medical Assistance Only (MAO) group, or through the Supplemental Security Income (SSI) program and SSI-related MAO groups. Federal regulations define these groups. The Arizona Department of Economic Security (DES) performs eligibility determinations for AFDC-related applications. The Social Security Administration, a federal agency, performs eligiblility determinations for the aged, blind and disabled

EXPANDING ACCESS TO HEALTH CARE FOR CALIFORNIA'S UNINSURED POPULATION

Prepared by:

The Senate Office of Research
Elisabeth Kersten, Director
March, 1990

484-S



CALIFORNIA LEGISLATURE

SENATE OFFICE OF RESEARCH

Elisabeth K. Kersten, Director

March 9, 1990

Dear Friend:

Over 5 million persons in California do not have health insurance and consequently face limited access to health care services.

Lack of health insurance and lack of access to health care are growing problems for California. Between 1979 and 1986 the number of persons without health insurance increased by 50 percent. Due to current population and immigration trends, the number is likely in excess of 6 million today. Especially vulnerable are low income working and nonworking persons, children, and minorities.

As a group, the uninsured frequently forego necessary medical treatment for economic reasons; often the only route to medical care is via the emergency room where the costs of intervention are high and overcrowding problems severe.

The 1989-90 Session is likely to see a number of legislative proposals for expanding access to health for the uninsured.

To assist in the review of these proposals, SOR has produced the attached briefing paper, entitled "Expanding Access to Health Care for California's Uninsured Population". The report is designed to provide background on the extent and nature of problems of lack of health insurance and uncompensated care and to outline options the Legislature has for responding. It is not designed to advocate any particular proposal or idea.

SOR welcomes your comments on the report and is available to provide further assistance in reviewing proposals for expanding access to health care. Peter Hansel is SOR's consultant on health care financing and health insurance issues and can be reached at (916) 445-1727 (ATSS 8-485-1727).

Sincerely,

Elisabeth Kersten

ELISABETH KERSTEN

EK:gd

1100 J STREET • SUITE 650 • SACRAMENTO CALIFORNIA 95814 • (916) 445-1727

EXPANDING ACCESS TO HEALTH CARE
FOR CALIFORNIA'S
UNINSURED POPULATION

Prepared by:
Peter Hansel, Consultant
Senate Office of Research
March, 1990

Table of Contents

Executive Summary

In the period since World War II health insurance has become the primary means of access to health care services for most Americans. Currently, over three-fourths of the U.S. population has private health insurance of some kind. Medicare and Medicaid, public insurance programs designed to assist elderly, disabled, and low income persons, provide coverage for an additional 8-10 percent of the population.

Historically, a relatively small percentage of the population (10-15 percent) has had neither private or public insurance coverage. Generally, this residual population has relied on charity care by providers and/or public health safety net programs for access to necessary health care and the costs of providing this care have been easily absorbed by the health care delivery system.

Since the late 1970s the number of persons without either private health insurance or eligibility for Medicaid has risen sharply. Between 1977 and 1985, the percentage of Americans without private insurance or Medicaid or Medicare coverage increased from 13 to 17.6 percent, or 37 million Americans.[1] In California the number of nonelderly persons without either private health insurance coverage or eligibility for Medi-Cal or Medicare increased from 3.5 to 5.2 million persons between 1979 and 1986, a 50 percent increase.[2] Given current population and immigration trends it is likely that the number of Californians without health insurance has increased to in excess of 6 million persons.

The rise in the number of uninsured Californians is placing severe demands on the state's private and public health care delivery system, including rising burdens of uncompensated care and burdens on the county health care safety net. Without measures to increase health insurance availability and access to health care services these impacts will become increasingly severe in future years.

This issue brief examines the problem of the growing number of Californians without health insurance and discusses options the state has for expanding access to health care for this growing population.

The report:

- Summarizes recent data on the composition of the uninsured population, recent trends in coverage, and examines economic and demographic changes that are contributing to the rise in the number of uninsured.

- Examines impacts associated with the growth of the uninsured population, including reduced access to health care services by uninsured persons and declining health status as a result of lack of access, rapid growth of uncompensated care expenditures of health care providers, the growing cost shift to private payors of health care, and the overburdening of the county health care system, including growing backlogs for clinic, emergency, and inpatient services.

- Presents a variety of options for expanding access to health care by the uninsured population, including comprehensive reform proposals that would change the manner in which health care is delivered to all persons in the state as well as incremental proposals targeted at segments of the uninsured population such as employees and their dependents. Where possible, the report references proposals adopted or being experimented with in other states.

In addition, the report contains an appexdix summarizing major pending or recently introduced proposals for expanding access to health care services by uninsured persons including the Health and Welfare Agency's proposal contained in its report of the AB 350 task force.

Additional copies of this publication may be purchased for $5.40 per copy from:
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Colorado's Indigent Care Program

Background

In 1974, the State of Colorado initiated a program to fund health care services to Colorado's non-Medicaid poor. The program was officially authorized by statute in 1983. The University of Colorado Health Sciences Center has managed the program since July 1982.

The Indigent Care Program is comprised of five separate line item appropriations. For fiscal year 1988-89, the total appropriation of $41,922,273 included:

Community Maternity Program	$ 3,349,705
Denver Indigent Care Program	16,059,496
Out-State Indigent Care Program	6,858,474
Specialty Indigent Care Program	1,389,078
Health Sciences Center Indigent Care Program	14,265,520
Total	$ 41,922,273

Providers

The MI statute establishes that Denver Health and Hospitals is the designated primary provider for health care for Denver County residents. The statute further designates the Health Sciences Center as the primary provider for non-Denver County residents within the Denver Metropolitan Statistical area. The Health Sciences Center, additionally, is designated as the specialty care provider where services may not be available throughout the state.

By statute, providers must be licensed by the State Department of Health as a general hospital, a community clinic, or a maternity hospital. Health Maintenance Organizations, issued a certificate of authority, may also be providers in the Out-State and Specialty Indigent Care Programs. To be eligible to apply as a provider, applicant institutions must provide at least 3% of their annual costs as charity care. Open enrollment for the program occurs each Spring prior to the State's new fiscal year.

The Out-State Indigent Care Program has received 57 applications for participation in the 1988-89 program year. Of the 57 providers, 42 were hospitals and 15 were community clinics. For the Specialty Indigent Care Program, 2 hospitals applied.

Providers are required, at a minimum, to provide emergency care to indigent patients up to the capacity of their physical, staff, and financial capabilities.

Patient Eligibility

The MI statute clearly states that the program as established is not an entitlement program. The medically indigent patients accepting services under this program are subject to limitations and requirements.

It is the responsibility of the individual patient to apply for eligibility under the program and provide the necessary documentation. Patients eligible for Medicaid do not qualify under the MI program. Other third party insurance coverage must be exhausted, prior to coverage under the MI program.

To determine a patient's eligibility, each provider uses the guidelines published in the 1988-89 Ability-to-Pay Manual. The ability-to-pay formula considers family size, income, assets, and liabilities to determine an indigent rating.

Services Covered

The services covered vary by provider and are established as part of the contractual process. A priority is placed on emergency acute care services. Although the MI statute has established target percentages for utilization of inpatient, outpatient, emergency and transportation services, these requirements may be waived by the Indigent Care Program Administration.

Provider Payment

For all programs, with the exception of the Community Maternity Program, providers are paid on the basis of percentage of costs within appropriation limitations. The 1988-89 projected reimbursement rate for Out-State providers is 29.5% of costs.

Reporting Requirements

Provider hospitals and clinics are required to report patient and financial data. The instructions on the reporting requirements are contained in the 1988-89 Uniform Data Reporting System Manual.

For further information on the Indigent Care Program, contact:

Ms. Laurie Shroyer
Manager, Indigent Care Program
University of Colorado Health
Sciences Center
4200 East 9th Ave., Box A019
Denver, Colorado 80262
(303) 393-2072

SCOPE
(Shared Cost Option for Private Employers)

Purpose The purpose of SCOPE is to provide low-cost health insurance for employees of small businesses, many of whom do not now have health benefits.

Sources of Funds The Robert Wood Johnson Foundation of Princeton, New Jersey, has provided grant funds under the auspices of its "Health Care for the Uninsured" Program for the development of SCOPE. The Colorado Trust, a Colorado philanthropic foundation, has provided matching funds for the project, as have The Piton Foundation and The Hill Foundation. The Denver Department of Health and Hospitals is also providing matching support for the project. The insurance plan, once developed, will be self-supporting.

Participants The SCOPE grant, which was awarded to the Denver Department of Health and Hospitals, is a collaborative effort; the other participating entities are University Hospital, the Colorado Business Coalition for Health and the Denver Medical Society.

SCOPE Plan Characteristics Preventive and primary care will be covered. Preventive care will be free, while a physician's office visit will require a nominal copayment. Inpatient hospital care will require a high deductible and coinsurance which, for low-income patients, may be absorbed by the State's medical indigency program. There will be limitations on the physicians and hospitals whose services may be used by plan enrollees. The premium price will be modest, lower than any other comprehensive health plan offered in the Denver market. Specific information on premium prices, copayments and deductibles and participating providers will be available in July, 1989.

Project Tasks The first task was to determine the size, composition and location of the potential market for low cost health insurance. A survey of 776 small employers in the Denver metropolitan area was undertaken to determine the extent of insurance coverage, the characteristics of employees, and the location of the small employer population. This has been invaluable in the process of benefit design, pricing, and location of physician and hospital providers.

Detailed benefit design, actuarial analysis, and determination of prices, deductibles, and copayment levels are complete.

Development of a network of participating physicians and hospitals has been completed.

The insurance package has been bid to existing insurers. United States Life Insurance Company is the underwriter. The plan will be marketed through agents and brokers as well as directly.

USLIFE CARE
S.C.O.P.E. PLAN OF BENEFITS

This plan requires that insureds take full advantage of the convenience and cost savings which are afforded when medical treatment, services or supplies are provided by a Participating Physician. See EXCEPTIONS below.

SCHEDULE OF BENEFITS

MEDICAL CARE MUST BE PROVIDED THROUGH A PARTICIPATING PHYSICIAN (See Exceptions Below)

Cash Deductibles:	• $250 per person, per calendar year, for hospital confinement in a Participating Hospital (but not for Well Baby Care) • $50 per person, per calendar year, for prescribed drugs obtained while not hospitalized
Coinsurance:	50% of the first $5,000 of all covered charges, 100% thereafter, EXCEPT as provided below.
Co-Payment:	• $15 per visit at a physician's office or for a physician's visit at home for evaluations and examinations. (but not for preventive care) *(an additional $15 co-payment will not be required if as a result of the visit you are referred by a participating physician to a lab or hospital for outpatient diagnostic tests)* *after the payment of the co-payment the remaining covered charges will be paid at 100%*
Pregnancy:	benefits are paid as for a sickness
Well Baby Care: (Routine Nursery Care)	100% of covered charges
Accident:	100% of the first $500 of covered charges before the cash deductible or co-payment is satisfied
Preventive Care:	100% of the covered charges for services shown on page 5
Maximum Benefit For Each Person While Insured *:	• Unlimited for persons under age 70 • $50,000 for persons age 70 and over

EXCEPTIONS: Medical Care Provided By A Nonparticipating Physician

• **Accident (In Service Area or Out of Service Area)**	100% of the first $500 of covered charges
• **Hospital Confinement**	If an insured person is admitted to a Participating Hospital by a Participating Physician, all expenses for services provided by a Non-Participating Physician which are incurred in connection with that admission will be covered as if they were provided by a Participating Physician.

*Limited benefits are payable for treatment of alcoholism, drug addiction and psychiatric disorders (see page 3)

DEFINITIONS

PARTICIPATING PHYSICIAN means a physician listed in the List of Participating Physicians, as periodically updated.

PARTICIPATING HOSPITAL means a hospital listed in the List of Participating Hospitals, as periodically updated.

COINSURANCE means the amount United States Life will pay each calendar year after the insured satisfies the cash deductible or co-payment requirement, as appropriate.

DEPENDENT means the employee's legal spouse, and each unmarried child who is under age 19 (or under age 25 if a full-time student) and is supported by the employee. "Child" includes a stepchild or an adopted child.

SERVICE AREA means the geographical area served by all the participating physicians listed in the List of Participating Physicians and the List of Participating Hospitals.

FAMILY DEDUCTIBLE

In no event will the insured members of a family, in combination, have to satisfy more than 2 times the cash deductible for hospital confinement, shown on page 1.

BENEFITS FOR PERSONS ELIGIBLE FOR MEDICARE

The benefits to be paid by the group policy will be reduced by the amount of Medicare benefits to which the person is entitled.

United States Life will presume that a person is entitled to all Medicare benefits on the date he is eligible for them, even though he may not apply for them on time.

For groups subject to COBRA, this "carve-out" wording will not apply.

PREGNANCY BENEFITS

Benefits for pregnancy, and complications of it, are provided to all insured persons on the same basis as those to be paid for a sickness.

WELL BABY CARE

Charges incurred for routine nursery care of a child will be considered covered charges under the major medical benefit plan if:

- the child is born while the mother is insured, and
- the charges are incurred while the mother is hospitalized having been admitted or referred for admission by a participating physician.

CONTINUATION OF DEPENDENTS' INSURANCE WITHOUT PREMIUM PAYMENT (SURVIVORS' BENEFIT)

At the employee's death, the spouse may not be eligible to continue his or her medical insurance in accordance with state law, or he or she may choose not to do so even if they are eligible. In either case, insurance will be continued for the spouse and dependent children if they were insured for such benefits when the employee died. Premium payment is not required. Insurance will continue for up to 12 months, but will end on the date:

- the spouse remarries
- the child no longer qualifies as a dependent, or
- the Employer's plan ends.

This benefit is not available to dependents who are eligible to continue their insurance under a COBRA continuation right.

MAJOR MEDICAL BENEFITS

COVERED CHARGES

The charges covered by the plan are those listed below. Any amount of such charges which exceeds reasonable and customary charges will not be covered.

REASONABLE AND CUSTOMARY CHARGE means a charge not more than the usual charge for medical treatment in the locality where it is received. The nature and severity of the injury or sickness involved will be taken into account.

Covered Charges Include Charges For:

- hospital room and board, up to the hospital's highest charge for a semi-private room; hospital services and supplies; physician's diagnosis, treatment and surgery; anesthesia and its administration; private duty nursing (but not by a member of the insured's immediate family or household); professional ambulance service (up to $100); prescription drugs; physiotherapy; x-ray and lab services; artificial limbs or crutches.

- confinement in a convalescent home, up to 50% of the amount to be paid for hospital room and board, limited to 50 days for all confinements due to related causes.

- hospice care for the terminally ill with 6 months or less to live, including services of registered nurses and home health aides, occupational, speech or respiratory therapy, medical social services, nutritional and family unit counseling and respite care; for each 3 month period, benefits will be paid up to $5,000, with a per diem maximum of $55, and up to $500 for bereavement support services for the family unit; the maximum benefit duration will be 9 months.

- home health care, including services of registered nurses and home health aides, occupational or speech therapy, medical social work and special meals and nutritional services; benefits will be paid up to 100 visits per calendar year.

Covered charges for treatment of alcoholism and drug addiction include:

1. charges incurred while hospitalized in a Participating Hospital for treatment, up to 45 days per calendar year.

2. charges incurred while not hospitalized, if made by:

- a Participating Hospital
- a facility licensed by the department of health to treat alcoholics/addicts
- a mental health facility approved as such by the department of institutions.

Benefits for item 2 will be paid up to $500 per calendar year.

Covered charges for psychiatric treatment include:

1. charges incurred while hospitalized in a Participating Hospital, up to $25,000 for each person while insured.

2. charges incurred while not hospitalized, if made by:

- a Participating Hospital
- a Participating Physician
- a comprehensive health care service corporation
- a community mental health center or mental health clinic approved by the department of institutions.

Benefits for item 2 will be paid up to $1,000 per calendar year.

PREAUTHORIZATION

The plan will pay the benefits described above for inpatient treatment of alcoholism, drug addiction and psychiatric treatment *only* if the insured person gets authorization from United States Life's designated utilization review organization (URO) prior to treatment.

LIMITED BENEFITS ARE PAYABLE FOR:

Dental care, treatment or surgery, temporomandibular joint dysfunctions (TMJ), eye exams and cosmetic treatment or surgery.

PRE-EXISTING CONDITIONS

PRE-EXISTING CONDITION means an injury or sickness for which a person:

- incurred charges
- received medical treatment
- consulted a physician, or
- took prescription drugs

within 3 months before he became insured under this plan.

No charges incurred for a pre-existing condition will be considered covered charges under this plan until:

1. the person has not:

- incurred charges
- received medical treatment
- consulted a physician, or
- taken prescription drugs

for such condition, or any complication of it, for 3 continuous months, while insured;

2. the employee stays insured under this plan as a full-time employee for 6 continuous months; or
3. the employee or dependent stays insured under this plan for 12 continuous months.

CHARGES NOT COVERED

1. Charges to buy or rent:

- air conditioners
- air purifiers
- motorized transportation equipment
- escalators or elevators in private homes
- eye glass frames or lenses
- hearing aids
- swimming pools or supplies for them
- general exercise equipment.

2. Charges incurred after a person's insurance ends, regardless of when the injury or sickness occurred. However, major medical benefits may be provided as described in the BENEFITS AFTER INSURANCE ENDS provision.

3. Charges for a routine physical exam, except as provided on Page 5.

BENEFITS AFTER INSURANCE ENDS

If a person's insurance ends while he is totally disabled, benefits will be paid for covered charges if:

- they are incurred to treat the injury or sickness which caused the total disability
- they are incurred within 12 months after insurance ends
- total disability is continuous from the day insurance ends to the day the charge is incurred, and
- the person is not covered for the total disability under another group plan.

GENERAL EXCLUSIONS FOR ALL MEDICAL CARE BENEFITS

No medical care benefits will be paid for treatment which:

- would be given free of charge if the person was not insured
- results from war or an act of war or intentional self-inflicted injury
- is for a job-related injury or sickness for which a person is entitled to benefits from a workers' compensation or similar law.

The benefits to be paid by this plan will be coordinated with benefits to be paid by other group plans.

PAYMENT FROM A THIRD PARTY

Medical benefits paid under the group policy must be returned to United States Life if the insured recovers from a third party for the same injury or sickness. No medical benefits will be paid under the group policy to an insured who has received payment from a third party for past or future medical care as the result of the negligence or intentional act of a third party.

If an insured makes a claim for medical benefits under the group policy prior to receiving payment from a third party, he must agree to repay United States Life from any payment received from a third party to the extent of the benefits paid by United States Life.

Repayment is required regardless of whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement.

SCHEDULE OF PREVENTIVE SERVICES -

Charges incurred for the following services will be covered only if such services are provided through a participating physician:

under 1 year of age	1 physical exam prior to hospital discharge 5 periodic physical exams by a physician during the first year of life, in periods as determined by the physician 1 blood test for phenylketonuria 1 blood test for hypothyroidism 1 phytonadione immunization 1 tuberculosis skin test 1 hematocrit/hemoglobin a series of 3 polio vaccines a series of 3 diphtheria, pertussis, tetanus immunizations
1 year but less than 6 years	3 physical exams between ages 1 and 2 3 physical exams between ages 2 and 6 (but no more than 1 in any 12 continuous months) 1 immunization for measles, mumps, rubella combined 2 diphtheria, pertussis, tetanus immunizations 2 polio vaccines 1 tuberculosis skin test 1 hematocrit/hemoglobin 1 urinalysis 1 haemophilus influenzae B (HIB) vaccination
6 years but less than 12 years	2 physical exams 1 tuberculosis skin test 1 urinalysis
12 years but less than 18 years	2 physical exams 1 diphtheria, tetanus booster, if it is 10 years from previous booster 1 tuberculosis skin test
18 years but less than 40 years	1 physical exam every 5 years 1 urinalysis every 5 years 1 hematocrit/hemoglobin every 5 years 1 multi-chemical screen every 5 years 1 single electrocardiogram (EKG) every 5 years
40 years and over	1 physical exam every 2 years 1 urinalysis every 2 years 1 hematocrit/hemoglobin every 2 years 1 multi-chemical screen every 2 years 1 single electrocardiogram (EKG) every 2 years 1 test of stool for occult blood every 2 years 1 sigmoidoscopy every 5 years
for women of all ages	1 breast and pelvic exam each year 1 hematocrit each year 1 urinalysis each year mammography and cytologic screening

SURVEY OF SMALL EMPLOYERS IN THE DENVER AREA REGARDING HEALTH INSURANCE BENEFITS[1]

A Summary of Findings

Susan K. Marine, Ph.D.[2]

PURPOSE

This report summarizes the results of surveying a representative sample of small employers in the Denver metropolitan area. The survey was designed to generate a usable base of information to support the development of a marketable health insurance plan for small employers.

INTRODUCTION

The Denver Department of Health and Hospitals received a three-year grant in 1987 from The Robert Wood Johnson Foundation and The Colorado Trust to develop low-cost health insurance for the small business market. University Hospital, The Colorado Business Coalition for Health and The Denver Medical Society are collaborating on the project. The first project task was to estimate the size, characteristics and insurance needs of small employers in the Denver area.

In 1987, 87 percent of all employers in Colorado had 20 or fewer employees, and 25 percent of the state's total employees worked for these small employers *(Unemployment Insurance Data Base, Colorado Department of Labor and Employment)*. Although small employers form an important segment of the economic community, this group is the least likely to provide health insurance. Furthermore, there is little information available to describe the attributes of this diverse group — except that cost is perceived by these employers to represent a major barrier in providing coverage.

The information obtained by the SCOPE survey addresses two major issues. First, the needs and constraints experienced by small employers will be described in order to design and market a plan that will fit their needs. Second, the characteristics of the small employers' workforce *(age and sex distribution, turnover rates)* will be described to assist the actuaries and insurance consultants in developing realistic risk estimates for this target population.

SURVEY METHODS[3]

A brief written questionnaire was designed and mailed to a random sample of small employers *(with 20 or fewer employees)* in the five-county metropolitan area *(Denver, Adams, Arapahoe, Jefferson and Boulder)*. Extensive phone follow-up was undertaken to maximize the response rate to the survey.

The sample was proportionally allocated according to the distribution of small employers among the five counties and according to the size of employers found in the population. Thus, about 39 percent of the sample was drawn from Denver County, and about 70 percent of the sample was drawn from very small employers *(5 and under)*.

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[1] *The survey was conducted on behalf of SCOPE (Shared Cost Option for Private Employers), a collaborative project of Denver Health and Hospitals with University Hospital, the Colorado Business Coalition for Health, and the Denver Medical Society. For further information: 777 Bannock Street, Mail Code 3650, Denver, CO 80204-4507 (303/893-7855).*

[2] *S. Marine is a consultant with strong experience in health care research. Trained as a sociologist, her special interest is bridging the gap between research and policy making. She conducted a study of employers about health insurance in Boulder County, reported by that county's Task Force on Health Care Access in 1986. She was formerly on the faculty at the University of Colorado Health Sciences Center and on the staff of the Western Interstate Commission for Higher Education.*

[3] *A more detailed description of the methodology is available upon request.*

Small employers are not an easy target for surveys. They are often difficult to reach, and they are generally very busy and anxious to avoid surveys. Therefore, the project staff was extremely pleased to obtain responses from 72 percent of the sample *(See Table 1)*. A sample size of 776 *(selected from a population of more that 43,000 small employers)* yields a small error rate. The reader can assume, with 95 percent confidence, that the characteristics of the sample measured by this survey deviate only ±3.5 percent from the characteristics of the larger population.

TABLE 1
Sample Size, Response and Refusals, and Error Rate
SCOPE Survey of Small Employers

Population Size *(employers of 20 and fewer)*	43,585
Original Sample Size	1,395
Number Unreachable *(not listed, disconnected, out of business, etc.)*	(237)
Number Discarded *(too large, out of town, etc.)*	(82)
Actual Sample Size	1,076
Number of Refusals	(294)
Refusal Rate	27.3%
Number of Responses	
Written	274
Phone	502
Total Number	776
Response Rate	72.1%

Error Rate of ±3.5% is associated with a confidence level of 95% for a dichotomous variable where p=.5.

The sample was selected to proportionally represent the size distribution of the small employer population. Nearly one third of small employers have but one employee. Yet this group is clearly under-represented in the final sample, largely because this group was the most likely to have gone out of business by the time of the survey *(see Table 2)*. Employers of two to five employees are, however, over-represented in comparison to their numbers in the larger population. If these two groups are combined *(the 0-1 and 2-5 employee companies)* for the sample and the total population, the proportion by size in the sample is quite similar to that found in the total population.

TABLE 2
Comparison of Size of Firm, Population of Small Employers and Sample

	Percent of Small Employers	
Number of Employees	Population (N=43,585)	Sample (N=772)[1]
0-1	32.0%	16.8%
2-5	38.8%	52.3%
6-10	17.5%	18.0%
11-15	7.4%	5.8%
16 or more	4.3%	7.0%
TOTAL	100.0%	99.9%

[1] *Size was unknown for four firms.*

With regard to type of industry, it is interesting to note that the service sector accounts for about 37 percent of the sample, and retail trade 16 percent.

SURVEY RESULTS

Fifty-nine percent of all small employers surveyed in the Denver area report that they **do offer health insurance to their employees**. Coverage varies directly with the **size of the firm** *(see Table 3)*; only a quarter of firms with one employee offer insurance, whereas over 90 percent of those with 16 to 19 employees provide coverage. Coverage also varies according to **type of industry** *(see Table 4)*. The industries that are most likely to provide insurance include manufacturing, mining, wholesale trade and agriculture. Coverage is most limited in construction and retail trade.

TABLE 3
Proportion of Small Employers by Size Offering Insurance to Employees

Number of Full-Time Employees	Percent Offering Health Insurance
0-1 (N = 130)	25.6%
2-5(N = 404)	57.4%
6-10(N = 139)	74.8%
11-15(N = 45)	82.2%
16-29(N = 54)	92.6%
TOTAL(N = 772)	59.1%

TABLE 4
Percent of Employers in Each Industry Offering Health Insurance

Industry	Number of Employers in Sample	Percent Offering Insurance
Agriculture, Forestry, Fisheries	14	71.4%[1]
Mining	13	76.9%[1]
Construction	76	40.8%
Manufacturing	44	79.5%
Transportation, Communications, Utilities	18	50.0%[1]
Wholesale Trade	68	73.5%
Retail Trade	124	46.0%
Finance, Insurance, Real Estate	86	62.8%
Services	283	59.0%
Nonclassified	45	68.9%
TOTAL	771	58.9%

[1] *Small numbers in these industries limit confidence in these figures.*

Insurance agents and brokers are by far the most important **source of information** *(about health insurance)* reported by these small employers *(see Table 5)*. Other sources of information were insignificant, and about 11 percent of all surveyed reported "no source of information". Those who had no insurance benefits were more likely to report "no source".

TABLE 5
Source of Information About Health Insurance Reported by Denver's Small Employers

	Percent of Employers Reporting		
Source	All (N = 766)	Those Offering Insurance (N = 455)	Those Not Offering Insurance (N = 311)
Insurance Agent	48.7%	50.7%	45.3%
Insurance Broker	31.9%	38.2%	22.5%
Nobody	11.1%	5.2%	19.9%
Other Employers	4.4%	5.4%	2.8%
Professional Association	4.4%	3.0%	6.4%
All Other Sources	17.1%	16.9%	18.3%

Note: Respondents could give more than one source of information.

