SCR

10

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO: SCR 10

Revision Date:
Title: Establishing a Health Resources and Access Task Force.
Sponsor: Senator Duncan
Requestor: Senator Duncan

Department Affected: Legislative Affairs Agency
BRU: Legislative Council
Component: Council & Subcommittees
Session Expenses, Legis. Oper Budget
COMPONENT SERIAL NO: 783

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	68.4	42.0	0	0	0	0
TRAVEL	22.5	11.0	0	0	0	0
CONTRACTUAL	92.0	46.0	0	0	0	0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	182.9	99.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	182.9	99.0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL	182.9	99.0	0	0	0	0

POSITIONS:

FULL-TIME	1	0	0	0	0	0
PART-TIME	0	1	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

SCR 10 establishes a Health Resources and Access Task Force within the Legislative Branch. The following is requested to adequately support the task force:

Prepared By: Pamela A. Stoops, Director — Phone: 465-3850
Division: Administrative Services — Date: 2/26/91

Approved By: Warren W. Endicott, Executive Director
Agency: Legislative Affairs Agency — Date: 2/26/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

PERSONAL SERVICES

Staff is requested as follows to assist the Health Resources & Access Task Force.

Legislative Assistant - Range 21A
$4,155 x 12 months = $49.860
$49,860 x 37% benefits = $68,427 68.4

Funding for FY 93 is for seven months. The task force is terminated February 1, 1993.

TRAVEL

It is anticipated there will be 3 meetings of the Health Resources & Access Task Force.

3 meetings x 12 members = 36 airfares
36 airfares x $436 = $15,696
2 days per diem x 36 = 72
72 days x $95 = $6,840 22.5

It is assumed that the travel costs for the two Executive Branch members will be absorbed within their existing budgets.

CONTRACTUAL

Professional services funding to carry out the task force duties--$90,000. 90.0

Advertising - advertising of public notice of meetings--$2,000. 2.0

SUPPLIES

Supplies for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

EQUIPMENT

Equipment for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

Anchorage - 7th Ave SCRLD 4/12/91 M Biel Burns

Assume 30-40 000 no Health Ins.
Some can buy
some poor
some unmentionable

Theoretical — 10 Physicians by contract. 20 000 a month - Pay + office rent parents. Enrol - agree by both parties. (1) Catastrophic excluded (2) Certain other labs etc —

Use British model. Assign ½ PF to panel. If Child ½ dependent also ½ — 10 Docs — 2.4 M
300,000 to Supreme = 3.0 M.
Enrol —
½ PF 3 to run Fund of 9 M —
need for office etc — Doc works up medical office for health care.
Can only spend what brings in.

Bill Barnes - have access to health care. Bill getting opted-
Alternatives -

Rod Wilson -- said Dems won't do it.

Says 25% of fees now are in paperwork.

Just people who are uninsured. People who had no other access. Also able to charge a fee.

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD

P.O. BOX V
ROOM 427
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on
Health, Education and Social Services

MEMORANDUM 03 March 1991

TO: Terri Lauterbach
Legislative Legal Services

FROM: Senator Arliss Sturgulewski
Chair, Senate HESS Committee

Please have a HESS Committee subsititute drafted for SCR 10 incorporating the changes on the attached bill draft. I would appreciate getting the draft back this afternoon.

FAX TRANSMITTAL MEMO

TO: [illegible]
DEPT: [illegible] FAX #: [illegible]
FROM: HESS PHONE [illegible]
CO [illegible] FAX # [illegible]
Post-it brand fax transmittal memo 7671

NO. OF PAGES 2

FAX COVER SHEET

DATE: 11 MARCH 91

TIME: 3:40

TO: Don Renfroe
Dillingham City Schools
842-5634

FROM:

Senator Sturgulewski's Office
Melissa Fouse
Pouch V, Juneau, Alaska 99811
907-465-3818
FAX 907-465-3810

This cover sheet plus 6 pages

FAX COVER SHEET

DATE: 11 MARCH 1991

TIME: 415

TO: Dr. Holloway
SITKA School District
747-5330

FROM:

Senator Sturgulewski's Office
Melissa Fouse
Pouch V, Juneau, Alaska 99811
907-465-3818
FAX 907-465-3810

We have added Sitka to the teleconference sites. The bill is to be up first on the committee schedule at 8 am.

This cover sheet plus 6 pages

7-LS0008\D
Ford
3/11/91

FROM SB 57-

CS FOR SENATE BILL NO. 7 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:
Sponsor(s): SENATORS KERTTULA, Fischer, Rodey, Menard, Jones

A BILL

FOR AN ACT ENTITLED

"An Act relating to state aid for education; and providing for an effective date."

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

SB 54 Section #1 deleted

* Section 1. AS 14.17.041(a) is amended to read:

(a) For funding communities that have an average daily membership of less than 200 in grades K-6 or less than 200 in grades 7-12, combined elementary and secondary instructional units are determined under the following table:

ADM	No. Instructional Units
1 - 10	2
11 - 20	2 + ((ADM-10)/5)
21 - 60	4 + ((ADM-20)/8)
61 - <u>240</u> [120]	9 + ((ADM-60)/12)
<u>241</u> [121] - 525	<u>24 + ((ADM-240)/14)</u> [14 + ((ADM-120)/15)]

* Sec. 2. AS 14.17.041(b) is amended to read:

<u>New Text Underlined</u> [DELETED TEXT BRACKETED]

(b) For funding communities that are not included under (a) of this section,

(1) instructional units for elementary students are determined by the formula: units = 16 [15] + ((ADM-200)/17), where ADM is the number of students in average daily membership in grades kindergarten through 6;

(2) instructional units for secondary students are determined by the formula: units = 19 [18] + ((ADM-200)/13), where ADM is the number of students in average daily membership in grades 7 through 12.

* **Sec. 3.** AS 14.17.041 is amended by adding a new subsection to read:

(e) A municipality that is a school district with an ADM of 750 or less that consists of one funding community shall increase the elementary and secondary instructional units received under (a) or (b) of this section by multiplying the instructional units by a percentage determined under the following table:

District ADM	Percentage
1 - 250	1.12
251 - 525	1.08
526 - 750	1.06

* **Sec. 4.** AS 14.17.056 is amended to read:

Sec. 14.17.056. INSTRUCTIONAL UNIT VALUE. The instructional unit value is $63,000 [$60,000].

* **Sec. 5.** This Act takes effect July 1, 1991.

ALASKA DEPARTMENT OF EDUCATION
PROJECTED FY92 FOUNDATION PROGRAM
AASA PROPOSED PROGRAM REVISIONS
PREPARED 2/13/91
REVISED 3/11/91

EFFECT OF COMMITTEE SUBSTITUTE SB 7 (HES) vs. SB 54
at $60,000

	FY92 ADM	NEW TABLES AASA SEC. 3 PROPOSAL	NEW TABLES AASA SEC. 2 PROPOSAL	SEC. 4 SINGLE SITE MUNICIPALITIES < 750 ADM	TOTAL COST OF SEC. 2,3 & 4 UNIT VALUE AT $60,000
★2 ADAK ·	715	$152,400	$0	★3 237,000 $0	$152,400
★2 ALASKA GATEWAY	499	$0	$157,800	$0	$157,800
ALEUTIAN REGION	33	$0	$0	★3 42,600 $0	$0
ALEUTIANS EAST	359	$0	$58,800	$0	$58,800
★1 ANCHORAGE	42070	$240,000	$14,400	$0	$254,400
ANNETTE ISLANDS	411	$0	$173,400	★3 165,000 $0	$173,400
BERING STRAIT	1398	$0	$225,000	$0	$225,000
BRISTOL BAY	265	$0	$153,000	★3 81,000 $0	$153,000
CHATHAM	384	$0	$70,800	$0	$70,800
CHUGACH	110	$0	$0	$0	$0
COPPER RIVER	578	$0	$157,200	$0	$157,200
CORDOVA	438	$0	$196,200	$187,800	$384,000
CRAIG	413	$0	$174,600	$165,600	$340,200
DELTA/GREELY	870	$139,200	$0	★3 262,800 $0	$139,200
DILLINGHAM	485	$0	$241,800	$234,000	$475,800
★1 FAIRBANKS	14683	$374,400	$0	$0	$374,400
GALENA	150	$0	$39,000	$150,000	$189,000
HAINES	411	$0	$177,000	$0	$177,000
HOONAH	230	$0	$119,400	$165,600	$285,000
HYDABURG	108	$0	$0	$96,600	$96,600
★2 IDITAROD ·	394	$0	$63,000	$0	$63,000
★1 JUNEAU	5328	$120,000	$0	$0	$120,000
KAKE	172	$0	$53,400	$129,600	$183,000
★2 KASHUNAMIUT ·	192	$0	$96,000	★3 180,600 $0	$96,000
★1 KENAI	9724	$600,000	$572,400	$0	$1,172,400
KETCHIKAN	2796	$120,000	$0	★3 350,400 $0	$120,000
KLAWOCK	200	$0	$82,800	$143,400	$226,200
KODIAK	2411	$130,800	$0	$0	$130,800
KUSPUK	413	$0	$82,800	$0	$82,800
LAKE AND PENN.	420	$0	$0	$0	$0
LOWER KUSKOKWIM	2835	$0	$93,000	$0	$93,000
LOWER YUKON	1352	$0	$393,000	$0	$393,000
★1 MATSU	9997	$480,000	$117,000	$0	$597,000
NENANA	180	$0	$72,000	$155,400	$227,400
NOME	778	$160,800	$0	★3 276,600 $0	$160,800
NORTH SLOPE	1406	$174,000	$158,400	$0	$332,400
NORTHWEST ARCTIC	1584	$174,000	$132,000	$0	$306,000
PELICAN	48	$0	$0	$58,200	$58,200
PETERSBURG	707	$120,000	$0	$189,000	$309,000
★2 PRIBILOF ·	153	$0	$600	★3 122,400 $0	$600
RAILBELT	338	$0	$99,000	$0	$99,000
SITKA	1745	$120,000	$0	★3 291,600 $0	$120,000
SKAGWAY	130	$0	$10,200	$111,000	$121,200
SOUTHEAST	557	$0	$66,600	$0	$66,600
SOUTHWEST	485	$0	$47,400	$0	$47,400
ST MARY'S	116	$0	$0	$127,800	$127,800
TANANA	109	$0	$0	$122,400	$122,400
UNALASKA	298	$0	$172,800	$157,800	$330,600
VALDEZ	765	$133,200	$0	★3 328,000 $0	$133,200
WRANGELL	520	$120,000	$0	$193,200	$313,200
YAKUTAT	152	$0	$34,800	$126,000	$160,800
YUKON FLATS	371	$0	$39,600	$0	$39,600
YUKON/KOYUKUK	510	$0	$59,400	$0	$59,400
YUPIIT	330	$0	$30,600	$0	$30,600
TOTALS		$3,358,800	$4,435,200	$2,513,400	$10,307,400

★1 NOT INCLUDED IN ORIGINAL BILL ★2 NOT A MUNICIPALITY ★3 FOLLOWS SB54

ALASKA DEPARTMENT OF EDUCATION
PROJECTED FY92 FOUNDATION PROGRAM
AASA PROPOSED PROGRAM REVISIONS

PREPARED 2/13/91
REVISED 3/11/91

EFFECT OF COMMITTEE SUBSTITUTE SB 7 (HES) vs. SB 54
at $63,000

	FY92 ADM	NEW TABLES AASA SEC. 3 PROPOSAL	NEW TABLES AASA SEC. 2 PROPOSAL	SEC. 4 SINGLE SITE MUNICIPALITIES ≤ 750 ADM	SEC. 5 INCREASE UNIT VALUE BY $3,000	TOTAL COST OF SEC. 2,3,4 & 5 UNIT VALUE AT $63,000
★1 ADAK	715	$160,020	$0 ★3	248,850	$0	$222,480	$382,500
ALASKA GATEWAY	499	$0	$165,690		$0	$242,880	$408,570
ALEUTIAN REGION	33	$0	$0 ★3	44,730	$0	$38,310	$38,310
ALEUTIANS EAST	359	$0	$61,740		$0	$192,360	$254,100
★1 ANCHORAGE	42,070	$252,000	$15,120		$0	$10,064,760	$10,331,880
ANNETTE ISLANDS	411	$0	$182,070 ★3	173,250	$0	$127,110	$309,210
BERING STRAIT	1398	$0	$236,250		$0	$839,250	$1,075,500
BRISTOL BAY	265	$0	$160,650	85,050	$0	$122,310	$282,960
CHATHAM	384	$0	$74,340		$0	$174,660	$249,000
CHUGACH	110	$0	$0		$0	$80,040	$80,040
COPPER RIVER	571	$0	$165,060		$0	$265,950	$431,010
CORDOVA	438	$0	$206,010	$197,190		$140,430	$543,630
CRAIG	413	$0	$183,330	$173,880		$117,510	$474,720
DELTA/GREELY	870	$146,160	$0 ★3	275,940	$0	$261,000	$407,160
DILLINGHAM	485	$0	$253,890	$245,700		$184,890	$684,480
★1 FAIRBANKS	14683	$393,120	$0		$0	$3,644,520	$4,037,640
GALENA	150	$0	$40,950	$157,500		$74,760	$273,210
HAINES	441	$0	$185,850		$0	$135,960	$321,810
HOONAH	230	$0	$125,370	$173,880		$80,070	$379,320
HYDABURG	108	$0	$0	$101,430		$51,030	$152,460
★2 IDITAROD	394	$0	$66,150		$0	$258,000	$324,150
★1 JUNEAU	5328	$126,000	$0		$0	$1,305,870	$1,431,870
KAKE	172	$0	$56,070	$136,080		$64,260	$256,410
★2 KASHUNAMIUT	192	$0	$100,800 ★3	189,630	$0	$92,370	$193,170
★1 KENAI	9724	$630,000	$601,020		$0	$2,666,340	$3,897,360
KETCHIKAN	2796	$126,000	$0 ★3	367,920	$0	$687,990	$813,990
KLAWOCK	200	$0	$86,940	$150,570		$72,180	$309,690
KODIAK	2411	$137,340	$0		$0	$743,400	$880,740
KUSPUK	413	$0	$86,940		$0	$259,620	$346,560
LAKE AND PENN.	420	$0	$0		$0	$315,330	$315,330
LOWER KUSKOKWIM	2835	$0	$97,650		$0	$1,666,680	$1,764,330
LOWER YUKON	1352	$0	$412,650		$0	$692,520	$1,105,170
★1 MATSU	9997	$504,000	$122,850		$0	$2,501,220	$3,128,070
NENANA	180	$0	$75,600	$163,170		$78,450	$317,220
NOME	778	$168,840	$0 ★3	290,430	$0	$274,740	$443,580
NORTH SLOPE	1406	$182,700	$166,320		$0	$657,630	$1,006,650
NORTHWEST ARCTIC	1584	$182,700	$138,600		$0	$823,200	$1,144,500
PELICAN	48	$0	$0	$61,110		$30,780	$91,890
PETERSBURG	707	$126,000	$0	$198,450		$186,960	$511,410
★2 PRIBILOF	153	$0	$630 ★3	128,520	$0	$93,870	$94,500
RAILBELT	338	$0	$103,950		$0	$152,700	$256,650
SITKA	1745	$126,000	$0 ★3	306,180	$0	$414,360	$540,360
SKAGWAY	130	$0	$10,710	$116,550		$53,010	$180,270
SOUTHEAST	557	$0	$69,930		$0	$294,720	$364,650
SOUTHWEST	485	$0	$49,770		$0	$318,060	$367,830
ST MARY'S	116	$0	$0	$134,190		$68,490	$202,680
TANANA	109	$0	$0	$128,520		$63,930	$192,450
UNALASKA	298	$0	$181,440	$165,690		$114,450	$461,580
VALDEZ	965	$139,860	$0 ★3	239,400	$0	$208,350	$348,210
WRANGELL	520	$126,000	$0	$202,860		$152,220	$481,080
YAKUTAT	152	$0	$36,540	$132,300		$63,540	$232,380
YUKON FLATS	371	$0	$41,580	$0		$266,340	$307,920
YUKON/KOYUKUK	570	$0	$62,370	$0		$333,930	$396,300
YUPIIT	330	$0	$32,130	$0		$223,020	$255,150
TOTALS		$3,526,740	$4,656,960	$2,639,070	$33,258,840		$44,081,610

★1 NOT INCLUDED IN ORIGINAL BILL ★2 NOT A MUNICIPALITY ★3 FORMER SB54

	A	B	C	D	E	F
1	ALASKA DEPARTMENT OF EDUCATION					PROJECTED FY92
2	FOUNDATION FUNDING PROGRAM					FOUNDATION
3	PREPARED 2/28/91 REVISED 3/11/91			PROJECTED FY92		SB54 SEC. 2&3
4			PROJECTED FY92	FOUNDATION	PROJECTED FY92	SINGLE SITE < 750
5		FY91 FOUNDATION	FOUNDATION	PRORATION TO	FOUNDATION	PRORATION TO
6		STATE AID	STATE AID	GOV. BUDGET	SB54 SEC. 2&3	GOV. BUDGET
7		100% ENTITLEMENT	100% ENTITLEMENT	OF $514,648.9	SINGLE SITE < 750	OF $514,648.9
8	ADAK	$2,083,942	$2,173,342	$1,993,966	$2,325,742	$2,070,899
9	ALASKA GATEWAY	$4,329,618	$4,346,718	$4,150,894	$4,504,518	$4,226,782
10	ALEUTIAN REGION	$680,468	$680,468	$649,580	$680,468	$638,038
11	ALEUTIANS EAST	$3,078,324	$2,916,674	$2,761,582	$2,976,074	$2,759,740
12	ANCHORAGE	$156,404,478	$162,149,942	$154,035,162	$162,404,342	$151,243,197
13	ANNETTE ISLANDS	$1,170,462	$1,305,462	$1,202,955	$1,479,462	$1,329,015
14	BERING STRAIT	$12,271,870	$12,719,470	$12,042,819	$12,944,470	$12,002,513
15	BRISTOL BAY	$1,663,843	$1,663,201	$1,564,588	$1,816,201	$1,672,266
16	CHATHAM	$2,554,523	$2,556,923	$2,416,102	$2,627,723	$2,430,361
17	CHUGACH	$1,461,376	$1,421,776	$1,357,243	$1,421,776	$1,333,129
18	COPPER RIVER	$5,221,136	$5,087,336	$4,872,912	$5,244,536	$4,941,282
19	CORDOVA	$2,301,985	$2,265,566	$2,152,343	$2,649,566	$2,472,770
20	CRAIG	$1,689,191	$2,136,924	$2,044,181	$2,479,724	$2,330,705
21	DELTA/GREELY	$4,269,949	$4,244,749	$4,034,316	$4,383,949	$4,087,174
22	DILLINGHAM	$2,936,054	$2,915,918	$2,766,849	$3,391,718	$3,160,598
23	FAIRBANKS	$57,115,905	$60,237,647	$57,299,228	$60,612,047	$56,554,887
24	GALENA	$1,085,274	$1,202,673	$1,142,397	$1,391,673	$1,298,408
25	HAINES	$2,374,218	$2,258,312	$2,148,693	$2,435,312	$2,274,930
26	HOONAH	$1,446,196	$1,405,719	$1,341,162	$1,690,719	$1,586,256
27	HYDABURG	$956,647	$981,799	$940,656	$1,077,799	$1,015,965
28	IDITAROD	$4,163,521	$4,386,121	$4,178,107	$4,449,121	$4,159,889
29	JUNEAU	$20,344,548	$20,626,989	$19,574,123	$20,746,989	$19,294,049
30	KAKE	$1,083,087	$1,036,056	$984,246	$1,219,056	$1,137,752
31	KASHUNAMIUT	$1,308,396	$1,390,596	$1,316,122	$1,486,596	$1,378,977
32	KENAI	$37,253,584	$39,335,955	$37,186,201	$40,508,355	$37,490,371
33	KETCHIKAN	$9,952,787	$10,378,089	$9,823,392	$10,498,089	$9,729,472
34	KLAWOCK	$1,333,158	$1,290,491	$1,232,295	$1,516,691	$1,424,223
35	KODIAK	$12,155,260	$11,967,600	$11,368,229	$12,098,400	$11,267,816
36	KUSPUK	$4,716,683	$4,684,283	$4,474,963	$4,767,683	$4,475,527
37	LAKE AND PENINSUL	$5,386,950	$5,474,080	$5,219,843	$5,474,080	$5,124,842
38	LOWER KUSKOKWIM	$27,176,760	$27,763,760	$26,419,988	$27,856,760	$26,005,706
39	LOWER YUKON	$10,288,288	$9,908,488	$9,350,139	$10,300,888	$9,512,169
40	MAT-SU	$39,817,389	$42,994,356	$40,977,731	$43,591,356	$40,788,112
41	NENANA	$1,577,456	$1,503,966	$1,440,715	$1,731,366	$1,631,887
42	NOME	$4,912,948	$4,913,430	$4,691,919	$5,074,230	$4,761,042
43	NORTH SLOPE	$7,888,743	$8,057,882	$7,527,660	$8,390,282	$7,643,528
44	NORTHWEST ARCTIC	$13,286,800	$11,464,556	$10,800,846	$11,770,556	$10,841,889
45	PELICAN	$581,637	$561,341	$536,524	$619,541	$582,228
46	PETERSBURG	$2,981,875	$3,051,475	$2,900,737	$3,360,475	$3,136,299
47	PRIBILOF	$1,344,889	$1,415,689	$1,340,006	$1,416,289	$1,312,292
48	RAILBELT	$2,966,307	$3,013,707	$2,890,592	$3,112,707	$2,938,104
49	SITKA	$6,441,269	$6,305,158	$5,971,077	$6,425,158	$5,959,595
50	SKAGWAY	$904,356	$822,752	$780,012	$943,952	$878,530
51	SOUTHEAST	$4,842,342	$5,096,142	$4,858,522	$5,162,742	$4,832,642
52	SOUTHWEST	$4,667,542	$5,029,342	$4,772,904	$5,076,142	$4,721,288
53	ST. MARY'S	$1,307,241	$1,304,147	$1,248,926	$1,431,947	$1,349,015
54	TANANA	$1,165,181	$1,168,693	$1,117,149	$1,291,093	$1,213,510
55	UNALASKA	$1,616,402	$1,668,678	$1,576,402	$1,999,278	$1,854,213
56	VALDEZ	$2,674,681	$2,699,117	$2,531,133	$2,832,317	$2,594,186
57	WRANGELL	$2,478,311	$2,603,887	$2,481,159	$2,917,087	$2,731,154
58	YAKUTAT	$1,131,374	$1,157,318	$1,106,088	$1,318,118	$1,238,841
59	YUKON FLATS	$4,973,684	$4,788,884	$4,574,146	$4,828,484	$4,531,311
60	YUKON/KOYUKUK	$5,449,696	$5,421,496	$5,152,263	$5,481,496	$5,108,335
61	YUPIIT	$3,491,802	$3,503,802	$3,323,991	$3,533,802	$3,285,139
62	OTHER	$9,704,648	$10,285,221	$10,003,119	$10,285,221	$10,286,052
63	TOTALS	$526,467,054	$541,746,166	$514,648,900	$552,054,166	$514,648,900

	G	H	I	J	K
1	ALASKA DEPARTMENT OF EDUCATION				
2	FOUNDATION FUNDING PROGRAM				
3	PREPARED 2/28/91 REVISED 3/11/91				
4					
5		COLUMN C	COLUMN D	COLUMN E	COLUMN F
6		LESS	LESS	LESS	LESS
7		COLUMN B	COLUMN B	COLUMN B	COLUMN B
8	ADAK	$89,400	($89,976)	$241,800	($13,043)
9	ALASKA GATEWAY	$17,100	($178,724)	$174,900	($102,836)
10	ALEUTIAN REGION	$0	($30,888)	$0	($42,430)
11	ALEUTIANS EAST	($161,650)	($316,742)	($102,250)	($318,584)
12	ANCHORAGE	$5,745,464	($2,369,316)	$5,999,864	($5,161,281)
13	ANNETTE ISLANDS	$135,000	$32,493	$309,000	$158,553
14	BERING STRAIT	$447,600	($229,051)	$672,600	($269,357)
15	BRISTOL BAY	($642)	($99,255)	$152,358	$8,423
16	CHATHAM	$2,400	($138,421)	$73,200	($124,162)
17	CHUGACH	($39,600)	($104,133)	($39,600)	($128,247)
18	COPPER RIVER	($133,800)	($348,224)	$23,400	($279,854)
19	CORDOVA	($36,419)	($149,642)	$347,581	$170,785
20	CRAIG	$449,733	$354,990	$790,533	$641,514
21	DELTA/GREELY	($25,200)	($235,633)	$114,000	($182,775)
22	DILLINGHAM	($20,136)	($169,205)	$455,664	$224,544
23	FAIRBANKS	$3,121,742	$183,323	$3,496,142	($561,018)
24	GALENA	$117,399	$57,123	$306,399	$213,134
25	HAINES	($115,906)	($225,525)	$61,094	($99,288)
26	HOONAH	($40,477)	($105,034)	$244,523	$140,060
27	HYDABURG	$25,152	($15,991)	$121,152	$59,318
28	IDITAROD	$222,600	$14,586	$265,600	($3,632)
29	JUNEAU	$282,441	($770,425)	$402,441	($1,050,499)
30	KAKE	($47,031)	($96,841)	$135,969	$54,665
31	KASHUNAMIUT	$82,200	$7,726	$178,200	$70,581
32	KENAI	$2,082,371	($67,383)	$3,254,771	$236,787
33	KETCHIKAN	$425,302	($129,395)	$545,302	($223,315)
34	KLAWOCK	($42,667)	($100,863)	$183,533	$91,065
35	KODIAK	($187,660)	($787,031)	($56,860)	($867,444)
36	KUSPUK	($32,400)	($241,720)	$51,000	($241,156)
37	LAKE AND PENINSULA	$87,130	($167,107)	$87,130	($262,108)
38	LOWER KUSKOKWIM	$585,000	($758,772)	$678,000	($1,173,054)
39	LOWER YUKON	($379,800)	($938,149)	$12,600	($776,119)
40	MAT-SU	$3,176,967	$1,160,342	$3,773,967	$970,723
41	NENANA	($73,490)	($136,741)	$153,910	$54,431
42	NOME	$482	($221,029)	$161,282	($151,906)
43	NORTH SLOPE	$169,139	($361,080)	$501,539	($245,215)
44	NORTHWEST ARCTIC	($1,822,244)	($2,485,954)	($1,516,244)	($2,444,911)
45	PELICAN	($20,296)	($45,113)	$37,904	$591
46	PETERSBURG	$69,600	($81,138)	$378,600	$154,424
47	PRIBILOF	$70,800	($4,883)	$71,400	($32,597)
48	RAILBELT	$47,400	($75,715)	$146,400	($28,203)
49	SITKA	($136,111)	($470,192)	($16,111)	($481,674)
50	SKAGWAY	($81,604)	($124,344)	$39,596	($25,826)
51	SOUTHEAST	$253,800	$16,180	$320,400	($9,700)
52	SOUTHWEST	$361,800	$105,362	$408,600	$53,746
53	ST. MARY'S	($3,094)	($58,315)	$124,706	$41,774
54	TANANA	$3,512	($48,032)	$125,912	$48,329
55	UNALASKA	$52,276	($40,000)	$382,876	$237,811
56	VALDEZ	$24,436	($143,548)	$157,636	($80,495)
57	WRANGELL	$125,576	$2,848	$438,776	$252,843
58	YAKUTAT	$25,944	($25,286)	$186,744	$107,467
59	YUKON FLATS	($184,800)	($399,538)	($145,200)	($442,373)
60	YUKON/KOYUKUK	($28,200)	($297,433)	$31,800	($341,361)
61	YUPIIT	$12,000	($167,811)	$42,000	($206,663)
62	OTHER	$580,573	$298,471	$580,573	$581,404
63	TOTALS	$15,279,112	($11,818,154)	$25,587,112	($11,818,154)

7-LS0681\P
Lauterbach
3/4/91

CS FOR SENATE CONCURRENT RESOLUTION NO. 10 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Kerttula, Pourchot, Menard

A RESOLUTION

Establishing a Health Resources and Access Task Force.