EMPLOYEES OF SMALL COMPANIES: AGE, SEX AND TURNOVER

The employees of small firms are generally young (see *Table 6*). About half *(47.2 percent)* of these employees are between the ages of 20 and 34. There are few elderly workers or youths under 20 years old employed in these small firms.

Overall, 41 percent of these employees are female. Half of the females working in small firms are in the 20 to 34 age group; these are also the primary years for child-bearing.

TABLE 6
Age and Sex of Employees in Firms with 20 or Fewer Employees:
Denver Metropolitan Area

Age Category	Male (N = 2370)	Female (N = 1683)	Total (N = 4053)
Younger than 20	2.3%	2.7%	2.5%
20-34	44.9%	50.6%	47.2%
35-44	31.8%	27.0%	29.8%
45-54	14.2%	13.3%	13.8%
55-64	5.2%	5.2%	5.2%
65 and older	1.7%	1.1%	1.5%
TOTAL	100.1%	99.9%	100.0%
	58.5%	41.5%	100.0%

While it is generally believed that turnover is a major problem for small employers, **41 percent of employers surveyed reported no turnover** during the last year (see *Table 7*). Twenty-eight percent reported one or two changes *(either from an employee leaving or joining the firm)*. About 30 percent reported higher turnover — 3, 4, 5, or more changes during the past year. Thus, it is not surprising that only about 20 percent of employers report that employee turnover is an issue they consider in buying health insurance.

TABLE 7
Turnover Among Small Employers

Number of Changes[1]	Number of Employees	Percent of All Employers
0	312	41.0%
1	102	13.4%
2	112	14.7%
3-4	109	14.3%
5 or more	126	16.5%
TOTAL	761	100.0%

[1] *"Changes" refers to the number of new employees plus the number who left the firm within the past year. This would be the number of additions and deletions to the group that an insuror would have to process.*

COSTS EMPLOYERS NOW PAY

Employers that do provide insurance benefits to full-time employees are also likely to offer benefits to dependents of those full-time employees; they are much less likely to pay the cost, however, of coverage for dependents. Whereas 74 percent of employers pay all of the health insurance premiums for full-time employees, only 38 percent pay the entire premium for dependents (see *Table 8*)..

TABLE 8
Portion of Premium Paid for Full-Time and Part-Time Employees
and Dependents: Employers Who Do Offer Health Insurance

Portion of Premium Paid	Full-Time Employees (N = 444)	Dependents of Full-Time Employees (N = 438)	Part-Time Employees (N = 197)	Dependents of Part-Time Employees (N = 195)
None	5.0%	47.5%	84.8%	94.9%
Some	21.4%	14.6%	5.1%	1.0%
All	73.6%	37.9%	10.2%	4.1%
TOTAL	100.0%	100.0%	100.1%	100.0%

Small employers make little contribution to the costs of health insurance for their part-time employees. Only 10 percent pay the entire premium for part-time employees, and an even smaller percentage pay the costs for the dependents of part-time employees. Yet 45 percent of all the small employers surveyed have one or more part-time employees *(who work less than 30 hours a week)*. These 349 small employers employ, on average, about three part-time employees *(3.08)* who are not likely to have health insurance by virtue of employment.

With regard to the cost of the monthly premiums paid by these small employers, over one-fourth of these small employers pay $125 or more for each full-time employee. Only about a third of these employers report a premium of $74 or less. On average, these small employers pay a little over $100 a month for the premium of one full-time employee. This amount can represent a sizable cost for many small employers.

FACTORS THAT INFLUENCE THE DECISION TO OFFER INSURANCE

The factors that influence the decision of these small employers about whether to offer insurance are shown in Table 9. The most important factor for small employers is cost. Those employers who do offer benefits are: 1) less likely to say they can hire easily without providing insurance; 2)less likely to report that their employees are insured elsewhere; and 3) more likely to report that they have employees who do not qualify for coverage because of pre-existing health problems. About 18 percent of all small employers surveyed reported they had employees who cannot qualify for insurance because of pre-existing health problems; only 8.6 percent of employers not providing insurance reported pre-existing conditions. Nearly a quarter *(23.1 percent)* of employers providing insurance report they "cannot find an acceptable plan", and a similar proportion report the company was turned down because it is "too small". Less than one fifth *(18.7 percent)* report a lack of information or difficulty judging plans.

Employers who do not provide health insurance benefits are somewhat more likely to report that coverage is too expensive *(56.1 versus 48.7 percent)*. Those who do not offer insurance are much more likely to report they can hire employees without providing insurance *(57.5 versus 34.6 percent)*. These employers also report that their employees are insured elsewhere more often than do employers who provide insurance *(46.5 versus 22.7 percent)*.

TABLE 9
Issues Considered When Deciding to Buy Health Insurance
(Mentioned as Important)

Issue	Employers Who Do Offer Insurance (N=458)	Employers Who Do Not Offer Insurance (N=318)	All Employers (N=776)
Too Expensive	48.7%	56.1%	51.7%
Can hire without providing health insurance	34.6%	57.5%	43.9%
Many employees insured elsewhere	22.7%	46.5%	32.4%
Can't find acceptable plan	23.1%	24.5%	23.7%
High employee turnover	20.9%	23.2%	21.9%
Company turned down because too small	20.7%	19.2%	20.1%
Lack of information / difficulty judging plans	18.7%	16.9%	18.0%
Employees cannot qualify because of pre-existing health problems	24.0%	8.6%	17.7%
Employees don't want it	11.0%	16.0%	13.0%
Problems in administering insurance	10.1%	12.1%	10.9%
Company turned down because of type of business	4.4%	2.9%	3.8%
Firm too new	1.1%	4.5%	2.5%

IMPLICATIONS

The characteristics of the small employer workforce appear to present a positive risk for insurors. With regard to age, about three quarters of these employees fall between 20 and 44 years of age. Since one half of female employees in these firms are between 20 and 34 years old, it is clear that providing maternity benefits is very important for this group. In addition, turnover is not as significant a problem for small employers as many believe. About 40 percent of small employers report no turnover within the last year.

Attrition among small employers in the original sample was 16.9 percent *(237 out of 1,395)*. This is the proportion of small employers that went out of business during the year from Spring of 1986 to Spring of 1987. Attrition was highest in firms with only one employee *(23.4 percent)* and in firms with 2 to 5 employees *(15.9 percent)*.

Small companies with only one employee are also the most elusive of small employers to reach by phone. It may be that the smallest of employers should not be a primary target group for the SCOPE plan.

In general, the survey demonstrates that there is a high level of interest in the proposed SCOPE plan. About a third of respondents said they would offer the plan, and another 20 percent was undecided. Extrapolated to the larger population, that means there are about 14,165 small employers in the five-county metropolitan area who say they are now interested in offering the SCOPE plan. Nearly 9,000 others are in a "maybe" or "don't know" category. Thus, the potential market for the new SCOPE plan is sizable.

About half of all employers *(46.9 percent)* are in favor of the employee paying part of the premium. In addition, however, 40 percent of employers said they would administer the proposed new plan even if they did not pay any of its cost. This argues for a plan that could be offered to individuals as well as to groups:

It appears that an effective marketing strategy must capitalize on the existing network of insurance agents and brokers. About half of all small employers reported they had an agent who is their source of information about insurance, and another third had an insurance broker who provided information to them.

From the response of employers, it appears that a plan that could be offered to individual employees — as well as to firms — is needed. More information about the employees as consumers is needed, however.

A major issue to be resolved is whether to make the plan available to part-time employees. It is clear that part-time workers are the most likely to be uninsured; however, at present we have the least information about this group of workers.

Further in-depth interviews will be conducted with a number of interested small employers. The results of this inquiry will help to further shape a marketing strategy that will be most effective with small employers.

THE COLORADO HEALTH CARE ACCESS ACT: HB 1034

By Rep. Carol Taylor-Little
and Senator Sally Hopper

Questions and Answers

1. What is the purpose of the bill?

- To provide access to basic health care to every poor person in the state
- To bring additional federal health matching funds into the state by leveraging state dollars more effectively
- To define a basic benefits package, taking into consideration effectiveness and appropriateness of health care services
- To control state health expenditures by delivering care under managed care contracts
- To assure that Medicaid providers receive fair compensation for their services
- To encourage more small employers to provide health insurance to their employees by offering them tax credits.

2. Why is this bill needed?

Health care for the poor in Colorado is unpredictable and erratic. Currently only about half of Colorado's poor receive publicly-supported medical care under Medicaid, which has reasonably good benefits but low reimbursement rates and consequently low provider participation. Some of the poor receive much more limited services through the state's Medically Indigent program. Many of the poor, especially the working poor, get no care at all.

The chance of receiving needed care in Colorado today is just that, chance. It depends on being in a certain favored group (such as elderly or certain family groups), living in certain areas (where clinics or hospitals exist and participate in a public program), and understanding how to enter the system.

Furthermore, when the state faces budget problems with its Medicaid or Medically Indigent programs, it generally cuts eligibility groups or provider payment levels in an attempt to maintain the illusion that it is still providing access to needed care. The first strategy disadvantages the poor who need care. The second shifts public costs onto providers, making them less willing to serve the poor. Neither is an honest or fair way to finance health care.

The act would address these problems in two ways: first, by guaranteeing basic health coverage for everyone under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor.

3. How many more people would be covered by the new Medicaid program under the act? How many working uninsured people and small businesses would benefit?

This act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the new Medicaid program, many of whom would be children. It would also benefit up to 245,000 Colorado workers and their families in thousands of small firms.

4. Who determines service priorities for the new Medicaid program under the act, the legislature or an independent commission?

An independent, objective commission comprising health care providers, consumers, and experts in health care financing, delivery and ethics will develop a list of health care services in order of priority, according to the relative benefits and costs of each service. This evaluation will be based on clinical research data, sound professional judgment, and broad community values. This objective process will permit the legislature to set its Medicaid budget with the confidence that services are funded according to their effectiveness and appropriateness, not based on pressure from special interest groups. The commission's work will be ongoing as new research and technological developments indicate a need to add to or change the list of priorities.

The integrity of the priority list depends on the commission's objectivity but the legislature maintains ultimate control through the appropriations process. The act requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the house and senate health committees.

5. Can my group have input to the priority setting process?

Yes. The act includes extensive requirements for public input. It calls for public hearings to be held throughout the state. It requires the commission, in conjunction with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the house and senate health committees, to use a community meeting process to solicit public comment in order to build consensus on the values to be used to guide health resource allocation decisions. And the act specifically directs the commission to solicit testimony and information from advocates for seniors, handicapped persons, mental health services consumers, low-income citizens, and providers of health care.

6. What criteria will the Commission use in setting priorities among services?

Among the criteria the Commission will use are effectiveness in improving health-related quality of life; cost-effectiveness; life-saving potential; and whether early, low-cost intervention can head off an expensive crisis later.

7. Does this bill benefit business? How?

Yes. It does so in three ways: 1) by giving small employers access to low cost health insurance through a state pool; 2) by providing a tax credit to small employers who purchase insurance through the pool; and 3) by giving all employer valuable information on the effectiveness and appropriatness of services produced by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

8. Who can take advantage of the tax credit?

In 1991, firms employing 25 or fewer people that buy insurance through the state pool created in the act, pay at least 70 percent of the employee's premium, and have not offered insurance within the previous two years are eligible for a credit for up to five years. Firms that currently offer insurance can receive a two year credit if they buy into the pool and claim the credit by January 1992.

THE COLORADO HEALTH CARE ACCESS ACT: HB 1034

by Representative Carol Taylor-Little
and Senator Sally Hopper

I. Medicaid Expansion

A. Health Services Commission

Establishes a Health Services Commission consisting of 15 provider and consumer, public and private members to be appointed by the Governor with Senate confirmation.

Directs the commission to develop a ranking of health care services "representing the comparative benefits relative to cost of each service to the entire population to be served."

Requires the commission to conduct public meetings to develop consensus on "values to be used to guide health resource allocation decisions."

B. New, Expanded Medicaid Program

Expands the state program to cover all persons under the federal poverty line ($5,980 per year for one person, $12,100 for a family of four) plus the "medically needy."

Defines the Medicaid benefits package to be as many of the top-ranked services on the commission's priority list for which legislative appropriations allow funding.

Directs that if funding is insufficient to cover all current Medicaid services, the service package will be reduced according to the commission's priority list rather than cutting eligible groups or provider payments.

Requires the state to contract with managed care plans wherever possible; allows for the use of fee-for-service if there are insufficient contractors in all areas of the state.

Protects from malpractice recovery providers who do not provide a service because it is not covered under the new Medicaid program, but requires providers to advise patients of services that are medically necessary but not covered under the contract "if an ordinarily careful practitioner would do so."

II. Employer Insurance

A. Insurance Pool

Establishes a state insurance pool and governing board to contract with private carrriers. The board is responsible for designing benefits package(s) with premiums no higher than $75 per month for the first two years of the program.

Allows for state benefit mandates to be waived or modified under the pool program to keep premium costs down.

Permits small employers who didn't offer insurance in the previous two years to buy insurance through the pool; also allows previously insuring firms to buy through the pool if they elect to do so by January 1992.

B. Small Business Health Insurance Tax Credits

Allows employers of under 25 workers not offering insurance in the previous two years that now cover employees to claim a tax credit for half of the premium costs up to $25 for individual employee plans and $65 for family plans; credit is for up to five years.

Requires an employer to buy insurance through the state pool and pay at least 70 percent of the employee share in order to qualify for the tax credit.

Allows small firms previously insuring to get two year tax credit if they elect to join the state pool by January 1992.

A Recent Development . . .

HAWAII'S UNIVERSAL HEALTH CARE PROGRAM: BRIDGING THE GAP

By Susan Claveria

In Hawaii, access to basic health care has long been regarded as a right to which all citizens of the state are entitled. In 1974, Hawaii enacted its Prepaid Health Care law requiring *all* employers, even those with only one employee, to provide coverage for employees working more than 20 hours per week for at least four consecutive weeks. Although the federal Employment Retirement Income Security Act (ERISA) prohibits states from regulating employer self-insurance plans for employee health care coverage, Hawaii's law received congressional exemption since it was enacted months before ERISA.

Despite this compulsory insurance program, however, there still exists an uninsured population of about 50,000, or 5 percent of the state's civilian population. Hawaii's universal health insurance law, Act 378, Session Laws of Hawaii, 1989, provides for the implementation, by March 1, 1990, of a state subsidized insurance program to be administered by the Department of Health for the estimated 5 percent of Hawaii residents who are not covered by a health insurance plan. Included in this uninsured group are the unemployed; women in single-worker low-income families not covered by the employed spouses' insurance plan; older women who do not qualify for Medicare; part-time workers; children not covered by their parent's insurance plan; self-employed people, seasonal workers, students, and others not covered under Hawaii's prepaid health care law; and immigrants.

As a precaution, the Legislature included provisions in the legislation requiring the Department of Health to submit a report by October 1, 1989, on its progress in developing the plan, and permitting the Legislature to withhold appropriated funds if dissatisfied with the insurance plan within 30 days after the final plan is completed or by March 1, 1990, whichever is later. The business community was silent but supportive on this issue since coverage of the uninsured could have a *positive* impact on their health care costs.

> **The business community was silent but supportive . . . since coverage of the uninsured could have a positive impact on their health care costs.**

According to the report submitted to the Legislature on October 13, 1989, the insurance program will be based on managed care by a health provider and coverage will be contracted through insurance companies. It will be a primary care outpatient program focused on prevention and early intervention services such as standard medical visits (limited to 12 visits a year), well child care, diagnostic radiology, diagnostic laboratory, immunization, and outpatient surgery (for emergency and nonelective procedures). Five days of inpatient care (two days for maternity) also will be provided, and waiting periods will be in effect for some expensive conditions. A flat copayment rate of $5 per office visit also is being considered.

Eligibility for the program will be limited to individuals earning up to 300 percent of the federal poverty standard for Hawaii, or $20,610 for an individual and $41,760 for a family of four. People eligible for other government programs such as Medicare and Medicaid, or for a prepaid health care plan, will not be eligible for this program. Enrollees will be required to pay a share of the premium by the use of a sliding scale structure. While the exact rates have not been set, it is estimated that the plan will be free for those at or below the poverty level; individuals between 251-300 percent of poverty will pay the maximum rate. Dr. Peter Sybinsky, Deputy Director of Health for Planning, Legislation and Operations, estimates that the average annual cost per insured will be $500 to the state and $200 to the insured.

The Legislature appropriated $14 million for the program for the 1989-1991 fiscal biennium of which only $1 million is for planning and design. In conjunction with the insurance program, the Legislature also committed fiscal support of Medicaid services for pregnant women and children from 0 to 4 years of age. The administration also has geared up efforts to increase the use of prepaid health care plans and Medicaid by eligible persons, and plans to set aside $400,000 in block grants for episodic care (aimed at the uninsured who need timely or immediate primary care, such as the homeless).

While the administration is unable to predict what the participation rate will be when enrollment begins in March, the Legislature is optimistic that the program will be successful and will serve as an excellent model for other states to follow. ■

Susan Claveria is a researcher for the Hawaii Legislative Reference Bureau.

Position Opening

The Vermont Legislative Council is accepting resumes from applicants for the position of Director of the Joint Fiscal Office. The appointment will be made in late spring 1990.

Send resumes or inquiries to William Russell, Chief Counsel, Legislative Council, State House, Montpelier VT 05602.

UPDATED ESTIMATES OF THE SIZE AND CHARACTERISTICS OF IOWA'S UNINSURED POPULATION

Prepared for the
Health Care Expansion Task Force
of the
Iowa General Assembly

Prepared by
Health Systems Research, Inc.
Washington, D.C.

March 2, 1990

THE UNINSURED IN IOWA

DEFINITION:

THE UNINSURED ARE PERSONS WHO LACK HEALTH CARE COVERAGE OF ANY TYPE, WHETHER FROM A PRIVATE CARRIER OR A GOVERNMENT PROGRAM

ESTIMATED SIZE:

ACCORDING TO DATA FROM THE IOWA PORTION OF THE 1989 CURRENT POPULATION SURVEY, APPROXIMATELY 220,000 IOWANS ARE UNINSURED.

THIS REPRESENTS ABOUT 9% OF THE STATE'S UNDER-65 POPULATION

Possible Reasons Why the 1989 Estimate of the Size of Iowa's Uninsured Population is Lower than Previous Years'

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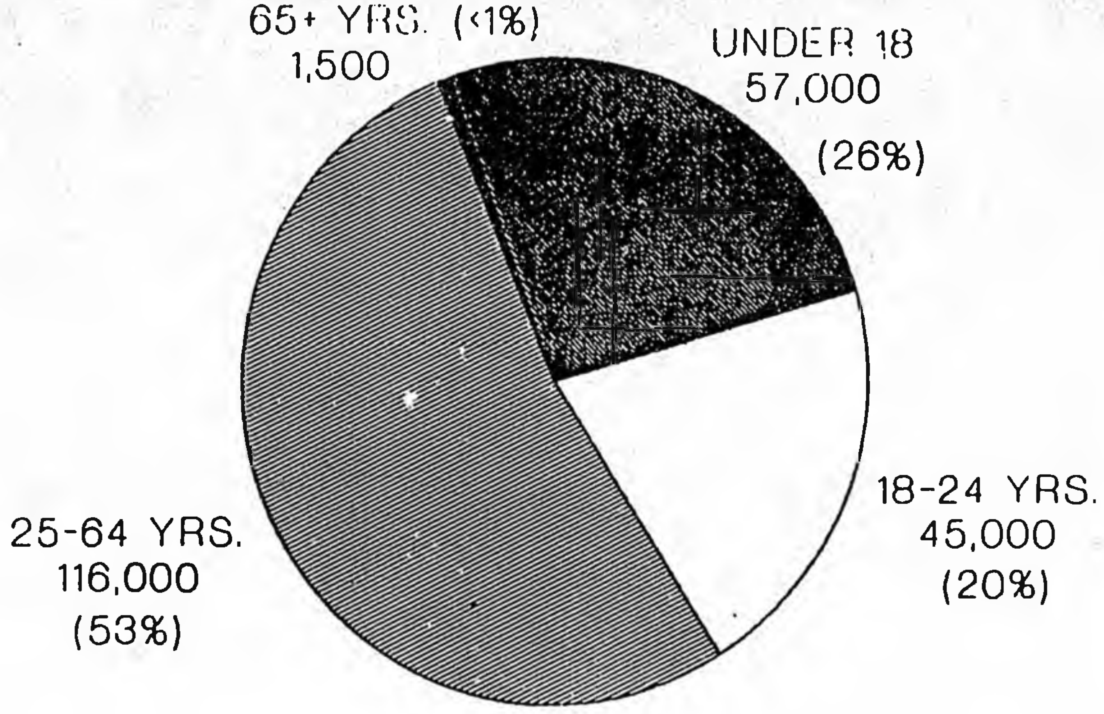
1. Changes in the questionnaire used to collect the data:
    - Questions revised
    - Additional questions asked
2. Variations in sample population from one year to the next
    - Actual 1989 number =
      1989 estimate ± 18,500 persons
      (at 90% confidence level)
3. Actual change in the number of uninsured Iowans

UNINSURED IOWANS:
By Age

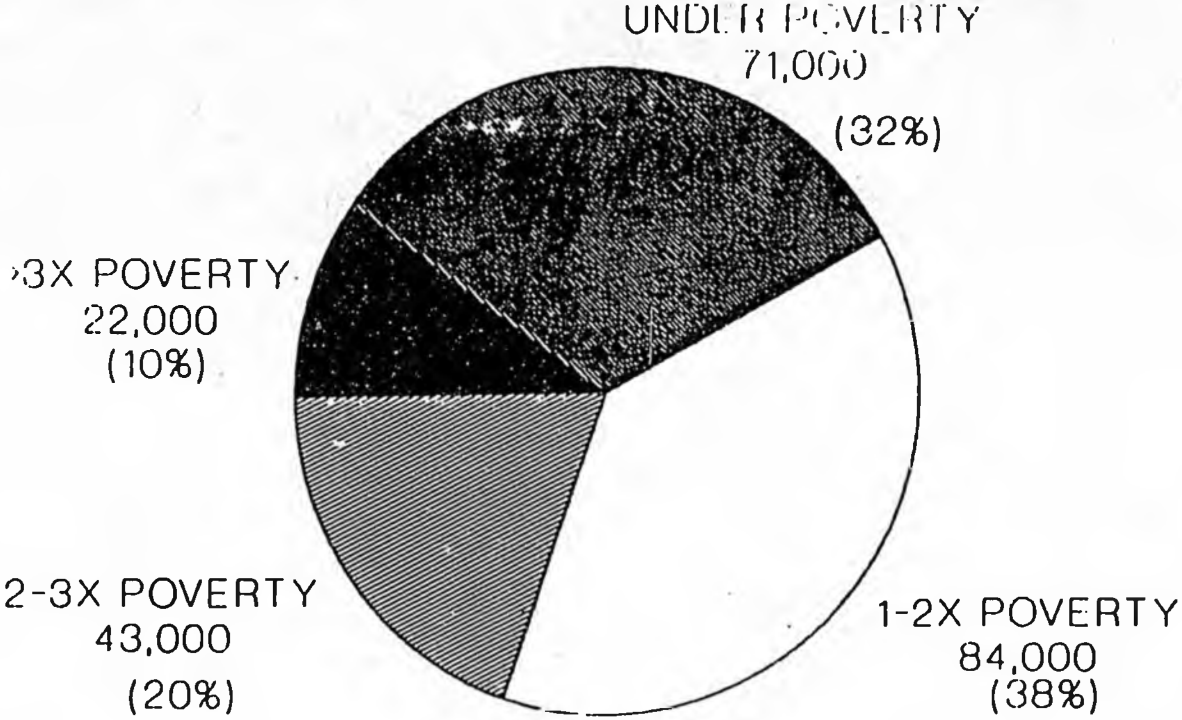


Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

1988 FEDERAL POVERTY GUIDELINES

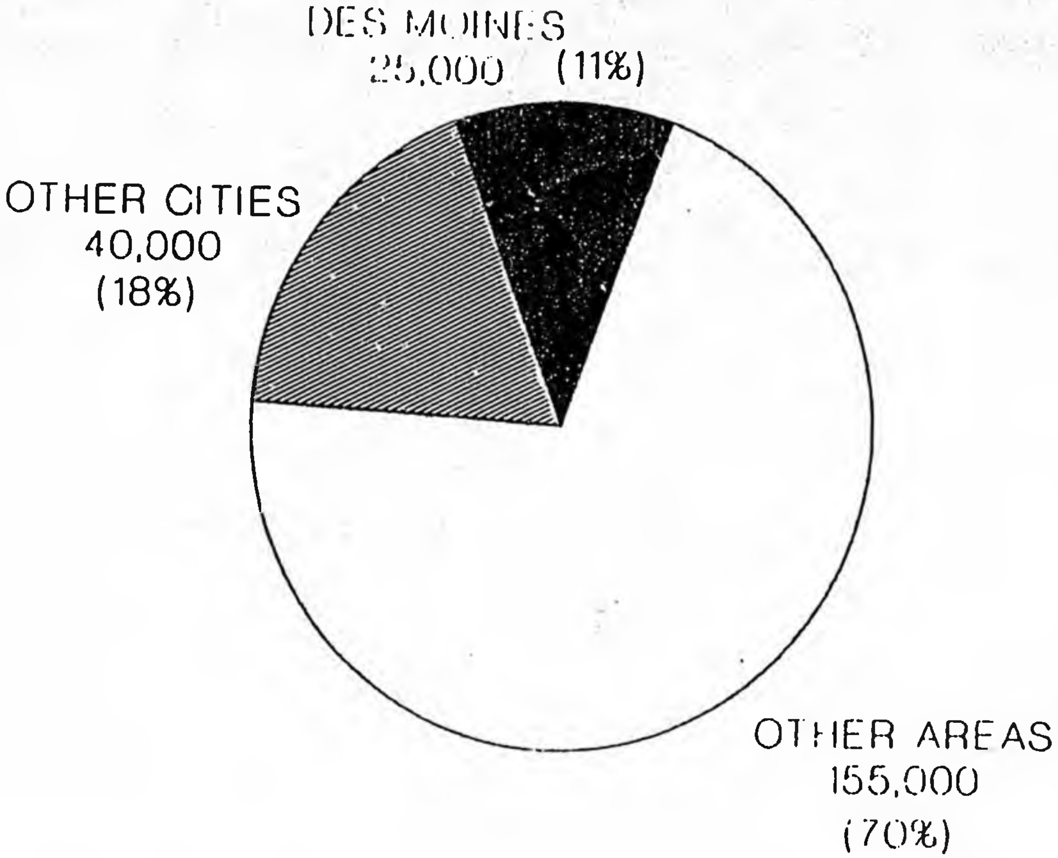
HOUSEHOLD SIZE	ANNUAL INCOME
1	$ 5,770
2	$ 7,730
3	$ 9,690
4	$11,650

UNINSURED IOWANS:
By Poverty Status



Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED IOWANS:
By Place of Residence

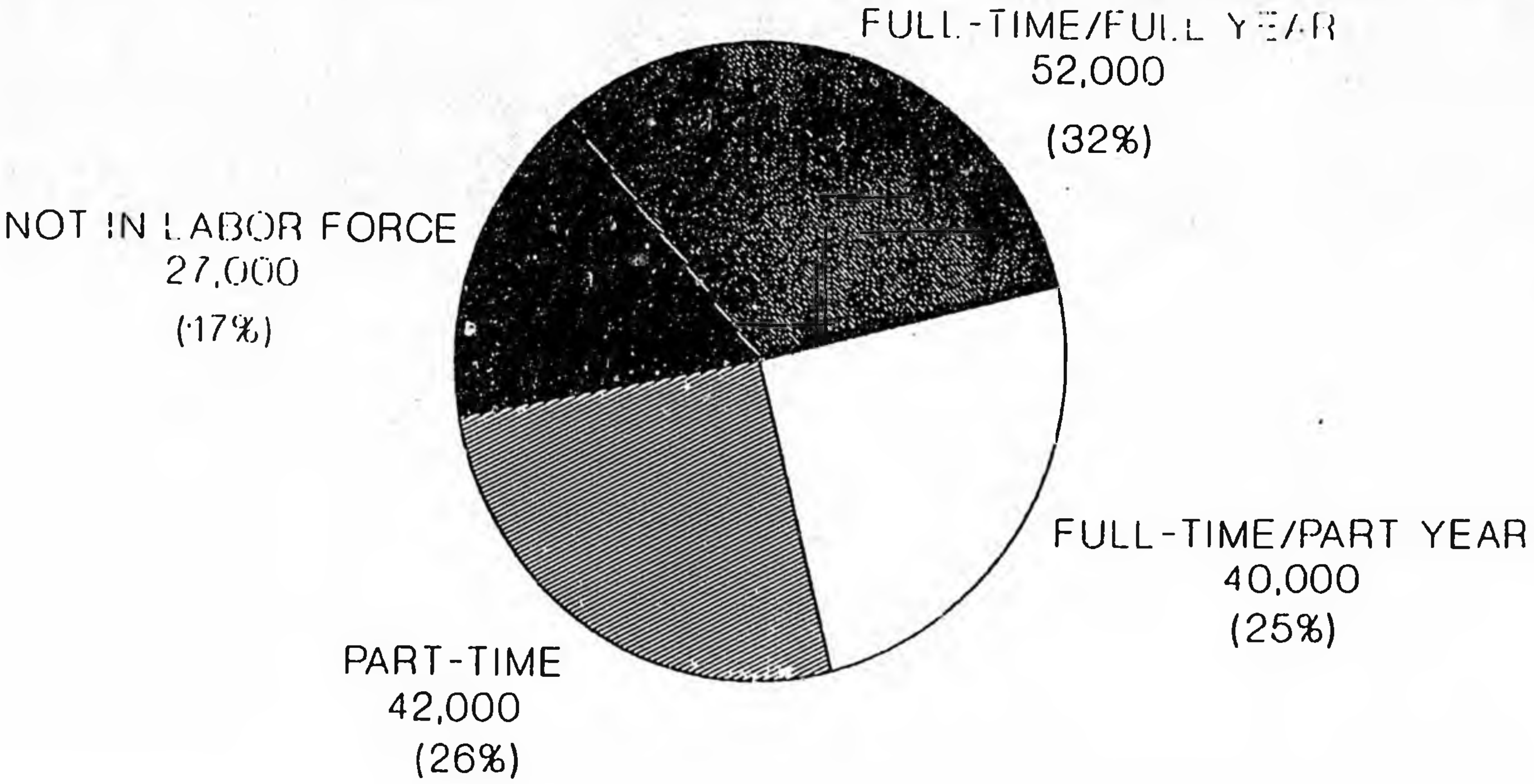


Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

EMPLOYMENT STATUS OF UNINSURED IOWANS:

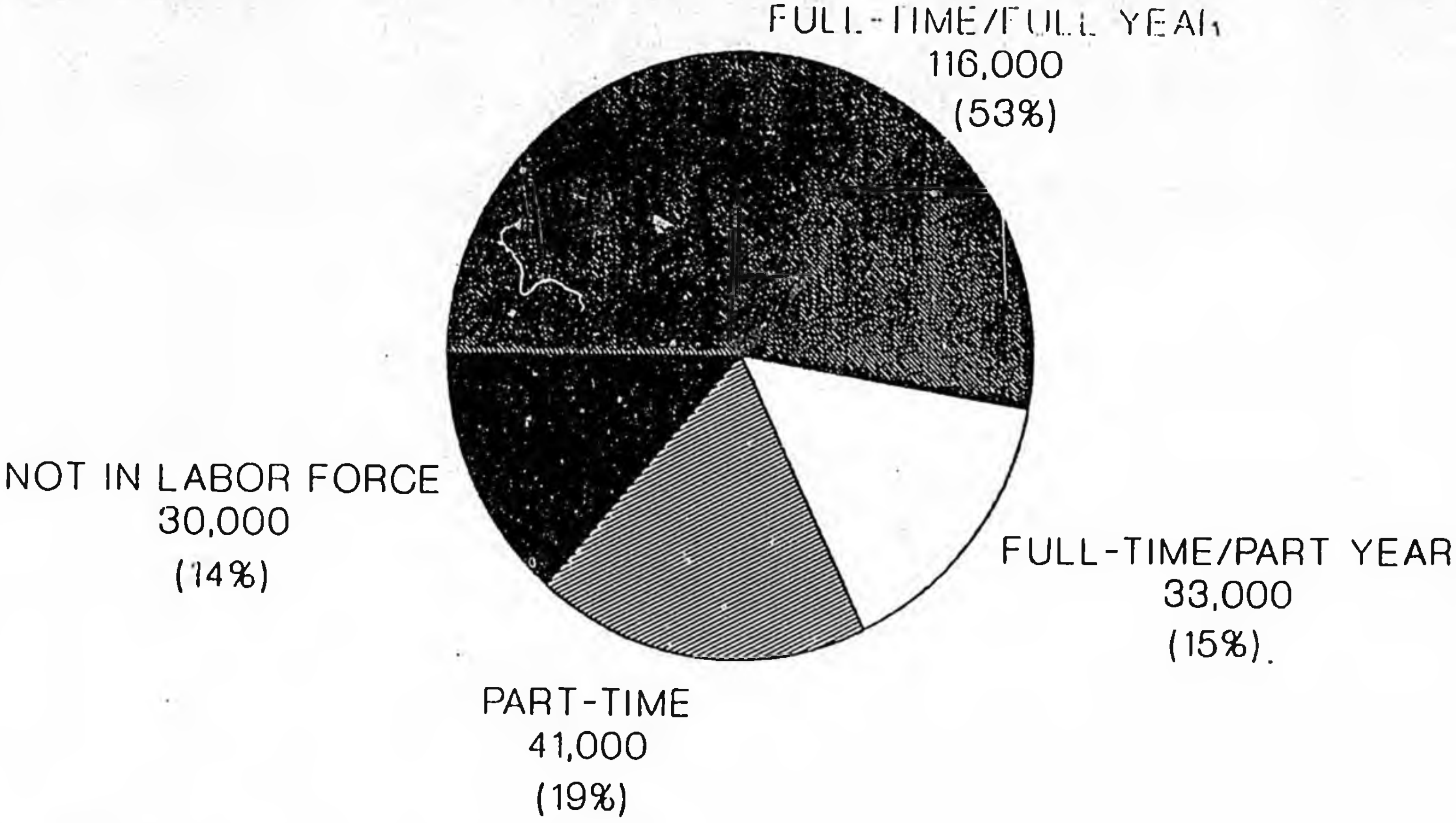
Ages 18-64

(N=161,000)



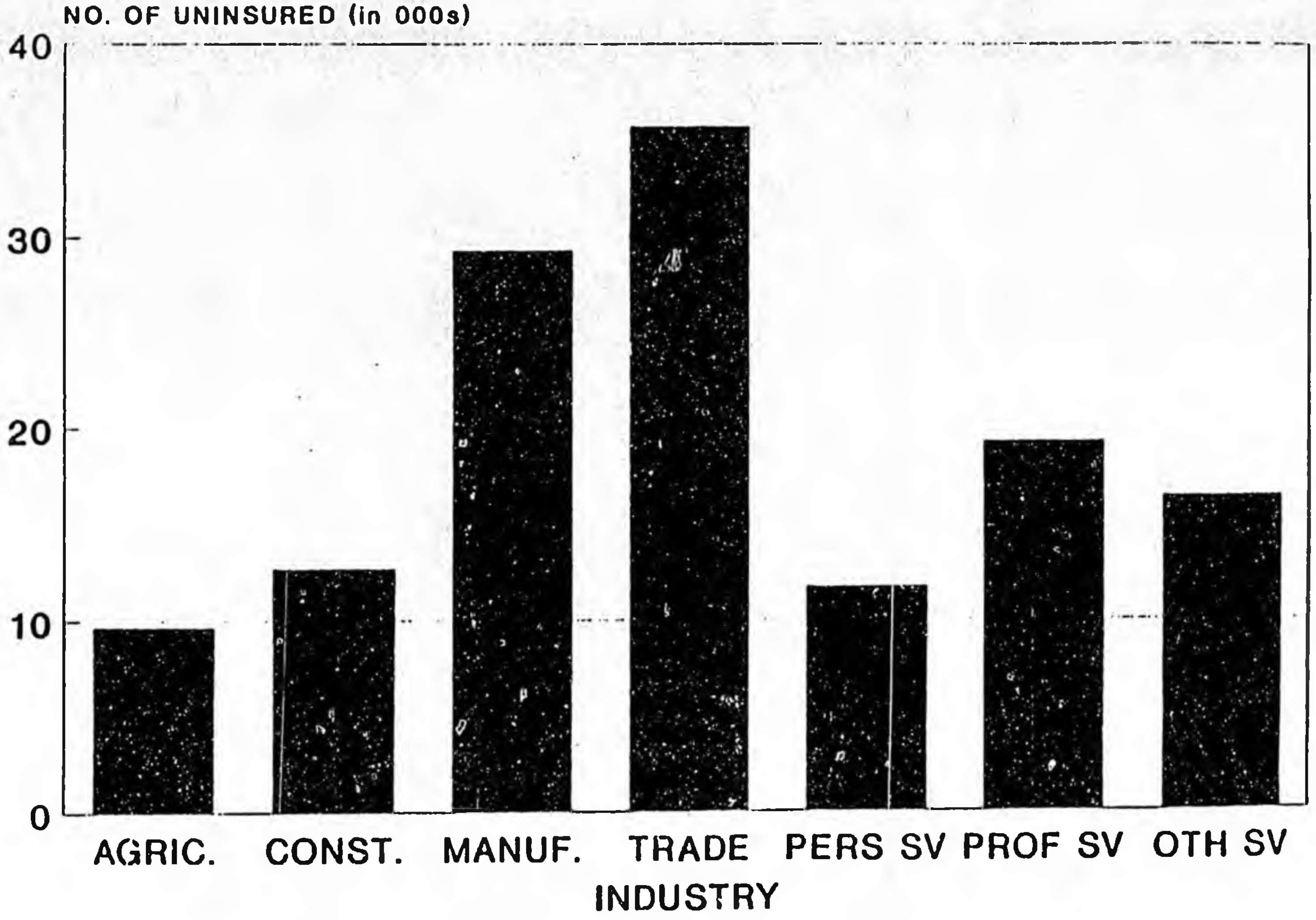
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

DISTRIBUTION OF UNINSURED IOWANS:
By Employment Status of Family Head
(N=220,000)



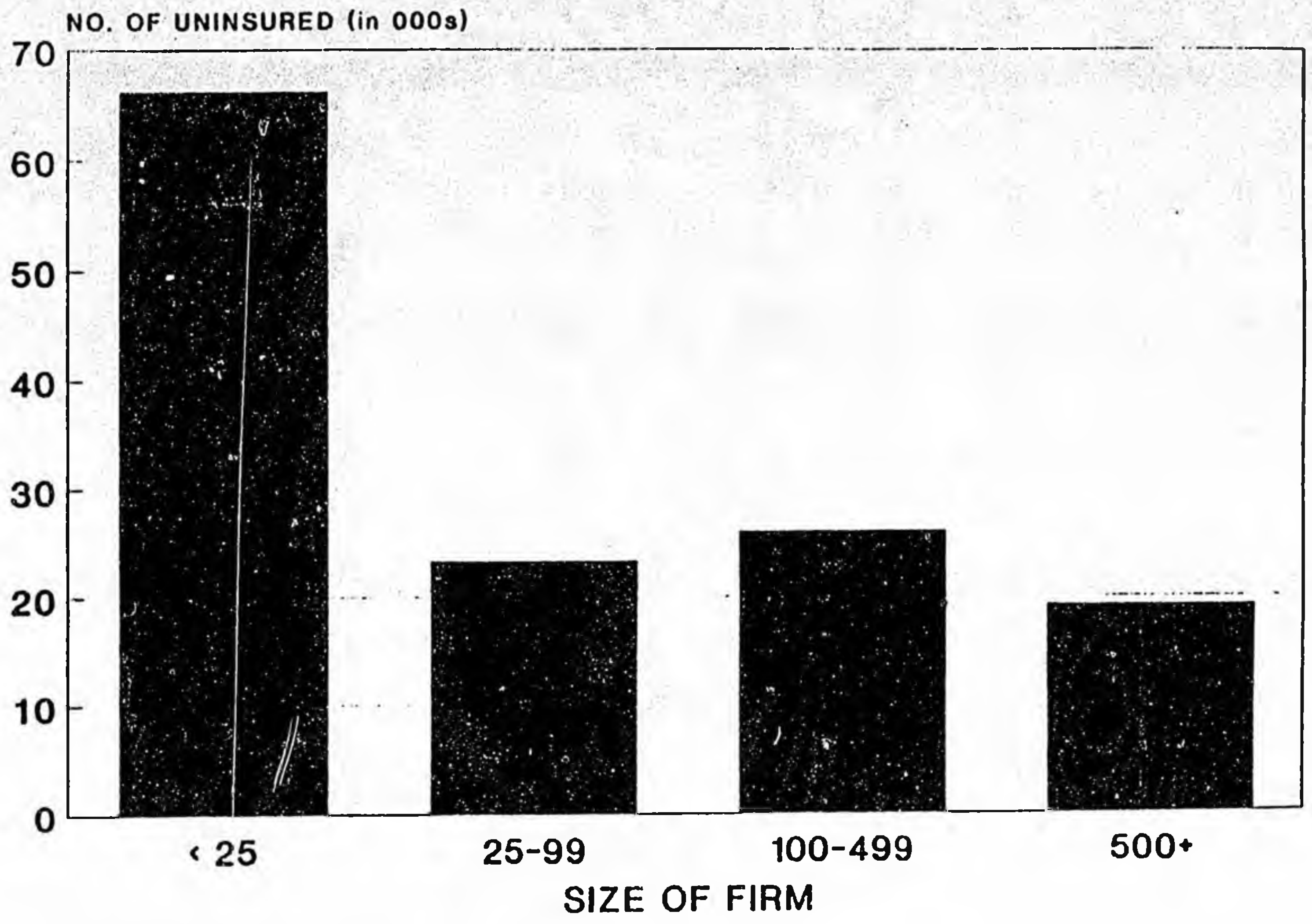
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED WORKERS IN IOWA:
By Industry



Source: Health Systems Research Inc.
Analysis of March, 1989 CPS

UNINSURED WORKERS IN IOWA:
By Size of Firm



Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

Medicine & Health

PERSPECTIVES

December 18, 1989

EYES ON THE MASSACHUSETTS MIRACLE

Enacted 18 months ago amid much hoopla, Massachusetts' universal health insurance system is out of the blocks. However, its path includes significant hurdles, including a crippled Bay State economy and the risk of being tarred with the brush of ignominy now slathering chief sponsor Gov. Michael Dukakis.

When he pushed through the law in July 1988, Dukakis was riding high, his nomination as the Democrats' presidential choice all but wired and his home state's economy living up to the popular phrase "Massachusetts Miracle." Now the failed candidate and lame duck governor is dodging brickbats from every sector, and the Massachusetts treasury is running on empty. For the fiscal year that began July 1, the state faces a deficit pegged at $800 million. In the fight to erase the deficit, the insurance law's opponents -- chiefly small businessmen and Republican legislators -- see a chance for repeal.

The Massachusetts law is an ambitious attempt to address at the state level a nationwide problem -- Americans without health insurance. When the law was passed, Massachusetts counted 600,000 uninsured residents, or 10 percent of its population. Like many of the 31 million to 37 million uninsured Americans in the nation at large, many of Massachusetts' uninsured work or are the dependents of workers. Others are unemployed, uninsurable because of medical conditions, or risk-takers willing to ride bareback and depend on others to catch them when they fall.

OFF THE GROUND

Phased in over several years to minimize sticker shock and let business prepare for its new burdens, the 1988 Massachusetts Health Security Act combines public and private sector solutions that together promise coverage -- or the opportunity for it -- to every Bay State resident. So far implementation has been piecemeal; the main elements take effect during 1990-92.

As of 1989, the law mandated coverage for full-time college students, upped state aid to pregnant women and the disabled, expanded community health centers to care for urban poor, and ordered development of models for less expensive forms of insurance for small business.

The largest public-sector element in place is CommonHealth, a state-run program covering pregnant women, disabled children, disabled adults, and former welfare recipients without employer-paid coverage. State Medicaid benefits are available to any pregnant woman whose income is 180 percent of the federal poverty line or less. Disabled residents can buy into Medicaid on a sliding premium scale. Those leaving welfare get 24 months of Medicaid coverage. The program now covers 16,000 people, says Larry Collins, spokesman for the state's new Dept. of Medical Security. The target for mid-1990 is 25,000.

CenterCare, the expanded community center program, has gotten care to 4,000 city dwellers. But the largest private program to be implemented requires that all full-time college students have health coverage through their parents, guardians, or schools. Of 400,000 students, 60,000 have bought insurance they otherwise would have eschewed. Most policies tend to be lean-- premiums average $270 a year. Besides lining insurers' pockets, the student mandate saves money. Before the law took effect, uninsured students ran up $15 million a year in bad debts for hospital and physician care. That sum cut into the state's $300 million bad debt payment pool derived from a 10 percent surcharge on all hospital bills.

The state also has launched a series of projects to test low-cost insurance. Five regional insurers -- John Hancock Mutual Life in Salem, Health New England in Springfield, Worcester's Fallon Community Health Plan and Central Massachusetts Health Plan, and Boston's Neighborhood Health Plan -- have contracts to test new tacks on coverage, via innovative plans that by July 1 should enroll 10,000 people. In 1990, another round of contracts will be awarded.

BIG PIECES. BIG PROBLEMS

The new year also will see the law's more sweeping -- and more difficult -- mandates arrive, as Massachusetts tries to cover unemployed and uninsured workers, with policies provided by the state but paid for by business via a $16.80 per worker yearly tax yielding $35 million a year.

Massachusetts hasn't yet defined the coverage format, but insurers expect a two-tiered program. Of the state's 100,000 unemployed, 60,000 can buy group rate health insurance for at least 18 months under the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), meaning only a minimal subsidy from Massachusetts, says Steven Tringale, VP for Health Policy at the Life Insurance Assn. of Massachusetts. But workers laid off by small companies don't have COBRA protection, and the state will have to foot nearly all of the bill, Tringale predicts.

The law's main section, which takes effect in 1992, applies to the thousands of uninsured workers employed mostly by small business. Employers would have to provide minimum coverage, or pay $1,680 per worker in taxes, to be placed in the state's coffers to pay for insurance for those left uncovered.

Their potential cost -- to the state and to business -- has had these elements in opponents' crosshairs since the bill's introduction, with several attempts to repeal the law or at least delay implementation of the most loathed provisions.

The most visible opponent of the insurance mandates is Rep. Peter Forman, the Republican Whip in the state's House of Representatives. Forman opposed the bill when it was being considered in 1988, but his challenge was swept aside. In his number two GOP post, Forman has stepped up his efforts to defeat the insurance law, relying on strong support from small business.

A CRUMBLING COALITION

Dukakis' popularity isn't the only thing that's crumbled since last year. Passage of the universal coverage law demanded a coalition of consumers, labor, business, and hospitals. None could dictate the law's contents, but all wound up getting something in the final deal.

The law began as a bid to revise state hospital payments. One of four states, along with New York, New Jersey, and Maryland, using an all-payer system for hospital care, Massachusetts was hearing gripes from hospitals about skimpy rates. In 1983, when Medicare switched to DRGs, the state opted, with industry support, to stay out of prospective payment. By 1984, however, the Massachusetts Hospital Assn. (MHA) saw that its members had missed the point -- and the boat -- on DRGs. Medicare's lucrative indirect medical education adjustment had the state's many teaching hospitals panting. MHA dropped its opposition to DRGs, forcing action from a state in which hospitals are the largest employer, and therefore a political power.

The payment system rewrite attracted the attention of businesses tired of higher medical costs, as well as labor and consumer groups nervous about access to care. In 1984, the consumer movement had been energized when it successfully fought for a mandatory assignment rule for doctors treating Medicare patients. Consumer groups urged Dukakis to use payment reform as a wedge to start movement on universal insurance. Initially reluctant, he signed on when it looked like a good agenda entry in his run for the presidency.

The final bill didn't make everybody happy, but no one left the table. Hospitals got the DRGs they demanded in 1984, but by the time the bill was finished in 1988, DRGs had gone sour, thanks to Washington budget cuts. MHA added a new demand: a $50 million state payment pool to help offset the "losses" hospitals would now incur under DRGs. Consumers balked but bought. "As an individual piece, we opposed it; as part of a package, we supported it," says Robert Restuccia, executive director of Health Care for All, a consumer group.

Within months of the 1988 election, the coalition was showing fissures, particularly when Dukakis reneged on the $50 million. He did so in the form of a refusal to spend $37 million appropriated for that purpose by the legislature for 1989. MHA went to court; eventually, the state legislature restored the money and later appropriated another $50 million for 1990.

Then the state began holding up Medicaid payments to hospitals and nursing homes. When the backlog reached nearly $500 million, MHA went back to court. Again, the legislature stepped in, approving a $488 million bond to repay providers.

Now hospitals are in another battle with the state. The insurance law ordered new rules for the bad debt pool; a draft aims at sanctioning those hospitals seen by the state as lax in collecting debts. MHA sees it differently. "The state promised us $77 million in bad debt payments in 1988-90; so far we've only received $15 million," says MHA spokesman Richard Pozniak. But Collins says 25 percent of the state's hospitals won't meet the new standards because they're too easy on debtors.

Consumers are the happiest members of the erstwhile coalition. Restuccia says some hospitals were dunning patients incorrectly. Collins agrees; 30 percent of Massachusetts hospitals "don't take the time to determine who is eligible for free care," he says. In Massachusetts, anyone earning less than 200 percent of the national poverty line is exempt from paying hospital bills, and is covered by the bad debt pool. But some facilities were billing those patients and dunning them for bad debts. "Consumers were getting screwed because hospitals were going by whims," says Restuccia.

Given the tumult, it's no wonder that industry support is lagging. "Universal health care is a very noble experiment but an experiment that is faltering due to the state budget crisis," says MHA's Pozniak. "If universal health care is to work in Massachusetts, it cannot be solely a state funded program, but must be a federal-state partnership." But he admits that help from Washington "isn't in the realm of reality."

So far, hospitals won't join the call for repeal, but small business has, especially among restaurant owners who term the 1992 mandate an indirect 25 percent hike in the minimum wage that will raise prices and repel customers.

In the legislature, opponents are watching Forman, now pressing for repeal of the 1992 employer mandate and a year's delay in implementing the 1990 program for the unemployed, which he says is too expensive. Forman also says the $400 million estimate for the annual state tab for the fully-implemented program is too low; he says it's closer to $750 million. Either way, he says, Massachusetts can't afford it.

Forman's campaign has had limited success. In July, with anti-Dukakis sentiment peaking, Forman seemed to have the votes for outright repeal of the employer mandate. But he was outflanked by Dukakis and House Speaker George Keverian, who came up with a plan to delay the mandate to 1993. The House went along in September.

In the state Senate, the insurance law has much greater support, in part because it was written by Ways & Means Chairman Patricia McGovern. So far the Democrat has foiled Forman's forays on behalf of delay and repeal, but the Senate this week is likely to approve a year's delay in the employer mandate. "The phase-in is going a little more slowly than we had first anticipated. If we did delay it for one year, proponents feel that wouldn't necessarily be a bad thing," says McGovern aide Joan Fallon.

One issue that must be resolved by year's end involves funding for the second round of demonstration projects. In the budget debate, the House stripped the $7 million appropriation from the 1990 budget. Earlier this month, McGovern's panel restored the money; a House-Senate conference committee must work out a compromise.

THE BATTLES TO COME

The insurance law may survive 1989 more or less intact, but with no end to the campaign for delay or repeal. And the 1989 budget crisis will become the 1990 budget crisis, part of the backdrop against which Massachusetts elects a successor to Dukakis. As the provisions for the unemployed kick in, the program could gain strength, says Restuccia. "That gives us a much broader constituency," he says.

But the gubernatorial election could be the key to the program's future, says Robert Blendon, chairman of Harvard's Dept. of Health Policy & Management. The insurance law hasn't gotten a public endorsement from either of the leading Democrats, Lieutenant Gov. Evelyn Murphy and former state Attorney General Francis Bellotti. Blendon says he and other supporters of the law have to get such commitments before the July primary. "We don't want a Democrat to get to the main election without taking a stand on this issue." Restuccia's armtwisters already have met with Bellotti and plan to meet with Murphy.

Neither GOP candidate -- ex-U.S. Deputy Attorney General William Weld and House Minority Leader Stephen Pierce -- has attacked the law, but either would be expected to back repeal if elected. Blendon predicts the Bush White House would push repeal to help deflate the mandatory insurance issue.

Help could appear in the form of survey results being tabulated by the Harvard School of Public Health, which is studying the demographics and economics of the uninsured. Instead of 600,000, that population could be as low as 450,000, says Restuccia, noting that if that is so, the program's costs would be much lower.

If the Massachusetts insurance law survives, it may provide a national model. Politicians in Washington and in several state capitals are watching closely. In Congress, Sen. Edward Kennedy (D-MA) and Rep. Henry Waxman (D-CA) continue to push for a Massachusetts-like program. And New York Health Commissioner David Axelrod recently unveiled an ambitious universal access proposal, although so far Gov. Mario Cuomo has steered clear of endorsement.

But if the Bay State experiment fails, it could suspend consideration of such national solutions. "If it's repealed, everybody will read this as, 'a state can't do this,'" says Harvard's Blendon. -- *by Richard Sorian, editor of <u>Medicine & Health</u>, currently an Alfred P. Sloan Foundation journalism fellow at the Harvard School of Public Health.*

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HEALTHCARE
INFORMATION
CENTER

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STATE HEALTH NOTES

INTERGOVERNMENTAL HEALTH POLICY PROJECT

The George Washington University
WASHINGTON DC

Massachusetts Health Security Act Is On Track And On Time, Dukakis Reports

Despite the initial confusion and controversy, implementation of the Massachusetts Health Security Act – the landmark universal insurance law signed in April of 1988 – is proceeding smoothly and is on schedule, according to Gov. Michael S. Dukakis. "After some early rocky moments, we are on target," Dukakis said in a recent interview with State Health Notes. "We expected to cover 100,000-plus people by this spring, and we're going to do so."