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

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS an estimated 90,000 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; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state could increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents may be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care to the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes:

(1) to design a cost-efficient program that allows access to a basic level of health care services for all state residents;

(2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and

(3) to define a strategy for implementing a health care program covering all Alaskans and a strategy for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update 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;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among 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;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

(12) consider the feasibility of redistributing funds currently spent by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

(14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 17 members as follows:

(1) three members of the Senate appointed by the President of the Senate;

(2) three members of the House of Representatives appointed by the Speaker of the House;

(3) three persons representing the executive branch, appointed by the Governor;

(4) eight members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, one individual representing private employers who are not health care providers, two individuals representing health care providers, one individual representing the health insurance industry, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

7-LS0681\M
Lauterbach
2/20/91

OK

CS FOR SENATE CONCURRENT RESOLUTION NO. 10 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Kerttula, Pourchot, Menard

A RESOLUTION

Establishing a Health Resources and Access Task Force.

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

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS ~~over~~ 90,000 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; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state ~~will~~ increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents ~~will~~ be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care in the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes:

(1) to design a cost-efficient program that allows access to a basic level of health care services for all state residents;

(2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and

(3) to define a strategy for implementing a health care program covering all Alaskans and a strategy for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update 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;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among 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;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

? (12) consider the feasibility of redistributing funds currently spent? by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

? (14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 16 17 members as follows:

(1) three members of the Senate appointed by the President of the Senate;

(2) three members of the House of Representatives appointed by the Speaker of the House;

(3) three persons representing the executive branch, appointed by the Governor;

(4) seven 8 members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, one individual representing private employers who are not health care providers, two individuals representing health care providers, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

O/C + REPRESENTATIVE OF ~~EMPLOYERS~~ THE HEALTH INSURANCE INDUSTRY

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

SENATE CONCURRENT RESOLUTION NO. 10

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Kerttula, Pourchot, Menard

Introduced: 2/13/91
Referred: HESS and Finance

A RESOLUTION

Establishing a Health Resources and Access Task Force.

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

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS over 90,000 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; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state will increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents will be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care in the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes.

(1) to design a cost-efficient program that allows access to a basic level of health care services for all state residents;

(2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and

(3) to define a strategy for implementing a health care program covering all Alaskans and a strategy for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update 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;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among 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;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

(12) consider the feasibility of redistributing funds currently spent by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

(14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 14 members and two alternates as follows:

(1) three members of the Senate appointed by the President of the Senate, one of whom shall be designated as an alternate;

(2) three members of the House of Representatives appointed by the Speaker of the House, one of whom shall be designated as an alternate;

(3) two persons representing the executive branch, appointed by the Governor;

(4) eight members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, two individuals representing private employers who are not health care providers, two individuals representing health care providers, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

Recd 6/28/91

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

P.O. Box H
Juneau, Alaska 99811-0650
Phone: (907) 465-3082

June 27, 1991

Dear Health Care Interest,

As you may know, Senate Concurrent Resolution 10, creating the Health Resources and Access Task Force, recently passed the Legislature. This Task Force combines the missions of the Universal Health Care Task Force and the Health Care Cost Containment Task Force. However, the future of this project remains uncertain due to recent budget cuts. The entire fiscal note for SCR 10 which included funding for project staff, travel, and contractual services was zeroed out.

The primary purpose of the Health Resources and Access Task Force is to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs. The Task Force is made up of 17 members, with three each from the Senate, the House, and the Executive Branch. These nine members select the remaining eight public members. The Senate members are Senators Duncan, Collins and Kerttula. The House members are Representatives Ellis, Boyer, and Navarre. The Executive Branch members are Commissioner Theodore Mala (Department of Health and Social Services), Commissioner Millet Keller (Department of Administration), and Commissioner Glenn Olds (Department of Commerce and Economic Development). For the purposes of getting the Task Force started, Senator Duncan and Representative Ellis have agreed to serve as temporary co-chairs until, as according to SCR 10, the Task Force members can choose a chair from among themselves.

The Health Resources and Access Task Force is soliciting applications for the eight public members. Please review the announcement on the back of this letter and reply by July 12 if you are interested in being considered.

The mailing address for the Task Force is:

Health Resources and Access Task Force
P.O. Box Y
Juneau, Alaska 99811

If you would like further information, please call either Senator Jim Duncan at 465-4766 or Representative Johnny Ellis at 561-7628. It has been my pleasure to work on this project.

Sincerely,

Nancy Cornwell

Nancy Cornwell
Project Director, Universal Health Care Task Force

06-F105LH

HEALTH RESOURCES AND ACCESS TASK FORCE

SOLICITS PUBLIC MEMBERS

The Health Resources and Access Task Force was created by the Legislature to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs.

The Task Force is soliciting applications for eight public members representing the following interests:

- (1) medically indigent
- (1) private employers (not health care providers)
- (2) health care providers
- (1) health insurer that offers health insurance in Alaska
- (1) nonprofit organizations
- (1) consumer of health services, not an employer or provider
- (1) labor organizations

If you are interested in being considered, send a resume (MAXIMUM OF 2 PAGES) TO:

Health Resources and Access Task Force
P.O. Box Y
Juneau, Alaska 99811

Resume must be postmarked by July 12, 1991. Note on the resume which of the public member categories listed above you believe you best represent. For further information, call 465-2933.

To: Rick Urion

Date: 01 March 911

RE: HCR 5 and SCR 10--talking points/DRAFT

From: David E. Johnson M.D., Alaska State Medical Association

This resolution, as introduced for consideration in both bodies in the Alaska state legislature, is flawed both in its "whereas" clauses and in its "resolveds". The "whereas" clauses in the current draft of the resolution are in some cases opinions masquerading as verities, and in other cases opinions masquerading as established public policies. Taken in sum, the clauses are sufficiently inflammatory and over-simplified that they significantly detract from rather than enhance the "resolveds". The "resolveds" are so broad-ranging that the task set out is impossible without vastly more resources than are projected.

We propose a new and much less grandiose set of "whereas" statements that can serve as a starting point that all participants can accept. The specific language could be something like this:

WHEREAS expenditures for health care in Alaska have risen faster than the overall cost of living index in the period 1980 to 1990; and

WHEREAS a substantial number of Alaskans are not covered by a group health insurance plan and do not qualify for existing state or federal public assistance programs, and some of them cannot afford to pay individual health insurance premiums or medical bills; and

WHEREAS increasing costs for health care and for health care insurance are a problem confronting all Alaskans and Alaskan institutions in both the public and private sector; and

WHEREAS Alaska has no explicit, stated health plan against which health status or health facilities or health expenditures can be measured; and

WHEREAS even a definition of what constitutes a basic level of health care and what is society's obligation to provide that basic level of health care has not been established by the legislature; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate ways to manage state health care expenditures;

The problem with the "resolveds" is that a volunteer group is being given an exhaustive charge to address a very large number of issues on a very short timetable. That means that in all likelihood the bulk of the task will fall to the staff, the tough issues will be ducked, and the task force will

perpetuate itself.

Just the first **BE IT RESOLVED** has three sections that are, in fact, at least six separate and daunting tasks:

(1) to design a cost-efficient program that

a) that allows (YET UNDEFINED) access

b) to a (YET UNDEFINED) basic level of health care services

c) for all state residents;

(2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and

(3) to define

a) a strategy for implementing a (BASIC OR COMPREHENSIVE?) health care program covering all Alaskans and

b) a strategy for continuing to contain the costs of health care in the state;

We would support narrowing the scope of work by eliminating item 3 from the first resolved and items 4, 7, 8, 11, 13, and 14 from the second resolved. Each of these items is worthy and worthwhile, and the issues raised need to be addressed, but they widen the scope of work to the point that it is virtually undoable.

The problem with the "whereas" statements is that they are taken whole cloth from the **State of Alaska Health Care Cost Containment Task Force Report to the Seventeenth Legislature.** This document, with little footnoting or explicit citation of references, presents an earnest but oversimplified snapshot of one particular point of view. In a tumble of highly questionable summaries of history, even more questionable estimates of what might come in the future, and subjective statements of social purpose and responsibility, the document provides a shaky foundation for any policy-making decisions.

To illustrate a highly questionable summary of history, refer to page 4 (bold face type is in the original): *Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods and services. **In 1990, total Alaska health care expenditures are estimated to be in excess of $1.5 billion up from $480 million in 1979.*** What is included in "health care costs"? "Two and three times"?--that's a range of 50%, not consistent with exactitude claimed in other statistics. All other goods and services? Is there any change in the population or in services rendered that explains any of the increase?

To illustrate an even more questionable estimate of what might come in the future, refer to exhibits one and two on pages 10 and 11. On page 10 Noble

Lowndes is cited as the source of the opinion that health care spending will increase exponentially, and that the state's share of health care expenditures will increase from 13% of the total in 1980 to nearly 33% twenty years later. On page 11 the same source is cited with the estimate that an exponential increase in costs will result in only a linear increase in the number of uninsureds, who will increase in this estimate from 7 1/2% of the population in 1980 to 25% of the population in the year 2000.

Earnest but very subjective statements regarding social purpose and responsibility include the summarizing sentence of the executive summary on page 6: *Although a long and far reaching list each contributing area must be comprehensively addresed to achieve the stated goal of stabilized medical costs in Alaska and basic health care access for all Alaskans.* On page 21 we read: *Wtih the increasing economic burden of health care expenditures, and the increasing number of residents without health care protection, Alaska is at a greater disadvantage than other states and nations to further its economy.* On page 28 a paragraph states: *A method must be developed to assure that the technology is available to residents without duplication or undue cost to the health care delivery system. In addition, we must weigh the benefits and cost of any new technology that has a substantial effect on the Alaska health care delivery system.* And the section titled <u>General Observations</u> in its entirety reads as follows: *Alaska has no central authority to provide health care planning, review of delivery, quality, access, and financing of health care protection. Alaska needs to have, in place, the Health Care Cost Containment Task Force, recommended long term strategies needed to assure the medical delivery system reamains accessible and affordable.*

The Alaska State Medical Association urges the legislature to define a task more clearly and less emotionally, and to focus the task force on a potentially attainable goal.

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Next month we will examine some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorced, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

Crisis: Delayed care

John Andrusyshyn worked in a Nevada casino. Three summers ago, he noticed a mole growing on his chest, but said nothing about it to his family. He could not afford to pay another bill, so he put off seeing a doctor. Andrusyshyn was not eligible for insurance from his employer until he had been at his job for a year; he couldn't afford his own coverage on the $880-a-month he was bringing home to support his wife, Karen, and two children, Laura and Nikolai (pictured at right).

Several months went by before Karen insisted he go to a doctor. Because dermatologists in Reno were booked up, three more months passed before a doctor examined him. By then, the mole had ulcerated, and John was so desperate for treatment he paid for the visit with a bad check.

The diagnosis was a malignant melanoma that was already coursing through his body. By the time he underwent surgery, he was eligible for insurance from the casino. But Karen had to scrape together $56 a week to pay his share of the premiums, forgoing food and other necessities. The policy covered the hospital bill, but not the $4000 surgeon's fee. On John's medical records, doctors noted: "Patient has no money; we'll do the best we can."

Soon afterward, the Andrusyshyns traded in their mobile home for a '62 Airstream trailer plus $1500 in cash, borrowed a credit card from a relative, and headed for Canada where John was born. As a Canadian citizen, he was entitled to free medical care. In Montreal, doctors tried various cancer treatments, including brain surgery, which he could not have paid for in Nevada. But treatment came too late. Last fall, at the age of 54, John Andrusyshyn died.

"Had we had the medical care available in Nevada like we have here, he would have said something to me," Karen says. "A little thing like an early diagnosis could have added four or five years to his life. That would have meant a lot to this family."

Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 23 other nations in the percentage of babies born with an inadequate birth weight and ranks 22nd in the rate of infant mortality, behind such countries as East Germany, Spain, and Singapore.

Shifting the cost

When the uninsured are able to obtain health care, everyone pays. Each year thousands of people are dumped into emergency rooms of public hospitals because private hospitals don't want patients who can't pay.

In 1988, unpaid hospital bills totaled more than $8-billion, up 10 percent from the previous year. To recoup the costs of unpaid care, hospitals and doctors simply raise their fees to those who do pay—primarily the private insurance carriers and the Federal government.

Such cost-shifting drives up the price of insurance, resulting in even more people who can't afford coverage. In New Jersey, for example, every hospital bill now carries a 13 percent surcharge, reflecting the hospital revenue lost to unpaid bills. That, in turn, feeds into higher insurance premiums.

Cost-shifting accounts for about one-third of the increase in insurance premiums, which are rising as much as 50 percent a year. The cost of medical care—which is increasing two to three times faster than the rate of inflation—is responsible for the rest.

Unaffordable premiums

The higher the price tag for insurance, the more people who go without it. Firms with fewer than 100 workers employ about one-third of the work force in the U.S., but only about half of them offer health insurance to their employees. Small-business owners say they have enough trouble staying afloat without assuming the heavy burden of health-insurance premiums.

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 48 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987 25 percent of the uninsured worked for very large employers, most of whom offered health insurance.

People who want coverage and must buy it on their own have little choice but to pay what the insur

ance company demands. In many instances, that can mean thousands of dollars each year. And premiums continue to rise dramatically.

Consider Stephen Beidner, a part-time worker at a California winery. When he first took out a policy with a company called Consumers United Insurance in 1985, he paid $912 a year. By 1989, his premium had jumped to nearly $3600.

Last year, after Beidner had arthroscopic surgery for a knee injury, the company hiked his premium a whopping 93 percent to $6900. After Beidner protested, the company reconsidered his case and let him raise his deductible from $100 to $1000. His new premium: $2177 a year.

Less coverage for many

Beidner is hardly alone in having to settle for less coverage. Spiraling premiums also affect millions of people whose employers provide their health insurance.

One major employee-benefits survey found that employers now spend an average of $2700 annually to cover each employee. In many cases, employers are shifting some of those ever-increasing costs to their workers by requiring them to pay a greater share of the premium and a larger portion of their medical expenses through higher deductibles and copayments. Other companies, such as American Airlines, try to reduce their insurance bill by refusing to cover preexisting health conditions for new employees.

In 1984, Hewitt Associates, a benefits consulting firm, found that 37 percent of large employers paid the full premium for their workers. By 1988, that figure was down to 24 percent. In 1984, 53 percent of large firms paid all hospital room-and-board charges for their workers; in 1988, the figure was 29 percent.

Losing coverage

About half of all large- and medium-sized firms try to trim their

Crisis: Benefits end, costs don't

David Curnow, 47, was a partner in a San Diego law firm. One Saturday, while riding his bicycle, he was struck by an uninsured motorist. After two months in intensive care, Curnow emerged a quadriplegic, paralyzed from the chest down.

His law firm had self-insured its employees' health coverage, agreeing to cover the first $7500 of a worker's claim, and paying premiums to an "excess-risk carrier" to cover the rest.

After the first $7500 was paid, the carrier refused to pay its share of Curnow's bills. Months passed. Doctors, hospitals, and companies providing necessary medical supplies dunned Curnow for payment.

Eventually the carrier paid most of Curnow's bills, which totaled nearly $250,000. But he is still waiting to be reimbursed for the services of the home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some $1500 each month—comes out of his pocket.

Curnow has another problem—how to pay for his continuing medical bills when insurance benefits from the law firm run out. If he doesn't work again, his disability will eventually qualify him for Medicare. But he will still have no insurance for services Medicare doesn't cover. Nor will he be able to buy any. Companies usually don't sell Medicare-supplement policies to the disabled under age 65. If he goes back to work, he must find a job in a large law firm whose insurance company doesn't require employees to be in perfect health. If he opts for a conversion policy from the company now insuring employees in his old firm, he will have to pay $6000 a year.

"How many sick and disabled people do you know who can afford to pay $6000 a year for health insurance?" he asks.

insurance outlays by self-insuring. They invest the money they would otherwise spend on premiums and pay employees' claims directly when they arise.

The Employee Retirement Income Security Act (ERISA) exempts these self-insured plans from state insurance regulations meant to protect consumers. For example, employers may not have to offer certain coverages, such as care for newborn children, or provide for continuation of coverage when employees leave.

Employers hire a third-party administrator, or TPA, to handle the claims. Because the administrator may be the local Blue Cross plan, employees may think that Blue Cross (or some other insurer) is actually underwriting their coverage. Little do they know that the loopholes created by ERISA can leave them without insurance if things go wrong.

If the employer goes out of business or drops the coverage, employees could be out of luck.

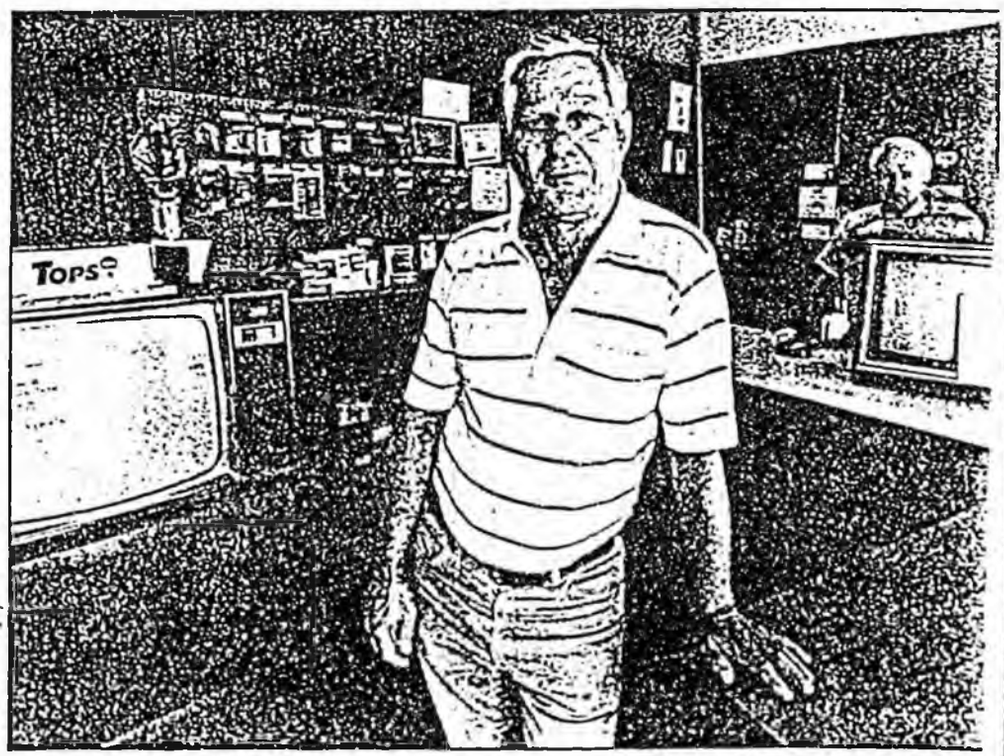
Crisis: Unaffordable premiums

Lloyd Pudiwitr owns a TV repair shop in Bakersfield, Calif. He has seven full-time employees and one part-timer. For years, he paid half the premium for his employees' health coverage. But by the end of 1988, the premiums had become so high he could no longer afford to pay his share. "It's one of those things that could break you," he says. His employees now pay the entire cost of their coverage.

Like many small employers, he changed carriers every few years, searching for the lowest premiums. Two years ago Pudiwitr, who is 55, had a heart attack, and the wife of one of his employees, Ian Sutherland (pictured in background), had cancer surgery.

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from $272 to $543, and the premium for Sutherland doubled from $421 to $842.

Luckily, Sutherland turned 65 and became eligible for Medicare, but he still must pay $450 a month for his wife's coverage. Pudiwitr has a long way to go until Medicare pays his bills, and he doesn't know what he'll do when his premiums rise again. "It's almost to the point where I can't afford it. If it doubles again, there's no way I can pay $1000 a month for health insurance," he says. "I didn't have any idea this would happen to people."



The woes at HMOs

When a health maintenance organization closes its doors, the people who received medical care there may also be left uninsured.

Established as alternatives to traditional insurance policies, HMOs provide a variety of prepaid health services to their members. Unfortunately, a number of HMOs have fallen on hard times.

Several states don't require conversion policies or continuation of coverage for members whose HMO has gone out of business. Even in states that do, HMO members have no assurance that their new coverage will be anything like the old. They may well find themselves assuming a greater portion of their medical expenses.

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

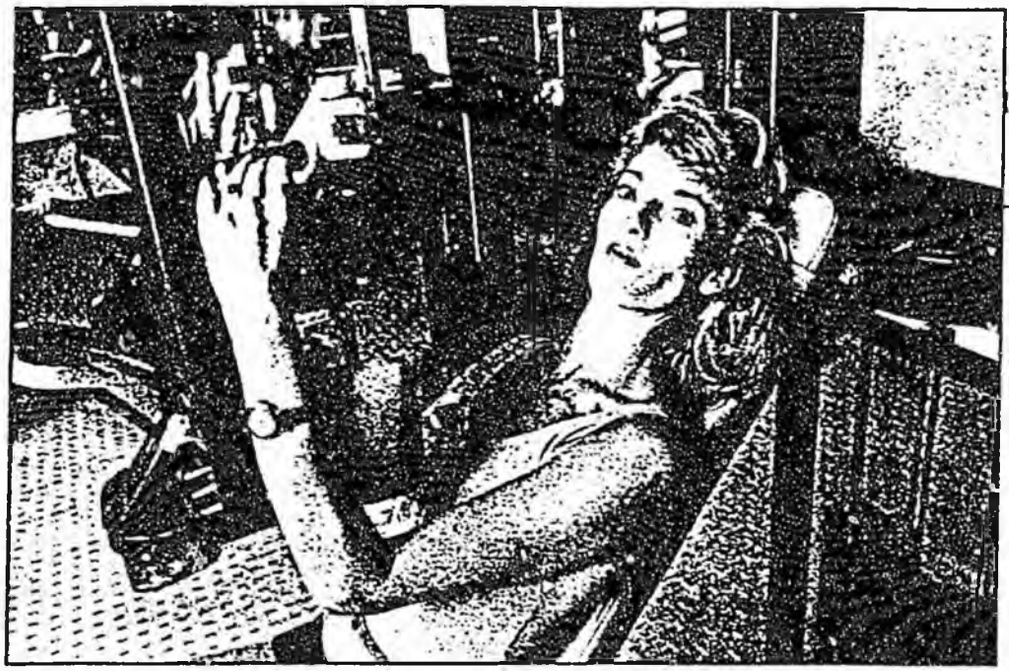
After the bankruptcy filing, Blue Cross and Blue Shield of Ohio took over Maxicare's subscribers. Stroup assumed that his $12,000 annual drug bill would be covered for the rest of his life. But Blue Cross had other ideas. It offered Stroup, who had turned 65, a Medicare-supplement policy that covered his drugs only after he paid a $2500 deductible and $1000 in coinsurance.

Stroup and his wife must now pay some $7000 a year for insurance premiums and drugs out of their $10,000 income from Social Security disability. They expect their $60,000 life savings to be depleted in 3½ years.

Clinging to coverage

Millions of Americans have yet to lose their insurance but could at any time fall victim to an insurance company's business practices. As healthcare providers continually raise their fees and pass on the higher cost of medical care to insurance companies, the companies respond by insuring fewer people. People who must buy coverage on their own and workers in small firms feel this pinch the hardest.

Insurance companies are not charities. Their goal is to make a



Crisis: Locked in

Kay Nichols, a fitness counselor at a Gainesville, Fla., health club, is in the pink of health except for glaucoma, an eye disease that can cause blindness if not treated. Not long ago, her employer wanted to switch insurance carriers to take advantage of lower premiums. When the health club found another insurer, the agent told Nichols that she would not be covered, even though her glaucoma is under control.

Nichols looked into a conversion policy from her present company but found she would have to pay $6000 for six months of coverage for her family. She tried Blue Cross, but its policy would have excluded coverage for glaucoma.

When her employer learned of her plight, he decided to keep the current policy despite its higher premiums. "If the premiums get phenomenally high, they can't keep the policy just for me, and I understand that," Nichols says. At the same time, she realizes she has a problem that won't go away. "Maybe I don't want to stay with this company the rest of my life," she says. "It makes me worry."

Nichols is 38.

profit, and they can increase their odds of success by insuring good risks who are unlikely to have health problems. Competition among carriers for the healthiest risks has become cutthroat.

In large businesses with many employees, it doesn't matter if some employees have serious medical conditions. The risk they pose can easily be spread among the healthy workers. But in a small group with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. So the rules for insuring workers in small businesses are more rigorous.

Insurers use a controversial scheme to insulate themselves from risk. They offer to insure employees in a small firm (usually those with fewer than 25 workers) at a "low-ball" premium for at least the first year. If members of the group experience costly health problems in the second and third years, the carrier tosses the firm into a pool with other groups whose health-care costs are high and jacks up its premiums as much as 200 percent.

By placing firms into several "rate tiers," insurance companies can bid for the healthiest groups with rock-bottom premiums. But employers and their employees who have had serious health problems are stuck with their present insurance carrier; they can't move to another because no other company is likely to take them at any premium. Worse, the present carrier may decide not to renew the group's coverage, forcing employers and employees to find other insurance. And that may be impossible.

No coverage for the sick

Companies insuring small groups require employees and their dependents to meet tough health requirements, just as they do for individuals buying policies on their own. No carrier wants to insure employees and dependents who have had heart attacks or cancer. They will either exclude them from the policy or decline to insure the group altogether. Sometimes a single employee with a serious disease is enough to earn a rejection slip for the whole group.

Increasingly, insurance companies are turning down people with far less serious health conditions than cancer or heart disease, excluding everyone except those in perfect or near-perfect health. "We don't want to buy a claim," is how one company official puts it.

Many people who become ill while they are working may find themselves without insurance when they leave the security of their employer's policy. Indeed, many are held hostage to their current job just to keep their insurance.

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns $19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to five weeks, she needs a lifesaving infusion of antibodies that costs about $2400.

The firm's Blue Cross policy has been paying most of the bills. But as a result of those expenses, the cost of coverage has risen sharply—both for the firm, which pays the premiums for its employees, and for the employees, who must pay the premiums for their dependents.

"When I was given my review, I was told I might look around to see if I can find another job," Turner says. "They intimated that if I did leave, it could lower the cost of their insurance."

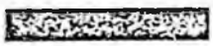
If Turner leaves her job, it's unlikely her daughter will ever again have coverage. And there's no way she can pay for the monthly infusions herself. "Without the medicine, my daughter dies. That's the black and white of the situation," Turner says.

Continued

WHICH POLICIES ARE BEST?

If you lose your health-insurance coverage for any reason, you can remain uninsured and take your chances, or you can venture into the marketplace for an individual policy. Be forewarned: You won't find a buyer's market. And even if you're in good health, you may have few options.

This report will help guide you through the process. We evaluated 71 policies from 40 insurance companies and Blue Cross and Blue Shield organizations. We rate those policies and list their features beginning on page 546. Before plunking down $2000 or $3000 for coverage, however, you'll need to know a little about how these policies work.



Declining coverage The proportion of employees in group health plans at large- and medium-sized firms dropped 14 percent from 1986 to 1988.

Types of policies

There are three basic kinds of health-insurance coverage:

☐ **Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.

☐ **Hospital-surgical policies.** These cover hospital services and surgical procedures only.

☐ **Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 539.

What's covered

Major-medical policies typically pay for most hospital services, including room and board; operating and recovery rooms; nursing care; and treatment in intensive-care units, emergency rooms, and outpatient facilities. They also pick up the tab for lab tests, X-rays, anesthesia, medical supplies, ambulance services, and physicians' office visits. Most pay for prescription drugs and cover confinements in skilled-nursing facilities, if necessary, following a hospital stay.

Some policies, however, don't pay for assistant surgeons or for standby surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

Hospital-surgical policies cover hospital room and board, often for a specified number of days; treatment in intensive-care and outpatient facilities; medical supplies; surgeon's fees; diagnostic tests relating to an operation; some radiation and chemotherapy; and sometimes second opinions. But they cover almost no expenses incurred outside a hospital. They won't pay for a doctor's office visit to check on a persistent cough, or to have your child's cast removed, or for any medical condition that does not require hospitalization. Most don't cover prescription drugs that you may need outside a hospital.

Generally, both major-medical and hospital-surgical policies pay for 30 days of inpatient treatment for mental illness and substance abuse. Some major-medical policies cover outpatient treatment as well. If they do, insurers limit the number of visits per year or even the dollar amount of their payments.

Maternity benefits

All the major-medical and hospital-surgical policies in our study pay for expenses arising from pregnancy complications. But with the exception of some Blue Cross and Blue Shield plans, they usually don't cover routine prenatal care or routine deliveries.

If you want coverage for that, you'll have to buy a separate rider, and at some companies, you'll need to decide on the rider the day you take out the policy. Some carriers won't let you buy the rider later (on the grounds that you'll probably use the coverage, and they'll be stuck with a claim). Many major-medical and hospital-surgical policies don't offer riders for routine maternity care, period.

Riders will pay up to a maximum benefit that policyholders select, usually $500, $1000, $2000, or $2500. Rarely do they cover the full cost of a normal delivery, which averaged $4334 in 1989.

Another drawback is that companies don't pay the full benefit during the first two years the policy is in force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

Annual premiums for pregnancy riders ranged from $316 at Golden Rule for a $1000 benefit to $2640 at Prudential for a benefit that would cover the hospital stay but only $1050 of an obstetrician's fee. (An obstetrician's services for prenatal care and delivery can cost as much as $4500 in some areas.)

What's not covered

Both major-medical and hospital-surgical policies cover only medically necessary care. Don't count on them to pay for routine physicals or other preventive services. (Some of them, however, cover Pap smears, mammograms, and well-child care.) Nor do companies pay for cosmetic surgery, fertility treatment, dental care, hearing aids, surgical treatment of obesity, treatment for self-inflicted injuries, or procedures that are considered experimental.

How policies pay

Insurance companies compute the amount of your reimbursement check according to their own complex formulas. The amount may be higher or lower depending on the following:

Eligible expenses. When you submit a bill for a service covered by a major-medical policy, the insurer compares it with the amount it normally pays for that service. If the charge is lower than what the company determines is "usual," "customary," "reasonable," or "common," then the entire bill is eligible for reimbursement. If it's greater, the carrier will consider only a portion of it.

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 90th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

hospital's posted charge, the hospital's cost, or a negotiated fee.)

Obviously, the higher the reimbursement standard, the more you'll receive. Unfortunately, policies don't spell that out, and some insurance companies were reluctant to explain their reimbursement standards to us.

Some hospital-surgical policies work differently, paying up to a maximum amount for each covered procedure or service listed in the policy. There's usually a fee schedule for hospital room and board, one for surgeon's fees, another for outpatient services, and a maximum amount the policy will pay for all other hospital services. This is the equivalent of a hospital-surgical policy's eligible charge.

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon who performs an appendectomy as little as $260 or as much as $480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was $846 for an appendectomy. The policy pays as little as $390 or as much as $720 for a hysterectomy; but a hysterectomy cost an average of $1737 in 1989.

Coinsurance. Once the insurer determines how much of your bill it will consider, it still pays only a portion. You pay the rest. That's called "coinsurance."

Most major-medical policies pay 80 percent of eligible expenses, leaving policyholders to pay the remaining 20 percent plus that part of the cost not covered at all.

Suppose a physician charges $3000 for an angioplasty (a cardiac procedure), but the carrier considers only $2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive $2088 (80 percent of $2610). He or she will then have to pay the remaining 20 percent, or $522, plus the $390 that's not eligible for reimbursement.

With some policies from Blue Cross and Blue Shield, a policyholder who used a "participating physician" would pay less. Participating physicians agree not to bill patients in excess of what Blue Cross and Blue Shield pays. This can be a significant advantage. Plans with this feature are noted in the Ratings.

Some major-medical policies require policyholders to pay less than the usual 20 percent coinsurance. For example, American Republic's *UltraCare* policy requires no coinsurance at all. Policies from Bankers Life and Casualty and its affiliated companies require none if policyholders select a deductible of at least $5000—that is, if the policy-

Pay by the Day? By the Disease?

THE WORST TYPES OF INSURANCE

The worst buys in health insurance are hospital-indemnity policies and dread-disease policies. Hospital-indemnity policies pay a fixed amount each day you're in the hospital. Dread-disease policies pay benefits only if you contract cancer or some other specified illness.

Such policies are a profitable staple for many well-known insurance companies and for the American Association of Retired Persons (AARP). They're sold to unsophisticated buyers through enticing but sometimes misleading advertising.

"Cash benefits of $2250 a month, $525 a week, $75 a day . . .You cannot be turned down . . .No salesman will call . . ." reads a flyer for a hospital-indemnity policy from Physicians Mutual. "Use these cash benefits any way you choose . . .Get extra benefits when you may need them most," promises an ad for a policy sold by the AARP.

The deal is simple and understandable. You get a fixed dollar amount for each day you spend in the hospital. No complicated deductibles or coinsurance. Trouble is, the fixed benefit is skimpy to start with and grows less valuable with each passing year.

At Physicians Mutual, a person can choose a daily benefit of $30, $50, or $75. AARP's top benefit is $75 for those age 50 to 64 and $45 for those 65 and older. But with the cost of a day in the hospital averaging around $800, even the most generous hospital-indemnity plans will barely dent your bill. Furthermore, to collect the high benefits touted by some of the ads, you'll need to be hospitalized as long as a month—an unlikely prospect, since the average stay is only about seven days. Finally, the benefit does not change. In time, inflation in hospital and medical costs inevitably shrinks its value.

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a $19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American Family Life, a large seller of this type of insurance, would pay a maximum of $4100; a policy from American Fidelity Assurance would cover as much as $6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

Companies also sell riders to cover such dread diseases as smallpox, polio, rabies, diphtheria, and typhoid fever. We don't know why anyone would buy them, since these diseases are now extremely rare.

Compared to other health coverages, these types of insurance are cheap. For the top daily benefit from Physicians Mutual, a 45-year-old man or woman would pay about $233 a year. A family would pay $540.

Insurers usually issue hospital-indemnity policies to anyone, whether or not they are in good health. But carriers often require a waiting period before covering policyholders for preexisting health conditions.

Most companies selling cancer insurance will not, however, issue policies to people who already have cancer. Nor do they usually pay benefits to anyone who is diagnosed as having the disease before the policy has been in force for 30 days.

These policies are no substitute for comprehensive health coverage. The price is low, but so are the benefits. With a dread-disease policy, you're also gambling that you'll contract one of the covered diseases. If you don't, the policy won't cover you.

Companies often market these policies as a supplement to other insurance. But we don't recommend them even for that. The $300, $400, or $500 you'd spend for inferior coverage may equal the difference in premium between a skimpy hospital-surgical policy and a more comprehensive major-medical policy. Or it may cover the cost of taking a lower deductible on a good major-medical policy.

THE CRISIS IN HEALTH INSURANCE

holder pays the first $5000 of covered expenses.

Other companies require policyholders to pay more. You might find policies with a 70/30 percent or even a 50/50 percent cost-sharing arrangement, especially if you don't use doctors and hospitals specified by the insurer.

Coinsurance maximums. Most policies specify a maximum dollar amount of coinsurance, typically $1000 (but it can be as much as $2500 or $5000), that policyholders must pay annually. After they've reached that amount, the carrier pays 100 percent of all additional, eligible medical expenses.

A few policies tie coinsurance maximums to the size of the deductible you select. The higher the deductible, the lower the maximum.

Several policies give a break to families. Usually two members must each pay the maximum coinsurance amount. The company will then pay 100 percent of all eligible expenses for other members who have not reached their maximums.

Lifetime maximums. Most major-medical and hospital-surgical policies cap the benefits they'll pay over a lifetime at $1-million or sometimes $2-million. A few have no cap, and others have a separate lifetime maximum for each illness or injury.

A company will sometimes give new lifetime benefits to policyholders who have generated enough claims to reach their lifetime cap. This is an important feature if the cap is low.

Deductibles. Most companies require policyholders to satisfy deductibles each year before benefits are paid. (Some hospital-surgical policies have no deductibles.) Deductibles can be as low as $100 or as high as $20,000. That means a policyholder must pay the first $100 (or $20,000) of expenses before the company pays any benefits. Obviously, a $20,000 deductible buys only catastrophic protection.

Sometimes a policy links the deductible to an illness or health condition; you would have to satisfy the deductible with each new illness. If the deductible is large and you have several different illnesses, you may never collect any benefits.

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a $1000 deductible," says John Hartnedy, the chief actuary at Golden Rule. "You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill."

As with most insurance, the higher the deductible, the lower the premium. A 45-year-old man in Chicago who chooses a $500 deductible for Benefit Trust Life's *Tele-Med* policy would pay an annual premium of $1443. If he selected a $2500 deductible, he would pay only $839.

Sometimes, for a small, extra premium, companies will waive the deductible or a portion of it if you are injured in an accident.

Can you renew?

Few companies will guarantee to renew your coverage. Of those in our study, only American Republic, Benefit Trust Life, and Metropolitan sell "guaranteed renewable" policies. The company can raise the premium, but it must continue your coverage.

Most policies, however, are now "conditionally renewable." The company can refuse to renew your policy only if it also refuses to renew all other similar policies in your state. You have some protection because the company can't single you out for cancellation. But you can still lose your coverage.

Some insurance companies use conditionally renewable policies as a lever to force insurance regulators to grant the rate increases those companies want. Certified Life, First National Life, Golden Rule, and Washington National told us they had canceled policies. In some cases, they offered policyholders alternative coverage.

A few policies are "optionally renewable." A company can opt not to renew your insurance whether or not it renews coverage for others who have the same policy. Prudential, State Farm, and Blue Cross and Blue Shield plans in Illinois, Kansas, Ohio, and Oklahoma have optionally renewable policies. (Prudential and Blue Cross and Blue Shield of Oklahoma at least say they won't cancel your policy if your health has deteriorated.)

Many companies also give themselves the option of not renewing if they find you have another policy that is similar.

Are you insurable?

People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Virtually no commercial carriers and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

If you have less serious conditions, you may get coverage, but on unfavorable terms.

Conditions that usually affect one part of the body are candidates for "exclusion riders." That is, companies will offer a policy, but exclude coverage for those conditions or that body part, either for a short period or for as long as the policy is in force. If you have had a recent knee operation, glaucoma, migraine headaches, varicose veins, arthritis, a cesarean delivery, or if your child suffers from chronic ear infections, your policy will probably carry an exclusion rider. "Any condition that would produce an immediate claim would be ridered out," says Frank Fugiel, a vice president at Washington National.

If you have a medical condition that affects your general health—for example, you're significantly overweight or have mild high blood pressure—you may get coverage, but at a price 15 to 100 percent higher than the standard premium.

Companies in our survey told us that between one-quarter and one-half of all their policies carry exclusion riders, higher-than-standard premiums, or both.

Insurers, however, are not restrictive in identical ways. Washington National will exclude coverage for your eyes if you had a cataract operation a year ago. Prudential will not. If you suffered from migraine headaches in the past but have had no treatment for the last two years, Central States Health and Life will cover future treatment for such headaches; Time will issue a policy but exclude coverage for migraines.

If a company rejects you, that fact will be recorded at the Medical Information Bureau in Boston, an industry clearinghouse. The next time you apply for coverage, the new carrier may check your file at the bureau. If it finds you've been turned down, that rejection could trigger further scrutiny of your health.

Even if your health is perfect, you still may be a less-than-perfect risk. In their quest for applicants who are

Truth will out

When you fill out an application for health insurance, be honest about your medical condition. If you don't reveal all your health problems and the company finds out about them when you file a claim, it could rescind your policy and leave you without coverage when you need it most.

unlikely to file claims, insurance companies blackball people in certain occupations. Some companies have long lists of jobs that are unacceptable, either for an individual policy or for a policy sold to employees in small firms. Chances are the insurance company won't cover you if it considers your work hazardous or if people in your profession are more likely to file claims or switch jobs frequently.

Better off at the Blues?

Historically, most Blue Cross and Blue Shield plans took all comers for individual health insurance, offering "open-enrollment" policies that anyone could buy. Even if your health was bad, you could count on getting a policy from the Blues.

Today, only 22 of the 74 Blue Cross and Blue Shield plans in the U.S. still make policies available to everyone. But their "open-enrollment" policies may require policyholders to pay a larger portion of their expenses than policies offered to those in good health. For example, the open-enrollment major-medical plan sold by Empire Blue Cross Blue Shield in New York requires 20 percent coinsurance for all services. By contrast, its high-rated *Tradition Plus Wraparound* policy, sold only to those with no medical problems, requires no coinsurance on hospital services and also offers a much lower deductible.

Most Blue Cross and Blue Shield organizations now "underwrite." That is, they evaluate an applicant's health much the same way their commercial competitors do. They decline people with cancer and heart disease and sometimes issue policies with exclusion riders and higher premiums.

It's hard to say whether you'll have an easier time buying coverage from the Blues than from commercial insurers. Most of the Blue Cross plans we contacted refused to respond to our survey. Through other sources, we obtained the plans sold by uncooperative Blues and evaluated them along with the others.

Blue Cross plans that do not exclude health conditions or charge higher premiums for them may simply refuse to sell you a policy. On the other hand, a Blue Cross plan might be more lenient than a commercial insurer. Empire Blue Cross Blue Shield does not require blood tests to detect AIDS. Kentucky Blue Cross and Blue Shield insures women with fibrocystic breast disease. Commercial carriers often require blood tests and almost always exclude coverage for fibrocystic breasts.

Preexisting conditions

If you get a policy from Blue Cross and Blue Shield or a commercial insurer, you still may have to wait a year or two to be covered for medical conditions you already have.

Most policies say that a preexisting condition is one for which a policyholder has received treatment or for which a reasonably prudent person *should have sought* treatment during the previous two years. Some policies have shorter or longer "look-back" periods. Those are noted in the Ratings. *Continued*

The Last Resort

HIGH-RISK POOLS

If you can't buy health insurance and you live in one of 23 states listed below, your insurer of last resort is a high-risk pool created for the people insurance carriers don't want. Similar to the high-risk plans for drivers who've been in accidents, health-insurance pools originated in the 1970s as the industry's alternative to national health insurance. But only in the last few years have states begun to get serious about them.

To obtain coverage, you usually must be a state resident for at least six months (a year in some states), and must have received a rejection notice from at least one carrier (Montana and Florida require two rejections).

If a carrier will insure you only at a premium exceeding the price of coverage from the pool, or if the insurance you're offered carries exclusion riders, you will also be eligible for a pool policy in most states.

The rules differ from state to state. Illinois, Iowa, Minnesota, and Nebraska, for example, allow people infected with the HIV virus to obtain a pool policy; South Carolina does not. In some states you can't get pool coverage if you're eligible for a conversion policy when you leave an employer group, even though the pool policy may be better than the conversion option.

Florida, Illinois, Iowa, Minnesota, North Dakota, Tennessee, Washington, and Wisconsin make Medicare-supplement policies available through their pools. That's a boon to the disabled under age 65 who rely on Medicare but can't find insurance to fill Medicare's gaps.

Pool coverage is similar to that offered by a major-medical policy, although benefits for mental and nervous disorders, organ transplants, and pregnancy may be less comprehensive. You may, however, pay more out-of-pocket than you would with a major-medical policy. Some plans require a high deductible, greater coinsurance, and relatively low lifetime-benefit maximums—$500,000 or even $250,000.

Premiums are no bargain, which is not surprising since policyholders in the pool will almost certainly file claims. For example, a policy with a $500 deductible from the Illinois pool will cost a 45-year-old man living in Chicago $3844 a year. That's twice as much as he'd pay for the most expensive individual policy in our study available to Chicagoans.

Long waiting lists

Pool policies provide decent coverage, but they are available only to a fraction of those who need them. CU surveyed the pools last spring and found that they now cover only 55,500 people nationwide. Pools in Illinois, Maine, and Oregon currently limit the number they can insure. The Illinois pool can issue only 4500 policies. The wait to buy into the Illinois pool is now at least a year.

It's hard to see how the pools can meet even the existing need. They operate at a loss, despite the high premiums. In most states, losses are covered by assessments against all health-insurance carriers doing business in the state. In return, some states relieve insurers from part of their obligation to pay taxes on the premiums they collect.

But the insurance industry is pressing the states to pick up more of the bill from the public purse. "We're not in the business of giving away insurance at a loss to these people," says Carl Schramm, president of the Health Insurance Association of America.

The 23 states with high-risk pools are: California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Louisiana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. (The pools in California, Colorado, Georgia, Louisiana, Texas, Utah, and Wyoming are not fully operational.) Your state insurance department can tell you how to contact your state's pool.

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The wrong job

Occupations some insurance companies consider unacceptable for health coverage:

Tree trimmers
Explosives handlers
House painters
Window cleaners
Heavy-equipment operators
Rodeo performers
Police officers
Doormen
Models
Freelance artists
Waiters
Masseurs
Hospital aides
Maids
Musicians
Bartenders
Fry cooks
Janitors
Street cleaners
Doctors
Lawyers
Pro athletes
Fishermen
Railroad workers
Test drivers
Car-wash workers
Dancers
Beauticians
Movers
Zoo attendants

To encourage applicants to reveal all their medical conditions, some companies waive their usual waiting periods *if* you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

What policies cost

The premiums you pay are based on your age, your sex, and where you live.

At Bankers Life and Casualty, a healthy 45-year-old man living in Chicago would pay $1245 a year; a 45-year-old woman, $1625; a 55-year-old man, $1748; and a 55-year-old woman, $1852.

The premium for a 40-year-old man, his 35-year-old wife, and two children would come to $3382.

A few Blue Cross plans still use "community rates," charging everyone the same premium regardless of their age or where they live. Other things being equal, older people are usually better off at a company using community rates. A 45-year-old man and a 60-year-old man living in Philadelphia would pay the same $2192 premium at Independence Blue Cross and Pennsylvania Blue Shield. But at Time, a company not using community rates, the 45-year-old man would pay only $1580; the 60-year-old, $3375.

With most policies, premiums increase as you get older. If you buy a policy at age 40, expect the premium to increase when you turn 45.

In addition to age-related increases, the rising cost of medical care also pushes up premiums every year or two. The premiums for policies in our study increased an average of 11 percent a year over the past five years. But premiums for some policies rose as much as 40 or 50 percent in a single year.

Pricing tricks

As a sales gimmick, some companies use a pricing scheme that gives policyholders a deceptively low premium the first year and very high premiums in later years.

When a company that uses so-called select and ultimate rates accepts you for coverage, it knows you're in good health and charges a low (select) premium to reflect the fact that you're not likely to file claims in the immediate future. But as the years go on, and as you make claims, the company will jack up the premium to the highest (ultimate) level.

Companies that don't use select and ultimate rates spread the anticipated costs of your claims over all the years you own the policy, so your premiums will be more stable. If you buy from a company using select and ultimate rates, you may face premium increases that far exceed what you can afford.

State insurance regulators don't require insurers to disclose whether they use select and ultimate rates, so it's often hard to know. It's a good idea, though, to ask whether a company you're considering uses such rates and to avoid their policies, especially if you plan to keep the coverage for several years. One carrier, Aid Association for Lutherans, gives buyers in some states a choice between policies with select and ultimate rates and those without, and clearly points out the differences in its sales material. (Our Ratings include Aid Association's policy without select and ultimate rates.)