The small business community, which will absorb the lion's share of the plan's cost, has lost its bid to repeal outright, or at least delay, implementation of a key provision of the law. That provision, scheduled to take effect in 1992, requires all firms employing six or more workers to pay a 12 percent surtax on the first $14,000 of wages for each eligible employee, or a maximum $1,680 per employee per year. Companies can, however, deduct from the tax any amounts they pay to provide health insurance for their employees, so that in effect, only those that do not provide insurance or contribute less than $1,680 will be subject to the tax.

Though there are still some small businesses opposing the mandate, Dukakis observed that many are beginning to see the plan as beneficial. "We're finding that in many cases, we can be helpful to small business people. Many of them already insure their employees and pay very high rates," he said, so that the combination of assistance and tax incentives "should be very, very helpful."

Beginning in January 1990, firms that employ 50 or fewer workers and had not contributed to health insurance for three years but now subsidize at least 50 percent of the cost of employee coverage can claim a 20 percent tax credit based on their first-year premium costs. Last year, small businesses were also offered the opportunity to participate in an insurance pool that will enable them to buy affordable coverage.

"My sense is that a lot of employers are already beginning to insure their employees, partly in anticipation of the mandate but partly, frankly, because in the tight labor market that we have, it's very difficult to attract good people these days without health benefits," Dukakis said.

Number 101
March 1990

Linda Demkovich, Editor
Dick Merritt, Editorial Director

In This Issue:

Management of the uncompensated care pool by the new Department of Medical Security (DMS) has also helped soften business opposition, the Governor said. The pool, established in 1985 to more evenly distribute the burden of bad debts and charity care across all hospitals, is financed by a 13 percent surcharge, paid by all insurers, on hospital bills. In October 1988, when the department took over, the obligation of private payers was capped and is being trimmed over time – from $325 million in FY 88 to $277 million in FY 91 – to reflect the drop in demand.

"One of the things we are trying to do here is to make this a fairer system," Dukakis stressed. "There are an awful lot of small businesses that do provide insurance." They are paying a "substantial surcharge on their premiums" to pay for uncompensated care, thereby "footing the bill" for others that do not subsidize employee insurance, he said.

Reservations expressed by the hospital industry also seem to have abated, the Governor noted. For one thing, he said, the state was finally able to pay hospitals $50 million, to make up for federal cuts in Medicare – money it had promised to win support for the Health Security Act. Initially, hospitals had also resisted the state's management of the uncompensated care pool and tried – and failed – to deny the DMS authority to issue performance standards governing the amount of bad debt they may charge to the pool. The standards are expected to save the pool $40 million, savings that will be passed along to the state and private businesses.

An analysis of the way in which hospitals were collecting bad debt found "enormous variations" in the amount of debt recovery, Dukakis said, with no pattern. "It wasn't that some were urban and some were suburban. It obviously had something to do with the management of the hospitals," he observed. After a good deal of consultation with the industry, standards were approved and to the hospitals' surprise, "are working better than they thought they would."

Other components of the law include:

- the CommonHealth program (July 1988), administered by the Public Welfare Department, provides coverage to three groups: those who leave the welfare rolls to work; disabled adults who want to work; and disabled children of working parents. The program was the first phase of the act to be implemented. As of the end of February, more than 17,000 individuals had been enrolled.
- CenterCare (May 1989), run by the DMS, contracts with community health centers to provide primary care to uninsured residents with incomes at or below 200 percent of poverty. Currently, more than 5,300 people are enrolled in 23 centers across the state.

- Student Health Insurance (September 1989) requires all college students in Massachusetts to either buy insurance through their institution or demonstrate they are covered by a comparable plan. An estimated 55,000 students who had no insurance before the law was enacted are now covered; savings to the uncompensated care pool are estimated at $15 million.

Effective in January of this year, employers also began paying a 0.12 percent tax on the first $14,000 of employee wages ($16.80 per employee) into a special health insurance account, to pay premiums for residents receiving unemployment compensation. Contributions to the account are expected to generate $34 million in 1990. A recent survey found that at any one time, 40 percent (1[illegible]) of those claiming unemployment compensation are without insurance.

By the end of 1990, the state also expects to be insuring an estimated 10,000 residents under so-called phase-in initiatives, designed to test various approaches to providing insurance. In round one, the DMS is contracting with HMOs and insurers for comprehensive insurance, targeted primarily to businesses with fewer than 25 employees. In the second round, the department will try to find plans with premiums at roughly $1,680 – the same level of contribution to be required of employers in 1992.

Is the Massachusetts plan a model that could be emulated on a national level? "It's one model, yes," Dukakis said. "If people are looking for an example of an employer-based system, using private insurance principally, this is the most advanced version."

Why hasn't the federal government succeeded in pulling together the diverse factions, as several states have, and developed a plan that addresses the needs of the uninsured on a national level? "You have chief executives at the state level who are willing to take leadership on the issue," Dukakis said. "During the Reagan years, it was impossible to get the Administration to seriously consider the problem ... I hope President Bush, with the directive he has given [HHS Secretary Louis B.] Sullivan, is going to take this seriously."

There is, he said, "tremendous congressional interest, on both sides of the aisle" in fashioning a national plan for the uninsured. If the Bush Administration is equally interested, he said, the governors – whose budgets are riding on a solution – can play a pivotal role. "We have an opportunity to do here exactly what we did on welfare reform and what we've done now on education, which is to be the catalyst that drives this ... and brings a Republican Administration and a Democratic Congress together."

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Retirement
Vice Chairman
Public Employee Retirement
(Joint Statutory Committee)
Member
Energy & Environment
Labor
Workers Compensation

To: Interested parties December 4, 1989
From: Rep. Gail Chatfield
Re: Proposed "Missouri Health Assurance Plan"

Enclosed is a draft of legislation creating a "Missouri Health Assurance Plan" which I intend to file by the end of this month. The basic idea of this bill is to establish a Canadian style comprehensive health program for our state. I would like to emphasize that this enclosure is a **draft**, not a finished product. The development of this bill is going to be an ongoing process which will just start with the filing of the initial version. I am circulating it to you, and other interested parties, in the sincere hope that you will help with this process by offering your comments, criticisms, and suggestions for improvement each step of the way.

Summary

The central idea behind this bill is to address our state's serious health care problems through a basic structural reform of the system, rather than continuing to attempt to apply bandaids to each individual crisis as it arises. This is not just an indigent care program, or just a cost containment program, or just a reform of Medicaid. It is a serious attempt to meet all of these, and many other, concerns by remodeling our system along the lines of one that is a proven success; i.e. the Canadian national health insurance program. The bill has three guiding principles. They are universal access, cost containment, and quality assurance.

Universal Access The bottom line here is that every resident of Missouri will be covered by the Plan. It is intended to basically replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible. There will be no means test or eligibility standards to differentiate one person in need of care from another on the basis of income, age, pre-existing condition or anything else. Every resident of our state will have access to a basic package of health care services.

Cost Containment One of the biggest successes of the Canadian system is that it is able to offer coverage to every Canadian citizen while costing proportionally far less than our system here in the U.S. The basic reason for this is that their system is based on a unified source of payment. Rather than trying to deal with patchwork of hundreds of private and public insurers and programs, the Canadians channel all of their health dollars through a single fund. This saves them money in two ways. First, it eliminates the tremendous administrative costs associated with maintaining hundreds of overlapping private and government insurance bureaucracies. Second, it puts a single payor in the position of containing costs by negotiating budgets and fee schedules with providers. Thus cost savings can be achieved by increased efficiency and consumer bargaining power, rather than by rationing care on the basis of ability to pay. The proposed Plan will consolidate all of the money presently being payed by private companies and individuals, as well as the state, Federal, and local governments into a single fund.

Quality Assurance Surveys show that consumer satisfaction with the quality of the Canadian system runs at well over 90%. This is achieved in two ways. First, their program (like this proposed Plan) contains provisions for constant monitoring and improvement of the quality of care. Once again, the unified source of payment plays a critical role in enforcing quality standards. Second, the program eliminates financial incentives for piling on medically unnecessary, and often harmful, procedures just because of their profitability. For example, studies show that unnecessary surgeries, such as hysterectomies and Caesarean sections, are among the most serious quality problems infecting our current system.

As I said at the beginning of this memo, the proposal that you have in your hand is a draft. Our hope is to involve you, and other key individuals and organizations in the process of improving and refining the program so that it will meet the needs and concerns of each, while keeping its basic principles intact. I look forward to hearing from you and working with you on this project.

Sincerely,

Gail R. Chatfield

Rep. Gail Chatfield

Description
Missouri Health Assurance Plan

Section A

Section 1 contains the title of the bill, outlines its purposes, and defines its most important terms.

Section 2 is enabling language needed for a statute of this type.

Section 3 sets up a Board of Governors for the Plan. It will have 21 members including the heads of four departments, two members of the Certificate of Need board, and fifteen appointees. The appointees will include five provider representatives and ten consumers. Among the consumers must be at least one poor person and one senior citizen.

Section 4 outlines the powers and responsibilities of the Board. It requires them to hold hearings on several of their more important duties.

Section 5 allows the appointment of an Executive Director for the Plan. It allows the Board to delegate powers to him/her, excluding the issuing of rules and the allocation of funds.

Section 6 sets up a Missouri health care trust fund. It includes in the fund money which comes into the state for Medicaid and Medicare payments, subject to a waiver issued by the Federal Department of Health and Human Services. This allows the inclusion of Medicaid and Medicare money in the unified source of payment. The section also requires the establishment of a reserve fund to protect the solvency of the program.

Section 7 creates a "Prevention Account" within the fund to earmark resources for preventive and primary care. It also sets up a "Health Services Account" from which to reimburse providers for the basic services covered by the plan.

Section 8 sets up a "Health Professional Education and Training Fund" to allow the dedication of resources to this purpose.

Section 9 states that all state residents are eligible for the Plan. It forbids providers from charging eligible persons more than they are reimbursed by the Plan.

Section 10 outlines covered services. Basically, all medically necessary services are covered. Prescription medications, most outpatient mental health services, and a limited amount of alcohol or drug rehabilitation are included. Basic nursing home care, elective or cosmetic services are not.

Section 11 prohibits discrimination by providers, allows freedom of consumer choice for covered persons, and sets up a mechanism for paying for the care of Missourians while outside the state.

Section 12 sets up the payment and cost containment system. Hospitals are paid on the basis of annual "global budget" which is meant to cover all of their costs (including justifiable capital needs) for each year. Individual providers are paid on a "fee-for-service" basis. Fee schedules are to be negotiated with the Board. Multispecialty provider groups may elect to be reimbursed on a "capitation" basis.

Section 13 is enabling language allowing the assignment of revenue raised by the state for the Plan to go into the trust fund.

Section 14 redirects state and local funds currently going for employee health care into the program. It includes a phase-in for units of government which have collective bargaining agreements with their employees.

Section B sets the effective date of the program two years after the receipt of the necessary Medicaid and Medicare waivers.

Section C increases corporate and individual income tax rates to fund part of the cost of the program. **Note: The intent of this tax is not to increase the health care expenditures of employers or individuals, but simply to redirect the money that they are already paying toward health insurance through the single state payment source, the trust fund. The tax will replace existing premium payments, not be added to them. The "blanks" have not been filled in because guidance is needed from industry and taxpayers on how this tax should be structured so as to ensure that the program does not increase the health care burden of individuals or employers that are already doing their share to pay for coverage. It is intended that this system will offer universal coverage and still reduce the overall amount Missourians pay for care.**

Section 15 instructs the Department of Social Services to apply for the necessary Medicare and Medicaid waivers.

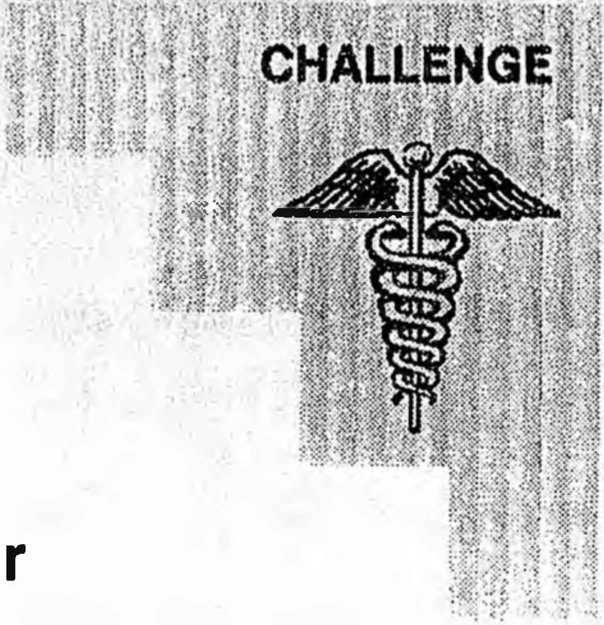
Section 17 sets the timeline for the governor's appointments to the Board.

Section D submits the Plan to a vote of the people.

The Oregon Health Standard

Prepared at the direction of the Joint Legislative Committee on Health Care

HEALTH
ACCESS
CARE



The Oregon Health Care Challenge.

Government, Business and Labor working together to:

- Promote access to health care for all Oregonians.
- Agree on a standard package of health care benefits for all Oregonians.
- Restrain health care cost inflation.
- Equitably share responsibility in financing health care.

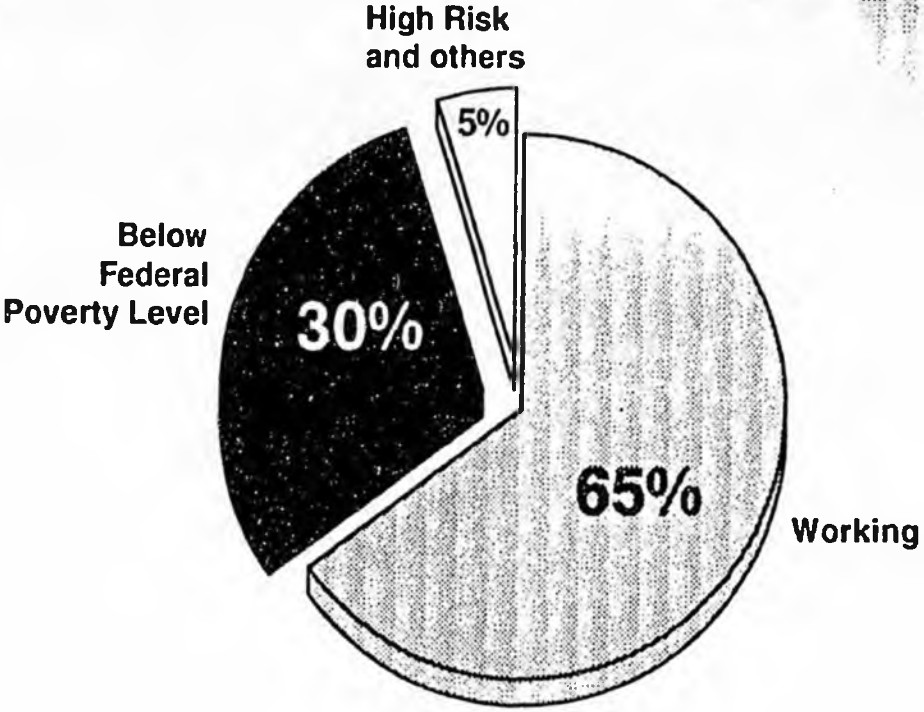
400,000 Oregonians are without any health insurance.

One out of six Oregonians under 65 are without health insurance.

120,000 are earning below the Federal Poverty Level.

260,000 are adults and families earning above the Federal Poverty Level.

20,000 are High Risk individuals and others.

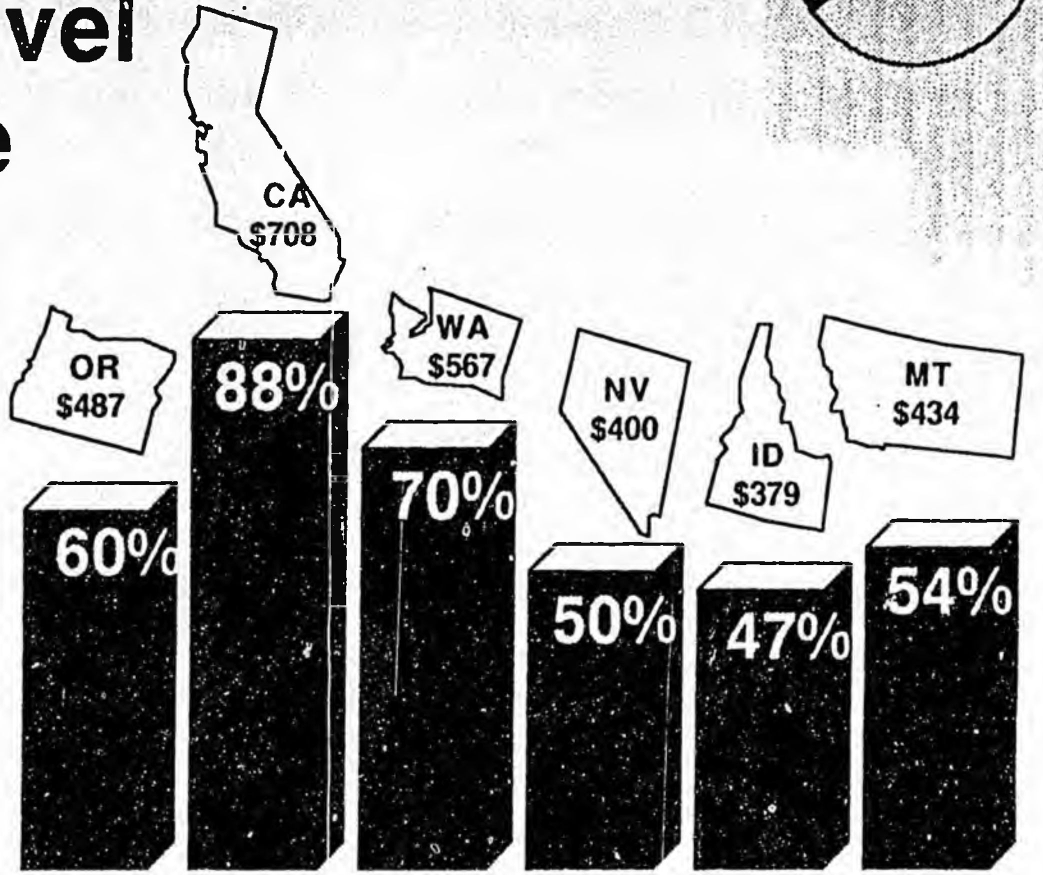


SYMPTOM

120,000 Oregonians below the Poverty Level cannot receive Medicaid.

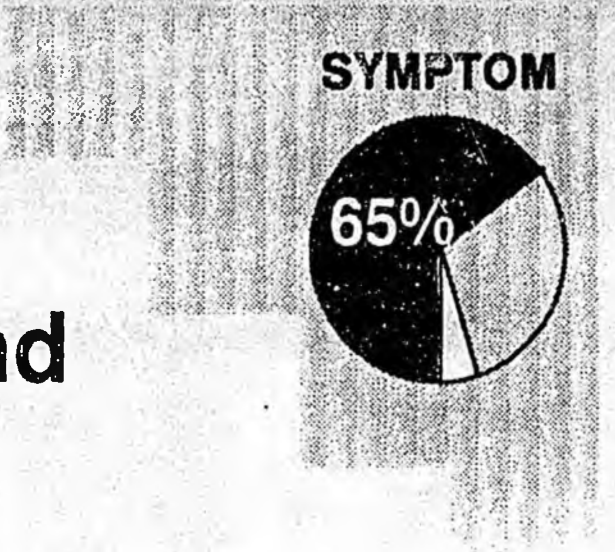
Congress passed Medicaid to provide health care for families living in poverty. Income levels used to determine Medicaid eligibility vary from state to state. The range is from Alabama's 24% to Utah's 95% of the Federal Poverty Level.

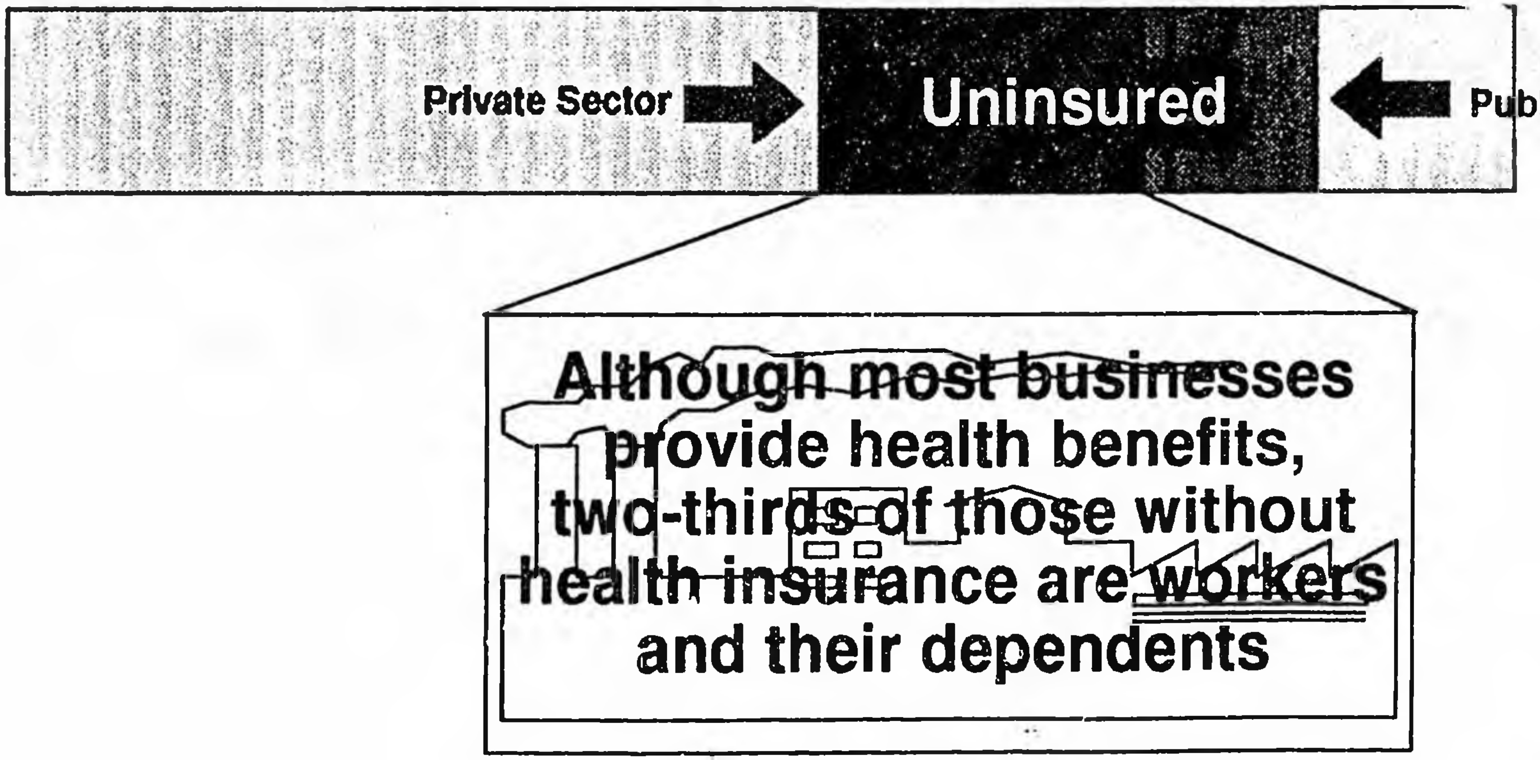
Oregon has provided sufficient matching funds to cover the poor with incomes up to only 60% of the Federal Poverty Level.



Maximum monthly income eligibility for the typical Medicaid family of three as a percentage of the 1988 Federal Poverty Level (Medicaid Source Book, Congressional Research Service)

260,000 of those without insurance are workers and their dependents.





Private Sector → **Uninsured** ← **Public Sector**

Although most businesses provide health benefits, two-thirds of those without health insurance are workers and their dependents

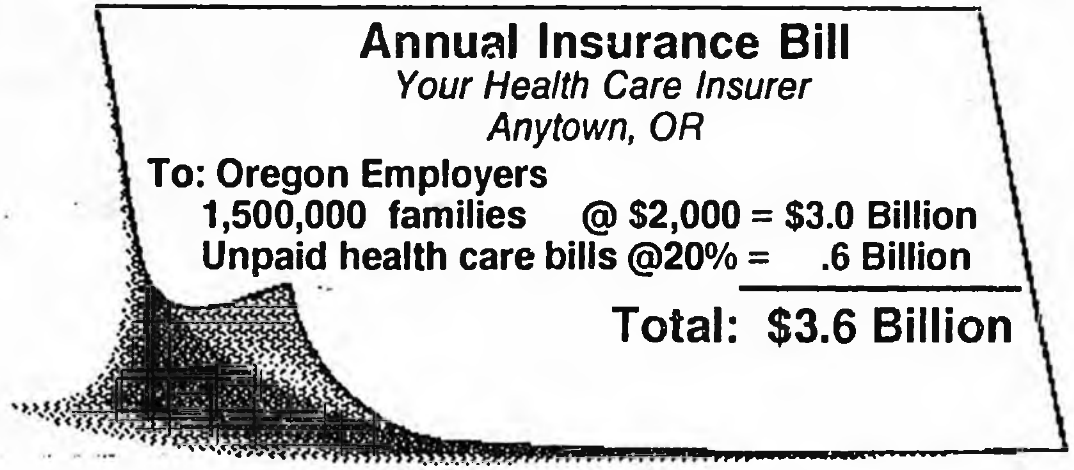
SYMPTOM

Employers pay the health care bills of 400,000 uninsured Oregonians.

The way health care for those without health insurance is paid for is unfair.

Employers who provide health benefits subsidize uninsured workers through higher premiums for their own workers.

These employers also pay the difference when Medicaid and Medicare don't cover all the costs.