Managed care and PPOs

Until recently, insurance companies seldom questioned physicians' fees. But to hold down their own costs, companies have now inserted a variety of "managed care" requirements into their policies.

As a result, you may have to ask the insurance company for prior approval for any elective surgery. You may have to use an outpatient facility for such procedures as arthroscopic surgery, dilation and curettage, and cataract removal. You may be required to seek second opinions before surgery. If you don't follow the rules, the company may reduce your benefit or increase the coinsurance and deductible you'll have to pay.

Some Blue Cross and Blue Shield plans offer Preferred Provider Organizations (PPOs). Those are groups of doctors who have agreed to discount their fees. If you sign up for a PPO and use a non-PPO doctor, you may have to pay as much as 40 or 50 percent of the doctor's bill yourself and also suffer other penalties.

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

A few other insurers also declined to participate. Celtic Life, a company waging a public campaign to educate people about shopping for health insurance, refused to shed any light on its policies or selling practices. A newcomer to health insurance, A.L. Williams, a company better known for its life-insurance policies, also declined to participate. A third company, World Insurance, claimed that if it won a favorable rating from CONSUMER REPORTS, it would not have the capacity to handle all the applications.

We rated the major-medical and hospital-surgical policies by measuring the coverage and cost-sharing features of each against actual claims, ranging from minor to catastrophic, filed by 25,000 employees. The average annual claims for a single person in the reference group totaled $1387; for families, it was $3175.

A policy that covers everything would pay 100 percent of those amounts. Of course, health-insurance policies are not designed to cover 100 percent of claims. But the best policies pay the most.

The best policy we found, a major-medical plan sold by Blue Cross and Blue Shield of Minnesota, would pay $1230 (or 89 percent) for singles and $2810 (or 89 percent) for families if you used physicians in the plan's preferred-provider organization. The worst, a hospital-surgical policy from Pyramid Life, would have paid only $490 (or 35 percent) for singles and $950 (or 30 percent) for families.

The Ratings show what percentage of the average annual claims each policy would pay after accounting for deductibles, coinsurance, coinsurance maximums, and other cost-sharing features spelled out in the contract.

Since most people want a policy that provides coverage for catastrophic expenses, we also measured how well each would pay for two major illnesses. One was a $19,774 claim for colon-cancer sur-

gery and follow-up chemotherapy. The other was a $49,767 claim for care of a serious heart attack, including an angioplasty procedure (see box on page 544).

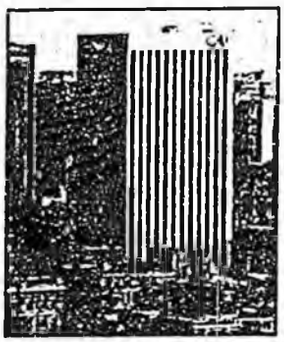
A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's lifetime benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

We could not obtain rate-increase histories or certain other information for noncooperative Blue Cross and Blue Shield plans or for new policies. Where we lacked information that might affect a plan's score,

Blue Cross and Blue Shield

ABANDONING THE MISSION



Sick people cannot buy a policy from Blue Cross and Blue Shield of Kentucky. The plan evaluates an applicant's health and rejects those with such afflictions as cancer, heart disease, emphysema, and AIDS.

Competition from commercial carriers has forced the plan to turn sick people away in order to keep its premiums affordable and attract new customers. At one time, Kentucky's Blue Cross and Blue Shield plan sold as much as 90 percent of all health insurance in the state. Today it sells just 30 percent.

The Kentucky plan, typical of many Blue Cross and Blue Shield organizations today, is a far cry from what such plans used to be. Founded by organized medicine in the 1930s, Blue Cross (and later Blue Shield) had two missions. The first was to make sure hospitals and doctors got paid. The second was to provide health insurance for the greatest number of people.

For years, the Blues had a virtual insurance monopoly. In some places, they were so powerful that they were able to negotiate large discounts from hospitals and use the savings to carry out their mission of community service. For example, Blue Cross plans subsidized such money-losers as individual health policies for the sick and Medicare-supplement coverage for the elderly.

As nonprofit organizations, the Blues had certain privileges. They paid no Federal income taxes and, in many states, no taxes on the premiums they collected.

"Community rating" was once the Blues' trademark. Everyone in the community—large employer groups, small employer groups, and individuals buying policies on their own—were in the same risk pool. They paid the same rates regardless of their age and sex, where they lived, or how sick they were.

That all began to change in the 1960s. Commercial insurers started skimming the best risks from the Blue Cross pool by offering lower premiums than the Blues charged. As large groups and then small ones took out cheaper policies with commercial carriers, the Blues increasingly found themselves covering people with health problems the commercial carriers didn't want. As healthy people deserted the pool, the Blues had little choice but to raise premiums higher and higher to cover the claims made by the sick people who remained.

In many areas, the plans also saw their hospital discounts whittled away. Some states now mandate smaller discounts and allow all insurers to receive them.

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned community rating a few years ago in favor of the kind of pricing used by its commercial competitors.

Most Blue Cross and Blue Shield plans now resemble Kentucky's. Many have become mutual insurance companies. They've lost their tax exemption from the Federal government, and they no longer try to provide coverage for everyone. Less than one-third still take all comers for health insurance. Of the 37 state regulators responding to a CU survey, only nine consider their local Blue Cross and Blue Shield plan an insurer of last resort.

"We think the Blues in our state do a pretty good job. But everyone here dislikes them, from their subscribers to the legislators," says one state insurance regulator who asked not to be identified. "They are some of the most defensive people you can imagine. Everything we ask for is a fight."

We know what he means. We asked 29 Blue plans to send us information about their policies. Only nine would do so, forcing us to seek information from state regulators, who sometimes couldn't or wouldn't help us. The California Insurance Department told us it had no rates on file for Blue Cross of California. When we asked the plan for a history of its rate increases, an official told us that information was "proprietary." When we asked the Washington Insurance Department to give us rate-increase data for the Washington and Alaska plan, the department said it could not oblige because Blue Cross had a right in that state to keep such information a secret.

"As their risk pool gets creamed, there's mission schizophrenia at the Blues," says Susan Sherry, an official at Families USA, a health-advocacy group. "It's the classic example of competition, and consumers are the real losers."

Some Blue Cross and Blue Shield plans, mostly in the Northeast, still cling to the old mission. But even for them, holding on is increasingly difficult.

In New York, a person no matter how sick can always get health insurance from Empire Blue Cross Blue Shield. It won't be the top-of-the-line policy, but it will provide some coverage.

Empire, which still uses community rates, can sell insurance even to people with terminal illnesses because their policies are heavily subsidized from premiums paid by large employer groups and from the savings obtained by negotiating a 13 percent discount with New York hospitals.

Even so, Empire officials say that the discount is not large enough, and that over the last few years some 100,000 people have left the pool, either going with commercial carriers or doing without coverage altogether. The plan has had to increase premiums on all its policies 40 to 50 percent to cover the claims of the sick people who remain.

"Our goal is to stay with the mission," says Eric Schlesinger, Empire's chief marketing officer. "But in the end, we will have a community price so high that no one will pay it, and the number of uninsured will skyrocket."

we assigned values representing the average for all plans in our survey. This lack of actual information for a plan is denoted by a dash in the Ratings. The plans are listed in order of an overall quality index that takes into account all the rating factors.

Recommendations

Naturally, you want a policy that will pay as many of your bills as possible, so coverage should be your first concern.

Unfortunately, there are few policies for any one individual to choose from. Your options boil down to a policy from one of the few remaining commercial carriers selling this insurance or one from your local Blue Cross and Blue Shield plan.

The best coverage is provided by a good major-medical plan. The plans listed high in the Ratings require policyholders to pay very few of their medical expenses.

A number of Blue plans—in Minnesota, New Jersey, New York, and Pennsylvania—ranked high. People in those states should certainly consider them. As the Ratings show, however, Blue Cross and Blue Shield organizations in other states offer mediocre or poor policies.

Fortunately, some good commercial plans are widely available. Look first at the high-rated policies offered by American Republic and Benefit Trust Life.

Maternity benefits from some of the Blues were better than those offered by most commercial carriers. Many Blue plans treat pregnancy as an illness and pay normal benefits, which will cover most of the cost of having a baby. But some offer maternity benefits only on family policies. Presumably a single woman who became pregnant would not have coverage.

Some Blue Cross and Blue Shield plans offer a choice of a regular insurance policy and a PPO. You might consider a PPO if you're willing to use its doctors rather than your own. The PPOs offered by Blue Cross and Blue Shield in Arizona, Illinois, Minnesota, and Washington and by Blue Shield of California ranked higher in our Ratings than those organizations' traditional insurance plans because they require their subscribers to pay less coinsurance.

Policies from First National and Washington National provide good benefits for catastrophic expenses but fall short in other important areas, such as policy cancellations or rate increases.

Note that the policy from the largest seller of individual major-medical insurance, Golden Rule, ranks near the bottom. The policy provides only average coverage. And the company has a history of large rate increases and canceled policies.

Once you have considered a policy's coverage and other dimensions, look at the premium. If two policies are comparable, pick the one with the lowest premium.

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay $806 a year for a hospital-surgical plan, compared with $1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

The highest room-and-board coverage offered by the hospital-surgical policy from Blue Cross and Blue Shield of Maine, for example, is $276. Some of the state's hospitals have room-and-board charges that exceed $400.

Hospital-surgical plans provide fewer benefits, and those benefits may not increase with the cost of medical care. Unless the carrier lets you upgrade, the benefits you buy today may be inadequate if you need hospital care several years from now.

If you can't swing the premiums for a high-rated major-medical policy, consider reducing the premium with a higher deductible, then budget to cover small medical expenses yourself.

If you're not in perfect health, it's hard to buy coverage at any price. It may nevertheless be worthwhile to shop several carriers to see if they'll issue coverage with exclusion riders.

If you live in Alabama, Hawaii, Maryland, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, or the District of Columbia, you will be able to buy an "open-enrollment" policy from Blue Cross and Blue Shield at least sometime during the year.

In Maine, the Blue Cross and Blue Shield organization accepts anyone for coverage, but will add exclusion riders for three years on policies for people with various health conditions.

If you live in one of 23 states with a high-risk pool, you may be able to purchase coverage from the pool.

There's no insurer of last resort for people living in the other 15 states. Short of getting a job with a large business or marrying someone who works for one, people who are unacceptable to insurance companies are out of luck. They have no choice under the current system but to join the growing ranks of the uninsured.

Ratings begin on page 54

CATASTROPHIC CLAIMS

PERCENTAGE GAMES

As part of our evaluation of health-insurance policies for the accompanying report, we measured how much each policy would help defray the actual bills run up by two patients in apparent good health who were suddenly stricken with a life-threatening illness—colon cancer and heart attack.

The case of colon cancer cost a total of $19,774, including $13,471 in hospital bills and $3665 for surgery.

The best plan we found, from Blue Cross and Blue Shield of Minnesota, would have paid about 92 percent of the $19,774 if the policyholder used only "preferred provider" doctors. (If the policyholder went to other physicians, the plan would pay up to 88 percent.) The highest-rated policy from a commercial carrier, American Republic's *UltraCare* with no coinsurance, would have paid 97 percent. A less generous major-medical plan, from Washington National, would have paid 87 percent of the claim. Least helpful was a hospital-surgical policy from Pyramid Life. It would have paid only 49 percent of the bill, leaving the patient about $10,000 in debt.

The treatment for the heart-attack patient came to $49,767. It included an angioplasty (a procedure to open blocked arteries) that cost $8730 in surgical fees, and a 21-day hospital stay that piled up bills of $34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the $49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a $28,000 debt as well as the heart attack.

WHEN YOU LEAVE A GROUP PLAN

If you leave a job, you may have two options for continuing your health insurance short of shopping for an individual policy on your own. Depending on the size of the firm you worked for and on your state's insurance regulations, you may be able to continue your group coverage for a short time as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Or you may be able to obtain an individual policy through a process known as conversion. Both options, though, will usually cost a lot more than you would spend for group coverage.

Because it is less expensive and generally offers better coverage than a conversion policy, your first line of defense should be COBRA.

COBRA: How it works

If you worked for a business with 20 or more employees, COBRA entitles you and your dependents to continued coverage for at least 18 months under your former employer's plan. If you are disabled and eligible for Social Security disability benefits when your employment ends, you can obtain an additional 11 months of coverage, for a total of 29 months.

If you are insured through your spouse's plan at work and your spouse dies, you become divorced or separated, or your spouse becomes eligible for Medicare, COBRA provides for coverage of up to 36 months.

COBRA requires that you pay 102 percent of your group insurance premium. If your employer has been paying a portion, you will have to assume that cost in addition to what you were already paying, plus an extra 2 percent for administrative costs. Disabled people who take COBRA coverage must pay as much as 150 percent of the premium for the extra 11 months.

You can lose coverage if you don't pay the premiums, if you become eligible for Medicare, if your employer discontinues health insurance for employees still working there, or if you join another plan.

However, if you join another plan and have an existing medical condition for which that plan imposes a waiting period, you can still keep your COBRA benefits until they would normally run out. By that time, your preexisting condition may be covered under the new plan. But you could be without coverage for that condition if your COBRA benefits stop before the waiting period on the new policy is over.

If you work for a company that has self-insured its workers' health coverage, you are entitled to COBRA benefits, even though such plans are normally exempt from other insurance regulations.

If you are not eligible for COBRA because your former firm employs fewer than 20 workers (or is a church organization), you may still have some protection under state laws. If your state provides for "continuation" of benefits, you may be able to stay on your employer's group policy for as little as three months in some states or as long as 18 months in others. (Those benefits are usually not available to workers in self-insured plans.)

The following states do *not* have comprehensive continuation laws: Alabama, Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Pennsylvania, Wisconsin, and Wyoming.

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

After COBRA coverage runs out, or if you're not eligible for it, your next options are to take a conversion policy or shop for individual coverage. (Unless, of course, you're covered under a new employer's health plan or become eligible for Medicare.)

The law requires that every employer who normally offers conversion policies to workers who leave also offer them to former employees once their COBRA benefits run out. Fifteen states, as well as the District of Columbia, don't require employers to offer conversion policies to employees who leave. They are: Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, and Oklahoma.

If an insurance company terminates a group plan, employees may also be out of luck. Two-thirds of the states require insurers that cancel group policies to offer conversion options to people losing their coverage.

Even when it is offered, conversion coverage is almost always inferior to what you received from your group plan. (Twenty-four states require companies to offer conversion policies with major-medical or comprehensive benefits.) If you currently have major-medical coverage, a conversion policy may provide only hospital-surgical benefits and only pay up to a fixed amount each day for hospital room and board and surgical procedures (see page 538).

For example, CIGNA, an insurer that offers several conversion options to employees converting from the group policies it underwrites, pays only $250 for hospital room and board if an employee chooses its top-of-the-line conversion coverage. For employees in a top-of-the-line group policy, CIGNA would pay most of the hospital charge, which runs considerably more than $250. (The average cost of a day in the hospital is about $800.)

While benefits are low, the prices of conversion policies are high, reflecting the fact that it is mostly people in poor health who buy this coverage. CIGNA, for example, charges a 45-year-old man or woman living in Chicago an annual premium of $4736 for its most generous conversion policy with a $500 deductible. By comparison, American Republic, the top-ranked commercial company in our study, would charge a 45-year-old man in Chicago $1904; a 45-year-old woman, $2240.

Despite those drawbacks, a conversion policy may be your only option if you have health problems. (Insurers must make these policies available to anyone regardless of their health.)

If only one member of your family suffers from some medical condition, you may want to take the conversion policy for him or her and try to find cheaper, individual coverage for the rest of the family. In some states, a person with health problems may be eligible for coverage from the high-risk pool, although in certain states, if you're eligible for a conversion policy, you can't have pool coverage.

If you're considering buying an individual policy instead of taking your conversion option when COBRA coverage ends, do your shopping well in advance. The slightest health problem can disqualify you, and it may take time for an insurer to collect your medical records and decide if it's willing to issue coverage. Once your COBRA benefits run out, you have only 31 days in most states to sign up for a conversion policy.

RATINGS

Health-insurance policies

Listed by types. Within types, listed in order of estimated overall quality, based on policies for a single person. (Family policies closely tracked single policies in overall quality.) Differences of less than 5 points were judged insignificant. Companies marked with an asterisk did not respond to our survey. Dashes indicate we could not obtain information; in those cases we assigned values representing the average for all policies.

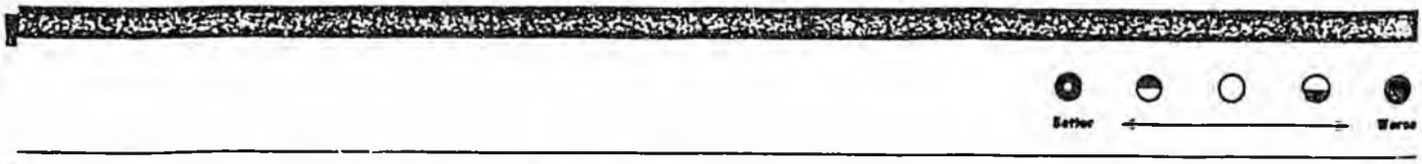
1 Annual premiums. These are annual premiums for 45-year-old **men** and **women** living in Chicago. For a company not selling there, the premium is for the company's major operating territory. **Family** premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with $500 deductibles. If the company does not offer a $500 deductible, we show the premium for the closest deductible to $500; footnotes (on pages 548-549) state the deductible on which the price is based. Premiums for **maternity rider** show the cost of adding coverage for routine pregnancies.

2 Quality index. A summary of how the policy performed for a **single** person.

3 Payout. The percentage the policy paid for a **single** person and for a **family** on an average mix of claims filed by 25,000 policyholders. We used a $1000 coinsurance maximum for each policy. If the policy did not offer this amount, we used its maximum that was closest to $1000. Most plans require 20 percent coinsurance. Exceptions are noted in the Comments.

4 Catastrophic claims. Measures how well a policy would have paid after the deductible was met on two actual claims involving catastrophic illness—one for treatment of colon cancer; the other, a serious heart attack. A policy that scored a ● paid more than 96 percent of the expenses for both claims. A policy with a ◓ paid more

		1 Annual premiums			
Policy		Men	Women	Family	Mat
Major-medical					
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	$1493 1 3	$1962 1 2	$5100 1 2	Included
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 2	1815 2	3923 3	Included
American Republic	UltraCare, no coinsurance	1904 4	2240 4	5012 4	$608
Blue Cross and Blue Shield of New Jersey	Medallion	1843 2 5	1843 2 5	4759 2 5	Included
Benefit Trust Life	MMI	1794 6	2096 6	4319 6	Included
Empire Blue Cross Blue Shield	Tradition Plus Wraparound (LGL 3252)	2392 7	2392 7	6126 7	Included
Independence Blue Cross w/Penn. Blue Shield	Major Medical w/Plan 100	2192 10	2192 10	5159 10	Included
Blue Cross and Blue Shield of Minnesota	Aware Care (F2239)	658 2	882 2	2226 2	Included
American Republic	UltraComp	1632 2	1953 2	4333 2	636
American Republic	UltraCare, 20% coinsurance	1596 4	1877 4	4200 4	608
Blue Cross of Washington and Alaska*	Personal Prudent Buyer, Low Option 200, Wash.	1092 2 8	1092 2 8	2376 2 8	None
Blue Cross and Blue Shield of Alabama*	ALPHA Plan	1308 2 9 10	1308 2 9 10	3432 2 9 10	72
Blue Cross and Blue Shield of Illinois*	Non-Group PPO	1543	1932	4363	261
Blue Cross and Blue Shield of Montana*	Personal Choice Plan	1851	1851	4241	Included
Blue Cross and Blue Shield of Montana*	Healthy Montanan Plan	1553	1553	3554	Included
Blue Cross and Blue Shield of New Jersey	Direct Payment Supplemental Major Medical	3167 10	3167 10	6135 10	Included
Blue Cross and Blue Shield of Indiana*	Personal Security	1293	1374	2935	1164
Blue Cross and Blue Shield of Oklahoma*	Health Check	1764 11	1764 11	3780 11	Included
Blue Cross and Blue Shield of Maryland*	Personal Comp	1001	1001	2604	Included
Central States Health & Life	Individual Major Medical (569-570, 571-572)	1463 2	1900 2	3721 2	781
Time	24 Karat (502)	1580 2	1876 2	3854 2	490
Benefit Trust Life	Tele-Med	1443	1822	3878	1257
Bankers Life and Casualty	VIP V (CR-G002)	1245 2	1625 2	3382 2	None
Bankers Multiple Line	The Spectrum Plan (D-G002)	1245 2	1625 2	3382 2	None
Union Bankers	The Spectrum Plan (MM-89)	1245 2	1625 2	3382 2	None
Blue Shield of California*	Preferred	1952	1952	3299	None
Blue Cross and Blue Shield of New Jersey	Blue Care	1261 2	1261 2	3400 2	Included
Blue Cross of Washington and Alaska*	Traditional Individual in Alaska	1933	1933	4123	None
Blue Cross of California*	Personal Prudent Buyer	1680	1680	3888	3360
Blue Cross and Blue Shield of Illinois*	Non-Group Comprehensive	1838 13	1992 13	4886 13	None
Blue Cross and Blue Shield of Maine	Blue Alliance	1294 13	1294 13	2580 13	Included
Empire Blue Cross Blue Shield	Tradition Plus Comprehensive (LGL 3253)	1507 14	1507 14	3228 14	Included
Benefit Trust Life	MM2	1496	1751	3603	None
Blue Cross and Blue Shield of Arizona*	Preferred Care	716	716	1928	None
Aid Association for Lutherans	TotalMed II (4945)	1708 2	1724 2	4032 2	1850



than 90 percent. A policy with a ○ paid at least 81 percent, and a policy with a ◒ paid at least 75 percent of the expenses.

5 Lifetime maximum. Total benefits a policy will pay over a policyholder's life.

6 Maternity coverage. This shows the quality of the maternity rider that covers routine pregnancies and deliveries. If a policy offered coverage for complications only if policyholders buy a rider for routine coverage, it scored a ●. It scored a ◒ if it offered coverage for complications without requiring purchase of the rider.

7 Renewability. **Guaranteed** means the policy is guaranteed renewable for the policyholder's life. **Conditional** means that the company can cancel it along with all similar policies. **Optional** means the company can cancel an individual policy.

8 Rate history. A ● indicates that over a five-year period the company has raised rates on the policy less than the medical consumer price index, which averaged 7.2 percent each year over the period. A ◒ means that it raised rates at least 17 percent a year.

9 Preexisting illness. The **waiting period** is the number of **months** a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for disclosed illnesses. The **look-back period** is how far back in time the insurance company will investigate for preexisting illness.

10 Available to anyone. A "yes" indicates the policy is available to any applicant regardless of health status.

11 Exclusion riders. A "yes" indicates the company will issue coverage with exclusions for certain conditions or for certain parts of the body.