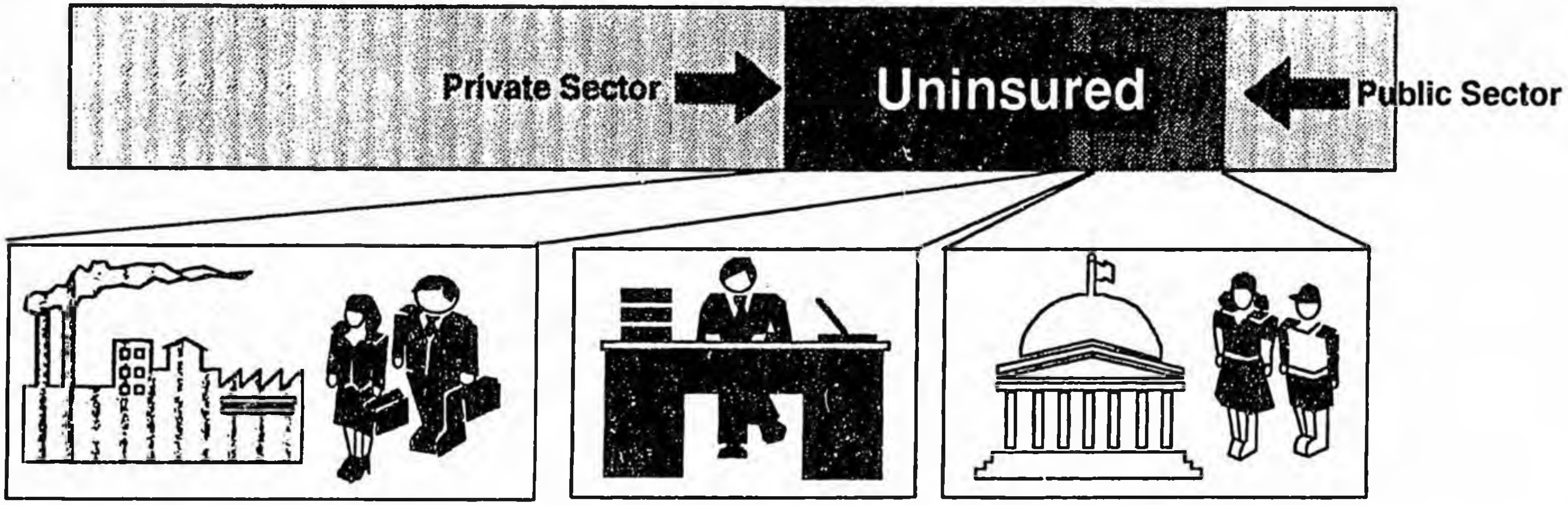


Annual Insurance Bill
Your Health Care Insurer
Anytown, OR

To: Oregon Employers
1,500,000 families @ $2,000 = $3.0 Billion
Unpaid health care bills @20% = .6 Billion

Total: $3.6 Billion

The Oregon Health Standard will expand access to care, covering nearly all Oregonians.



Business and Labor
Insurance Pool

Insurers
High Risk Pool

Government
Expanded Medicaid

PARTNERSHIP

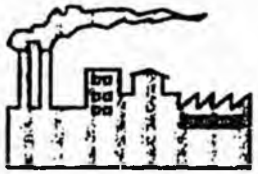
The Oregon Health Standard will assure health care for workers, the poor and the sick.

The Legislature established a partnership to provide health care access for the 400,000 uninsured Oregonians.

Business' responsibility is to provide standard health coverage for workers and their dependents.

Government's responsibility expands to all those living in poverty and is shared with Insurers for coverage of the chronically ill.

Senate Bill 935



Employers provide health care benefits for all permanent workers and dependents.

Senate Bill 534

Insurers provide risk pool coverage for the uninsurable, chronically ill. The State subsidizes the pool.

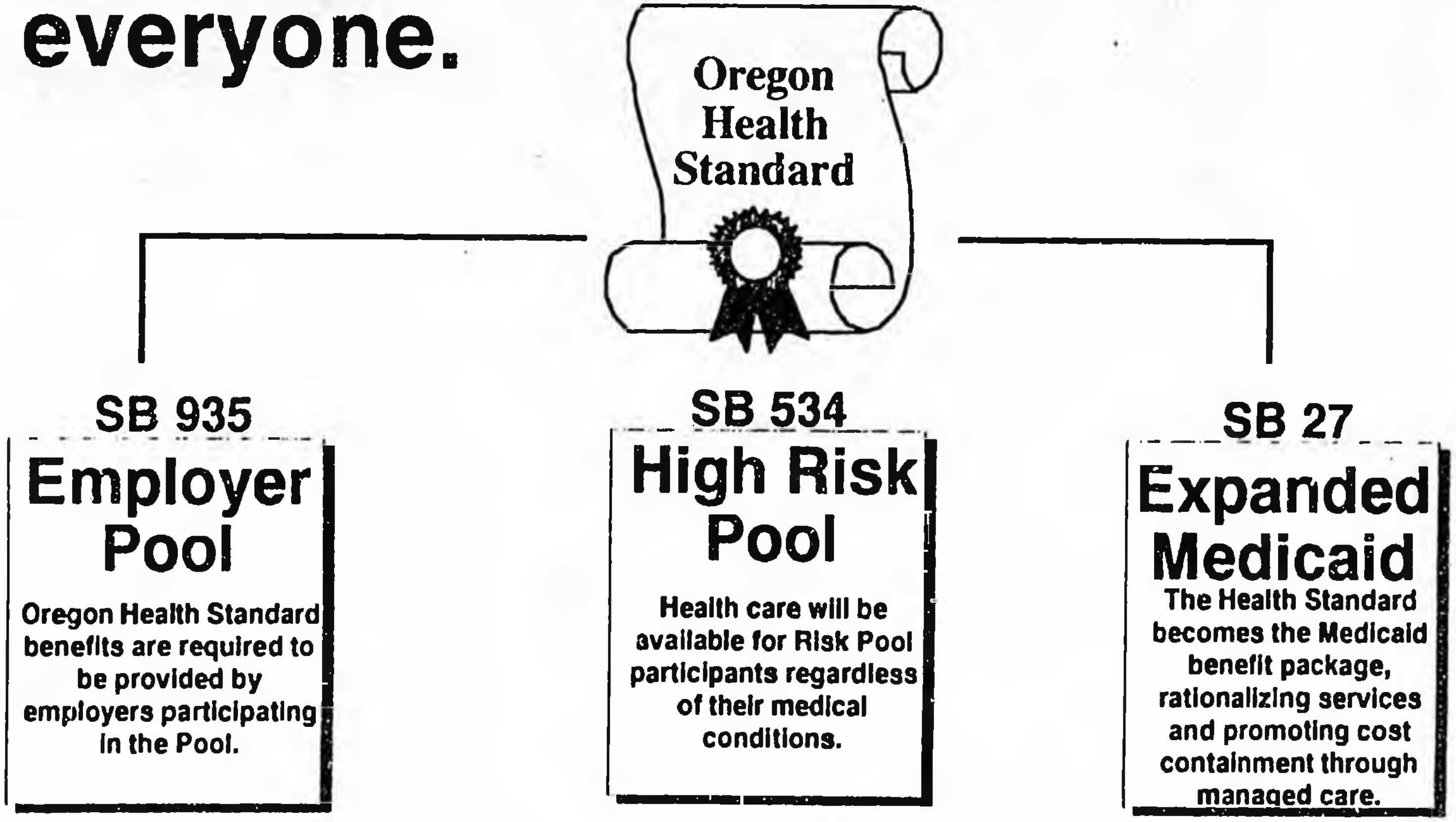
Senate Bill 27

Government expands Medicaid to cover all those below the Federal Poverty Level.

PACKAGE

HEALTH
ACCESS
CARE

The Oregon Health Standard links programs together to gain access for everyone.



Oregon Health Standard

SB 935

Employer Pool

Oregon Health Standard benefits are required to be provided by employers participating in the Pool.

SB 534

High Risk Pool

Health care will be available for Risk Pool participants regardless of their medical conditions.

SB 27

Expanded Medicaid

The Health Standard becomes the Medicaid benefit package, rationalizing services and promoting cost containment through managed care.

SENATE BILL 27

Congress is asked to approve the Oregon Health Standard.

The Oregon Health Services Commission:

Establishes a set of health care services in rank order of priority, based on the effectiveness of health care treatments and on societal expectations for an Oregon health care system.

Identifies costs for each prioritized medical procedure.

Presents its report to the Legislature and to the Governor for funding to begin July 1, 1991, pending Federal approval.

Federal Medicaid requirements may stand in the way of the Oregon plan. Congress needs to waive eligibility barriers for single adults and childless couples living in poverty. The Federal Government must agree to the Oregon Health Standard benefit package.

SENATE BILL 27

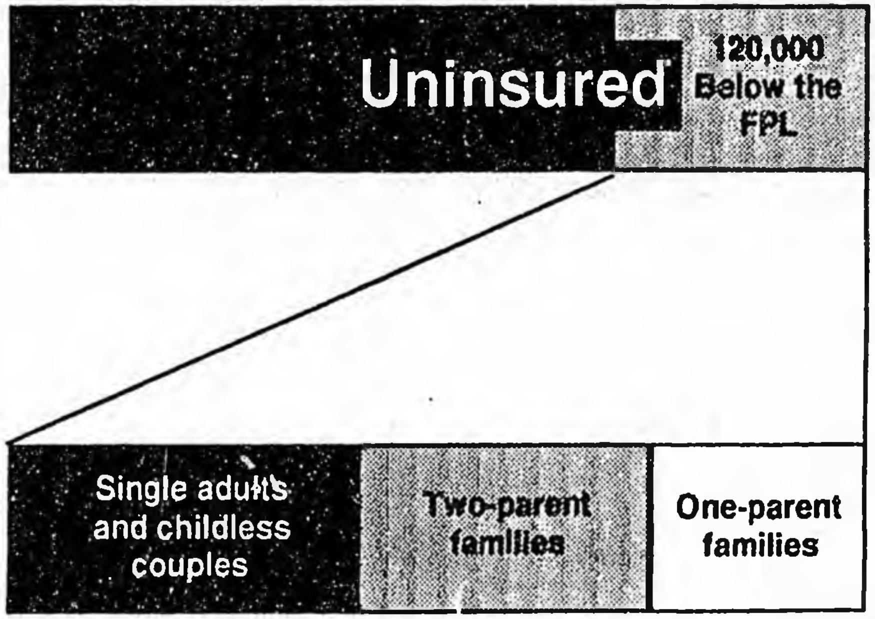
Oregonians living in poverty will benefit from the Oregon Health Standard.

Oregon's Medicaid Program will be expanded to cover all families with incomes below the Federal Poverty Level.

120,000 additional Oregonians will be eligible for Health Standard benefits through Medicaid.

59% of those to be covered are in families with children.

Children living in poor two-parent families, now uninsured because Medicaid is tied to welfare cash assistance, will be covered.



Uninsured

120,000 Below the FPL

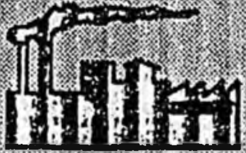
Single adults and childless couples

Two-parent families

One-parent families

Oregon Expanded Medicaid

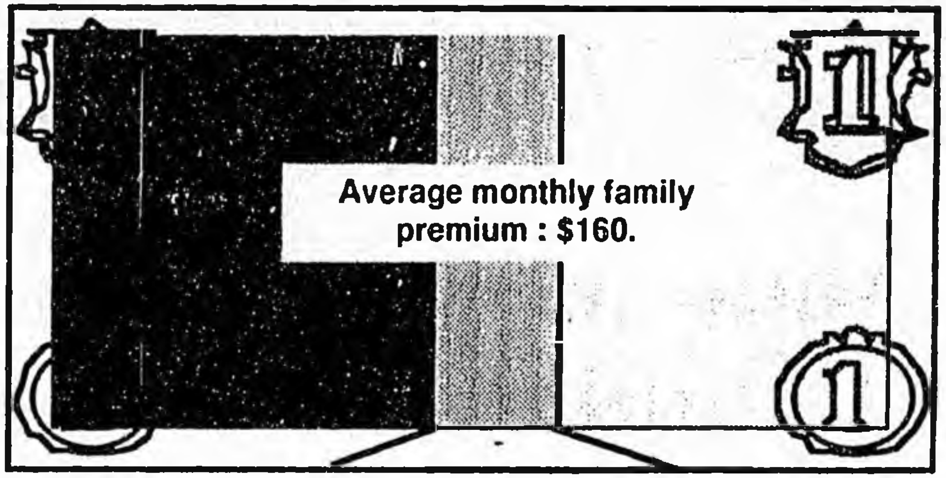
SENATE BILL 935



Oregon businesses will provide health benefits for all workers.

An Employer Pool has been established offering affordable and comprehensive health plans. These plans must provide at least Oregon Health Standard benefits, but not necessarily other health care mandates.

$45 million in tax credits per year is available to encourage small businesses to provide health benefits now. The 1994 requirement that all employers provide health benefits would be repealed only if most uninsured workers become covered through voluntary efforts.



Average monthly family premium : $160.

Employer

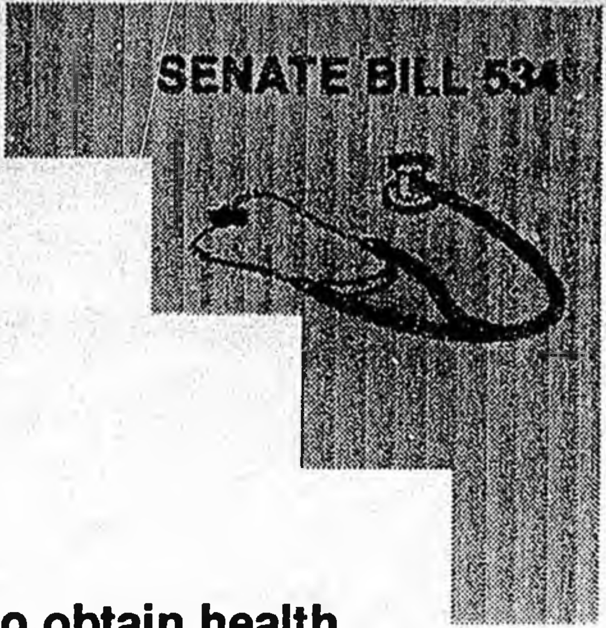
Pays 75% of the workers premium, 50% for dependent coverage, receives $25 tax credit, net cost: $70 per employee per month.

Tax Credit

Pays maximum $20 for worker and $5 towards dependents, net $25 per month.

Worker

Pays 25% of own premium, 50% for optional dependent coverage, net cost: $65 per month.



▶ Oregon's High Risk Pool reaches thousands who need health insurance.

About 15,000 Oregonians are unable to obtain health insurance because of pre-existing medical conditions.

Oregon has taken the first step in helping the chronically ill get the care they need. Many can now be enrolled in the new High Risk Pool.

The State has appropriated a $1 million subsidy and provided for an assessment on insurance company revenues to start up the Pool. Participants pay no more than 150% of a standard premium.

PROGNOSIS

In 1994, nearly all Oregonians will have access to health care.

The Oregon Health Standard's benefits and managed care will make the best use of health care dollars.

Private and public insurance expansions will provide access for all workers and their dependents, all those living in poverty, and the chronically ill.

Some unemployed and self-employed persons, and some college students, would continue to be without coverage.

THE WASHINGTON UNIVERSAL HEALTH ACCESS ACT OF 1990

[CONCEPTUAL OUTLINE]
*** not written in statutory syntax ***

Proposed by

Representative Dennis Braddock
Chair, Committee on Health Care
Washington State House of Representatives

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FINDINGS AND CONCLUSIONS

The Legislature finds Washington state has been an innovator in health care.

Over the past three years the state has pioneered several nationally recognized model programs, including: the **Basic Health Plan** and the **High Risk Health Pool** to provide access to health services for the uninsured; the **Omnibus AIDS Act** to provide a prevention and treatment framework to address that serious disease; the **Maternity Care Access Act** to provide needed prenatal care to low income women and health care to poor children; **Rural Health Legislation** to meet the health needs of rural communities; the **Health Care Authority**, a single payer administration, to improve the efficiency of health benefit plans for public employees; and a **state Department of Health** to provide greater focus and leadership regarding health matters.

These accomplishments, although significant, are piecemeal attempts to address pervasive problems of access, equity, quality of care, and cost control.

Close to 700,000 Washington state citizens are without access to health services. This number is growing as increased health insurance costs push low wage earners off health insurance rolls, administrative and bureaucratic costs continue to rise, and the multi-tiered complex system breeds additional inequities in access and quality.

Problems of access, quality, and cost also have a detrimental effect on the state's economy. Washington state, and the nation as a whole, cannot gain a competitive edge when health care costs continue to grow at an alarming rate and workers cannot access health services. On a per capita basis, the United States spends 41% more on health services than Canada, 61% more than Sweden, and 131% more than Japan. All of these countries have universal health coverage while this country fails to provide coverage for an estimated 37 million of its citizens. Also, in some areas of health outcomes, e.g. infant mortality, these countries fare better than the United States.

The Legislature concludes that any future reforms must be systemic, encompassing all the major components of health service delivery and finance. It must also result in universal coverage for state residents, insure quality of care, and include effective cost controls.

INTENT

It is the intent of the Legislature that by 1995 the Washington Universal Health Access Program [WUHAP] be fully implemented, incorporating the following principles.

1. Comprehensive health service and long term care coverage for all residents of the state.

2. Annual premium participation for all enrollees based on income, except for those of the lowest income levels.

3. Minimal co-payments to be paid at the point of service for all enrollees, with a sliding fee schedule for those enrollees whose income is below 200% of the federal poverty level [FPL].

4. An efficient single administrator, with uniformity of billing, payment, and data collection.

5. A global state health service budget based on a percentage of the gross state product or revenue capacity.

6. Freedom of choice of provider.

7. Funding through employers, individual premiums and payments, and state and federal governments.

8. Development of a state universal coverage program in anticipation of some form of national health insurance.

DEVELOPMENTAL PROCESS

The elements of WUHAP will take several years to put in place. Most likely, it will need to be phased in over a multi-year period.

The responsibility for overseeing the development of WUHAP is given to the **Health Care Access and Cost Control Council [HCACCC]** recently created by SB 6152 [Sec 503]. Present membership includes the Secretary of Health; the Secretary of Social and Health Services; the Administrator of the Basic Health Plan; the Administrator of the Health Care Authority; the Director of Labor & Industries; and one public member. The statute should be amended to include the Insurance Commissioner, since the development of the WUHAP will require significant modification of the insurance system.

The developmental process will involve the participation of several groups and organizations including the Board of Health, through the State Health Report; business, labor, the pubic at large, and the health provider community.

ADMINISTRATION

The **WUHAP** shall be organized as a single administrative entity, encompassing the following elements:

1. Uniform benefits package;

2. Simplified uniform billing and payment procedures;

3. Complete and timely access to all health data;

4. Complete authority to make operational decisions regarding the program.

The **WUHAP** may contract with existing health entities to perform financial intermediary or "Administrative Services Only" [ASO] functions, if necessary for the effective and efficient operation of the program.

SERVICES COVERED

Covered health services shall include those that are determined to be effective in the following categories.

1. Inpatient hospital;
2. Outpatient hospital;
3. Physicians services;
4. Other licensed health professional services;
5. Prescription drugs;
6. Health promotion and illness and injury prevention;
7. Long term care, including nursing homes and community-based services.

The secretary of Health, pursuant to her or his authority to evaluate outcomes of health service intervention [SB 6152 (Sec 107 &9)], shall periodically recommend to the WUHAP health services and medical technologies to be covered. Such determination shall be conducted through the public process.

SERVICE DELIVERY AND REIMBURSEMENT

Global State Health Service Budget [GSHSB]: This budget will reflect the total amount to be spent on health services in the state. It will be developed on a per capita basis, taking into consideration an established percentage of the gross state product or revenue capacity. Premiums and co-payments with be established based on a fixed portion of the GSHSB.

Health providers: Health providers will be reimbursed on a fee for service, salaried, or capitation basis set uniformly by the **WUHAP**.

Hospitals: Hospital budgets will be set on a GSHSB basis for each hospital, using historical data, and projected changes. Retrospective adjustment will be permitted for unforseen circumstances.

Trauma and tertiary care services, where efficiency is sensitive to volume of service, will be designated among hospitals based on geographic distribution and need.

Capital projects would be approved separately.

Funds for graduate medical education will be excluded from hospital budgets and separately approved.

Hospital budgets will include a factor for uncompensated care to provide emergency services to those who are not enrolled.

Drugs and durable goods: Prescription drugs, durable medical equipment and supplies, eyeglass, hearing aids, oxygen, and related services will be provided through a uniform state contracting process.

Long Term Care: The HCACCC shall consider the recommendations of the Long-Term Care Commission [HB 1968] in determining service delivery and reimbursement for LTC consistent with the intent of this act.

After 1995, no insurer, health service contractor, nor health maintenance organization may independently insure, contract, or provide those health services included in the WUHAP benefits package.

HEALTH PROFESSION RECRUITMENT

The secretary of Health shall identify shortages of needed health providers and, with universities, colleges, and vocational technical institutes, shall develop proposals for training, recruitment, and retention.

HEALTH SERVICE UTILIZATION MANAGEMENT

The secretary of Health, with the state's academic health science programs, shall develop training and continuing education programs that incorporate utilization management schemes to improve timeliness and efficiency of health services interventions and cost controls. The results of this effort shall include practice guideline development, on a consensus basis, using available data on efficacy.

PHASE-IN OF EXISTING PAYMENT SYSTEMS

The HCACCC shall develop a time line and method for incorporating the following payment systems into the **WUHAP**:

Medicaid and state funded indigent health programs;

Medicare;

CHAMPUS;

State Employee Health Plans;

Common School Employee Health Plans;

Basic Health Plan;

High Risk Health Pool;

Labor and Industries health services;

Veteran health services;

Department of Correction health services; and

All other private coverage.

FEDERAL WAIVERS AND STATUTE CHANGES

The state of Washington shall seek waivers and federal statutory changes necessary to incorporate Medicaid, Medicare, ERISA, Veteran Health Services, and CHAMPUS into the **WUHAP**.

FUNDING

Participation:

Except for persons of the lowest income, all enrollees or their employers will pay premiums. There will be a sliding fee scale for enrollees with income between 100% to 200% of the FPL, with a maximum out-of-pocket limit. For families over 200% of the FPL, premiums will be actuarially set based on family size; this amount will be capped.

A minimal co-payment will be collected at the point of service.

Funding sources:

Federal: Medicare; Medicaid; CHAMPUS; Veterans Administration.

State General Fund: Existing sources.

Employers: Participation in premium and/or WUHAP fees. Possible sliding scale based on company size and gross revenue.

Enrollees: Participation in premium and copayments.

Fund Administration:

Funds shall be deposited into the Washington Universal Health Access Trust Fund.

Amounts shall be allocated on a formula basis to the following four accounts.

I. **Health Services:** health providers, hospitals, drugs, etc.

II. **Prevention and Education:** wellness, illness and injury prevention, and health promotion.

III. **Capital Projects:** renovation, construction, and major equipment.

IV. **Graduate Medical Education:** funding of medical schools, hospitals, and other health professional training.

MEDICAL INDIGENCY **ProjectNotes**

National Conference of State Legislatures Vol. 1, No. 1 December 1989

RIGHT OR PRIVILEGE:

SHOULD EVERYONE HAVE ACCESS TO BASIC HEALTH CARE?

"In a civilized society, every member of society should have access to a basic package of health services." Uwe Reinhardt, a Princeton economist and member of the National Leadership Commission on Health Care, has likened this to the guarantee of universal access to public education. Yet, the United States and South Africa are the only major industrialized powers that fail to guarantee access to health care.

Americans struggle with the issue of whether health care is a right or a privilege. In a country that has the best health care technology in the world, nearly 37 million of its citizens do not have health insurance. Those who cannot afford to pay, often called the "medically indigent," face major access barriers to health care services.

In the absence of a national health policy, the health care access and rights debate is centered in state legislative chambers. Medical indigency and uncompensated health care costs were identified as top priority issues for the 1989 legislative sessions, and will continue to demand attention in the 1990s. The three primary concerns identified by legislators are ensuring access to health care, paying for it, and expanding the availability of insurance to uninsured persons. Health care analysts have suggested that while in past years state legislatures proceeded slowly, states are now taking a leadership position on these issues. Access, cost, and quality issues continue to headline the policy concerns of consumers, providers, and payers.

Financing health care for people who do not have private insurance or who are not eligible for government programs is a major problem for state legislatures. Medical indigency has taken on greater urgency in recent years because of changes in the health care system. In the past, health care providers used a portion of their profits from paying patients to subsidize the costs of care to this nonpaying group. Recent efforts by insurers, the business community, and government to reduce their health care costs have made it increasingly difficult for providers to continue this practice. The focus of this article is universal access to health care and state efforts to ensure availability.

Who are the medically indigent?

The term "medically indigent" usually applies to low-income uninsured people who are unable to pay for their medical care. Others may also be included in a state's definition, including insured persons who cannot afford to pay for services not covered by their policies, or for high insurance deductibles or co-payments. Even middle-class individuals may be considered medically indigent if they cannot pay for the costs of a catastrophic illness or accident. The following items reveal information about uninsured and medically indigent people that may be of interest to state lawmakers:

- Although Medicaid eligibility criteria vary widely among states, on the average, an American with two children may earn no more than \$6,036 annually to qualify for Medicaid. In *Alabama*, a family of three can earn no more that \$1,418 per year to be eligible for Medicaid, in *California*, the threshold is \$10,704.
- One in three Americans is without adequate insurance coverage and millions go without basic health care services.
- Nearly one-third of Hispanic Americans are uninsured.
- More than one in five African Americans do not have health insurance.
- One-third of the uninsured are children, including some five million adolescents aged 10 to 18. Uninsured children receive 40 percent less physician care than insured children, according to the National Association of Children's Hospitals & Related Institutions (NACHRI).
- Forty-four percent of uninsured children live in families with incomes below the federal poverty level.
- Almost 20 percent of uninsured children live with an adult who is insured through the workplace.
- The incidence of uninsured residents is almost twice as high in the Western and Southern states than in the North Central and Northeastern states.
- Persons without health insurance "self ration" by seeing a doctor about 65 percent as frequently as those with coverage or by not even seeking medical care.
- Millions of persons who do receive health care services, but either cannot pay or do not pay for them, generate billions of dollars of uncompensated health care costs each year.

> *"Establishing priorities in health care is a necessary step toward defining adequate health care."* Sen. John Kitzhaber, MD, President, Oregon State Senate

Should the health system be restructured ?

The last several years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The health care system is seeing a change in the "Robin Hood" ethic of compliance with the expectation that providers are somehow obliged to serve patients regardless of their ability to pay. Public debate is brewing about how much health care is "adequate" for those who cannot pay for it. As this debate continues, several factors point to a health care system with growing problems:

- Health care costs continue to skyrocket. In 1988, national health expenditures were 11.3 percent of the gross national product (GNP), the broadest measure of U.S. economic activity. By 1993, health care spending will grow to an estimated 13 percent of the GNP.
- The gap between the medical "haves" and "have nots" is widening.
- Millions of Americans report financial barriers to receiving adequate health care.
- The U.S. has one of the highest infant mortality rates in the industrialized world, exceeding that of 16 other developed nations.
- Our nation's safety net is fraying. Public hospitals are endangered and no longer have the resources to serve as health providers of last resort.
- The ability of hospitals to absorb uncompensated care costs has diminished as their ability to shift costs has declined and as the uninsured population has grown.
- Physicians report that the aged, poor, and uninsured utilize emergency rooms as a primary source of health care and that overcrowding is severely limiting the public's right to timely and good quality care.
- Access to emergency medical and trauma services is threatened by the continuing problems of health care financing and because so many emergency room patients are uninsured. Emergency room closures present access problems even for those who are fully insured.
- U.S. hospitals and emergency rooms with too many patients and too few beds are in a widespread and growing crisis, according to the American College of Emergency Physicians (ACEP).
- In some quarters, Medicare and Medicaid are equated with charity care because reimbursements under these programs sometimes are far below costs.
- Medicaid eligibility has been eroded over the past decade, government reimbursement levels and "red tape" inhibit physicians from treating the poor, and emergency rooms have been labeled as the "opening through which debts blow."

These and other problems fuel the national health care debate. State legislators find themselves in the middle of the fray.

Can change be expected?

The overriding problem will not be solved right away, and the issues raised as a result will set the agenda for change. Inequities in the distribution and provision of care will require change at many levels. The need for change is apparent, but there is no consensus as to what form the change will take in light of expectations versus economic realities.