12 Higher rates. A "yes" means the company will issue coverage but at higher premiums for some medical conditions.

13 Other coverage. Additional coverages and features a policy may offer. See Key.

	3 Payout						9 Preexisting illness									
	Quality index 2	Single	Family	Catastrophic claims 4	Lifetime maximum 5	Maternity coverage 6	Renewability 7	Rate history 8	Waiting period, mo.	Look-back period, mo.	Available to anyone 10	Exclusion riders 11	Higher rates 12	Other coverage 13	Comments	Telephone
	85	89%	89%	●	None	●	Conditional	●	24	3	No	Yes	Yes	a,b,c	A	800-382-2000
	83	84	87	●	None for basic policy	●	Conditional	◓	12	12	Yes	No	No	a,c,d	C	717-255-0820
	81	82	68	●	$1-million per condition	○	Guaranteed	●	24	24	No	Yes	Yes	a,d	B	800-247-2190
	80	88	88	●	None	◒	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500
	80	86	85	○	1-million	●	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	80	83	82	●	1-million	◒	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757
	80	83	83	●	None for basic policy	◓	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100
	79	76	72	●	None	◓	Conditional	●	24	3	No	Yes	Yes	a,c,h	—	800-382-2000
	78	74	60	●	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190
	77	75	61	●	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190
	75	82	67	—	1-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663
	75	75	60	—	None for hospital	○	Conditional	●	12	24	No	Yes	No	a	J	800-392-5705
	75	73	61	—	1-million	◓	Optional	●	12	12	No	No	No	a,c,h	E	312-938-7209
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	74	74	●	None for basic policy	●	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500
	74	62	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075
	74	77	72	—	1-million	◓	Optional	●	12	6	No	Yes	No	a,c,h	K	918-560-2121
	74	73	72	—	1-million	●	Conditional	◓	9	No limit	No	Yes	No	a,c,d	—	800-992-2308
	73	73	60	●	1-million	○	Conditional	●	12	24	No	Yes	Yes	a	—	402-397-1111
	73	72	60	◓	2-million	○	Conditional	●	24	12	No	Yes	Yes	a	—	800-333-1203
	72	71	58	◓	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	214-939-0821
	71	73	60	—	2-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150
	71	70	70	◓	100,000 per year	●	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500
	71	75	60	—	1-million	◒	Conditional	◓	12	12	No	Yes	No	a	—	800-752-6663
	71	68	55	—	2-million	◓	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-6000
	71	70	56	—	1-million	◒	Optional	●	12	12	No	No	No	a	—	312-938-7209
	70	67	72	—	None for basic policy	◓	Conditional	●	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966
	70	61	59	●	500,000	●	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757
	69	72	60	○	1-million	◒	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	69	75	62	—	1-million	◒	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	800-543-2944
	69	71	60	◓	2-million	○	Conditional	●	24	No limit	No	Yes	Yes	a,d	—	414-734-5721

Ratings
Continued

Policy	Annual premium: Men	Women	Family	
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 928	$ 987	$2108	$116
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 12	2044 12	4359 12	Incluc
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 12	1169 12	2454 12	Incluc
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2085	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1208	1208	2653	Inclu
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Inclu
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 14	2042 14	4030 14	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 2	1748 2	3382 2	Non
First National Life	Major Medical (MM-286)	1005 16	1137 16	2142 16	748
Blue Shield of California*	Coronet	2941 14	2941 14	4229 14	Non
Pyramid Life	G91	1501 2	1863 2	4015 2	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3623	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 14	940 14	1814 14	Non
Prudential	Pru-Med (PM-83)	1228 2 14 17	1584 2 14 17	3127 2 14 15	264
Washington National	Classic Choice (AM2836)	1764 2	2205 2	3249 2	90
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 16	1579 16	3451 16	Incl
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 16	1968 16	4729 16	Incl
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 16	2004 16	3742 16	Incl
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 16	1250 16	2472 16	Incl
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 20	1216 20	2966 20	Incl
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 9	756 9	1848 9	Inc
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 16	1162 16	2846 16	Nor
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 16	1033 16	2058 16	Incl
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 8	814 8	1844 8	Inc
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 16	1266 16	2683 16	51
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 16	1336 16	2796 16	Inc
Blue Cross and Blue Shield of New Jersey	Co-op Protection Plan and Series 14/20	1992 16	1992 16	3439 16	Inc
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	806 2	1043 2	2137 2	Nc
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 2	1043 2	2137 2	Nc
Union Bankers	Major Hospital Surgical (HS-89)	806 2	1043 2	2137 2	Nc
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 4	853 4	2177 4	Nc
Certified Life	Hospital Surgical Protection (CER-G020)	806 2	1043 2	2137 2	Nc
Pyramid Life	G95	1016 2 16	1250 2 16	2472 2 16	6
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 16	839 16	1886 16	Ir

1 *$500 deductible on hospital services only.*
2 *Rates for nonsmokers.*
3 *$350 deductible on nonhospital only.*
4 *$500 deductible for each condition every 3 years.*
5 *$300 deductible only for supplies and drugs.*
6 *$250 for nonhospital services.*
7 *$300 deductible.*
8 *$200 deductible.*
9 *$200 deductible for each hospital admission.*
16 *$500 deductible on nonhospital only.*
17 *$400 deductible.*
18 *$750 deductible.*
19 *$300 deductible for each hospital admission; $500 for all services.*
14 *$1000 deductible.*
15 *$200 deductible for nonhospital services.*
16 *Atlanta rates; $500 deductible for each condition.*
17 *$100 deductible for hospital inpatient stays only; $1000 for other services.*
16 *No deductible required.*
19 *$250 deductible.*
20 *$60 deductible for each hospital admission.*

Key to Other Coverages
a–Prescription drugs for home use.
b–Preventive care for all ages.
c–Participating physicians for all families
d–Mammography
e–Pap smears.

	Quality index			Payout				Preexisting illness									
	2	Single	Family	4	Catastrophic claims	Lifetime maximum 5	Maternity coverage 6	Renewability 7	Rate history 8	Waiting period, mo.	Look-back period, mo.	Available to anyone 10	Exclusion riders 11	Higher rates 12	Other coverage 13	Comments	Telephone
	69	74%	60%	—	$1-million		○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075
	68	66	65	—	1-million		●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164
	68	66	65	—	1-million		●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164
	68	70	62	—	1-million		◒	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600
	68	74	61	—	1-million		◒	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663
	67	70	58	◓	1-million		○	Conditional	◓	12	No limit	No	Yes	No	a	—	800-868-2500
	67	70	67	—	1-million		●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622
	67	71	68	—	1-million		●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011
	65	62	51	◓	1-million		○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211
	64	75	64	●	None		◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	64	65	53	●	1-million		○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850
	63	65	53	—	2-million		◒	Conditional	◒	12	12	No	Yes	No	a,c,d	—	800-624-5150
	63	72	60	◓	2-million		○	Conditional	◒	24	24	No	Yes	Yes	a,d,e	—	913-722-1110
	62	74	60	●	1-million		○	Conditional	◒	12	24	No	Yes	No	a	—	817-297-4123
	61	62	51	—	1-million		◒	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944
	61	63	55	○	None		○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642
	61	71	59	◓	2-million		○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500
	81	77	80	●	None		●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820
	77	76	77	●	None		●	Conditional	○	12	12	Yes	No	No	c	C	215-564-2100
	76	70	70	—	None		◓	Conditional	◓	6	6	Yes	No	No	c	B,L	313-225-8000
	76	76	75	—	None		●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200
	71	63	66	—	None		●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200
	70	71	75	—	500,000		●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797
	68	58	50	◓	none		◒	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211
	67	55	53	—	none		◓	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3535
	67	59	59	—	1-million		◓	Conditional	—	12	12	No	No	No	c	F	406-444-8210
	66	62	66	—	1-million		◓	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	216-687-7218
	62	65	67	○	None		●	Conditional	◒	12	12	No	No	No	f	B,H	201-822-4500
	61	63	66	○	None		●	Conditional	◒	12	12	Yes	No	No	f	C,H	201-822-4500
	58	52	45	◓	None		◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None		◒	Conditonal	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	58	52	45	◓	None		◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	53	55	45	◓	1-million		◒	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311
	50	52	45	◓	None		◒	Conditional	◓	24	24	No	Yes	Yes	—	—	312-777-7000
	42	35	30	◓	2-million		○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110
	67	68	72	◒	None		●	Conditional	●	11	24	Yes	No	No	d	B	212-490-4757

f-Participating physicians for families below some income levels.
g-$50/year for preventive care per person.
h-Well-child care.
i-Major-medical coverage after $2500 deductible is met.
j-Major-medical coverage after $25,000 of covered expenses are incurred.

Key to Comments

A-Coinsurance on hospital and $10 copayments for physicians' visits.
B-No coinsurance.
C-Coinsurance only for certain services.
D-Less coinsurance after the first year.
E-If PPO doctors not used, coinsurance and coinsurance maximums are higher.
F-30 percent coinsurance.
G-Pays a set amount for hospital room and board.
H-Surgical-fee schedule.
I-Pays set amount for all services for each day in the hospital.
J-Routine maternity rider offered only with family policies.
K-Routine maternity coverage is included as part of policy only with family policies.
L-Maternity coverage only for delivery and hospital stays—no doctor visits covered.
M-Routine maternity coverage and coverage for maternity complications offered only with family policies.
N-No maternity coverage even for complications unless rider is purchased.

THE CRISIS IN HEALTH INSURANCE

PART 2

Last month, in the first part of this series, we looked at the problems millions of Americans have in obtaining and keeping health insurance. We evaluated 71 individual health-insurance policies sold by 40 commercial carriers and Blue Cross and Blue Shield organizations, and discussed other alternatives for people who lose their group insurance.

This month, we go beyond the short-term remedies to examine the various solutions to the health-insurance crisis that have been proposed by insurance companies, physician organizations, and the business community. We also visit Canada to look at how that nation pays for its health care. The Canadian example is considered by some as a model for the U.S.

HEALTH INSURANCE FOR ALL?

The American health-care system is the costliest in the world. The U.S. spends 171 percent more on health care per person than Great Britain; 124 percent more than Japan; 88 percent more than West Germany; and 38 percent more than Canada.

Over the last five years, the cost of health care in the U.S. has risen 42 percent, faster than the cost of food, housing, or transportation. In 1990, the nation's medical bill will total some $666-billion, or about $2564 for every man, woman, and child. Health-care spending now consumes 11¼ percent of Gross National Product; by the end of the decade, it could account for as much as 15 percent.

Not all of those dollars pay for medical treatment. The cost of administration, claims handling, and insurance-company bureaucracy eats up at least $65-billion, almost 10 percent of the total. "We waste more of our medical dollars on bureaucracy and paper pushing than any other country," says Dr. David Himmelstein, national coordinator of Physicians for a National Health Program.

Despite the vast sums poured into health care, the U.S. ranks 12th in life expectancy, behind Japan, Italy, France, and the Scandinavian countries. It ranks 21st in the number of deaths of children under age 5; 22nd in infant mortality; and 24th in the percentage of babies born with an adequate birthweight (Bulgaria, Hong Kong, and the Soviet Union all do better on that last measure).

Among industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens.

A joint venture

The U.S. health-care system is built on a lucrative partnership of fee-for-service medicine and private insurance. For years, doctors and hospitals had carte blanche to set their own fees and pass the cost of their services along to private insurance carriers or to their patients. Insurance companies (and patients) rarely questioned the amount of those bills. "No one ever paid us to go fight with doctors," says one insurance executive.

If fees rose higher than the premiums the insurance companies needed to pay claims and turn a profit, the insurers simply raised the price of coverage. Policyholders could either pay the higher premiums or go uninsured.

The cost of medical care has now forced insurance premiums so high that millions of people *are* going uninsured. "The whole system keeps pricing more and more people out of it," admits Howard Bolnick, president of Celtic Life, a seller of health insurance. "The mar-

ket is working efficiently, but it's less than optimum from society's point of view."

Decades of debate

As more people are squeezed out of the American health-care system, and as basic public-health statistics underline the system's comparative inadequacies, a decades-old debate over public-health policy has been rekindled. The debate has been simmering for some 80 years.

In the years before World War I, in the 1930s, in 1949, in 1965, and again in the 1970s, the U.S. seemed on the verge of establishing universal health insurance. A 1939 issue of CONSUMER REPORTS noted: "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'"

A decade later, in 1949, we reported: "As the new Congress meets, prospects for national health insurance have never looked better. There are a number of reasons why 1949 may see a Federal insurance law passed at last. The American public has overwhelmingly demonstrated its approval of health insurance in many surveys, in legislative programs of consumer, civic, and labor groups, in government policy reports, and in endorsements by political leaders. Soaring prices have made the cost of medical care even more difficult for most families to afford."

Sixteen years later, a national health-insurance program still hadn't come to pass, despite the committed leadership of President Lyndon Johnson. In 1965, after powerful lobbying against national health insurance by organized medicine, Congress voted to authorize it only for the elderly, in the form of Medicare. (At the same time, it established Medicaid, a new government program for the poor.)

Even then, the Medicare Act was tailored to the economic demands of the American Medical Association and Blue Cross and Blue Shield, the primary insurance carrier of the day. Fee-for-service medicine and the Blue Cross method of reimbursing health-care providers became part and parcel of Medicare. They laid the foundation for today's towering health-care costs. (Blue Cross and Blue Shield also got the job of paying Medicare claims for the Government.)

Again in the 1970s, there was serious talk of universal health insurance. But President Jimmy Carter could not muster the political backing needed to fulfill his campaign pledge to implement it.

How has a system that costs so much and still falls short managed to survive and resist reform?

The power of the AMA

Fearful that universal health insurance will lower the incomes of its 271,000 members, the American Medical Association has for years denounced national health insurance as "socialized medicine." More to the point, the AMA has paid politicians handsomely to view national health insurance in the same light.

The AMA is one of the largest contributors to political campaigns, appearing near the top of almost every list of the big money raisers, the big contributors, and the big trade association political action committees (PACs) compiled by the Federal Elections Commission.

During a 15-month period ending in March 1990, the AMA ranked second on the election commission's list of the top 50 PACs in amount of receipts, second in total spending (which includes funds for advertising and mailings as well as contributions), and seventh in the amount of cash on hand, with some $2-million in reserve to bankroll future campaigns.

In the 1988 Congressional elections, the AMA spent $5.3-million, including $2.3-million in direct contributions to House and Senate candidates. From January 1989 through March of this year, it has given money to 348 members of Congress, including eight of the 12 Congressional members of the Pepper Commission, a bipartisan group composed of members of Congress and industry representatives that was established to study health-care financing and recommend changes. The Commission was chaired by Sen. John D. Rockefeller IV, D-W.Va.

To replenish its coffers, the AMA embarked on a special effort last year to discredit the Canadian health-care system, often viewed as a model for reform in the U.S. In what it called its "Strengthening the U.S. health-care system" campaign, the AMA wrote to member physicians: "We need your help to continue reaching millions of Americans. We must tell them the facts about the dangers in a Canadian-type health-care system—before it's too late. Help us continue publishing our messages in leading magazines and newspapers . . . ." Enough doctors sent checks that the AMA was able to buy ads disparaging the Canadian system in major magazines. (For one example, see the illustration on page 610.)

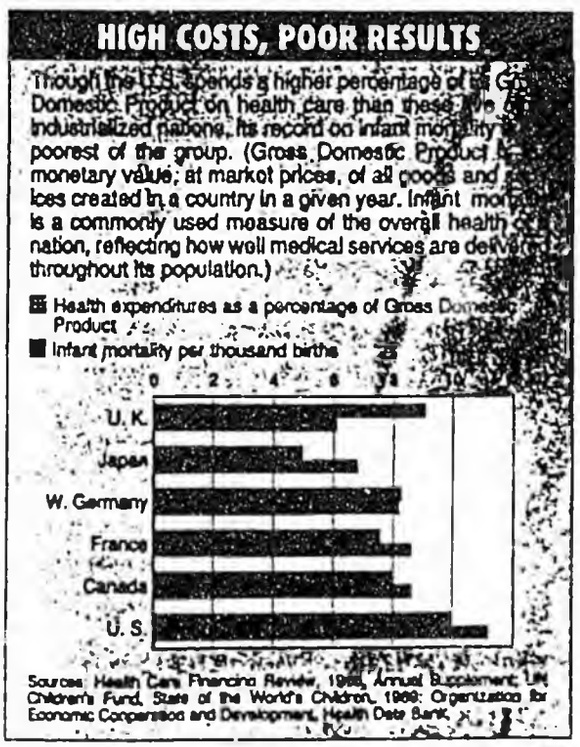
The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some $4.1-million on behalf of political candidates.

Insurance clout

The insurance industry's stake in the battle is the $175-billion it collects each year in health-insurance premiums. In a letter sent to member companies last summer, Carl Schramm, president of the Health Insurance Association of America (HIAA), warned that "a move in the United States to a Canadian approach to health-care financing is antithetical to our interests." Schramm subsequently told CU: "We'd be out of business. It's a life-and-death struggle."

The insurance industry also shovels money at politicians. American Family Corp., the fifth-largest seller of health insurance, particularly dread-disease and cancer policies, ranks eighth on the election com-

Doctors on the picket line
Just as organized medicine in the U.S. has opposed universal medical insurance, many Canadian physicians were none too fond of the notion. When Saskatchewan became the first province to adopt universal medical coverage, doctors there went on strike. When Quebec followed suit in 1970, its doctors also staged a short strike.



mission's list of the top 50 corporate campaign contributors, ahead of such giant corporations as Boeing, Citicorp, and Ford Motor Co. It donated some $250,000 from the beginning of 1989 through March of this year. Three other large sellers of health insurance—The Travelers, Metropolitan, and Prudential, all of which collect well over $1-billion in health-insurance premiums each year—are also among the top 50 corporate contributors.

But the insurers don't limit themselves to campaign contributions. Their forte is "educational" lobbying. "We produce lots of research bulletins that are classy little numbers," HIAA president Schramm told CU. When the Pepper Commission issued its report last March, its recommendations for reforming sales practices in the small-employer market were strikingly similar to those of the HIAA. "The Pepper Commission basically ceded the small-group issues to us," Schramm says. "They [the commission's recommendations] are our proposals."

Changes in the wind

But public dissatisfaction with the current system has once again brought health insurance onto the national agenda. Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 percent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals." This year, a Los Angeles Times poll asking a similar question found that 66 percent of Americans would prefer a health-insurance system similar to Canada's. "People are far ahead of the political leadership on this issue," says Susan Sherry, an official at Families USA, a senior citizens health-advocacy group.

The business community has also become vocal on the issue. Some corporate leaders are calling for changes that they would have considered unthinkable a few years ago. "We need fundamental reform. Whether we have the courage to move forward remains to be seen," says Walter Maher, a lobbyist for Chrysler Corp. Chrysler says that workers' health insurance adds $700 to the cost of every car it builds in the U.S.—an amount that must come down if the company is to remain competitive.

Not all doctors side with the AMA. The 68,000-member American College of Physicians is calling for reforms that would guarantee all Americans access to medical services and reduce the waste and inefficiency in the present system. The 3000 members of Physicians for a National Health Program have a similar goal. (Those groups, however, don't back their programs with political contributions.)

Privately, even some insurance-industry executives recognize that universal health insurance is probably inevitable, and they have been preparing for their eventual role in it. "Some companies are saying, 'If we can survive until there's national health insurance, we have a shot at administering it,'" says an official at one Blue Cross and Blue Shield organization.

Solving the crisis

A number of remedies for the health-insurance crisis have been proposed by various interest groups. Some are limited; others are more far-reaching. Some deal only with controlling costs of the health-care system. Others confront the more basic question of providing access to care for everyone. Among the proposals likely to be part of the public debate in the coming months are these:

1. Encourage people to use fewer medical services by writing higher deductibles into policies. The theory behind this proposal is that when people pay a greater share of their bills, they'll use health care more frugally. As a result, the argument goes, health-care costs will decrease, premiums will rise more slowly, and more people will be able to afford coverage.

Such a notion assumes that people prescribe their own medical care. Most of the time they don't; their doctors do.

Health-care providers also stimulate much of the demand for elective medical care. Hospitals now advertise in magazines, on television, and on billboards—drumming up business for their inpatient psychiatric services, for example, when such cases might be handled more appropriately on an outpatient basis. As part of its corporate-image promotion, General Electric advertises magnetic resonance imaging machines (MRIs) on television. "It doesn't hurt to have people aware of MRIs," says a GE spokesperson. If people ask for MRIs instead of ordinary X-rays, hospitals will have no choice but to shell out $1.4-million to $2-million for a machine.

Higher deductibles may indeed make some people think twice before seeking care in the first place. While discouraging unnecessary services is a reasonable goal, there's an obvious danger that people will postpone *necessary* treatment. Then more costly procedures may be necessary, or it may be too late.

There is even some doubt as to whether any savings would result from a switch to higher deductibles. "Our experience has shown that higher deductibles have not prevented our [claim] costs from going up," says Andy Perkins, a vice president at The Travelers.

2. Do away with state-mandated benefits. Each state requires that health-insurance policies sold there include certain coverages. These so-called state mandates vary among states, but many require insurers to cover newborn babies, adopted children, prenatal care, and


In Some Countries She Could Wait Months For Her Surgery...

On the offensive To counteract positive media portrayals of universal health insurance programs in Canada and elsewhere, the American Medical Association launched a national advertising campaign in 1989. This ad ran in Newsweek.

mammographic screening. They may also offer employees the option of continuing their coverage when they leave a job.

The insurance industry contends that some mandated benefits, such as coverage for visits to psychologists, podiatrists, chiropractors, and social workers, are of questionable value and unnecessarily raise the price of insurance. However, the industry has no estimate of the overall premium savings that would result.

In CU's view, repealing mandated coverage moves in the wrong direction—toward less access to care. To shave a few dollars off premiums, more women would lose their prenatal care, more newborns and children would go without preventive treatment, and more employees would have no coverage when they left their jobs.

3. Design stripped-down policies. Some insurance-company and Blue Cross and Blue Shield executives have suggested designing policies with limited benefits that they can sell for about half the price of more comprehensive coverage.

While such basic policies might improve the overall statistics on the uninsured, they, too, would result in less coverage for individuals. We reported on some of them last month. An "affordable" basic policy from Blue Cross and Blue Shield of Oklahoma, for instance, covers only 21 days of hospital care. That might be enough for most sicknesses, but a catastrophic illness or injury would leave a policyholder uninsured and possibly on the road to bankruptcy. A person whose serious heart attack cost almost $50,000 would have been left $10,000 in debt by an affordable hospital-surgical policy sold by Pyramid Life, the policy that ranked at the bottom of our Ratings last month.

4. Institute "managed care." Under the rubric of "managed care," insurance companies are belatedly paying attention to what their dollars are buying. Managed care includes formal programs for monitoring the quality of treatment and determining whether it's appropriate for the patient's condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals, and to obtain approval from insurance companies before starting a proposed course of treatment.

Managed care attempts to put controls on doctors—ironically some of the same controls doctors have feared from a national health-insurance program. In the process, it is creating a brand-new profession, health-care cost management, one of the fastest growing segments of the health-care industry. Health-care cost management firms are expected to generate some $7-billion in revenue in the next few years—revenue that will, of course, come from insurance premiums.

Whether the savings in the cost of health care will be greater than the money spent to "manage" it remains to be seen. "None of this stuff has done anything to make the fundamental health-care system cost less and [be] more efficient," says Curt Fuhrmann, president of the individual health division of Washington National. And even if managed care eventually reduces the nation's health-care bill, it will do nothing to expand access to medical services for people who currently have no insurance coverage.

5. Establish risk pools. The insurance industry wants each state to set up a high-risk pool that would provide policies for people the companies don't want to insure. Such pools are yet another way for the industry to shed a group of policyholders who are not profitable. The HIAA further proposes that the states pick up the tab for pools' losses; that is, make up the difference between what the pools collect in premiums and what they pay out in claims.

Last spring, when we surveyed the risk pools that had been organized in 19 states, we found that they covered only about 55,500 people in total, and all the pools were operating at a loss. Pool administrators estimated that at least 413,000 people in those states needed pool coverage but couldn't obtain it. In Illinois, for example, the waiting list was so long that people have to wait at least a year for coverage.

6. Expand Medicaid coverage. When Medicaid was first established in the mid-1960s, it covered some 70 percent of those with incomes below the poverty line. Today Medicaid covers just 38 percent, because states and the Federal government have raised their eligibility standards.

The insurance industry and the American Medical Association want to reverse that trend by requiring Medicaid to cover anyone whose income falls below the official poverty line, currently $12,675 for a family of four; $8075 for a couple; and $6314 for a single person.

Under some proposals, people whose incomes are as high as twice the poverty level could "buy" Medicaid benefits. Under other proposals, these people would have to turn to the private market for their coverage. It's hard to see how any family whose income is around $13,000—or even $26,000—can afford some of the policies we rated last month. Premiums for families of four ranged from about $2000 to more than $6000 a year.

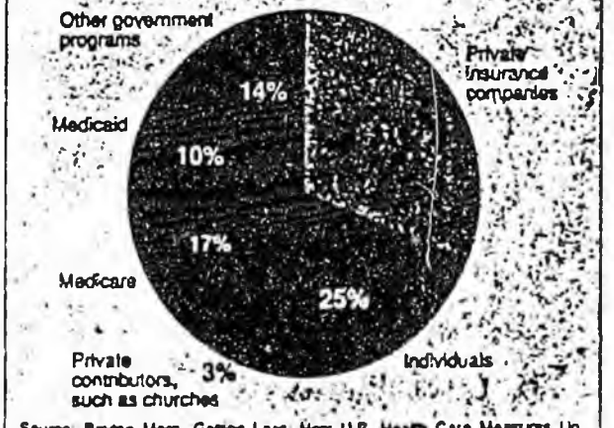
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

Putting Medicaid cards into the hands of more people wouldn't necessarily assure them access to health care. Many doctors refuse to treat Medicaid patients because reimbursement rates are low. Reforming Medicaid would expand coverage for some, but it would also increase the government bureaucracy needed to determine eligibility. It is at best a stopgap measure that will do little to curb waste in the health-care system.

7. Reform insurance-company practices. One plan proposed by insurers themselves would excuse people who were once covered under a small employer's group policy from satisfying a new waiting period for pre-existing illnesses

WHO WRITES THE CHECKS?

As costly as the private-insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1990

Signs of the times Hospitals in some parts of the country now advertise to fill their beds, partly because of recent insurance-company rules requiring that more procedures be done on an outpatient basis. These two billboards beckon motorists along a New Jersey highway.

when their employers change carriers or when they change jobs. In those cases, people with health problems would have immediate coverage. This proposal would also prohibit insurers from excluding coverage for certain health conditions or parts of the body by means of exclusion riders.

But insurers still don't want to take on any unnecessary risk. So their proposal also calls for the establishment of a reinsurance agency (essentially a company that insures insurance companies) to assume the risk of waiving pre-existing conditions clauses and eliminating exclusion riders. Insurers themselves would fund the reinsurance program through assessments, but if assessments proved to be inadequate, the government could be called on to make up the difference.

Another industry-sponsored proposal would limit the sometimes huge annual increases experienced by employees who work for small firms—to no more than 15 percent above an insurance company's general yearly rate increase for all its policyholders.