Can improvement at the state and local level resolve the increasing financial burden of providing care on the national level? Department of Health and Human Services Secretary Louis Sullivan, MD has declared that state and local government and private employers must share in the solution to the problem. Scholars suggest that total resources be determined in the context of federal and state budgets.

Rationing has been proposed as one possible solution to the current crisis of cost in health care. Advocates believe the allocation of resources makes funding decisions more rational.

> *"In an era of federal budget deficits and tight state budgets, how to assist the medically indigent has become a question of what is the most efficient allocation of limited dollars."*
> Katherine Swartz and Debra Lipson, *Strategies for Assisting the Medically Uninsured*

Rationing also has been criticized as an unhealthy "stopgap" measure that denies care to the most deserving segments of the medically indigent population. Proponents argue that a two-tier system is developed, offering "second class" medicine in a top quality environment.

Over the past five years, the states have taken the lead in developing legislation to address the growing problem of paying for and ensuring access to medical services for the medically indigent. States have experimented with a number of different programs for the indigent. The majority of state legislatures have enacted or considered bills to expand access to and finance health care for medically indigent persons.

Conclusion

The answer to the question of whether access to basic health care for all is a right or a privilege is both political and policy oriented. The U.S. Supreme Court has determined that there is no *constitutional* right to medical care, even to medical care that is lifesaving. Future solutions will come from Congress and the individual state legislatures. Changes to the current health care system will require an examination of the following:

1. Community interdependency -- the inevitable conclusion that no one group can do it alone.
2. Voluntary action -- the acceptance of short-term and intermediate strategies to develop an equitable and affordable long-term solution.
3. Decision making process -- the promise of specific benefits or the rationing of health care services.

FYI

For further information on
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STATE ACTIVITY

Hawaii

"Hawaii did it first," said State Representative Jim Shon, chair of Hawaii's Health Committee in the House of Representatives, referring to the state's 1989 Universal Health Care Insurance Act. "By guaranteeing health care insurance for all of Hawaii's people, we have taken another step toward national leadership in health care."

The new law focuses on basic coverage for preventive primary care, prenatal care, childhood immunizations, mammograms, pap smears, and all aspects of outpatient care. Also included are an expansion of Medicaid services and specially targeted health services for gap groups that have difficulty obtaining conventional insurance, such as the homeless. Fifty thousand uninsured Hawaiians will gain health insurance coverage under the new law. The state Department of Health will administer the program and purchase health care coverage for specific services from private health insurance contractors for individuals who qualify for, and choose to purchase the bargain coverage on a sliding-fee-scale basis. These are primarily low-income individuals who cannot participate in existing programs and do not have the means to purchase private health care insurance coverage.

Massachusetts

The Health Security Act of 1988 created one of the most comprehensive health insurance plans in the nation. The law guarantees the gradual introduction, over four years, of coverage for all residents. The legislation was designed to expand the number of businesses providing insurance to their employees. Other uninsured persons are to receive insurance through a state program administered by the new Department of Medical Security. By 1992, businesses with more than five employees will be required to pay a surcharge of 12 percent of each full-time employee's first $14,000 in wages into a health insurance trust fund, up to a maximum of $1,680 per employee.

Employers who provide health insurance can deduct those costs from the surcharge, resulting in major new costs only to employers who do not provide insurance. Although this approach is designed to comply with the federal Employee Retirement Income Security Act (ERISA) provisions, it is unclear whether it would survive a court challenge. The law also provides positive incentives for small businesses to provide insurance before the 1992 deadline. A number of insurers are in the implementation phase of the health insurance program and some 15,000 residents have gained insurance coverage from the state; most are disabled unemployed adults, disabled children, pregnant women, and people who have left welfare to take a job without insurance. However, Massachusetts is currently in the midst of a serious economic crisis that is likely to affect the universal health law. Critics worry that the state will not carry its share of the costs.

California

In the last 10 years California's uninsured population has risen approximately 60 percent to 5.2 million people. Two-thirds of the uninsured residents are either employed or dependents of someone who is employed. Two bills signed into law this fall are designed to ensure coverage to all working residents by 1992:

A task force authorized under Chapter 829 (AB 350) will report to the legislature March 1, 1990 on the statutory responsibility of employers to provide employees with insurance and changes in insurance rate-setting practices to ensure that coverage is both available and affordable.

Chapter 797 (SB 1207) expands eligibility for small business tax credits for employer-sponsored health coverage. A tax credit of up to $25 a month per employee (or 25 percent of the cost paid or incurred during a tax year by an employer to provide coverage) to firms that provide benefits equal to or better than those in the basic program. Eligible firms are those that employ 25 or fewer workers and employers will be required to pay at least 75 percent of the premiums. The tax credit will take effect in January 1992.

Oregon

In Oregon, over 400,000 people -- one out of every five living in the state -- have no health coverage. In the absence of a federally approved national health policy, Oregon arrived at the following prescription to provide access to health care for everybody:

Of the 300,000 Oregonians living below the Federal Poverty Level (FPL), only 160,000 are being served by the state Medicaid program. Chapter 836 (SB 27) revises the current state Medicaid program to expand eligibility and redesign the health care package. Eligibility would expand by allowing all residents under 100 percent FPL to have access to Medicaid benefits. Currently, eligibles include families under 58 percent FPL, pregnant women with young children up to 100 percent FPL, medically needy, and aged, blind, and disabled.

The benefit package would be redesigned by the Health Service Commission appointed to review all health services, as generally prescribed by the act, and rank them in order of most important to least important. The commission will present its recommendations to the Joint Legislative Committee on Health Care, which will make recommendations to the Emergency Board. The Emergency Board and subsequent Ways and Means Committees will appropriate funds on a per capita rate, which will determine the quality of the health care package. Revenue shortfalls will not result in reduction in eligibles or provider rates, but by reduction in the benefit package.

A tax credit program was established in 1988 to encourage small businesses, who have not previously offered health care benefits, to provide such benefits. In return, the employer receives an affordable benefit package and a tax credit of up to $25 per employee per month for as long as the employer provides the benefit. **Chapter 381 (SB 935)** attempts to provide access to health care for uninsured working Oregonians by expanding the existing tax credit program administered by the Insurance Pool Governing Board and creating incentives and rewards to employers who provide health benefits.

Chapter 838 (SB 534) addresses the problem of providing health care services to the uninsured and uninsurable and the need to spread the cost to as broad a base as possible. The measure establishes the Oregon Medical Insurance Pool Board as a state agency to supervise a medical insurance risk pool. It also appropriates $1 in million general funds to the Oregon Medical Insurance Pool Account.

Other

In New York, state health commissioner David Axelrod, MD, proposed a universal insurance coverage plan, with elements of cost control, in September of this year. The UNY•Care plan is expected to be introduced in the 1990 legislative session. In Pennsylvania, state representative Donald W. Dorr introduced a package of bills to increase the availability of health insurance and health services.

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MEDICAL INDIGENCY ProjectNotes

National Conference of State Legislatures Vol. 1, No. 2 February 1990

HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;" and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was $600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately $2,400 per person. 1990 health spending is expected to reach $661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.[1]
- Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- o Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.[2] Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.[3]
- o Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- o Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

FINANCING INSURANCE COVERAGE

> *"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace."* John C. Goodman and Gerald L. Musgrave, Freedom of Choice in Health Insurance, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- o One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- o Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- o Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- o The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- o Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- o At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- o The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- o Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

[1] Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

[2] Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in Hunger Action Forum, Vol. 2, No. 8, August 1989.

[3] Paula Braveman, MD, et al., *"Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," The Western Journal of Medicine,* 1988 December: 149: 708-11.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (HB 1034) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (1989 Georgia Laws, p. 1749, HR 162). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (1989 Indiana Acts, P.L. 327, SEA 385) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (HB 1127). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of **North Carolina** either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be $1.4 billion, but institute officials contend that the net cost would be much lower -- about $700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In **Washington** state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of $3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g, "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care, and eliminate unnecessary procedures."

> *"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do no offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs."* Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more copayments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.

FYI

For further information, contact:
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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in **Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina, and Wisconsin.** The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

MEDICAL INDIGENCY ProjectNotes

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Access Issues Continue to Command Attention

With anywhere from 31 million to 37 million Americans still without basic health insurance, "access" – the code word of the 1980s for making certain that the poor and uninsured receive health care – appears likely to remain the dominant health policy issue of the new decade.

At the federal level, the Bipartisan Commission on Comprehensive Health Care (called the Pepper Commission after its first chairman, the late Rep. Claude Pepper) weighed in with its long-awaited report. The report which spells out a detailed – and costly – plan for guaranteeing access, not only to basic health services but to long-term care services as well. But because it will almost certainly require new taxes to finance it, the plan is not considered likely to advance far, at least in this election year.

In the states, meanwhile, a wide range of bills aimed at reducing the number of uninsured are undergoing legislative scrutiny. This edition of State Health Notes summarizes proposals to establish universal access modeled after the Canadian system other "gap group" proposals that use a combination of strategies to provide health coverage; and programs targeted to employers and the working uninsured, such as tax credits and subsidies, "play-or-pay" incentives and mandated coverage for part-time workers. The next issue of the newsletter will look at the remaining access proposals, including state indigent care programs; hospital-based programs; approaches targeted to special populations; private sector plans; demonstration projects to provide coverage to low-income individuals who for one reason or another fall through the "safety net"; and work being undertaken by various task forces and study groups.

Pepper Commission Report

With respect to health care, the Pepper Commission voted 8-7 in favor of universal health care coverage for all Americans through a job-based, public system. Net new federal costs to implement the access provisions would total an estimated $23.4 billion. Some of the key features of the plan include:

- Businesses with more than 100 employees would be required to provide private insurance (for a minimum benefit package) or contribute to the public plan for all employees and non-working dependents.
- Businesses with fewer than 100 employees would be encouraged to provide insurance. Tax credits or subsidies would be available for certain small employers.
- The public plan would cover employees and dependents who contribute and non-working individuals who buy in or are subsidized. States would no longer have responsibility for providing the specified benefit package for their low-income residents. The new plan would replace Medicaid for those services, though a residual Medicaid program would remain to cover services not included in the package. State contributions equal to Medicaid expenditures for covered services (adjusted for inflation) would be maintained. States could opt to administer the public plan, subject to federal guidelines.
- The minimum benefit package includes primary and preventive care, physician and hospital care and other services. Services would be subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

With regard to long-term care, the Commission emphasized the need for home and community-based long-term care services and protection against impoverishment for people in nursing homes. Net new federal costs associated with implementing the long-term care recommendations, which were endorsed by a vote of 11-4, would be an estimated $42.8 billion. The key elements of the plan include:

- Social insurance for home and community-based care would be available to severely disabled persons of all ages.
- A nursing home program would provide an ample floor of financial protection, ensuring that no one faces impoverishment. All nursing home users would be entitled to social insurance for the first three months of nursing home care.
- The federal government would assume responsibility for financing the home and community-based program and the three-month "front-end" nursing home care; it and the states would share financial responsibility for the nursing home program.
- Development of private long-term care insurance would be encouraged to fill gaps not covered by the plan, subject to government standards and oversight.

Commissioners voting for the plan focused on the consensus around the need for universal access and coverage, reliance on the currant employer-based insurance system and the principle that no one should face impoverishment in order to get nursing home care. Said Rep. Henry Waxman (D-CA): "We have a minimum wage and therefore we ought to have a minimum health care benefit for everyone."

Commissioners opposing the plan zeroed in on the $66.2 billion price tag and the fact that the Commission was silent as to how the federal monies ought to be raised. Said Fortney (Pete) Stark (D-CA), "Without a way to pay for it, it's a non-starter; it's dead legislatively even before it's introduced." Rep. Willis Gradison (R-OH) noted that the cost translates into $750 a year in new taxes for the average taxpayer.

Universal Access Proposals

So far in 1990, the legislatures in seven states – **OHIO**, **WASHINGTON**, **FLORIDA**, **MISSOURI**, **INDIANA**, **MINNESOTA** and **ARIZONA** – have taken up universal access legislation. The **OHIO**, **WASHINGTON**, **FLORIDA** and **MISSOURI** bills are patterned after principals of the Canadian system, which promotes consumer education and responsibility as key factors in controlling costs; the availability of appropriate services to all residents, with an emphasis on preventive care; health promotion programs and quality assurance; fair reimbursement rates and the freedom of providers to choose practice settings, with incentives to participate in cost-effective managed care systems where provider shortages exist; and a global and finite health care budget.

The **OHIO**, **WASHINGTON**, **FLORIDA** and **MISSOURI** measures propose giving a single public or private administrative organization complete operational authority over the plan, including uniform budgeting, billing, payment and data systems.

WASHINGTON's plan, which was passed by the House but rejected by the Senate, would be financed through a combination of government sources (Medicaid, Medicare, public employee benefits and other sources); employer contributions based on a set per capita basis, with special consideration given to small businesses; and individual premiums based on family size, with reduced or no premiums for low-income families. Health providers would have the option of being reimbursed on a fee-for-service, global or capitated basis, but [illegible] es will be set uniformly and capitation rates will be uniform and based on the number of eligible persons enrolling in the plan. While the bill has not been adopted, sources indicate that the legislature is likely to agree to the creation of a Universal Access and Cost Containment Commission (proposed by the bill), which will examine the feasibility of a universal health plan for state residents as well as other proposals.

OHIO's plan, which is similar to **WASHINGTON**'s, sets out a broad concept of universal access and establishes a commission to determine the range of services to be provided in the basic benefit package. Individuals would be able to choose their providers; the plan would be financed through a combination of sources, including an eight percent payroll tax on employers and a one percent payroll tax on employees; a two percent tax on interest and dividends in excess of $1,000; and a 10 percent excise tax on alcohol and cigarettes. As in **WASHINGTON**, **OHIO**'s plan additionally calls for federal waivers to include Medicaid and Medicare funds. The bill, which has the apparent support of grassroots organizations, is currently being studied by the House Insurance Committee's Health Insurance Subcommittee.

Both the **FLORIDA** and **MISSOURI** plans would be financed through taxes on employers. **FLORIDA**'s bill, which is modeled after **OHIO**'s, calls for an eight percent payroll tax on employers to supplant the existing private insurance system. Under the proposal, money generated from the tax would be used to reimburse providers for their services, and providers would be prohibited from billing patients or insurance plans. All state residents would be eligible for coverage; there are an estimated 2.5 million uninsured individuals in the state. The state will hold a workshop in late April to take testimony from insurers, providers and consumers but sources say there is a high level of support in both the legislature and local communities for the bill.

In **MISSOURI**, the employer tax would be levied at a rate of 75 cents for each hour an employee works (about $2,100 per year for full-time salaried workers). Efforts are also underway to implement a personal income tax, which would be levied on a sliding scale basis. Under the legislation, the proposal would be put to a vote in the November general election.

Another **MISSOURI** bill would establish a system to provide access to health insurance for all state residents, regardless of health or economic status. Individuals with incomes below $6,000 for the last calendar year may apply for a waiver of premium payments; those with incomes of more than $6,000 will be required to pay a monthly premium of $30. Individuals who have covered medical expenses in excess of the maximum limitation of $20,000 will be eligible for increased coverage by paying a premium of $50 per month, thereby doubling their maximum coverage. The legislation includes co-payments for physician services and outpatient hospital care and sets limits on benefits for home health, outpatient care, prescription drugs, clinical laboratory services, mental health services and nursing home care. The system will be financed by increasing by one percent the tax on retail and property sales; the basic rate for sale of gas, electricity, water and telephone services; sales associated with recreation services, travel and entertainment; and vehicle registration.

Like MISSOURI, a MINNESOTA proposal would put the question of universal access up for a vote in the November election. A bill introduced in the House asks voters to amend the state's constitution to require the state to guarantee affordable health insurance for all residents. The bill stipulates that this be the first question on the ballot. Sources indicate that sufficient support for the bill is lacking in the Senate; further initiatives targeting access for children's services may be introduced later this year, however.

A bill introduced in INDIANA this year proposes to create a state-administered health plan that would provide uniform access to comprehensive care for all residents, regardless of disability or pre-existing conditions. The plan would be financed through a combination of sources, including income taxes, alcohol and tobacco taxes, a per capita employee tax on employers and other government and private funding sources. Cost containment measures built into the legislation include pre-admission certification for hospital care; discharge planning; claims data analysis; protocols for preventive care and common acute care; and spending limits for reimbursement of non-institutional providers.

An omnibus bill in ARIZONA seeks to assure essential and affordable health care to all state residents. The bill, which includes a provision that requires all employers to provide coverage for their workers, establishes an oversight commission; a state medical assurance corporation to implement the commission's policies and to provide a catastrophic and uninsurable risk pool; and a state medical fund to provide health care to uninsured, underinsured or uninsurable individuals in the state.

Other Access Proposals

In four states – NEBRASKA, WEST VIRGINIA, NEW JERSEY and RHODE ISLAND – legislation has been developed to fill in gaps in coverage for those individuals who do not qualify for public programs and do not have access to health insurance through the private sector.

The bills in both NEBRASKA and WEST VIRGINIA would assist low-income uninsured residents. NEBRASKA's "Health Insurance Access Act" would subsidize individuals and families whose family incomes are below 185 poverty of poverty and who do not qualify for Medicaid or Medicare, while WEST VIRGINIA's "Health Insurance Program Act" would help uninsured residents pay part or all of their health insurance premiums.

A measure pending in NEW JERSEY would establish a state "Group Health Insurance Plan," to be administered by the Commissioner of Insurance, to provide unemployed residents who are unable to obtain group coverage with access to insurance. The plan is intended to be self-supporting and would be rated on an expense incurred basis, with premiums adjusted annually to reflect the actual medical experience of enrollees.

Legislation in RHODE ISLAND would provide health coverage to all uninsured workers whose income is below the federal poverty level. The bill specifies services to be covered; cost containment measures such as the use of a primary care gatekeeper; pre-admission certification, concurrent utilization review and discharge planning; and employee responsibility for premium payments. The program would be financed through the state's temporary disability insurance fund; participating employees would make a contribution equal to 1.25 percent of their wages, up to a maximum wage base (defined as the annual earnings an individual needs to qualify for the maximum weekly temporary disability benefit).

Employer-Based Initiatives

Play-or-Pay Programs: A number of states have based new legislation on the "play-or-pay" scheme developed by MASSACHUSETTS in 1988. Such programs give employers the option of providing insurance coverage for their workers and generally include incentives to participate – tax credits or subsidies, for example – or pay a specified fee, which the state then uses either to subsidize coverage directly or reimburse providers for uncompensated care.

A 1990 DELAWARE bill offers an example of the approach of requiring mandatory health insurance for workers. Under the plan, employers could elect to either offer health insurance to employees and pay at least 75 percent of the premium or pay a fee of up to 50 cents for each hour that an employee worked. The money from the fees would be put into a "Medicaid Supplement Trust Fund" and used to subsidize coverage of uninsured employees with incomes below 300 percent of poverty whose employers do not participate in the state plan. Workers receiving coverage through the trust fund would be required to contribute to the premium on a sliding scale, based on their family income.

A series of bills in MISSOURI also target employer-based health coverage for uninsured workers. One bill proposes to establish an "Employers Health Insurance Purchasing Group" through which employers may provide a low-cost health insurance package to uninsured workers. The purchasing group would contract with an insurer to provide an essential benefit package to members on a managed care basis and a limited indemnity plan, including a $500 deductible and a 20 percent co-payment, not to exceed total year out-of-pocket expenditures of $1,500.

The plan excludes routine services and contains utilization review, mandatory second opinion for certain procedures and certification of medical necessity for certain services. The employee's contribution would be based upon the number of hours worked per week, with a 20 percent premium contribution for those employed for more than 34 hours per week and a 40 percent contribution for those working less than 23 hours per week. Eligible participants must have worked at least 17 1/2 hours per week for three consecutive months; dependent children under the age of two are also eligible. To encourage participation, employers that do not elect to join the purchasing group will face a tax of $100 per month per employee.

Another **MISSOURI** measure designed to give employers a strong incentive to offer their workers insurance coverage would require all companies with more than 15 employees to make a "medical security contribution" for each uninsured employee, equal to six percent of the worker's wages. Finally, a third proposal would allow employers that provide health insurance that is at least as comprehensive as the state employee's retirement system a tax credit of $25 per month for each month of coverage during the taxable year.

Small Employers: Although mandatory employer insurance plans are an intriguing option that many states are considering, one argument against them is that smaller firms are put at a disadvantage for a variety of reasons – the costs associated with overhead and administration, search and information costs, limited benefit plans offered by insurers and smaller pools for determining risk, to name a few – when they attempt to purchase insurance on the open market.

As a result, many states are trying to eliminate these inequities by targeting smaller firms for tax credits and subsidies. The states in which such legislation has been introduced include **CALIFORNIA, COLORADO, GEORGIA, KANSAS, MARYLAND, MINNESOTA, MISSOURI, NEW MEXICO, SOUTH CAROLINA** and **WASHINGTON**.

While states are using a combination of cut-off points for firm size, income thresholds, cost-sharing requirements and tax credit levels, there seems to be some consistency to the overall method. The bills introduced this year, for example, generally target firms with fewer than 25 workers, although **MARYLAND** uses 50 employees as a limit and **WASHINGTON** uses 100. The cost-sharing requirements most often stipulate that employers are responsible for paying 75 percent of premium costs and employees the remaining 25 percent, but giving employers the option of picking up more. One exception is in **COLORADO**, where the bill being considered sets cost-sharing at 70 percent for employers and 30 percent for employees.

The amount of tax credits being proposed also varies but generally ranges from $25 per month per employee or 50 percent of the total premium cost, whichever is more. Variations on this are found in **COLORADO**, which uses $25 for individuals, $65 for families or 50 percent, and in **GEORGIA**, which uses $25 or 25 percent, respectively. To encourage employers to participate as soon as possible, most states considering this approach have included a provision reducing the amount of the tax credit in subsequent years.

There are other variations as well. The legislation introduced in **COLORADO, KANSAS** and **NEW MEXICO**, for example, proposes a dual structure – one plan that is mandatory and covers catastrophic care, with additional benefit plans that employees may elect to purchase at their own expense. The **GEORGIA** bill allows employers to receive an additional credit of $5 per month per employee for providing supplemental benefits, defined as prenatal and well-baby care and mental health services. The credit is in lieu of any deduction to the which the employer may be entitled. The **WASHINGTON** bill also contains a provision that allows participating employers to deduct the entire cost of the premiums as a business expense. Currently, small businesses may only deduct 25 percent of health insurance premiums as a business expense.

Part-Time Workers: Following the lead of **VERMONT**, which last year enacted a law that mandates coverage of certain part-time workers, the **NEW HAMPSHIRE** and **WASHINGTON** legislatures are debating bills to require employers that offer group insurance to full-time workers to make similar policies available to part-time employees who would be eligible if they were working full-time.

The **NEW HAMPSHIRE** bill would apply only to firms with more than 15 employees; both states include only those employees who work at least 15 hours per week. Like **VERMONT**, neither requires the employer to pay any part of the premium; rather, cost-sharing requirements are left to the employer's discretion. – Michele Solloway and Dick Merritt

StateSide

Discussions with Health Policymakers

Intergovernmental Health Policy Project

March 1990

by Linda Demkovich

Governors' Goals: Improve Access, Cut Costs

The nation's governors are preparing to declare war on a common enemy – rising health costs – and are looking to enlist a frequent adversary – the federal government – as their leading ally.

Without controlling costs, the governors contend, there will be little hope of helping the millions of Americans who have no health insurance and who must, as a result, often forego care. And without a helping hand from the federal government, they add, both of those goals will be out of reach.

To begin the strategic planning, the National Governors' Association (NGA) last summer created a new subcommittee on health, lodged under its standing Committee on Human Resources. According to Washington Governor Booth Gardner, the subcommittee's co-chairman, the panel's mission is two-fold: to compile the record on what states have done already in the areas of access and costs and, working with the federal government, to develop options that will promote universal access and cost containment.

Gardner, a Democrat, who will take over the chairmanship of the NGA in July and who has put health issues at the top of his agenda, says the states "will be limited only by our ability to gain consensus amongst ourselves." The most divisive issue, he predicted in a recent interview, "will be who will pay." But, he added, "the driver is the fact that all of us are looking at tremendous budget increases in the area of health, if we don't do something. That's the bond that ties us together. We have got to find the ground that we can all stand on together."

The subcommittee's other co-chairman is Maine's Governor, John R. McKernan Jr., a Republican. Also serving on the panel are Governors Bill Clinton of Arkansas (D) and Edward D. DiPrete of Rhode Island (R). Ohio Governor Richard F. Celeste (D), chairman of the full Human Resources Committee, serves as an ex officio member.

Gardner and McKernan, who were in Washington, D.C. in late February to attend the NGA's winter meeting, talked with State Health Notes about the scope of the problems facing the states and about their expectations for solving those problems.

Fostering Dialogue

The opening volley in the cost war was fired last August, when 49 of the 50 governors (only New York's Governor, Mario M. Cuomo, abstained) petitioned Congress for a two-year moratorium on additional mandates requiring the states to expand Medicaid eligibility. Figures compiled by the National Association of State Budget Officers (NASBO) show that the mandates enacted between 1984 and 1988 will add $1.5 billion to state Medicaid expenditures by 1991, pushing total state spending close to the $39 billion mark.

From a strictly financial standpoint, McKernan observed, Maine has probably benefitted from the mandates, since it covers most of the options states can offer under Medicaid and has therefore reaped the matching federal funds. But, he noted, support for an incremental approach to extending coverage to the poor and uninsured had worn increasingly thin in most of the states.

"What we said was that rather than continuing to nickel and dime the issue, Congress ought to understand that this is a very serious national problem that needs to be addressed in a new way ... and that it ought to postpone any new mandates until it's done that," he said.

Although they were spared major mandates last year, the point the states were – and still are – attempting to drive home, Gardner added, "is that a lot of states are doing a lot of things in the health field, but there are others that can't get there yet." A state like North Dakota, for instance, "is just strung by its thumbs financially. To add an extra burden and force them into a situation where they can't comply [with the mandates] because of internal financial problems is unreasonable," he stressed. The federal government must "be sensitive to the financial situation of states and to acknowledge what's already been done."

With the mandate battle behind them for now, the states hope to move on to a more productive debate with Congress and the Bush Administration over ways to improve access and cut costs. What the governors want next, McKernan said, is the "beginning of a dialogue in which there is a general consensus reached by the end of this summer on the direction we ought to be going ... so that we can arrive next January at the point where the only debate is on the specifics and maybe even the technical aspects of the program, as opposed to the overall direction."

Thus far, the NGA health subcommittee has held meetings with other groups – including the Pepper Commission – that have also been looking into the access issue. Sometime in early April, the members hope to sit down with key congressional health leaders and, after that, with Administration officials, for what Gardner describes as "basically a get-acquainted session."

The reason the states have taken the lead, Gardner noted, is that they "are on the firing line as far as delivery of services. We're far more sensitive to the problems that impact on our budgets." But, he stressed, there is a growing realization on the federal government's part that "we are in this together and that the only way we're going to get an answer that is satisfactory is that we work very closely together."

Fashioning Solutions

What kind of answer would be satisfactory to the states? Gardner was circumspect, saying only that "the wider the circle gets, the more I realize what I don't know."

According to McKernan, however, a consensus seems to be emerging among the governors "that the current system is inadequate to deal with the problem, that we can't continue to tinker around the edges and think we're going to be able to fill the gaps that way [and] that a new new program is probably needed."