Both of those proposals would help people already safely inside the insurance loop. But they won't help people with health problems who are outside the system or who must buy their own coverage.

8. Require all employers to offer coverage. The main proponent of this approach is Senator Edward Kennedy. He is sponsoring a bill that would require all employers to offer insurance to employees who work at least 17½ hours a week. Under Kennedy's bill, employers would also have to pay 80 percent of the cost of a basic package of benefits for their full-time employees.

Others have proposed variations on Kennedy's plan. These so-called pay-or-play approaches to health-care coverage would require employers to offer insurance to their workers or pay into a special government-operated fund that would provide the coverage. In other words, employers would either "play" by providing coverage or "pay" into the special fund. The Pepper Commission recommended such a plan.

To win support of the AMA, Kennedy's bill does not address cost containment. More people would be covered, but most doctors and hospitals would still have a blank check. That omission, a serious one in CU's view, has also given employers and the insurance industry reason for opposing this approach.

Lobbyists for small business argue that the costs of providing coverage are too great for many marginal firms. Unless small businesses received tax relief in exchange for providing coverage, this approach could give them a powerful incentive to hire employees to work fewer than 17½ hours a week. Seasonal and part-time workers could still be left without insurance.

Congress is likely to give pay-or-play proposals serious consideration in the next few years. At best, these proposals can expand insurance coverage for some people. At worst, they fail to offer a way to curb health-care costs. They also perpetuate the current system of private insurance with all its administrative waste. In fact, they would add another layer of administrative bureaucracy in creating the special government fund for workers whose employers would still not provide coverage.

9. Introduce universal health insurance. This is the approach Canada has taken to fund medical care for its citizens. Under this system, everyone is entitled to health care, and the public pays the bills through tax dollars rather than through insurance premiums.

Providers of health care charge a fee for their services, just as in the U.S. But their fee schedules must be negotiated with the government, which has an incentive to control costs, since tax increases are as politically unpopular in Canada as in the U.S.

In CU's view, the first eight of these proposals fall short of the goal of affordable health care for all Americans. They would still limit employment options—forcing some people to stay on a job that may otherwise be unsatisfactory simply to keep their health insurance. They could still force a person to spend as much as $12,000 a year to cover a family under a conversion policy. Some sick people would still have to settle for an inferior hospital-indemnity policy just because it is better than nothing. Worst of all, many Americans would still be denied proper health

Paying for long-term care The Pepper Commission has recommended a publicly funded program to pay for nursing-home expenses and for home care needed by people of all ages. That would eliminate the need for most nursing-home insurance. CU supports this approach.

care simply because they couldn't afford to buy insurance.

Recommendations

The few reforms that were won in the past were simply bargains struck with doctors and insurance companies. People who could least afford the cost of medical care or insurance were sloughed off onto public programs. The public assumed the cost of health care for those patients through Medicare and Medicaid while health-care providers and insurance companies kept control of the system and retained for themselves the ability to profit from those who could pay.

Meaningful reform must provide for universal access to health care; cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

The only model for reform that attempts to meet those criteria is the Canadian system. It is not a system

Doctors vs. Insurers

THE BATTLE OVER FEES

Insurance companies and the Federal government say they're trying to control health-care costs. And in the process, they're going head to head with the medical establishment.

Insurers are now requiring many policyholders to obtain approval before beginning a course of treatment. They require that policyholders have certain types of surgery done in hospital outpatient facilities and that they obtain second opinions before having any surgery performed. They are also establishing preferred-provider organizations, PPOs, in which doctors agree to reduce their fees to the insurer in exchange for more patients; the insurer lowers deductibles and coinsurance as an inducement for policyholders to use PPO doctors.

Since 1984, the Federal government has limited the fees it pays to doctors who treat Medicare patients. It will soon implement a new way of paying doctors based on the relative value of the various services they perform. This new system is aimed at reducing the fees of some highly compensated specialists, such as anesthesiologists and radiologists, and increasing the fees of others, such as family doctors. The system also includes limits on billing and on the number of services performed.

So far, all these efforts at taming health-care costs have been about as successful as trying to squeeze a balloon. When insurers or the Federal government clamp down on costs in one area, costs expand rapidly in another. "We pay less per claim, but we pay for more claims," says Curt Fuhrmann, president of the individual health division of Washington National, a seller of health insurance. "A lot of this stuff works initially, but after a while the system adapts and finds a way around it." Nowhere is that more evident than in the war over bills that has erupted between doctors and insurance companies.

The fine art of bill coding

Pressure from insurance carriers to limit physician payments, as Medicare does, has spawned a new industry devoted to teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system.

"Reimbursement guaranteed. You'll improve your reimbursement, or you'll get your money back," reads an advertisement for one such company, Medbooks. "Start now to bill for *all* of the services you provide—and receive *all* of the payments you're entitled to!" reads a flyer for St. Anthony Publishing Inc., a company that proclaims it has grown into an industry leader in "five short years."

The primers sold by these new firms tell physicians how to choose certain billing codes over others that would net them less income. There are some 7000 codes representing all the services physicians perform, and doctors customarily list the codes on the bills they present to patients and their insurance companies.

For example, one newsletter reported that insurance companies are not paying if doctors use the code for "hospital discharge day management", when they discharge hospital patients. It advised doctors to use either the code for "medical conference by physician regarding medical management with patient and/or relative, guardian, or other, approximately 25 minutes" or a code for a higher level of daily hospital visit. The newsletter recommended that doctors use both codes for a while and see which one insurance companies will go for.

A physicians' newsletter from St. Anthony Publishing carried this headline: "Updating superbill brings financial rewards." Superbills are the detailed bills that patients receive for the procedures doctors perform. St. Anthony advised doctors in family practice that adding and billing separately for such services as minimal [office] visits, brief [office] visits, injections such as tetanus and DPT, new patient office visits, supplies, and brief follow-up consultations could bring an increase in weekly revenue of $845, or $40,560 a year (based on 48 weeks).

The books and newsletters also offer guidance on "unbundling"—that is, charging separately for services that were once priced together, or "bundled." Unbundling almost invariably means more income.

Another newsletter from St. Anthony Publishing described one medical office in which doctors were performing dilatation and curettage procedures 10 to 15 times a week. When the doctors were shown how to charge separately for dilatation and for curettage, and even for sterile surgical dressings, the average payment from insurance companies increased from $300 to $535, and the practice increased its revenue some 78 percent.

Insurers strike back

To combat these practices, insurance companies are now hiring firms to "rebundle" the bills that come into their claims departments. Indeed, a rival industry has sprung up to scrutinize bills for evidence of the billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers "medical claims editor" computer software that will rebundle a $2500 bill for performing an appendectomy ($1500) with a laparotomy ($1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only $1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on books, seminars, and software is doing little to improve the health of Americans.

of "socialized medicine," in which doctors and hospitals work for the government and patients are assigned to clinics. Canadians are free to pick their doctors and hospitals. The Canadian health-care system costs less than the U.S. system and delivers more, mostly because it spends less on administration and bureaucracy. Canada spends about 1 to 2½ percent of every health-care dollar on administering health claims, compared with 10 to 11 percent spent by private insurers in the U.S.

A move to a universal health-care system modeled on Canada's would save money in other ways. Because medical care would be available to everyone, there would be no need for medical-payments coverage under workers' compensation insurance or automobile-insurance policies, or for the liability portion of homeowners insurance that goes to cover injury claims.

As we explain in the report that begins below, Canada has by no means found the ideal system. It is facing the same cost pressures on medical care as the U.S. and European countries, and, like those nations, it is examining ways to contain them. But public debate there has long since moved away from reforming insurance practices and toward targeting the country's resources to improve the health of its people.

The U.S. should take the best of the Canadian system and add to it the techniques that have shown the most promise for controlling health-care costs and curbing the overuse of health-care services that occurs in both countries. Those techniques include establishing "practice guidelines" for physicians (which define procedures that are effective under various circumstances) and assessing whether new technologies are effective in treating disease. Borrowing the best from Canada and adding effective cost containment would produce a uniquely American system that would serve all citizens.

It may be that the American model will evolve first in one of the states. (The Canadian system was patterned after universal hospital coverage introduced in the province of Saskatchewan in the 1940s.)

Some states are already looking for ways to improve access to health care for their residents. In California, for instance, there is a serious proposal in the legislature for the state to pay for health care, including long-term care, for all Californians. In New York, the state legislature recently passed a state-subsidized insurance plan for young children of the working poor, a step some see as a move in the direction of universal health insurance.

"In the next decade, if you don't have a national health system, the insurance companies will continue to selectively deinsure. No matter how many premiums you've paid, you'll never know if you'll be next," says Dr. Jane Fulton, a professor of health policy at the University of Ottawa. "That risk should be intolerable to Americans."

A LOOK AT THE CANADIAN ALTERNATIVE

Near downtown Montreal, a pregnant woman arrives at a *centre local de services communautaires*. Here at the CLSC, as the center is called, she receives regular checkups and counseling on the right foods to eat during her pregnancy.

When it's time for her to deliver, she will go to a local hospital. One of the two doctors who has been caring for her will deliver the baby. After the baby is born, she can bring it back to the CLSC for immunizations and follow-up care.

A social worker at the center will help her adjust to the demands of motherhood if she needs help, and a staff nurse will visit two weeks after the baby is born to give breast-feeding advice and answer other questions.

If the nurse finds that the mother lacks the skills to care for her baby, or detects more serious problems such as child abuse or neglect, more intensive counseling, either in the mother's home or at the CLSC, will be scheduled. When the mother needs a break, she can take the baby to the CLSC's day-care center, where women from the surrounding community drop off their children for a few hours each week.

The woman will pay nothing for these services. She simply presents her orange-and-yellow health card, issued by the government of Quebec. That card entitles her to free medical care at any of the 158 CLSCs in the province or from any doctor or hospital she chooses.

The CLSCs in Quebec, as well as similar community health centers in other provinces, represent an attempt at integrating medical care and social services within the framework of Canada's universal health-care system.

CLSCs help community residents find housing or day care for elderly or sick parents. Some offer smoking-cessation clinics. At others, elderly residents from the surrounding community can come by for a hot lunch at noon or for flu shots. A few CLSCs function as mini-hospitals where patients are admitted and kept overnight for observation and treatment.

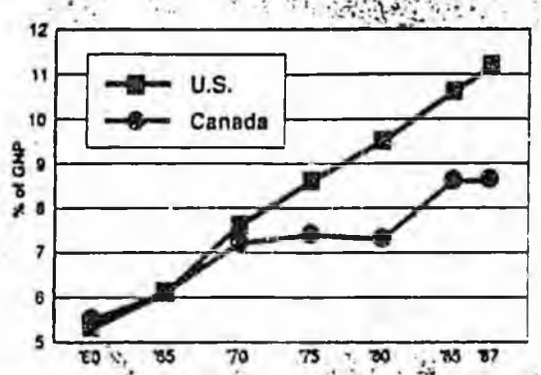
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

How the system evolved

Twenty-five years ago, just before Canada began phasing in universal insurance for medical services, the U.S. and Canadian health-care systems were on parallel tracks. Both

THE ROAD NOT TAKEN

Canada and the U.S. were spending about the same percentage of their Gross National Products on health care in 1965, just before Canada established its publicly funded insurance system for medical services. Since then, the U.S., which has retained private insurance, has spent a greater portion of GNP on health care.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988

countries were spending about 6 percent of Gross National Product on health care. By 1987, as health-care costs increased throughout the industrialized world, Canadians were spending 8.6 percent, while Americans were spending 11.2 percent.

But by then, the two countries were already on very different tracks. In 1966, Canada passed its Medical Care Act, entitling all residents to medical care funded through the tax system. (Free hospital care had been established in 1957.) About the same time in the U.S., the president of the American Medical Association declared that health care was a privilege, not a right—an issue still not fully resolved in the U.S. today.

Photos CYNTHIA JOHNSON

Prenatal care At a clinic near downtown Montreal, Dr. Stephen DiTommaso examines Sandra Gail Dalgleish while her son Antoine watches. Pregnant women are closely monitored at Canadian clinics and offered services ranging from nutritional counseling to home visits after their babies are born.

No private insurance

Canada outlawed private insurance for any services covered by its universal programs. Insurance companies there can sell health policies only to pay for uncovered services, such as private rooms in hospitals, medical expenses incurred in foreign countries, and dental care. When Canadians go to a hospital or see a doctor, they simply show their medical card, issued by the provincial government. The doctor then bills the government and is reimbursed according to fee schedules negotiated earlier. (Hospitals receive an annual budget that covers virtually all patient costs. They are paid one-twelfth of their budget each month.)

Since the billing forms used by doctors are standardized and only the government pays the bills, processing costs are low and providers receive payment in about 30 days. Patients don't have to cope with the deductibles, coinsurance, coinsurance maximums, or out-of-pocket expenses that are part of virtually every American health-insurance policy. Nor do they have to fill out complicated forms. There are no user fees, and doctors cannot "balance bill"—that is, charge more than the negotiated fee. (In the U.S., doctors can bill patients for more than the insurance company's allowable charge.)

Canada's program covers most medical services. However, eyeglasses, prescription drugs for people under 65, out-of-hospital dental care for adults, and cosmetic surgery are usually not covered in most provinces. Some provincial governments also pay for a few nonphysician services, such as physiotherapy, podiatry, and chiropractic treatments.

Fee-for-service doctors

Although Canada replaced private insurance policies with a public-insurance system, it retained fee-for-service medicine; that is, most doctors receive fees for the services they perform, rather than a salary. Today physicians' incomes are among the highest in Canada—four to five times higher than the average industrial wage. (In the U.S., the average physician in private practice earns five to six times the average industrial wage.)

Each year, medical associations and the provincial governments negotiate an overall increase in the fee schedule. The associations then allocate the increases among various specialties and services.

The negotiated fees, however, tend to be lower than in the U.S. (where doctors also care for patients who can't pay). In Quebec, for instance, medical groups have negotiated a fee of $217 for doctors who perform cesarean sections (they receive $87 more if there are complications and $109 more if the delivery is at night or on the weekend). They receive a fee of $174 for performing an appendectomy. (Here and elsewhere in this report, all Canadian figures are given in U.S. dollars.) In the U.S., the average physician fee for delivering a baby by cesarean is $1222, and the surgeon's fee for performing an appendectomy averages $846.

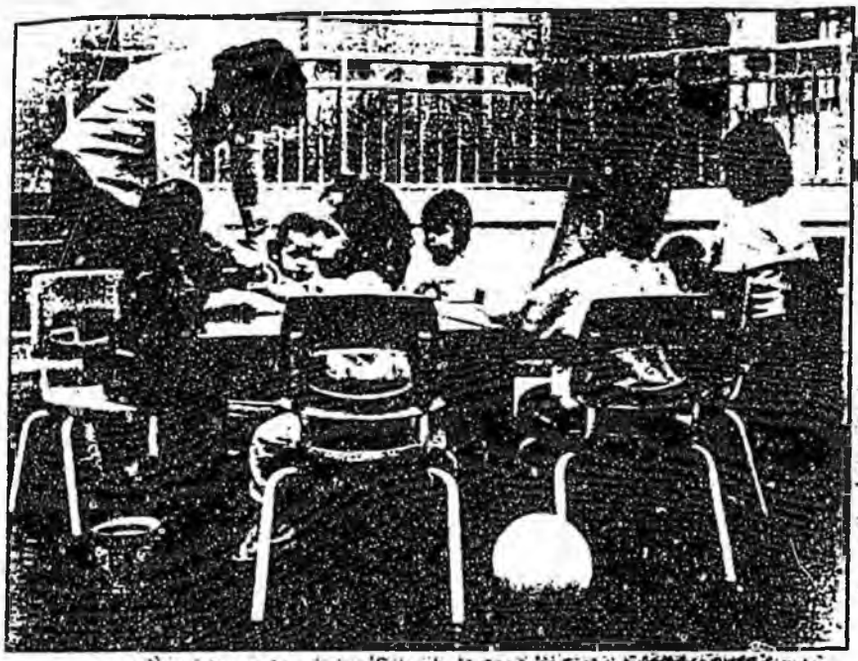
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two health-care systems, according to Dr. David Himmelstein of Physicians for a National Health Program.

Compared with the U.S., Canada spends much less on health care, but its system is still the second most expensive in the world, a statistic some trace to an oversupply of doctors who bill for too many services and to overutilization of medical services by patients. The government gives Canadian doctors considerable autonomy in their practice of medicine. And they have no insurance companies looking over their shoulders as do doctors in the U.S.

Hospital budgets

Hospitals also negotiate their budgets with the provincial ministries of health. Budgets are based on a baseline amount that the hospital spent in 1969. Each year, the ministries grant increases for inflation, for new programs, and for increased activity in the hospital's services.

Because the ministries have tended to hold increases to less than the actual rate of inflation, hospitals



Child's play Pierrette Croteau, a child-care worker at the Montreal clinic, helps toddlers and preschoolers at the facility's day-care center. Each day the center looks after 10 to 20 neighborhood children whose parents drop them off either for half-day or full-day care.

have had to redistribute their funds internally to live within their budgets. Ottawa Civic Hospital, for instance, closed 82 beds in 1989 but was able to serve more people than the previous year by shifting patients to outpatient care and surgical day-care centers, eliminating overnight stays for preadmission testing, and shortening the length of stays. Canadian health-policy planners say that reducing the number of days patients spend in hospitals is vital if the system is to get its costs under control.

In the U.S., hospitals in states without limits on hospital rates can simply raise their daily charges and pass them along to insurance companies that pay the bills for patients who are not on Medicare. Insurers then pass them along to policyholders. (For Medicare patients, the Government pays a fixed amount based on the diagnosis.)

New technology

Provincial governments also control the introduction of expensive new technology like magnetic resonance imaging machines, which take sharp pictures of internal organs, and lithotripters, which crush kidney stones and gallstones with sound waves. A hospital can raise private funds to buy an MRI, but since the money to operate it comes from the government, hospitals generally don't do that. Furthermore, doctors can't bill the government for use of the equipment unless it is authorized.

The introduction of new technology has, therefore, gone more slowly than in the U.S. Critics of the system, mostly doctors and hospitals, contend that as a result, some people are being deprived of state-of-the-art treatment. But other Canadians, including health-policy planners and government officials, say there is a benefit in introducing new technology more slowly. They argue that by waiting for reasonable evidence that new technology really works they can make a more informed decision about whether to commit scarce resources to it.

In the U.S., when a new machine comes on the market, its use tends to spread rapidly throughout the medical community—often before there has been time to assess the technology's effectiveness. Once a hospital or a group of doctors buys a new machine, the incentive to use it to recoup the investment exists side by side with the need to use it to improve medical care. That inevitably drives up health-care costs.

No Canadian who is acutely ill is denied prompt medical care. If patients need emergency care and the local hospital has no facilities or equipment to provide it, they are transported to the nearest hospital that does. If necessary services are available only in another province, or in the U.S., the patient goes there, and his or her provincial government pays the entire bill.

The slower implementation of technology sometimes means waiting lists for some procedures, however. A person complaining of headaches doesn't immediately receive a CAT scan and may have to wait several weeks for one. But if doctors suspect the person has a life-threatening ailment such as a brain tumor, a CAT scan will be done right away. The same is true of such costly procedures as coronary-artery bypass surgery.

"None of my patients has ever suffered or been deprived of medical care because of this system," says Dr. Philip Berger, a physician who treats AIDS patients in downtown Toronto. "I treat the poorest and the sickest, and they get everything they need." Even the costly drug AZT is supplied free to AIDS patients by the Ontario government.

Who pays the bill?

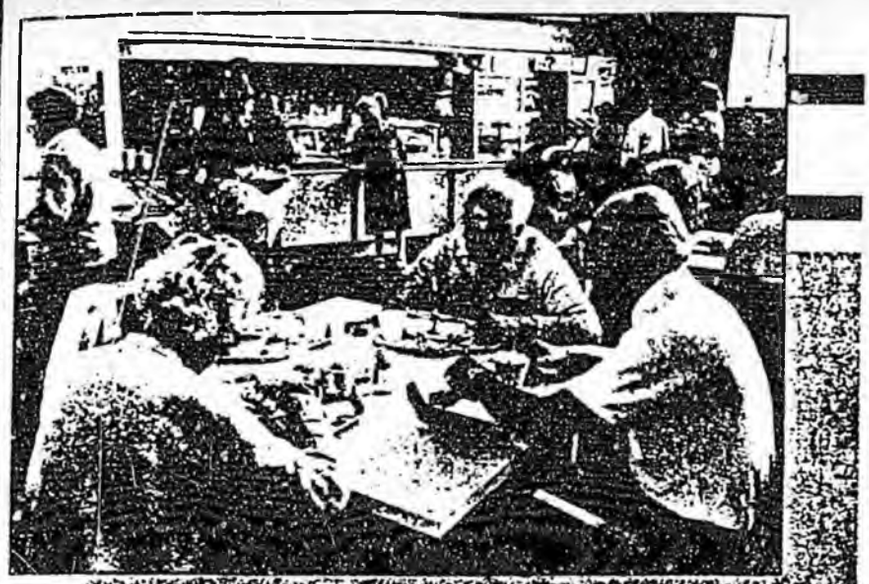
The Canadian federal government pays part of the health bill for each province. It pays more of the cost for poorer provinces and less for wealthier ones. The provinces themselves fund the rest of their health-care budgets, which usually account for about one-third of their total annual spending.

At both the federal and provincial level, the money to pay for health care is raised through a combination of personal income taxes; corporate taxes; excise taxes on gasoline, tobacco, and alcohol; and lottery profits.

In Alberta and British Columbia, residents also pay a special insurance premium earmarked for health care. In Alberta, a family of any size pays $552 a year; a single person pays $276. Ontario did away with insurance premiums earlier this year and replaced them with an employer health tax. In Ontario, employers with a payroll greater than $347,826 (U.S.) would pay a rate of 1.95 percent. Employers with smaller payrolls pay less. (Quebec and Manitoba levy a similar tax.) Unlike U.S. payroll taxes, the employee does not pay a matching amount.

A Canadian with a taxable income of $26,086 (U.S.) living in Ontario would pay about $7184 a year in Federal and provincial taxes. Of that, roughly $1340, or about 19 percent, goes to fund health care.

In the U.S., a person with $26,086



A place for the elderly. The Montreal center feeds about 100 elderly men and women from the surrounding community each noon. The cost of lunch is nominal—the U.S. equivalent of $2.39. The 158 clinics across the province of Quebec tailor their programs to the needs of the communities they serve.

in taxable income would pay $4776 in Federal income taxes and perhaps another $1304 in state taxes, bringing his or her total income tax to about $6080. None of that money would pay for his or her health care. The person would also pay Social Security taxes, of which about $378 would go to fund Medicare.

The American (or his or her employer) would pay for his or her medical care through private insurance; that typically costs $1500 to $2000 a year. In addition, he or she would have to pay out of pocket the deductibles, coinsurance, and other expenses not covered by the insurance policy. Together, those out-of-pocket costs can easily run between $500 and $1000 per year.

Looking ahead

There's virtually no debate in Canada about whether there should be a publicly funded insurance system or whether all people should have access to health care. There is plenty of debate, however, about whether the dollars the country spends on health care are spent in the right place.

Like other industrialized countries, Canada is also experimenting with ways to control costs. In Quebec, for example, there are caps on doctors' incomes. When a general practitioner's gross quarterly income (before taxes and practice expenses) reaches the U.S. equivalent of $37,102, the government will pay him or her only 25 percent of the usual fee for the rest of the quarter. In effect, then, Quebec has put a damper on the ability of general practitioners to gross much more than $148,000 a year. (In the U.S., the typical general practitioner earns about $216,900 before taxes and practice expenses. But high practice expenses, including the cost of dealing with the fragmented private and public insurance systems and the cost of malpractice insurance, reduced that to a mean net income of about $95,000 in 1988.)

In Canada, as elsewhere, doctors and the medical establishment have been vocal in demanding more resources. The community health centers are controversial, for example, because traditional medical practitioners see them as diverting health-care dollars from new equipment, more operating rooms, and larger fees.

Most Canadians like their health-care system, and would dispute the American Medical Association ad in U.S. magazines last year that characterized their system (without actually naming it) as "underfinanced, overextended, and ill-equipped."