Any new program, he speculated, will probably "use the components that are already in place and will be employer driven, for the most part." The federal role, he added, will be to set standards for a basic minimum insurance plan, guaranteed across all states. "I don't think any of us want to tell employers and states they can't give more benefits if they want to pay for them. We have to be careful not to run the red flag of a two-tiered health system up the flagpole too soon."

On the issue of access, according to McKernan, most of the evidence suggests that the problem is not with hospitals but rather with the lack of availability of outpatient care. "That looks like the hole we really have to plug," he said, plus finding a better way of distributing the cost of the hospital care that the uninsured are currently receiving.

Gardner agrees. The demand for universal access is manifesting itself in the high cost of emergency medicine, he said. "People who are uninsured or underinsured don't get care in early stages and end up in our emergency wards and we pay for that, at a higher cost." It may be, he added, that even with the best cost containment efforts, government will have to expend more resources to ensure access, "but at least you'll be doing that on a basis where you control the growth."

Will the new subcommittee's effort to achieve a consensus on two such pressing issues succeed? Gardner said it is too soon to say. Complicating the process, he stated, is the fact that 36 governorships are up for grabs in the November elections (11 incumbents have already announced they will not seek reelection) "and anybody new is going to want to take time to study the issues." But the bottom line, he said, "is what their budget directors will be telling them."

In Washington State, for instance, health costs currently represent from 12-14 percent of the state's total budget (Medicaid and employee health insurance); by the year 2000, Gardner said, "we're looking at 23-24 percent." Those figures coincide with NASBO figures, which show that on average, Medicaid costs accounted for 13 percent of total state budgets in 1989 and that by 1994 – without any new expansions – they will reach 17 percent.

Designing and implementing a plan of national scope may be difficult, McKernan conceded. "That's the reason the states are the crucibles, designing new policy on pressing issues facing the country. But at some point, you have to decide whether the problem is so big that you have to take the best of the state models and craft an appropriate national model." In McKernan's view, that point has now been reached.

Added Gardner: "I think the awareness and the need for cost containment and better access are becoming more and more clear. And the only way we can get there is for the states and the federal government to work together," he stressed again. "We have to begin to act."

StateSide ... Discussions with Health Policymakers is a periodic feature of State Health Notes. Both publications are supported by Contract # 500-86-0009 from the Office of Intergovernmental Affairs, Health Care Financing Administration. The views and opinions expressed in these publications belong to the authors and those who are interviewed and should not be construed as representing the thinking and policies of the Health Care Financing Administration.

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Medicaid Mandates and Fiscal Federalism

By Tony Hutchison

Due in part to the National Conference of State Legislatures' role in promoting a compromise with congressional advocates of extensive mandated expansions in the Medicaid program, the states have temporarily avoided a series of budget shocks set to take effect by 1991.

The compromise included reducing a proposed Medicaid eligibility level from 185 percent of poverty to 133 percent, with the proviso that states cover pregnant women and infants and children up to age six who fall under the new income guidelines. The compromise also extended Medicaid coverage to several other health services.

These changes will still cost states money but not nearly as much as the earlier congressional proposals would have. This article examines the potential impact of all the proposals for expanded Medicaid mandates that Congress seriously considered in 1989. States have not heard the last of these specific proposals: Their proponents see them as a major building block of a national health policy. Even more important, this debate over Medicaid programs is a debate over fiscal federalism as well. It raises the fundamental but rarely addressed issue of whether states should continue to decide health policy for themselves in line with their fiscal abilities and policy preferences. State analysts should be concerned that the congressional debate overlooked the states' ability to pay for expanded programs, as well as differences among the fiscal conditions of the states.

The mandates being debated included the 1991 costs of welfare reform, Medicare catastrophic coverage, nursing home reform, and improved programs for pregnant women, children, the mentally retarded or developmentally disabled, and the frail and elderly, designed to reach millions of poor citizens across the United States.

While not many opponents of the mandates would argue with the need for additional medical care for the poor, particularly for children and pregnant women, policymakers at the state level opposed the Medicaid expansions as another unfunded mandate imposed by the federal government. Opponents further argued that many states would not be able to afford the mandates without raising taxes or cutting back in other important areas of state funding. Proponents argued, however, that the states have the financial resources to fund the expansions if they were willing to make the effort and should therefore be required to take on this responsibility because of national needs.

Could states have afforded the proposed mandates? By analyzing state Medicaid spending on both a national aggregate basis and on a state-by-state basis, it is possible to develop some indicators of how the proposed Medicaid expansions would have affected state budgets. This study of the question uses estimated state costs prepared by the Congressional Budget Office and the National Association of State Budget Officers (NASBO). The analysis applies only to the 29 states for which NASBO prepared cost estimates.

Proposed Expansions as a Percent of Current Medicaid Spending

The proposed expansions would, on average, increase state Medicaid spending by 12 percent (see Table 1 on page 2). There would be wide variations from this average. In Alabama the expansions would have resulted in a 50 percent increase in that state's FY89 Medicaid expenditures. On the other

(continued on page 2)

Tony Hutchison is a senior fiscal policy specialist for NCSL in Denver.

Table of Contents

Features

Departments

National Conference of State Legislatures .... William T. Pound, Executive Director

Medicaid (continued)

hand, Minnesota's increase would have been only 0.3 percent of FY89 Medicaid spending.

This variation is due almost entirely to current state administrative and policy choices about the Medicaid program and who and what services it will cover. States that have chosen to limit eligibility and constrain the number of services offered through Medicaid would have had the hardest fiscal hit from the mandated expansions. States that have elected to participate in optional Medicaid programs (the medically needy program for example) would have suffered fewer budget consequences as a result of the mandates.

In many cases it is the poorer states that would have felt the biggest budget hit from the Medicaid expansions. Proponents of the mandated expansions tend to view these states as those most likely to have citizens in need of increased services. Of course, these states are also less likely to have the budgetary resources to fund their share of the mandates.

Medicaid Spending as a Percent of General Fund Spending

Currently state Medicaid spending takes about 8 percent of state general funds a year. Without the proposed expansions, Medicaid would probably grow to about 9 percent by 1991. If all the expanded mandates were to take effect for 1991, the percentage would jump to 10.7 percent. There would again be wide variations among the states. Michigan would spend the equivalent of 18.2 percent of its general fund on Medicaid, while South Carolina would spend 4.3 percent of its general fund on Medicaid.

Were the Mandated Expansions Affordable?

Many of the states that would have experienced large increases in their state spending for Medicaid due to the proposed expansions are currently spending significantly below the national average for Medicaid. Although Utah and South Carolina would both experience 22 percent increases in Medicaid spending, both still would be spending only slightly more than 4 percent of their general fund on Medicaid. This is significantly below the national average of 10.7 percent.

Of the 13 states that would experience

(concluded on page 11)

TABLE 1

Medicaid Expansion as a Percent of State Medicaid Expenditures in 1991 (estimated)

State	Percent	State	Percent
New England		**Southeast**	
Connecticut	0%	Alabama	50%
Maine	6	Arkansas	19
Massachusetts	NA	Florida	2
New Hampshire	NA	Georgia	9
Rhode Island	NA	Kentucky	5
Vermont	3	Louisiana	NA
		Mississippi	6
Mid-Atlantic		North Carolina	12
Delaware	NA	South Carolina	22
District of Columbia	2	Tennessee	NA
Maryland	7	Virginia	24
New Jersey	NA	West Virginia	18
New York	2		
Pennsylvania	8	**Southwest**	
		Arizona	NA
Great Lakes		New Mexico	7
Illinois	13	Oklahoma	18
Indiana	NA	Texas	NA
Michigan	8		
Ohio	14	**Rocky Mountain**	
Wisconsin	NA	Colorado	NA
		Idaho	22
Plains		Montana	15
Iowa	17	Utah	22
Kansas	12	Wyoming	23
Minnesota	0		
Missouri	18	**Far West**	
Nebraska	7	Alaska	NA
North Dakota	NA	California	4
South Dakota	17	Hawaii	5
		Nevada	NA
Puerto Rico	NA	Oregon	10
		Washington	10
U.S. Total	7%	**Average of State Percentages**	**12%**

NA - Not available

Source: National Association of State Budget Officers and National Conference of State Legislatures.

Calendar of Upcoming Meetings

AOL to Meet April 19-21 in Boise, Idaho

The Assembly on the Legislature is scheduled to meet **April 19-21 in Boise, Idaho.** The 11 AOL committees and four task forces will convene to discuss a wide variety of issues of interest to state legislators and legislative staff.

The AOL serves as a major forum for the exchange of ideas and information among state legislatures. It allows each legislature to benefit from the experiences of other states in shaping public policy, experimenting with new laws, and managing the legislative institution.

Among the standing committees meeting in Boise are the Fiscal Affairs and Oversight Committee and the State-Local Relations Committee. These committees examine issues that are of interest to readers of *The Fiscal Letter*. For Boise, the tentative agendas for these committees are:

Fiscal Affairs and Oversight Committee –
- Forging an Effective Public-Private Partnership;
- Higher Education Finance and Accountability;
- Fiscal Implications of Demographic Changes; and
- Workers Compensation: An Idaho Case Study.

State-Local Relations Committee –
- The Cost of Deferred Maintenance;
- Rural Economic Development;
- Legislative Planning in Intergovernmental Relations; and
- What's New in State-Local Relations.

In addition to meeting in Boise, the AOL will meet in conjunction with NCSL's **Annual Meeting in Nashville (August 14) and in Chicago (November 8-10).**

For more information regarding the Fiscal Affairs and Oversight Committee contact Corina Eckl; for more information about the State-Local Relations Committee contact Martha Fabricius at (303)623-7800.

NALFO to Meet in Boise

All members of the National Association of Legislative Fiscal Officers are invited to attend a NALFO/NCSL Annual Meeting planning session on **April 19 in Boise, Idaho**, during the spring Assembly on the Legislature. Session topics, time slots, and the time and logistics for the annual business meeting in Nashville in August will be discussed. There will also be a demonstration of Idaho's new computer network that allows fiscal staff to communicate with committee members' computer monitors during committee meetings.

Details of the NALFO meeting can be obtained from Tony Hutchison at (303)623-7800.

"Beyond Welfare" is Theme of May Conference in Washington, D.C.

NCSL will sponsor a major conference on policies that could eventually replace welfare. The conference, **May 16-17 in Washington, D.C.**, will focus on state innovations aimed at reducing poverty and dependency. It will highlight such promising ideas as the earned income tax credit, reform of child support, health care, child care, and job training.

Speakers will be experts who are in the forefront of these important policy innovations, including David Ellwood (Harvard University), Judith Gueron (Manpower Demonstrations Research Corporation), Robert Greenstein (Center on Budget and Policy Priorities), Larry Bartlett (Health Systems Research, Inc.), and David Riemer (City of Milwaukee).

Further details will be available from Steven Gold or Tony Hutchison at (303)623-7800. ■

Medicaid (conclusion)

greater than 12 percent increases (the national average) in their Medicaid programs, only three states (Illinois, Ohio and Oklahoma) are currently spending more than the national average. For the 10 states with below average Medicaid expenditures, proponents of expansion can continue to argue that budget effort, not affordability, is the key issue.

But with the average state budget reserve standing at 4.5 percent in mid-1989 (below the recommended level of 5 percent), few states were in a position to fund expensive expansions. In the 10 states that spend below the national average on Medicaid as a percent of their general budget (Alabama, Arkansas, Iowa, Missouri, Montana, South Carolina, South Dakota, Vermont, Virginia, and Wyoming) the average surplus was 4.2 percent, including a healthy 17.1 percent reserve in Montana. Without Montana the average would be 2.8 percent. Of the ten states spending below the national average on Medicaid, only Virginia has a per capita income above the national average. In general, the states that would be hit hardest by the mandated expansions would be the states least able to afford it.

Nor is it reasonable to expect all states to be able to absorb the Medicaid budget increases that would have been forced on them, ranging from 12.6 percent (the national average) to 49.5 percent increase (the high in Alabama). Arkansas' 1991 bill for Medicaid for the proposed mandates was $29.5 million, or roughly equivalent to 60 percent of that state's entire corrections budget, an area of state expenditure growing at an even faster rate than Medicaid. In the state of Virginia, the proposed mandates would have cost 6.5 percent of that state's K-12 education budget and 13 percent of its higher education budget.

Conclusion

While an improved national health policy makes good sense, it makes no sense for Congress to mandate one that states cannot afford. Policies that were adopted by the U.S. House of Representatives in 1989, attractive as their beneficial effects would have been, could have completely disrupted budget policies in a number of states. The policy of using unfunded federal mandates to express national policy holds disastrous potential for the states. The desirability of a policy should not be allowed to hide the question of who pays, or state budgets will collapse into chaos just like the federal government has. ■

sections

The

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Original Articles

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Contact Extended Programs in Med. Educ., Univ. of California, Rm. C-124, San Francisco, CA 94143-0742; or call (415) 476-4151.

UNIVERSITY OF LOUISVILLE–OPHTHALMOLOGY

The "18th C. Dwight Townes Seminar" will be held in Louisville, Ky., on March 24.

Contact Nancy Rodman, 301 E. Muhammad Ali Blvd., Louisville, KY 40202; or call (502) 588-5466.

MOUNT SINAI SCHOOL OF MEDICINE

A course, entitled "Modern Management of Malignant Melanoma," will be held in New York on March 24.

Contact Virginia Harrison, Post-Grad. School, Box 1193, Mount Sinai School of Med., 1 Gustave Levy Pl., New York, NY 10021; or call (212) 241-6737.

INTERVENTIONAL RADIOLOGY

The 15th annual meeting will take place in Miami Beach, Fla., March 26–29.

Contact Soc. of Cardiovascular and Interventional Radiology, 1891 Preston White Dr., Reston, VA 22091; or call (703) 648-8953.

TEMPORAL BONE DISSECTION

The course will be offered in New York, March 26–30.

Contact New York Univ. Medical Center, Post-Grad. Medical School, 550 First Ave., New York, NY 10016; or call (212) 340-5295.

HEALTH POLICY REPORT

CANADA'S HEALTH CARE SYSTEM FACES ITS PROBLEMS

JOHN K. IGLEHART

CANADA'S provincial health insurance plans have demonstrated an impressive capacity to operate successfully despite a basic policy conflict that says health care funding must be public and universal, physicians must retain their professional autonomy, consumers must have free choice of doctors and first-dollar coverage, and provincial governments must control their budgets. But now provinces are finding it increasingly difficult to maintain this equation, because a variety of factors are perturbing its balance. In the face of a large budget deficit, the national government continues to reduce its financial commitment to the plans, patients and practitioners are demanding better access to the latest forms of medical technology, the supply of physicians continues to increase at a rate outstripping the growth of the population, and doctors are restive as provinces work more aggressively to stem the rise in health expenditures.

Among industrialized nations, such conflicts are certainly not unique. Indeed, every major Western country grapples with similar issues to one degree or another. But when tax-financed programs in most nations are stretched to the limit, their stewards usually turn to private funding for relief. What is unique to Canada is the virtual absence of private-sector involvement in health insurance and the unwillingness of policy makers to encourage the development of such alternatives, which could ease the financial pressure on the provincial health plans. These plans account for 75 percent of the nation's total expenditure for medical care, which amounted to $50.4 billion (Canadian) in 1988, or 8.7 percent of the gross domestic product. The remainder of the health expenditure purchases services not covered by the plans, such as outpatient prescription drugs, dental care, cosmetic surgery, optometry, and physiotherapy.

Canada designed its provincial health insurance plans this way because of a strong belief that all citizens should have equal access to medical care, regardless of ability to pay. In essence, Canadian policy says that simply because people can afford to pay, they should not be able to purchase care that is better or more readily available than that available to the less well off. Canada has further discouraged private payment by requiring physicians who bill patients directly to leave the provincial health insurance plans altogether. As a result, such doctors are few.

Canada's refusal to allow private health insurance to be sold, except for incidental items not covered by the provincial plans, arises from "deep-rooted suspicion of class-based systems of any kind," economist Robert G. Evans wrote recently.[1] Private schools are only a small part of Canada's educational system before college, private universities do not exist, and in public transportation only a single class of travel is usually available, except in some air and train travel. As Evans put it, "equality before the health care system" in Canada is a political principle similar to equality before the law.

This policy contrasts markedly with the method by which the bulk of care is financed in the pluralistic system of the United States and is contrary to the direction in which the socialized health schemes of Sweden and the United Kingdom are moving. Most U.S. policy makers and representatives of private-sector interests believe that except in the case of poor people, consumers should be directly responsible for a portion of the cost of care. The board of trustees of the American Medical Association (AMA), in a 1989 report to its House of Delegates about Canadian health care, characterized the absence of a direct economic link between payer and patient in the provincial health plans as "a structural defect which leads directly to an excessive demand for services, and will be a growing source of conflict between government and consumers."[2]

Whether Canada, faced with a budget deficit, general opposition to higher taxes, and real resistance to reducing the scope of covered medical benefits, can maintain a health care policy that relies on public expenditures and strongly discourages the infusion of private resources is a question asked more frequently there. At this point there is certainly no clamor for major change among private corporations; they seem well satisfied with letting government finance the bulk of medical care and limiting their involvement to paying for part of it through taxation.[3] The Progressive Conservative government of Prime Minister Brian Mulroney has shown no disposition to propose that Canadian medical care be made more readily available through private alternatives, but in other spheres of the economy it has demonstrated a philosophical preference for private investment. For example, 18 crown corporations have been privatized since Mulroney assumed office in 1984. Thus far, Canada has been able to finance its system of universal access to health care by constraining medical expenditures in various ways, as Evans outlined recently in the *Journal*: keeping its insurance overhead low through the administrative simplicity of its provincial plans, controlling payments to physicians and hospitals through negotiated fees and global budgets, and restraining the diffusion of forms of technology.[4]

In this report, I cover some of the major issues that are enlivening Canada's health care debate, particularly as they apply to Ontario, which is the most populous province (with 9 million residents), the seat of the nation's capital (Ottawa), and the place where the largest number of physicians practice (about 40 percent). For a variety of reasons, conflict between provincial governments and organized medicine is more pronounced in Ontario, British Columbia, and Quebec than in the seven other provinces. As I have pointed out elsewhere,[2] some American health policy makers have become fascinated with Canada's ability to balance a host of conflicting interests and objectives on behalf of the provision of medical care to its entire population. These cross-national pursuits are not necessarily welcomed by many physicians in either country. The AMA has made it clear that philosophically, Canada's model is repugnant to its leadership and probably most of its members. Dr. David K. Peachey, director of professional affairs of the Ontario Medical Association, provided a Canadian perspective on the subject in a speech last October to the Roanoke (Va.) Academy of Medicine: "The managed care component of American medicine is being held like a Damocles' sword over the heads of Canadian physicians, while our universal health insurance is held like a Damocles' sword over you."

The Principles of Canadian Health Insurance

Canada's debate has not prompted many second thoughts about the basic conditions that Parliament established in 1965 when it created the framework of the provincial health insurance plans. To qualify for federal support, the plans must provide universal access to care with equal terms and conditions for all, cover all medically necessary services as determined by physicians, provide portable benefits (those that are in effect throughout the country), and be publicly administered on a nonprofit basis. The insured services of physicians include all medically required services rendered by licensed practitioners in hospitals, clinics, and doctors' offices. The insured services of hospitals include all inpatient services provided at the standard ward level, unless private or semiprivate accommodation is considered medically necessary, and all necessary drugs, biologic products, supplies, and diagnostic tests, as well as a broad range of outpatient services. The services of psychiatrists and mental hospitals are fully covered. There are no upper limits to the provision of care, as long as it is deemed medically necessary.

Despite Canada's universal coverage, the life expectancy of its citizens continues to vary according to income, although the disparity has decreased over the past 15 years. All industrialized countries report a similar phenomenon, underscoring the fact that life expectancy is derived from a variety of factors, including wealth, lifestyle, social policy, and access to medical care. In 1971, the difference in life expectancy at birth between earners of the highest and lowest incomes in Canada was 6.3 years for men, and 2.8 years for women. By 1986, according to a new study produced by the government, these differences had decreased to 5.6 years for men and 1.9 years for women.[5]

In sharp contrast to the United States, where the federal government holds far more authority over the financing of medical care than the states, Canadian health care is dominated by the provinces. The provincial medical associations are more influential than the Canadian Medical Association. In both domains, governmental and professional, the provincial entities strive to guard their prerogatives. The provinces have a broad constitutional authority to tax their citizens and private corporations. In consequence, they spend more in total tax revenues than the national government. Increasingly, the proportion (ranging from one fifth to one third) of tax revenues expended by the provinces is consumed by the provincial health insurance plans.

When Parliament established the conditions for the financing of Canadian medical care, government prohibited private insurers from paying for care already covered by the provincial plans. Thus, all funding for covered services flows through the provincial plans, which wield their monopsony powers (power of one buyer) to constrain expenditures. In this regard, the contrast with the United States is obvious, but as Evans recently pointed out, the comparison with the United Kingdom is more instructive.[1] The British National Health Service (NHS) is a public program, funded from tax revenue, and accessible to all. But if they so choose, people can seek care from a private system, to which about 8 percent of England's citizens have access — usually through their employers — as a way to avoid queues and receive care provided with more amenities.

In most Canadian provinces, it is not prohibited for patients to pay privately for medical or hospital care. What is prohibited is for physicians or hospitals to treat both patients whose care is financed by the provincial plans and patients who pay directly, as is the case in Britain. Evans views this prohibition as a critically important constraint. He writes:

> The British private consultant can use his dual role to select and steer patients according to their resources and the nature of their problems. He can even use his position within the NHS to manipulate waiting lists and other aspects of access so as to ensure that private care will be preferable to those who can afford it. The Canadian physician who decides to "go private" must go all the way. He cannot use a strategic position within the public system to cream off only the profitable patients for his private services.[1]

Canada's capacity to protect all its citizens against the economic consequences of illness at a cost that is socially acceptable has been widely admired, but its resistance to private funding makes it an exception in the Western world. Even in Sweden, a generous welfare state and one of the world's most highly taxed nations, the governing Social Democrats are promoting health care alternatives in the private sector and lower taxes. Kjell-Olof Feldt, Sweden's minister of finance and a leading advocate of private-sector alternatives to the nation's welfare state, said recently: "The squeeze in funds for the public sector has forced people to think in new ways."[6]

At both the national and the provincial levels, Canada's medical associations have been cautious in advocating multiple-source funding out of concern that such a stance would be seen more as promoting their members' self-interest than as bringing financial relief to the stressed provincial plans. One outspoken physician, Dr. John O'Brien-Bell, did express this view in 1989 in his farewell speech as president of the Canadian Medical Association. He said, "In a country that now spends 35 cents of every [tax] dollar servicing its debt, we have to ask ourselves whether we can maintain our high standards of health care without any involvement from the private sector." O'Brien-Bell suggested that an infusion of private resources would allow the provinces to raise "sorely needed" revenues to finance the strong patient demand for service.

CANADA'S STRUGGLE OVER CONFLICTING IMPERATIVES

As I suggested at the outset, Canada's provincial health insurance plans face an increasing financial struggle because of the conflicting imperatives built into them at their creation. One source of tension is the moderation of support for the plans from the national government. As medical costs escalated in the 1970s, Ottawa concluded that it would have to abandon its practice of making an open-ended financial contribution to the plans. The original formula by which the provinces were encouraged to create their plans was based on an agreement that no matter how rapidly medical expenditures grew, Ottawa and the provinces would share the costs equally. This formula was incorporated into the Hospital Insurance and Diagnostic Services Act of 1957 and again in the Medical Care Act of 1971 — the original federal laws on which the provincial plans were based.

Since 1977, through the enactment of the Federal–Provincial Fiscal Arrangements and Established Programs Act, the provincial governments have been placed at higher risk for increases in the cost of medical care. This change came about because the 1977 law linked the annual increase in the federal contribution to the provincial health insurance plans to the growth of the gross national product, leaving the provinces to absorb more of the health care costs when the aggregate outlays for health grew faster than the economy as a whole; health costs have increased more rapidly than the growth of Canada's economy in 8 of the past 13 years.

In 1986 and again in 1989, as Mulroney's government has sought to reduce an annual budget deficit of $30.5 billion (Canadian) on federal tax revenues of $112.4 billion, the Progressive Conservatives have altered the formula for the federal transfer of funds in ways that reduce the growth of Ottawa's contribution to the provincial plans (as well as to the costs of post-secondary education). Instead of a transfer formula based on the growth rate of a three-year running average of the gross national product, the formula is now based on this same prescription minus 3 percentage points of the gross national product. In the years 1987, 1988, and 1989, Canada's gross national product grew at rates of 9.4 percent, 9.2 percent, and 7.1 percent, respectively. The 3 percentage point reduction may seem small, but its cumulative effect on the provincial health budgets will amount to billions of dollars by the early 1990s.

To illustrate, data from Health and Welfare Canada show that Ottawa provided 44.6 percent of the total revenues of $14.1 billion expended by the provincial health insurance plans in fiscal 1979 and 1980. A decade later, Health and Welfare Canada estimates that the provincial plans will spend $39.2 billion in 1989 and 1990, only 36.7 percent of which will have been provided by the national government. In future years, officials in Ottawa anticipate that federal transfers, as a proportion of provincial health expenditures, will drop to percentages in the low 30s, although the precise projections are kept confidential. This trend, buried in the minutiae of federal–provincial transfer payments, has provoked little opposition from the provincial governments or the medical profession, although it is certain to intensify pressures on the health insurance plans.

One of the interesting aspects of Canadian health care is that the public is remarkably uninvolved in the ongoing struggles over resource allocation that pit the provincial governments against providers of care. An official of the Ontario Medical Association characterized this conflict as "tuxedo warfare," and with good reason. As political scientists would say, it engages the "elite" interest of government and medicine. Except for the occasional consumer who encounters an obstacle in obtaining access to care, the average citizen is not concerned about allocations of medical resources because government has insulated citizens time and again from worrying about the rising cost of care. Although Canadians pay the bill through general taxation (and in addition residents of Alberta and British Columbia pay legislated monthly premiums), the relation between the financing of care and the citizens to whom it is delivered is not tightly drawn, because patients do not pay at the point of service. Effective January 1, Ontario's provincial government abolished monthly premiums, which had been paid in roughly equal amounts by workers and employers, in favor of a payroll tax strictly on employers. In so doing it reinforced its policy that all possible obstacles to access should be removed. The income from premiums totaled about 13 percent of the current annual expenditure of $13.9 billion by the Ontario plan. One consequence of the overriding preference of policy makers to insulate consumers from paying for care directly is that the level of public support for the provincial plans remains very high. For example, a survey conducted in December 1987 for the Ontario Medical Association of attitudes toward the health care system in Ontario found that the vast majority of people (87 percent) were "very" (39 percent) or "somewhat" (48 percent) satisfied.

The outstanding recent example of government's commitment to safeguard unlimited access by patients to medical care came in 1984, when Parliament unanimously approved the Canada Health Act. In essence, this measure forced the provinces to ban the practice of extra billing by physicians (the charging of fees to patients in excess of those allowed by the provincial benefit schedule) and the practice of hospitals' charging fees directly to inpatients. Over the strong opposition of organized medicine, every province enacted legislation implementing the ban, because a failure to do so would have meant the loss of federal grants, dollar for dollar, in proportion to the amount of extra billing and user fees imposed on patients by providers. In Ontario, the provincial legislature's action provoked the longest strike by physicians in the nation's history — 25 days — and ruptured relations between the provincial government and the Ontario Medical Association, which characterized the new policy as a "mortal attack on our professional freedom." The passions stirred by the strike were not altogether matched by the actions of the province's physicians; most continued to treat their patients, as data compiled by the provincial plan show. The numbers of bills submitted to the plan by physicians during the strike (from June 12 through July 6, 1986), expressed as a percentage of the average billing for each day of the week from May 1 through July 31, were: Sunday, 93.5 percent; Monday, 69.0 percent; Tuesday, 76.1 percent; Wednesday, 82.0 percent; Thursday, 82.4 percent; Friday, 80.1 percent; and Saturday, 88.1 percent.

CONSTRAINING THE DIFFUSION OF MEDICAL TECHNOLOGY

An important feature of Canada's approach to hospital budgeting is the separation of operating expenses and capital spending. Every year, Canada's 1243 hospitals (all but 9 of which are nonprofit institutions) must negotiate their annual operating budgets with the provincial government. They must apply separately for the approval and funding of new capital acquisitions. Thus, the provincial ministries have two major levers with which to control hospital growth. In some instances, hospitals raise private funds for new technological services through contributions from the community and philanthropic donors, but if an acquisition has not previously been approved by the government, the provincial plans often deny the necessary operating funds.

Through this process, the provincial plans have successfully contained the growth of hospital resources, including labor, supplies, and equipment. In three separate studies, Detsky and colleagues have documented the success of this strategy as applied by the Ontario Health Insurance Plan.[7-9] A central feature of the strategy, used by all the provincial plans, is to distribute forms of medical technology according to region in a fashion that compels physicians to judge carefully which patients would profit from their use. Virtually all the most sophisticated forms of technology are diffused in teaching hospitals only. One consequence of this effort to restrain the use of modern techniques is that such techniques are far less available in Canada than in the United States. For example, a recent study by Rublee showed that in comparison with the Federal Republic of Germany and the United States, Canada has appreciably slowed the diffusion of six major forms of technology: open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extracorporeal shock-wave lithotripsy, and magnetic resonance imaging (MRI).[10] Key comparisons between Canada and the United States reveal that there are nearly eight times more MRI and radiation-therapy units per capita in the United States, more than six times as many lithotripsy centers, roughly three times as many cardiac catheterization and open-heart surgery units, and slightly more organ transplantation units. Rublee, a researcher affiliated with the AMA, conceded that "the differences in levels of major technology, in themselves, indicate little about the overall effectiveness, achievements, and weaknesses of the health care systems of any of the three countries studied."[10]

For the visitor to Canada, the growing conflict over the availability of technology is most readily seen in the newspaper articles and televised news accounts that report obstacles to the system's vaunted access to care, usually in a hospital setting. As the provincial plans restrain the use of technology, physicians increasingly face the difficult choice of providing care on the basis of medical need rather than rendering it to all who could benefit. Some forms of technology are more valuable than others, as is the case in all countries, but most have not been subjected to clinical trials. Recognizing the need for more information, in early December the federal, provincial, and territorial health ministers announced the creation of a Canadian Coordinating Office for Health Technology Assessment.

The prime illustration of the problems provincial plans and providers are encountering in their efforts to match available resources with an effective system of triaging patients was provided by the case of Charles Coleman, a 63-year-old man who died shortly after a heart operation in a Toronto hospital. Coleman's operation had been postponed 11 times. *Maclean's*, a Canadian weekly magazine, ran a cover story[11] about the case that provoked the Ontario Health Insurance Plan to investigate the cardiac-surgery program at St. Michael's Hospital in Toronto.

The three investigators identified various problems at St. Michael's and eight other Ontario teaching hospitals that offer adult cardiac-surgery programs for the province's 9 million citizens.[12] The team found a substantial increase in the length of the waiting lists and of the wait for cardiac surgery at St. Michael's; the number of patients waiting had increased from 38 in 1984 to 232 by 1989, and the wait had increased from two to three weeks to three to five months. These trends were consistent with conditions in other Toronto-area hospitals; in the same period, the total number of patients waiting increased from 356 in 1984 to 848 by 1989, and the length of the wait increased from two to three weeks to three to nine months. Although the waiting lists have grown, the number of cardiovascular surgical procedures performed at St. Michael's and some of the other hospitals began to decline in 1986. The number of cardiac surgeons performing operations has remained about the same.

A number of problems combined to lengthen the waiting lists and times and reduce the total number of cases that could be accommodated, the investigators found. An older patient population (the average age increased from 51 to 61 over the past decade) requiring longer hospitalizations was having cardiac operations and staying longer in the intensive care unit; a pronounced shortage of nurses trained in cardiac care forced a closure of beds in the cardiovascular ward, which in turn reduced the number of planned discharges from intensive care; and new methods of treating patients who have had heart attacks increased the number of patients requiring cardiac catheterization and ultimately cardiac surgery. Dr. Martin Barkin, the deputy minister of health, commented in an interview:

> We clearly did fall behind on cardiovascular surgery, and we're now quickly moving to bring that back up to standard. But that was not a deliberate withholding of funding because we wanted to have a queue there, it's because we couldn't respond fast enough to certain changes in practice patterns.[13]

Barkin's comment points up one aspect of a planned health care system. Although it has a greater capacity at first for rational allocation of resources, its strictly planned nature inhibits needed adjustments as circumstances change. Since the circumstances of Coleman's death triggered action, Ontario's health ministry has appointed a coordinator of cardiovascular services for the province, approved additional funding to expand the capacity of St. Michael's Hospital, and created Toronto's fourth cardiovascular-surgery unit as Sunnybrook Medical Centre — a project that had been planned for almost a decade. But these actions have not alleviated the problem totally. The head of St. Michael's cardiovascular division, Dr. Tom Salerno, put it simply in a recent telephone interview: "In reality, we are still going through a lot of hardship."

Because of the problems Canadians have had in gaining rapid access to some services (cardiac care, lithotripsy, radiotherapy, and renal dialysis), there has been an assumption, reinforced by news coverage, that patients in increasing numbers are turning for treatment to American medical facilities across the border. These reports were discussed last summer by the Pepper Commission in a meeting partly devoted to a review of Canadian health care. Representative Willis D. Gradison, Jr. (R-Ohio), asked the committee's staff members to investigate the reports. They surveyed 10 institutions — Buffalo General Hospital, the Cleveland Clinic, the Detroit Medical Center, Henry Ford Hospital, Johns Hopkins Medical Center, Massachusetts General Hospital, the Mayo Clinic, the Memorial Sloan–Kettering Cancer Center, the University of Rochester Medical Center, and the University of Washington Medical Center. Only two of the institutions provided evidence that they had treated a substantial number of Canadians. Buffalo General reported that 3 percent of its patients were Canadian and that 50 of the 100 patients receiving monthly lithotripsy treatments were doing so under a formal agreement with the province of Ontario. The University of Washington Medical Center reported that 125 of the 250 in vitro fertilization procedures it performed annually involved Canadians, who paid about $5,000 out of pocket for each procedure. On the basis of these findings, the commission's staff reported to Gradison on August 10 that there was "no evidence that substantial numbers of Canadians are seeking care at American medical centers." In the vast number of cases, Canadians normally travel only to medical institutions adjacent to the border for treatment, so the survey was somewhat skewed because of the inclusion of hospitals located farther away. More recently, patients in western Ontario who have needed cardiac surgery have been sent to St. John's Hospital in Detroit under an agreement initiated by physicians in Windsor, Ontario, and accepted by the provincial health insurance plan.

Supply and Incomes of Physicians

In 1986, I noted that most Western nations have a common problem of public policy: they are training more physicians than they seem prepared to accommodate, but few have decided how many physicians are enough.[14] That is certainly the case in Canada, where neither the federal nor the provincial government, organized medicine, nor the Association of Canadian Medical Colleges has adopted a definitive policy on the matter. In its most recent comment on the subject, in 1989, the Canadian Medical Association declared cautiously that it was "committed to working with governments, the medical profession, hospital associations and other parties" to strike "the best balance of physician resources to realize the objective of improving health status."[15]

The pool of Canadian physicians has grown faster than the population every year since 1965, and medicine remains an attractive profession despite the problems doctors encounter. The number of physicians leaving Canada each year, presumably to practice elsewhere, has decreased from 663 in 1978 to 386 in 1985; more stringent U.S. immigration policies may influence this trend. For each of the 1759 first-year positions filled by students in Canada's 16 medical schools in the academic year 1988–1989, there was an average of four applicants, as compared with a ratio of 1:1.6 in the United States. Eva Ryten, director of the Office of Research and Information Services of the Association of Canadian Medical Colleges, said in an interview: "On average, we have a more able applicant pool today than we had a decade ago. So medical schools are rejecting more highly qualified applicants now." There were 7124 medical school students (44.4 percent of whom were women) enrolled in Canadian universities in 1988–1989, as compared with 7492 in the peak year of 1982–1983. The total number of postdoctoral residency training positions in Canadian teaching hospitals has remained largely stable (7621 in 1989, as compared with 7633 in 1985 and 6870 in 1981), although more positions (an increase from 625 in 1981 to 1262 in 1989) are being funded by sources other than the health ministries (internal funds of the medical faculties, foreign governments, charitable foundations, and organizations established to combat a single disease), particularly in Ontario. This development saves the health ministries some money, but it does not alter the number of new doctors being produced.

As of December 1988, there were 49,706 active civilian physicians, excluding interns and residents, as compared with 35,432 a decade earlier and 25,656 in 1970. The population per practicing physician has declined over this period, from 837 in 1970 to 525 in December 1988; it ranges from a high of 766 people per physician in New Brunswick to a low of 490 in British Columbia and Quebec. In sharp contrast to the United States, where the number of primary care physicians is dwindling in proportion to the total supply, general and family practitioners represent 52.5 percent of all doctors in Canada; in most of Canada's urban areas, the demand for general practitioners is saturated. The medical specialties generally deemed to be in short supply are general surgery, psychiatry, medical and radiation oncology, and neonatology and the other pediatric subspecialties. In 1987, 16.8 percent of all practicing Canadian physicians were women. The rapidly increasing numbers of women will influence the availability of care, because in that same year male generalist physicians reported working 49.1 hours per week, and their female counterparts 38.6 hours. Male medical specialists reported working 50.1 hours per week in 1987, and their female counterparts 43.6 hours.

There are various reasons that medicine remains, on balance, an attractive profession in Canada. One is that physicians are held in high esteem even though their public image has diminished a bit over the years. Another reason is that because the 16 medical schools are public, university-based institutions, they are subsidized heavily by the federal and provincial governments. In 1988–1989, medical students paid school fees ranging from approximately $750 a year in Quebec to $3,000 a year in British Columbia. Thus, very few Canadian medical students begin their professional careers heavily in debt, in contrast to students in the United States.

Another important reason for the continued appeal of medicine as a career is that despite the growing number of practicing doctors, physicians remain Canada's highest-paid professionals, according to the reports of the Department of National Health and Welfare last October, based on taxation data from Revenue Canada. Expressed in U.S. dollars, the average net income of physicians was $84,700 in 1987, as compared with $70,800 for dentists, $63,500 for lawyers and notaries, and $49,300 for accountants. A decade ago, the corresponding figures were $41,500 for physicians, $35,500 for dentists, $34,200 for lawyers and notaries, and $29,400 for accountants. For the sake of comparison, I asked the Center for Health Policy Research of the AMA how U.S. physicians' incomes compared with those of other professional groups. Although no precisely comparable survey was available, the data showed that U.S. physicians in private practice earned an average net income of $132,300 in 1987. Dentists in independent private practice earned an average of $88,000 in the same year, according to the American Dental Association. The Bureau of Labor Statistics reported that lawyers working in the private sector had an average net income of $57,300, whereas those working in firms with two or more attorneys earned an average of $120,000.[16] The average income of men over the age of 25 working full-time who have had four years of college was $40,962.

Ontario's physicians are the highest-paid practitioners in Canada, on average. Table 1 compares their incomes with those of doctors in the United States, according to specialty. As the number of Canadian physicians has increased, the number of services they have provided to their patients has risen even more rapidly. This development has prompted 5 of Canada's 10 provinces — British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec — to incorporate some method of accounting for increases in the use of services into their negotiations with the provincial medical associations about fee schedules.[17]

On the other hand, physicians themselves are less concerned about the effect of their increasing numbers on the financial accounts of the provincial plans than about what they regard as governments' contradictory efforts to squeeze spending while promoting universal access. Concern over the current trends has been expressed by physicians in academic medicine and organized medicine, as well as by individual practitioners who do not participate in medical politics. Dr.

Table 1. Average Practice Expenses and Net Incomes of Self-Employed Physicians in Ontario and the United States in 1986, According to Specialty.*

SPECIALTY	ONTARIO		UNITED STATES	
	EXPENSES	INCOME	EXPENSES	INCOME
	thousands of U.S. dollars			
General practice	54.6	78.6	119.9†	84.3†
Family practice	54.9	74.7		
Internal medicine	57.3	121.9	110.5	118.6
Anesthesia	24.4	106.4	96.7	160.6
Psychiatry	35.0	91.0	46.7	98.3
Pediatrics	63.9	103.4	93.2	90.8
General surgery	63.3	109.7	112.3	152.8
Orthopedic surgery	68.4	130.4	210.3	212.8
Urology	28.2	136.1	125.5	136.6
Ophthalmology	90.6	116.4	152.3	163.5
Otolaryngology	80.2	132.5	159.6	154.2
Obstetrics and gynecology	75.7	114.9	149.5	144.5
Pathology	100.0	106.1	67.8	177.8

*The sources of these data are the Ontario Medical Association, which bases its data on information provided by Revenue Canada, and the American Medical Association's Socioeconomic Monitoring System. Income figures for Ontario are based on data for physicians whose income is derived solely from self-employment. U.S. physicians cited are nonfederal patient care practitioners.

†Figures for general practice and family practice are combined in the AMA data.

Frederick H. Lowy, a professor of psychiatry at the University of Toronto and former dean of its faculty of medicine, who recently chaired the Pharmaceutical Inquiry of Ontario, a commission established by the Ontario Ministry of Health to study the rapid rise in the cost of prescription drugs, summarized the sentiment in an interview:

> My physician colleagues are increasingly dissatisfied. Medical incomes are really quite good, that's not the central problem. It is more psychological. Physicians feel they are being increasingly conscripted by administrators and government. The cost containment methods allow government to negotiate from great strength. The playing field is quite unequal. There are significant restrictions on the availability of technology and hospital beds. Physicians are being asked to make unusual sacrifices compared to other segments of society.

A survey in 1989 of 608 physicians randomly selected from all parts of Ontario, conducted for the Ontario Medical Association, agreed with Lowy's view. When the physicians were asked whether they approved of the provincial government's handling of rising costs, 94 percent said they disapproved, and only 3 percent approved. Half the physicians polled said that they were finding it increasingly difficult to have patients admitted to hospitals; in Ontario, hospitals have an average occupancy rate of 90 percent.

CONCLUSION

In 1986, I reported that Canada's provincial health insurance plans resembled a pressure cooker building up steam on a hot stove.[18] Three and a half years later, the analogy holds, but the heat has been turned up. Canada's health care system is buffeted by conflicting forces — its strong commitment to universal access, of which Canadians are justifiably proud; the accelerating efforts of the provinces to control costs while they continue to expand the scope of covered benefits; and the increasing frustration of practicing physicians and hospital stewards who are caught in the middle. Until recently, these tensions have remained within manageable bounds throughout Canada, but whether that will continue, without a new accommodation, particularly if the national economy slows, is an open question. Most of the provinces have created blue-ribbon working groups in the past several years to seek solutions to identified problems, and these exercises have eased some of the tension temporarily. But it seems inevitable that Canada will eventually reopen the question of how care is financed. The provinces will jeopardize their capacity to support other social priorities if they continue to rely on tax revenues to finance unlimited access to most health services, and to produce more physicians than can be accommodated. At the same time, private investment could endanger the egalitarian nature of Canadian health care. Revising the current formulation of policy will require a more meaningful dialogue than exists at present among the federal and provincial governments, organized medicine, and other major stakeholders in the system. Without such dialogue, Canadians place at risk the future of their provincial health insurance plans, social enterprises that are admired throughout the Western world. The medical profession faces an additional challenge: to examine more rigorously the appropriateness and efficacy of the clinical care it renders.[19]

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CSHB 581 (FIN)
FISCAL NOTE CALCULATIONS AND ASSUMPTIONS April 18, 1990

		FY91 was	FY 91	FY 92	FY 92 was
PERSONNEL WAS ↓					
RAIII 20^{22} months	= $ 84,740		$ 33,896	$ 50,844	
RA II 16^{17} months	= 54,912		24,024	30,888	
CTIII 18^{23} months	= 39,564		15,386	24,178	
Total personnel	$179,216	93,031	$ 73,306	$105,910	102,470
TRAVEL			FY 91	FY 92	
Task Force travel:					
8 meetings, 5 members, 3 days per diem		$17,250	$ 15,000	25,000	25,750
Evenings will be public meeting & discussion Next day is education/work session 3 days stipend @ $100; avg. fare $400; misc. $30 total per meeting, per member $850					
Staff travel for research and meetings:		9,000	7,000	9,000	12,000
Total travel		26,250	$22,000	$34,000	40,750
CONTRACTUAL			FY 91	FY 92	
Printing				-0-	1,000
3 X $5,000 for expert testimony & task force education		10,000	14,000	-0-	10,000
Advertizing (display ads)		1,500	3,500	6,500	2,500
Telephone long distance calls			350	650	
Office Space		6,750	-0-	-0-	9,000
Employer survey (phone)			20,000		
Characteristics survey (phone, interview and observation)			50,000		
Total contractual		88,600	$87,850	$ 7,150	23,150
SUPPLIES			FY 91	FY 92	
Paper goods, office supplies		Same	$ 600	450	Same
Reference books			300		
Total supplies			$ 900	$ 450	
EQUIPMENT			FY 91	FY 92	
Personal Computer ≈ $4,500 Value		Same	-0-	-0-	Same.
TOTAL FOR PROJECT		208,751	$184,056	$147,510	166,820

Assumptions:

Total Reduction from HB581 - 44,035

1. Written work of the task force in providing program description and supportive documentation will be provided by legislative research agency, including any report printing.

2. Teleconferencing of public meetings will be provided at no cost through the legislative network or other comparable arrangement.

3. Reimbursement for services of those appointed by the Governor will be limited to $100 per day plus travel and per diem.

4. Advisory committee members will provide funding for travel and other costs for their participation from their respective budgets.

5. Office space to be provided within existing legislative offices or by other donated arrangement.

6. Computer used for staff research work will be donated.

WE WERE ABLE TO REDUCE THE FISCAL NOTE FOR THIS BILL BY OVER $44,000 BY:

CAREFULLY REVIEWING THE NUMBER OF MONTHS THAT PERSONNEL WOULD BE REQUIRED FOR THE PROJECT:

	FROM	TO	DIFFERENCE
RESEARCH ANALYST III	22	20	2 MONTHS
RESEARCH ANALYST II	17	16	1 MONTH
CLERK TYPIST III	20	18	2 MONTHS

PERSONNEL REDUCTIONS IN FY 91 SAVE ABOUT $20,000 ON THE PROJECT.

REDUCING STAFF TRAVEL AND ADVISORY COMMITTEE STIPENDS
FROM $150 PER DAY TO $100 PER DAY
KNOCKS OFF OVER:

FY 91		FY 92
$4,000	AND	$5,000

WHILE A CERTAIN AMOUNT OF EXPERT TESTIMONY WILL BE NECESSARY WE THINK THE ORIGINAL $20,000 IS TOO MUCH AND HAVE REDUCED THAT BY $6,000.

ADDING CONTRACTUAL COST OF ALMOST $16,000 FOR OFFICE SPACE WAS A REDICULOUS EXPENSE THAT CAN BE HANDLED WITHIN THE SPACE WE ALREADY HAVE. THIS COST IS TOTALLY ELIMINATED.

WE DO NOT REQUIRE ANOTHER COMPUTER $4,500 FOR THIS PROJECT.

ALL OF THESE REDUCTIONS ADD UP TO A $44,000 REDUCED COST FOR TH3E TOTAL PROJECT:

FY 91	FY 92	TOTAL REDUCTION IN FISCAL NOTE
$24,725	$19,310	$44,035

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSHB 581 (FIN)
PUBLISH DATE: April 9, 1990

FISCAL NOTE

REQUEST:

Revision Date: April 4, 1990
Title: "An Act creating a universal health care task force and providing for an effective date."
Sponsor: by the HESS Committee
Requestor: by the HESS Committee

Agency Affecte DHSS
BRU: Admininstrative Services
Components: Planning and Development

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	73.3	105.9				
TRAVEL	22.0	34.0				
CONTRACTUAL	87.8	7.2				
SUPPLIES	0.9	0.5				
EQUIPMENT	0.0	0.0				
LAND & STRUCTURES	0.0	0.0				
GRANTS, CLAIMS	0.0	0.0				
MISCELLANEOUS	0.0	0.0				
TOTAL OPERATING	184.0	147.6	0.0	0.0	0.0	0.0

CAPITAL	0.0	0.0				

REVENUE	0.0	0.0				

FUNDING: (Thousands of Dollars)

GENERAL FUND	184.0	147.6				
FEDERAL FUNDS	0.0	0.0				
OTHER	0.0	0.0				
TOTAL	184.0	147.6	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY	3	3				

ANALYSIS: (Attach a separate page if necessary)

See attached assumptions and calculation analysis. No fiscal impact in FY 1990.

Prepared by: D. Williams DW
Division: Div. of Admin. Svcs., DHSS
Phone: 465-3015
Date: April 18, 1990

Approved by Ⓡ Commissioner Myra M. Munson
Agency: Dept. of Health & Soc. Svcs
Date: 4/18/90

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

CSHB 581 (FIN)
FISCAL NOTE CALCULATIONS AND ASSUMPTIONS April 18, 1990

PERSONNEL			FY 91	FY 92
RAIII	20 months	= $ 84,740	$ 33,896	$ 50,844
RA II	16 months	= 54,912	24,024	30,888
CTIII	18 months	= 39,564	15,386	24,178
Total personnel		$179,216	$ 73,306	$105,910

TRAVEL	FY 91	FY 92
Task Force travel:		
8 meetings, 5 members, 3 days per diem Evenings will be public meeting & discussion Next day is education/work session 3 days stipend @ $100; avg. fare $400; misc. $30 total per meeting, per member $850	$ 15,000	25,000
Staff travel for research and meetings:	7,000	9,000
Total travel	$22,000	$34,000

CONTRACTUAL	FY 91	FY 92
Printing		-0-
3 X $5,000 for expert testimony & task force education	14,000	-0-
Advertizing (display ads)	3,500	6,500
Telephone long distance calls	350	650
Office Space	-0-	-0-
Employer survey (phone)	20,000	
Characteristics survey (phone, interview and observation)	50,000	
Total contractual	$87,850	$ 7,150

SUPPLIES	FY 91	FY 92
Paper goods, office supplies	$ 600	450
Reference books	300	
Total supplies	$ 900	$ 450

EQUIPMENT	FY 91	FY 92
Personal Computer	-0-	-0-
TOTAL FOR PROJECT	$184,056	$147,510

Assumptions:

1. Written work of the task force in providing program description and supportive documentation will be provided by legislative research agency, including any report printing.

2. Teleconferencing of public meetings will be provided at r cost through the legislative network or other comparable arrangement.

3. Reimbursement for services of those appointed by the Governor will be limited to $100 per day plus travel and per diem.

4. Advisory committee members will provide funding for travel and other costs for their participation from their respective budgets.

5. Office space to be provided within existing legislative offices or by other donated arrangement.

6. Computer used for staff research work will be donated.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

cc

BILL VERSION: CSHB 581(HESS) No. 1
PUBLISH DATE: HOUSE 4/9/90

FISCAL NOTE

REQUEST:

Revision Date: April 4, 1990
Title: "An Act creating a universal health care task force and providing for an effective date."
Sponsor: by the HESS Committee
Requestor: by the HESS Committee

Agency Affecte DHSS
BRU: Admininstrative Services
Components: Planning and Development

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY92	FY93	FY94	FY 95	FY 96
PERSONAL SERVICES	93.0	102.5				
TRAVEL	26.3	40.8				
CONTRACTUAL	88.6	23.2				
SUPPLIES	0.9	0.5				
EQUIPMENT	0.0	0.0				
LAND & STRUCTURES	0.0	0.0				
GRANTS, CLAIMS	0.0	0.0				
MISCELLANEOUS	0.0	0.0				
TOTAL OPERATING	208.8	167.0	0.0	0.0	0.0	0.0

CAPITAL	0.0	0.0				

REVENUE	0.0	0.0				

FUNDING: (Thousands of Dollars)

GENERAL FUND	208.8	167.0				
FEDERAL FUNDS	0.0	0.0				
OTHER	0.0	0.0				
TOTAL	208.8	167.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY	3	3				

ANALYSIS: (Attach a separate page if necessary)

See attached assumptions and calculation analysis. No fiscal impact in FY 1990.

Prepared by: D. Williams DW
Division: Div. of Admin. Svcs., DHSS
Phone: 465-3015
Date: April 4, 1990

Approved by Commissioner:
Agency: Dept. of Health & Soc. Svcs
Date: 4/4/90

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

CSHB 581
FISCAL NOTE CALCULATIONS AND ASSUMPTIONS

PERSONNEL		FY 91	FY 92
RAIII 22 months	= $ 93,214	$ 42,370	$ 50,844
RA II 17 months	= 58,327	30,879	27,448
CTIII 20 months	= 43,960	19,782	24,178
Total personnel	$195,501	$93,031	$102,470

TRAVEL	FY 91	FY 92
Task Force travel:		
8 meetings, 5 members, 3 days per diem	$ 17,250	28,750
Evenings will be public meeting & discussion		
Next day is education/work session		
3 days stipend @ $150; avg. fare $400; misc. $30 total per meeting, per member $850		
Staff travel for research and meetings:	9,000	12,000
Total travel	$26,250	$40,750

CONTRACTUAL	FY 91	FY 92
Printing		1,000
4 X $5,000 for expert testimony & task force education	10,000	10,000
Advertizing (display ads)	1,500	2,500
Telephone long distance calls	350	650
Office space (500 sq. ft. lease @ 1.50 per sq ft)	6,750	9,000
Employer survey (phone)	20,000	
Characteristics survey (phone, interview and observation)	50,000	
Total contractual	$88,600	$23,150

SUPPLIES	FY 91	FY 92
Paper goods, office supplies	$ 600	450
Reference books	300	
Total supplies	$ 900	$ 450

EQUIPMENT		
Personal Computer ≈ $4,500 value donated	-0-	-0-

TOTAL FOR PROJECT	$208,781	$166,820

Assumptions:

1. Written work of the task force in providing program description and supportive documentation will be provided by legislative research agency.

2. Teleconferencing of public meetings will be provided at no cost through the legislative network or other comparable arrangement.

3. Reimbursement for services of those appointed by the Governor will be limited to $150 per day plus travel and per diem.

4. Advisory committee members will provide funding for travel and other costs for their participation from their respective budgets.

5. Computer used for staff research work will be donated.