Dr. Eugene Vayda, a U.S. and Canadian citizen who is a professor of medicine at the University of Toronto, has practiced under both the Canadian and U.S. health-care systems. "It's a pleasure to practice in a system where everyone has the same buying power," he says. "It allows you to focus on the patients and their needs. The Canadian system is so much better than the U.S., you can't even speak of them in the same breath." ■

Falling through the net

90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON
Daily News reporter

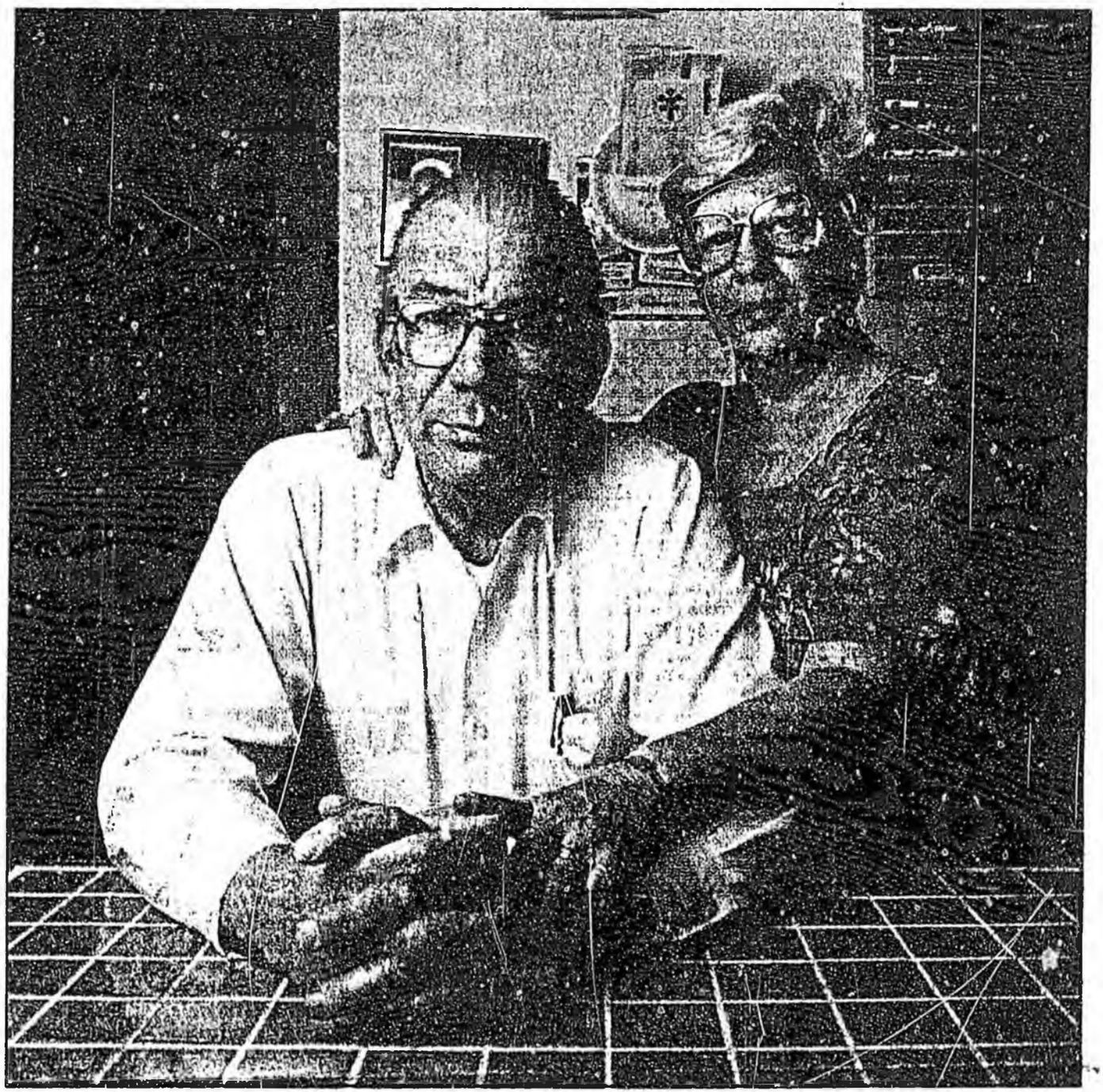
Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with fluid. The date was June 16, 1989, a day that for the Waltons marked a turning point in struggles against both a severe physical disability and a crippling financial burden.

Walton was rushed to Ketchikan Memorial, then Providence Hospital in Anchorage for a difficult recovery period in which he slipped in and out of consciousness. Walton, a career Army veteran, fell back on a military benefits program to pick up more than 70 percent of the medical bills from more than two dozen creditors.

But Walton didn't have any supplementary insurance. And his life savings of $2,000 wasn't enough to pay his share of the bills and still keep current on an old batch of medical bills resulting from his wife's stay in a Las Vegas hospital.

At an age when many couples are busying planning their retirements, the Waltons sold their trail[illegible]moved in with Margaret's mother in Mountain View and filed for protection from creditors. The bankruptcy petition filed earlier this year lists assets of $3,639 and debts — almost all of them medical — of $22,944.

"We get phone call after phone call from the hospitals," said Margaret Walton. "Naturally, they want their money. I can't blame them for that. But we just don't have



PAUL GOUDERY / [illegible]

The Waltons are part of an increasing number of Alaskans who run the risk of financial ruin if they get seriously sick or injured. They are among the unfortunates in an Alaska health-care system that is out of control.

For more than a decade, the costs of state medical care have leaped ahead at rates frequently exceeding 20 percent a year. Today, Alaska health care carries an annual price tag of more than $1.5 billion, according to one state study.

Insurers have been raising their rates to match the medical costs. That has made it harder and harder for employers to offer — or self-employed people to purchase — good medical coverage. Today, an estimated 90,000 Alaskans — nearly double the number of a decade ago — lack adequate medical insurance or don't have any insurance at all, according to a state legislative task force study.

"There's a huge gaping hole" in the medical safety net, said Heidi Thomas, a counselor for homeless women at the Clare House in Anchorage. For the women who seek refuge at the Clare House, just getting in the front door of a doctor's office can be a challenge. "The homeless have medical needs but often no insurance to cover them," Thomas said.

Doctors and hospital officials say they try not to turn away those who can't pay. As proof, they point to bad debt that continues to mount even as the economy improves.

Providence Hospital, for example, recorded $4 million in bad debt in 1987, near the height of a severe recession. In 1990, a red-hot year for the state economy, bad debt increased to $9.1 million.

The more bad debt increases, the more the hospital raises prices to help compensate for the costs of the unpaid care, said Dave Hennigan, a Providence Hospital financial officer.

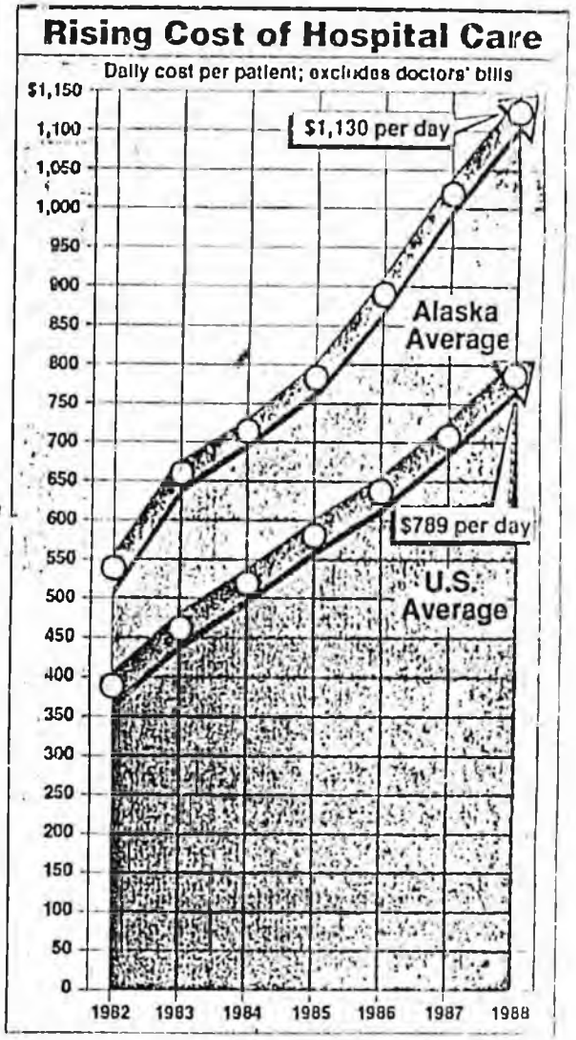
Doctors often do the same, and many have been able to keep earning more money each year.

Anchorage doctors' incomes have risen at roughly the same 6 percent annual rate noted in a national survey by the American Medical Association, according to Ray Schalow, executive director of the Alaska State Medical Association.

PAUL SOUDERS / Anchorage Daily News

A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.

FRAN DURNER / Anchorage Daily News



RON ENGSTROM / Anchorage Daily News

Sonja Javier, who had no insurance from her seasonal job, sought and eventually found help to fix a painful infection of her teeth. "I can't believe I live in a state that has so much money it pays you to live here but none for my teeth," said Javier. Others without insurance depend on a patchwork of state aid and charity.

The national survey reported that the average U.S. physician's net income before taxes rose from $104,100 in 1983 to $144,700 in 1988, the last year in which statistics were available.

Schalow said Anchorage doctors are willing to tighten their belts to help keep costs under control.

"I can tell you we are willing to come to the table and take our hits like anybody else," said Schalow.

But there is no consensus about how to address the twin problems of rising numbers of uninsured patients and skyrocketing costs.

Doctors and hospitals want to attack the mounting bad debt by creating some sort of universal health insurance — possibly through a state-subsidized insurance pool — that would be available to all Alaskans. They are forming a private task force to develop draft legislation.

Meanwhile, insurer and and employers are pressing proposals to help limit costs. One bill introduced by Sen. Jim Duncan, D-Juneau, would attempt to clamp down on medical costs with a rate-setting board roughly akin to the public utilities commission.

That bill — in its present form — is certain to be fought by the health-care industry officials.

"It's fair to say they're not real pleased with this," Duncan said.

□

Alaska's health-care problems are part of a national crisis that has triggered a soul-searching debate — in Congress, the health-care industry and academia — about the costs of medicine and who should bear it.

In Alaska, those costs have soared higher and often faster than those of almost any other state.

Spend a day in an Anchorage private hospital, and your bill will average more than $1,500, according to Medicaid statistics. That's more than double the daily cost of 1983.

That's also over 25 percent higher than the national average, according to American Hospital Association statistics.

Visit an Anchorage doctor for a checkup, and you'll pay an average of $46.17 compared to the national average of $34.76, according to Runzheimer International, a Wisconsin-based consulting firm.

Drop by an Anchorage dentist for teeth cleaning and you'll pay an average of $64.50, about 31 percent more than the national average, according to the Runzheimer survey.

Last year, more than $340 million of the health-care spending came straight out of the state budget. That spending included $263 million for Medicaid and other entitlement programs and $78 million for child health, mental health and other services.

On a per capita basis, state health-care spending topped $2,800 in 1990 and if left unchecked would exceed $18,000 per capita by the year 2000, according to Jeff Malek, a San Francisco-based health consultant who has been studying Alaska health costs for a state task force.

Please see Page F-4, BILLS

BILLS: Insurers, doctors ha

Continued from Page F-1

What forces push up the cost of Alaska health care?

Hospitals and doctors point to the state's higher-than-average wage costs in an extremely labor-intensive health-care industry. Much of the labor is highly skilled and often in short supply.

"I could go down to Kentucky and get a dental assistant for $5 an hour," said Ken Wynne, an Anchorage dentist. In Alaska, such help is hard to find and "makes anywhere from $9 to $15 an hour," Wynne said.

Doctors also cite malpractice insurance costs that for some specialties have more than tripled since 1986.

An Alaska obstetrician, for example, may pay $70,000 for a year's malpractice insurance, nearly 90 percent higher than in California, according to Ron Neupauer, underwriting manager for the Medical Insurance Exchange of California, which writes policies in Alaska.

"It's not that there are so many claims in Alaska," Neupauer said. "But my goodness, when there is one it's in the multimillion-dollar range, and there's not that many obstetricians to spread the risk around," he said.

The state task force, in a draft report, cited other reasons for rising costs of Alaska health care.

Alaska doctors, for example, lack the competition from health maintenance organizations and other discount health-care systems common in the Lower 48. Such systems may offer a 25 percent savings from traditional fee-for-service care, according to a Rand Corp., study in Seattle.

The state task force also pointed to the overexpansion by hospitals in the 1980s. That has pushed up operating expenses and might force administrators to charge more for services, Malek said.

Humana Hospital-Alaska, for example, opened a $23.5 million wing in 1986. The new tower increased Humana's capacity from 199 beds to 238, according to the American Hospital Association.

But Humana has had a hard time bringing in patients to help pay off the expansion. In 1989, the hospital association reported Humana had a 37 percent occupancy. That's substantially below the 70 percent national average.

Despite the low occupancy rate, Humana reported a 1989 profit of $4.5 million on revenues of $61 million.

Lyn Whitley, a Humana spokeswoman, said the expansion is a long-range project and the beds will be needed. In the meantime, the hospital has cut costs by staffing less than 160 of the hospital's beds.

The upward spiral of health care has left both insurers and employers scrambling to find ways to keep costs under control.

One major push has been aimed at people who are insured.

The state, for example, offered one of

> *"It's fair to say (health care officials) are not real pleased with this."*
>
> — Sen. Jim Duncan
> on his attempt to start a rate-setting board

Alaska's most comprehensive health-insurance packages. But the cost jumped from $218 a month in 1984 to $425 a month in fiscal year 1989.

Then, in May 1989, the state signed an agreement with the employees' union calling for precertification of surgery, auditing of medical bills, modest reductions in certain coverage limits and other cost-cutting steps. The new policy booklet developed from that agreement also advised — much to the dismay of Alaska hospital officials — for subscribers to shop around and check rates of Lower 48 hospitals.

Since the new plan went into effect, the cost of insuring state workers has declined to $385 a month.

But policy restrictions aren't always painless to employees. Some businesses make their workers pay much larger shares of monthly premiums and much higher deductibles. And sometimes the policies don't cover the really big bills the employee desperately needs paid.

Rolando Standridge, for example, has a

ıve different ideas on costs

Veterans Administration job that comes with a family health-insurance package that promises to pay 85 percent of all bills, once a deductible is met. But it won't cover pre-existing medical conditions. And that means the insurance won't pay a penny to help treat the heart ailment of Ron Standridge, her husband of one year.

Ron is a self-employed jeweler who hasn't been able to afford his own insurance. He has had several serious heart operations and may need more surgery.

But the couple can't pay off Ron's old medical bills, much less take on any new ones, according to Rolinda. Earlier this year, the couple filed for bankruptcy, listing debts to hospitals and doctors of more than $20,000.

"I'm not sure what will happen," Rolinda said. "We'll be going to our first meeting of creditors soon."

Other workers, struggling to survive on part-time or seasonal employment, find they can't work enough hours to qualify for insurance benefits.

Sonja Javier is a 41-year-old Anchorage woman who has worked in the housekeeping division of the Anchorage Holiday Inn. She had steady hours during the summer tourist season but said she was asked to come into work only a few times in the lean fall and winter months.

Javier said she didn't have enough time on the job to qualify for health insurance offered through her local union.

She wanted that coverage to help finance treatment of rotting teeth that were infecting her body.

"The infection has really been spreading. At one point last June I had blue streaks traveling all the way up my neck," said Javier.

Javier has less than half or her original 32 teeth, and the survivors perch unsteadily on the soft flesh of the sickly gums.

"Right now, it embarrasses me to even to go out and look for another job. When I keep my mouth closed, I'm OK. But when I open my mouth, forget it. When I talk, I start foaming at the mouth."

The pain had been building for more than a year.

Javier first sought help from the Anchorage Neighborhood Health Center, the only center set up to aid low-income people. She said she couldn't secure an appointment from the dental clinic, which later shut down due lack of funds.

Then she sought help from several dentists but says she was refused treatment because she had no money to pay for the costly job of pulling her teeth, treating the gums and fitting dentures.

"I wasn't asking for something unreasonable. I said, 'Give me a payment plan.'" Javier said. "If that's crazy, I'm sorry. But I can't believe I live in a state that has so much money it pays you to live here but none for my teeth."

The infection kept getting worse, and Javier resorted to begging antibiotics from friends to help keep the pain in check. Two weeks ago, after a trip to the Providence Emergency Room and several telephone calls to the Southcentral Dental Society, Javier finally found Wynne, the Anchorage dentist.

"She had three badly abscessed teeth that were really terrible," Wynne said. "She was in real pain."

Wynne pulled the three infected teeth on Feb. 7 and has agreed to see Javier for follow-up treatment and worry about the billings later. He said most Anchorage dentists attempt to do at least some charity work, and many participate in a rotating weekly on-call roster. Those signed on to the roster agree to treat emergencies, no matter what the patient's ability to pay.

But for the first six months of this year, no dentists have signed up for the on-call roster. So Wynne found himself unexpectedly drafted to treat Javier. "It's a highly unusual situation. We'll have to do something about the roster at the next dental society meeting," Wynne said.

□

Employees aren't the only ones feeling the bite of cost-control efforts.

Insurers and others who pay medical bills also are targeting hospitals, doctors and others who provide medical services.

The strongest thrust so far has come from the federal government, which has developed programs to help finance the care of the elderly, disabled and poor. In recent years, the government, sometimes working with the state, has set tough new limits on reimbursements. Due largely to these restrictions, Providence Hospital has seen its unreimbursed costs for contract care skyrocket from $8.1 million in 1987 to $30 million in 1990.

Providence, in turn, increases its rates to help compensate for the loss of federal payments, Hennigan said.

Thus the hospital — despite the rising tide of bad debt and payment shortfalls — was able to earn a net income of $8.2 million from revenues of $119.3 million, according to a hospital financial statement.

But Alaska insurers don't want to get stuck with subsidizing the government care. They are attempting to curb their medical costs with contract agreements in which hospitals and doctors agree to limit fees to amounts approved by the companies.

The most aggressive, has been launched by Blue Cross of Washington and Alaska, which this month announced a new "participating provider" network of 94 state doctors.

The doctors won't charge more than what Blue Cross considers "customary and reasonable." The program is designed in part to eliminate any surprises subscribers get when their medical costs are higher than the norm.

Doctors have long fought such price-control efforts, and so far, only 22 percent of the state's eligible doctors have opted to join the new network. "Once they get a hold, they'll ratchet down, or try to freeze rates," said Doug G. Smith, an

Please see Page F-5 BILLS

BILLS: Insurers, doctors have different ideas on cutting costs

Continued from Page F-1

orthopedic surgeon who refused to join the network. "These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

Doctors, as well as hospitals, also are preparing to fight Duncan's bill to set up a much more wide-ranging price-control system.

Duncan's bill would establish a nine-member board composed of public, labor and private sector representatives including at least one person from the health-care industry. The board would set maximum rates that doctors, hospitals and pharmacists could charge for their services. Those charges would vary from region to region and could increase only when approved by the authority.

Doctors might not like those rates, but the proposed legislation would forbid them from trying to collect more money by billing subscribers for a balance due.

The rate schedule would initially cover the 135,000 Alaskans insured by state, municipal and school district insurance plans. But Duncan hopes many state businesses would choose to join the program to help keep down employee health-insurance costs.

The legislation includes several other provisions, including one measure that would create insurance pools that small employers could join to try and get better rates.

"With this bill, Alaska would come out of the dark ages and to the forefront of national cost-control efforts," said Malek, the California consultant who helped draft the legislation.

But doctors and hospital officials think the legislation unfairly singles their operations out as the cause of the state's health-care crisis.

"We cannot support any legislation that has, as its primary method of health-care cost controls, regulating reimbursements to physicians and hospitals," said Harlan Knudson, executive director of the Alaska State Hospital & Nursing Home Association.

"It's crazy, unless we address the whole damn (health care) problem," said Schalow of the state medical association.

Health-care industry officials, in a recent policy paper, declare the need for a comprehensive state health plan. Some technologies, they say, may have to be rationed because there's just not enough money to pay for their routine use.

They also seek universal health insurance so more of their patients could pay for treatment.

Such a plan may be developed by a state health-care task force, then submitted to the legislature. But Schalow said the doctors don't have enough representation on the task force, and will develop their own plan.

Doctors and hospitals also are seeking further reform of state liability laws to help curb the cost of malpractice insurance.

"Liability insurance premiums for malpractice have reached levels that physicians can no longer afford nor can their patients afford through increased fees," the policy paper stated.

Duncan said he knows his legislation may face a tough fight from the health-care industry. But he hopes for allies among major state employers hurt by the rising cost of health-care insurance.

"Our goal is not to reduce the quality of health care, or put people out of business. We just want to make this whole system work," Duncan said.

NATIONAL GOVERNORS' ASSOCIATION
Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
Telephone (202) 624-5300

BACKGROUNDER

OFFICE OF PUBLIC AFFAIRS
February 2, 1991 (12-91)
Contact: Rae Young Bond, 202/624-5330

HEALTH CARE REFORM: Rx FOR A HEALTHY AMERICA

WASHINGTON, D.C. -- The nation's Governors have made health care reform their number one priority this year for several reasons:

- Health care costs have risen so dramatically that states -- who finance health care for the needy, directly provide services through public health and other programs, and pay for health benefits as employers -- find it increasingly difficult to fund other critical state priorities.
- Despite the expenditure of ever-increasing amounts of money, access to health care services is limited and may become increasingly limited.
- The shifting of costs and responsibilities from one payor to another in the system is exacerbating the problems of both cost and access and is contributing to an inefficient system.
- The current health care system is not structured to encourage the delivery of preventive health care services, which Governors increasingly understand is critical to a healthy and productive citizenry.

Health care in the United States is nearing a state of crisis. In 1983, the United States spent $357 billion, or 10.5 percent of the gross national product (GNP) on health care. By 1989, those figures had climbed to more than $599 billion, or 11.5 percent of GNP -- that's $2,400 for every man, woman, and child in the country. Left unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of the GNP, by the year 2000.

Yet, millions of Americans have limited or no access to the health care services they need. Based on insurance statistics alone, the figures are appalling. Approximately 31 million people are uninsured annually, and 37 million are uninsured in any given month. Governors, who are responsible for the health and welfare of their citizens, understand clearly that having health insurance or Medicaid coverage does not ensure access to services, particularly for poor and rural citizens.

-more-

Because there are so many other factors that make a difference in whether people actually have access to health care services, Governors must address the following kinds of issues: adequately funding public health efforts; meeting the transportation needs of poor and rural citizens; coordinating the outreach efforts that result in people using health care services more effectively; and screening and licensing health care personnel and facilities.

Employers, the traditional source of insurance coverage for workers and their families, are experiencing double-digit increases in their employee health insurance premiums. Their responses have ranged from dropping coverage for their workers' dependents to decreasing coverage for their employees. For most small businesses, increasingly expensive health insurance is simply beyond their financial reach.

Governors are employers too. In fact, in some states, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer.

Where Does Medicaid Fit?

While the Governors are taking an expansive view of health care reform in their initiative, "Rx for a Healthy America," it is clear that the genesis of their interest is their concern and frustration with the current direction of the Medicaid program.

Since its inception in 1965 as a program designed to provide health care services to women and children eligible for Aid to Families with Dependent Children (AFDC) and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI), Medicaid has grown to include a wide variety of special populations and services. This growth has created problems both in the states' ability to fund and effectively administer the program.

For instance, in 1980, Medicaid spending accounted for 9 percent of a state's budget; in 1990, it accounted for nearly 14 percent of all state spending. Further, the rapid expansion of mandated populations and federal micro-management of services has created an administrative nightmare.

The NGA Task Force on Health will consider and discuss a variety of conceptual options for restructuring the Medicaid program when it meets in Washington, D.C., on February 3, 1991. Although Medicaid is but one piece of a larger puzzle, it is a very large piece.

Wide-reaching and thoughtful discussion about Medicaid could lead to the creative use of its resources.

What Are the Governors Doing?

To provide the larger context for Medicaid and the other critical and interlocking issues in health care, National Governors' Association Chairman Booth Gardner of Washington established the Task Force on Health. The task force is working on two products that will be completed by August 1991: a report on state options in health care reform and a policy on health care.

Task Force Report. The task force report will detail state options to both increase access to health care and control costs throughout the health care system. The options in the report will both identify incremental steps states have already taken successfully and describe comprehensive ways states can restructure their health care financing and delivery.

The report will guide states in reorienting their health care systems to emphasize preventive and primary care. It also will discuss how to overcome the barriers to the provision of preventive and primary care; barriers that riddle the current structure of the health care system.

The report will outline steps Governors can take to help the working uninsured. Constructive guidance will be offered to Governors interested in working with their business community to help small businesses obtain affordable health insurance for their employees. It will offer suggestions to help stabilize the insurance situation for businesses that now provide health insurance coverage but are finding it increasingly difficult to do so.

A variety of options for expanding access to health care for the non-working population will also be covered. The options will range from expanded use of Medicaid and Medicare to the development of a totally new publicly funded health insurance program for non-working people.

Because the Governors know that without significant new cost controls, the goal of increasing access to care will never be realized, the report will contain a wide range of options for cost containment.

The report will describe a series of incremental and discrete cost control strategies, such as the expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies, such as a state-level all-payor system and global budgeting for the control of capital expansion.*

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* All-Payor System: A system in which association of purchasers come together to negotiate payment with an association of providers.

Global Budgeting: The idea of defining limits on the total amount of health care expenditures. Allocations are then made within that amount.

Managed Care: The concept of managing the access to health care, the utilization of services, and the cost of care.

Finally, although the focus of the report will clearly be on state action, the report will contain suggestions for federal action that would help the states implement the strategies.

Policy on the Federal Role. To complement the report, the task force will develop a policy for consideration during their annual meeting in August 1991. The policy will focus on the key issues that would require federal action to restructure the health care system. The policy will focus on recommendations on the future of the Medicaid program, changes in insurance practices, and small market reforms to enhance increased access to health insurance.

How Are the Governors Reaching Out?

The Governors began the process of reaching out to a wide variety of people when they hosted a national conference on health care reform in September 1990. During the two-day conference, some of the best health policy analysts and experts in the country participated in roundtable discussions. The participants and Governors explored issues ranging from ensuring the delivery of quality care to helping business find affordable, stable insurance policies; from insurance practice reforms to the individual's responsibility for health care. That conference gave the task force valuable information and insight with which to begin its work.

As the report is developed, Governors will seek extensive feedback and "reality-testing" from the wider community. This spring, Governors will hold a series of regional meetings to elicit comments on drafts of the report from business, labor, the insurance industry, and the provider community.

Further, the Governors will host a working meeting of state health policy analysts and health and human service executives to invite review and comment on the report as it moves to its final form. By involving the widest variety of interested people, Governors believe the strategies in the report will be tested for "workability" and will have benefitted from the best thinking of those involved in the health care system.

What Happens Beyond the Task Force?

Although the formal work of the task force will conclude in August 1991, the issue of health care reform will remain a high priority for the nation's Governors. As the Governors begin to implement the recommendations contained in the report, policymakers at all levels of government will have the opportunity to learn more about what works and what does not.

The Governors want to have the participation and cooperation of their federal partners in fashioning innovative approaches to health care reform. As the Governors and their federal partners evaluate these approaches, there will be opportunities to develop an informed national consensus about how best to move the nation's health care system toward a day when access to health care can be ensured for everyone at prices all can afford.

To The Rescue

Toward Solving America's Health Cost Crisis

A report by
Families USA Foundation

in cooperation with
Citizen Action

November 1990

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

EXECUTIVE SUMMARY

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill in the year 2000. This is a bill none of us can afford. The United States health care system can be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

By taking action now to control provider rates, reduce unnecessary procedures, and eliminate insurance administrative waste, the United States could reduce the health care bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

The data in this report demonstrates that both universal access and cost containment are achievable goals. Three specific and straight-forward steps would produce the following savings and benefits:

- *Insurance administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high cost of private insurance administration. This does not include additional savings that physicians and hospitals may realize under a simplified insurance administration system.*

- *By holding health expenditures to a 6.6% annual rate of growth (still above general inflation, but 2% below projected health care inflation), $245.7 billion can be saved in 2000. The Medicare program is already committed to achieving this level of savings through rate and volume controls. It is time to make a national commitment to apply the 2% solution system-wide.*

- *The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion. This cost is far less than the savings described above.*

Tables at the end of this report present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill by the year 2000. This is a bill none of us can afford to pay without seriously jeopardizing our standard of living, access to care and our economy. The United States health care system needs to be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

This report presents data, on a state-by-state and national basis, about specific steps this country could take to achieve lower health care costs, universal access and improved quality of care for all Americans. By taking action now to control provider rates and reduce insurance administrative waste, the United States could reduce this bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

In the face of rising health costs and declining access, public dissatisfaction with the American health care system has been increasing. Most Americans (89%) see the need for fundamental change in the direction and structure of the U.S. health care system. Only 10% agree with the statement that "on the whole, the health care system works pretty well." Americans are significantly less satisfied with their health care system and physician care than either the Canadians or British.[1]

Economist Uwe Reinhardt has observed that this public disenchantment with the health care system reflects serious misgivings over the way American health care is financed. The American health insurance system lacks the security, portability and administrative simplicity desired by American citizens.[2] The approaches to health care reform described in this report address the sources of this public dissatisfaction.

CAUSES OF EXCESSIVE HEALTH CARE INFLATION

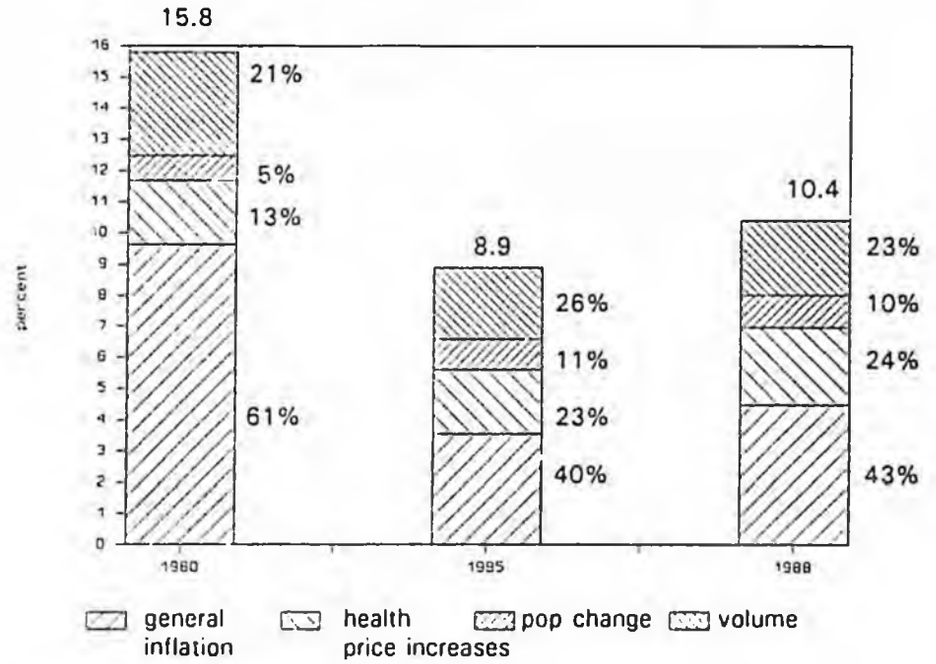
Health care spending has increased at more than twice the rate of general inflation during the last decade and, absent reform, this trend is expected to continue during the 1990s. An analysis of the components of health care inflation reveals areas that can be controlled without affecting quality.

Health care inflation is usually broken down into four components: general price inflation; medical price inflation; population changes; and intensity, or the volume of services provided. Although the United States has an aging population, changing demographics account for a relatively minor portion of increased health care spending -- 1% of the 11.7% annual compound rate of growth between 1975-87.[3] The fact that as Americans grow older they need more health care is <u>not</u> the major contributor to spiraling health costs. This factor accounts for one-tenth of rising costs.

A major factor driving up health care costs is the amount health care prices have increased <u>above</u> the general rate of inflation -- that is, the amount that health care providers have increased their prices for services by more than the rate of general inflation. These excess

price increases accounted for 2.2% of the 11.7% rate of growth between 1975-87.[4] These excessive health care price increases account for one-fifth of rising health costs. Such price increases are encouraged by the fee-for-service reimbursement system that is prevalent in the United States. Under many insurance plans, providers are paid more the more they increase their fees. The last decade has been marked by sustained increases in real net physician income. Physician incomes have increased an average of 7.1% from 1981-88 compared to average earnings increases of 4.1%.[5] Health care chief executives were the nation's highest paid CEOs in 1989.[6]

HEALTH INFLATION COMPONENTS



Source: Health Care Financing Administration

The American fee-for-service system rewards physicians more for performing surgery and other procedures, than for time spent counseling, diagnosing and examining patients. The financial incentives inherent in this type of payment system contribute to the second major factor which drives up health care spending -- the increasing quantity, or volume and intensity, of services provided to each person. Volume and intensity growth accounted for 2.3% of the 11.7% growth rate, or one-fifth of health care inflation.[7]

This increase in the amount and type of medical procedures is especially worrisome since there is overwhelming evidence that a significant proportion of the American health care dollar is spent on unnecessary tests and procedures, endangering health and quality of care. Recent research has found that 32% of carotid endarterectomies, 17% of coronary angiographies, and 17% of upper gastrointestinal endoscopies are inappropriate. The General

Accounting Office found that inappropriate use of surgical procedures ranged from 14% to 32%. Many common procedures, such as Caesarean section deliveries and coronary artery bypass surgery, are often used without producing any medical benefit for the patient.[8]

The cost-containment strategies described below are designed to reduce the size of the two most troublesome components of health care inflation: excess health price increases and increases in the volume and intensity of health care services provided. The other two components -- economy-wide inflation and increases in the population -- are determined outside of the health care system.

Although both public and private health care plans have initiated a variety of cost containment efforts in the last decade, these piecemeal approaches have failed to control costs system-wide. The fragmented nature of our multiple-payer approach has been a major barrier to effective cost containment. All too often one payer's success at controlling use and charges has resulted in another payer's loss, as providers just shift costs to those with less bargaining power in the health care marketplace. Private employers are paying an estimated $31 billion, or 27% of their health care costs, for uninsurance, underinsurance or underpayments by other sectors of our society.[9] The lack of uniform cost and quality data and standards is also an impediment to controlling system-wide costs.

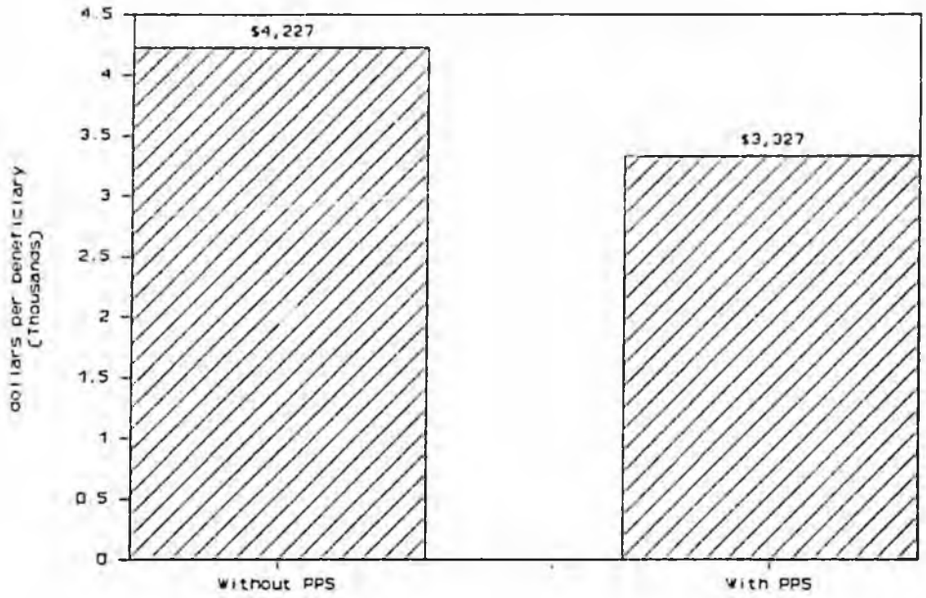
CONTROLLING HEALTH CARE EXPENDITURES

THE 2% SOLUTION -- MAKING A NATIONAL COMMITMENT

The Medicare program, which accounts for almost one-fifth of our national health spending, has developed successful methodologies for holding down costs. These methodologies would have a far greater impact if they could be applied system-wide. Without mechanisms for controlling costs system-wide, providers have the ability to shift costs to other payers. Other industrialized countries and some states have also adopted strategies that have held down costs.

The Medicare program is putting into place a new system for paying physicians. This new system addresses many of the problems identified above. A new physician fee schedule will increase reimbursement for primary care services and reduce fees for over-valued procedures. At the same time, Medicare will use a volume performance standard, or VPS, to protect Medicare against physicians performing more services to make up for any fee reductions. The new legislation assumes that Medicare physician costs will be reduced 2% annually beginning in 1993, below what they would have been without any volume controls. The VPS is modelled after the concept of expenditure targets used in several Canadian provinces.

Prospective Payment System Savings
1991 costs per beneficiary

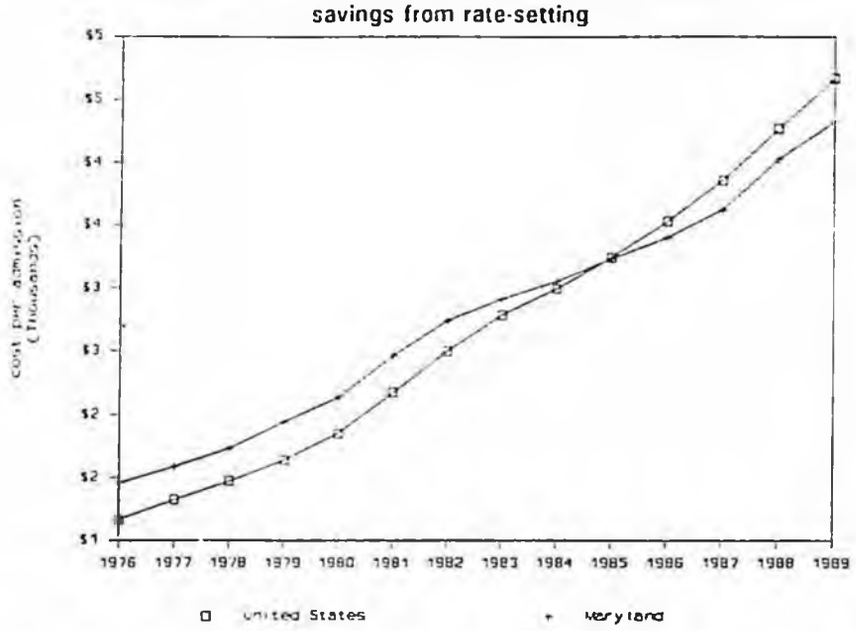


Source: Committee on Ways & Means, *1990 Green Book*, p. 238

Since 1984, Medicare has been paying hospitals a set dollar amount per admission based on diagnosis and adjusted for geographic variations in labor costs. This prospective payment system (PPS) will save Medicare $30 billion in 1991 alone. As the graph illustrates, Medicare's prospective payment system for hospitals has saved the program 21% on hospital costs per beneficiary.[10] The Health Care Financing Administration has estimated that increases in hospital costs could be reduced 2% nationally through practice pattern changes (primarily reduced length of stay).[11]

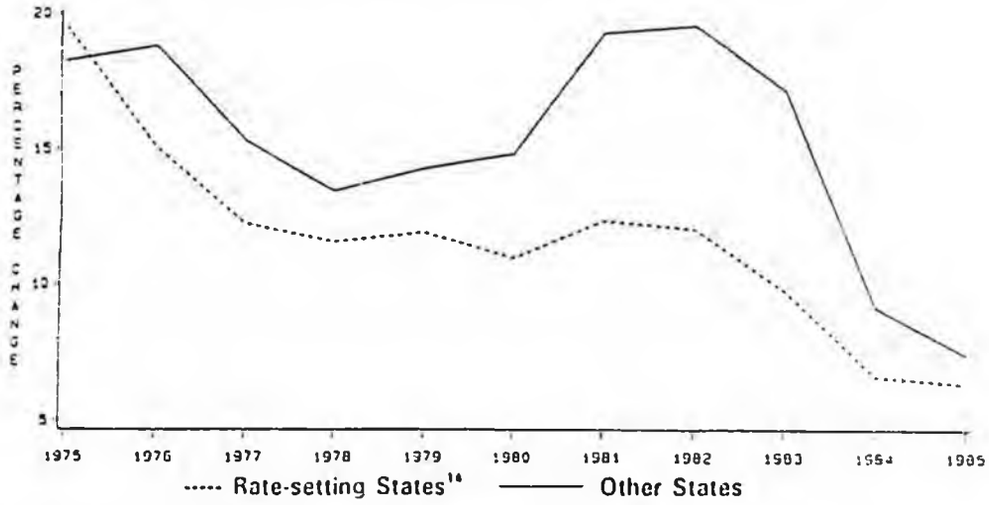
Several states have controlled hospital costs by establishing rates for all payers, public and private, large and small. The rate of increase in individual hospital expenses was reduced 4% in these states. Hospital charges per admission were 3.8% lower in the experimental states compared to other states.[12] As of 1988, Maryland's cost per admission rose 7.5%, as compared with a national rate of increase of 9.1%. This difference saved residents of Maryland $38 million in 1988 alone. If costs per admission in Maryland had risen at the national rate since 1976, when Maryland began its rate-setting system, Marylanders would have paid an additional $845 million for hospital costs between 1976 and 1988.[13]

Maryland vs. United States 1976-1988
savings from rate-setting



Source: Maryland Health Services Cost Review Commission, FY 1989 Report

Rate-Setting States vs. United States
Change in Gross Inpatient Revenue per Admission



Source: Johns Hopkins Center for Hospital Finance and Management

The development by the Medicare program of new methodologies to set physician fees fairly and to control the volume of physician services means that states now have the tools to control all health expenditures within the state.

Reducing health expenditures by 2% annually is a realistic and modest goal. Using rate control authority to reduce anticipated medical inflation by just 2% per year would produce

enormous savings by the year 2000. This expenditure control approach would still allow an annual medical inflation rate of 6.6%, well above projected general inflation of just over 4%, and produce savings of $245.7 billion in 2000.

Establishment of system-wide rate controls for providers would go far to get at the two causes of health care inflation identified above -- excess price and volume increases -- and would effectively contain costs. Unified payment rates would also eliminate the destructive cost-shifting and high administrative burden imposed by our current fragmented health care system. Such an approach would draw on the proven cost containment successes of other countries and on our own Medicare and state-based approaches.

ACHIEVING THE SAVINGS

There are a wide variety of ways this nation can achieve this annual 2% savings without reducing quality of care. Holding down the rates of increase in providers' income is one way. Other ways involve using our national resources in a more rational manner.

The development and use of **practice guidelines** for care is one way to reduce unnecessary care and the high costs associated with it. Studies consistently find striking variations in practice patterns in different geographic regions. These variations are not explained by differences in the population. Rather, practice styles of physicians account for the differences, not patient needs or superior care. Research has shown that once physicians do learn about the results of appropriateness studies and variations in use of procedures, their practice patterns change. The elimination of unnecessary procedures not only saves money, but improves quality of care for all Americans. The National Leadership Commission on Health Care estimated that practice pattern changes could reduce health expenditures by up to $22 billion annually.[15]

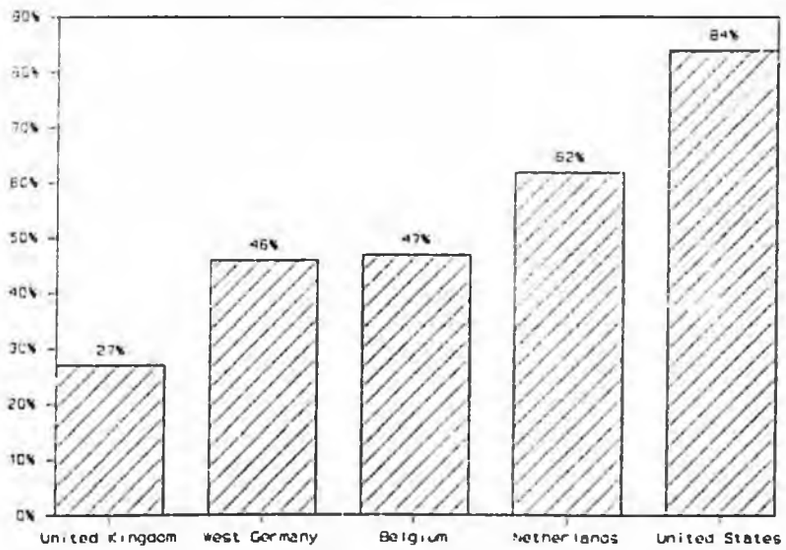
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes. Technology assessment could both save costs and improve quality. Similarly, capital spending review and budgets for both inpatient and outpatient services would eliminate incentives for wasteful and duplicative capital spending. Excess hospital beds are costing the United States at least $3.1 billion in 1990.[16] Furthermore, quality is improved when providers perform procedures frequently. Studies have found that a greater concentration of surgery in fewer hospitals tended to lower mortality rates.[17]

Other countries, including Canada, have used their rate-setting and budget authority to directly address the tough questions of a **fair net income for physicians and the appropriate supply of physicians**. In Canada physician incomes are four to five times the average industrial wage, as compared with five to six times the average industrial wage in the United States. In contrast to the United States, income differentials between primary care

and specialties are relatively small in Canada.[18] In the United States, the number of primary care physicians is decreasing relative to other physicians. In Canada, primary care physicians account for 52.5% of all physicians.[19]

Other Western countries have successfully increased the percentage of primary care physicians relative to specialists. As of 1980, the percentage of active physicians who were specialists varied among industrialized countries as follows: United Kingdom - 27%; West Germany - 46%; Belgium - 47%; Netherlands - 62%; United States - 84%.[20]

Specialists by Country
percent of physicians, 1980



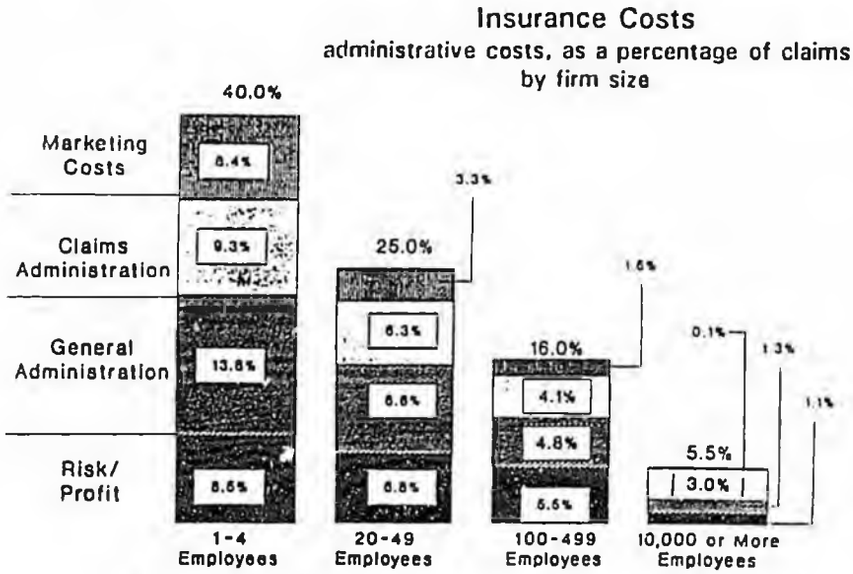
Source: *Journal of the American Medical Association*

INSURANCE ADMINISTRATIVE SAVINGS

The United States health care system has the highest proportion of administrative costs in the world. Our pluralistic health insurance system, with over 1,500 different insurance companies and several public programs, spawns diverse and duplicative payment rules, differing rates, dozens of separate utilization review systems, complex and costly eligibility determinations, high marketing costs and profits. Americans, in effect, pay what one economist has described as a "plurality tax" on all health services.[21]

The high administrative costs of the private insurance industry are disproportionately borne by small business and individuals who must purchase coverage on their own. The costs of marketing, insurance company profits, medical underwriting, and commissions fall most heavily on those groups with the least market power. For every dollar of health care costs paid by groups of 1-4 individuals, 40 cents goes for administrative costs under our private

insurance system. Groups of 20-49 incur 25 cents in administrative costs for every dollar spent. Even groups of 100-500 pay administrative costs of 16 cents for every dollar spent.[22]



Source: Hay/Huggins, Inc.

By 2000 the United States could save $52.8 billion annually in insurance administration costs by eliminating this plurality tax and utilizing a single, public administrative system. These savings are calculated by reducing health insurance administrative costs to those of the Medicare and Medicaid programs (2.7%).

Simplifying insurance administration in the U.S. may also allow physicians and hospitals to save on overhead costs associated with billing. Such savings are not included in the above estimates. The **provider administrative and billing overhead costs** associated with the American multiple-payer system are higher than any other country. In the United States, 18% of hospital spending is for administration and billing and 45% of gross physician income is for professional expenses, much of it for billing. Under Canada's single-payor system, only 8% of hospital costs are for administration and billing, and 36% of physician costs for professional expenses. According to one estimate, adopting a Canadian-style, single-payor health insurance system in the United States could have saved $22.5 billion in hospital, physician and nursing home expenses in 1983.[23] Reducing these costs incurred by American hospitals, doctors and other providers is another way to reduce provider rates without reducing provider income or quality of care. Administrative simplification would also address the dissatisfaction with complex and overlapping bureaucracy increasingly expressed by patients and providers.

UNIVERSAL COVERAGE

Savings from either of the reforms presented in this report -- 2% rate reductions and/or 12% administrative savings -- are more than enough to fund coverage for the uninsured.

A fundamental aspect of any health care reform must be the provision of universal access. Without universal access, Americans will continue to incur unnecessary costs due to delayed care, lack of cost-effective preventive care for children and pre-natal care for women, and untreated chronic illnesses which become more serious and costly. If everyone is insured, the risks can be spread evenly across the population.

Universal access will also help to ensure an adequate supply and distribution of health care providers. The financial burden of hospital uncompensated care is forcing hospitals to eliminate services that attract uninsured patients -- such as emergency and trauma centers. This curtails access for insured patients and forces everyone to travel further for emergency care. In geographic areas with large proportions of uninsured people, providers find that losses from uninsured patients cannot be recovered from the shrinking base of insured people and that continued provision of service to the entire community is not financially viable.[24]

The costs of providing coverage for the uninsured in the year 2000 will be $24.3 billion. This cost is based on a basic benefit package of hospital, physician services, diagnostic tests, limited mental health preventive services and prescription drug coverage. Since the uninsured use approximately one-third less health care than insured persons, this estimate shows the cost of the increase in the use of services. This estimate does not include any savings that would be generated by ensuring cost-effective preventive care and on-going treatment of chronic illnesses.

CONCLUSION

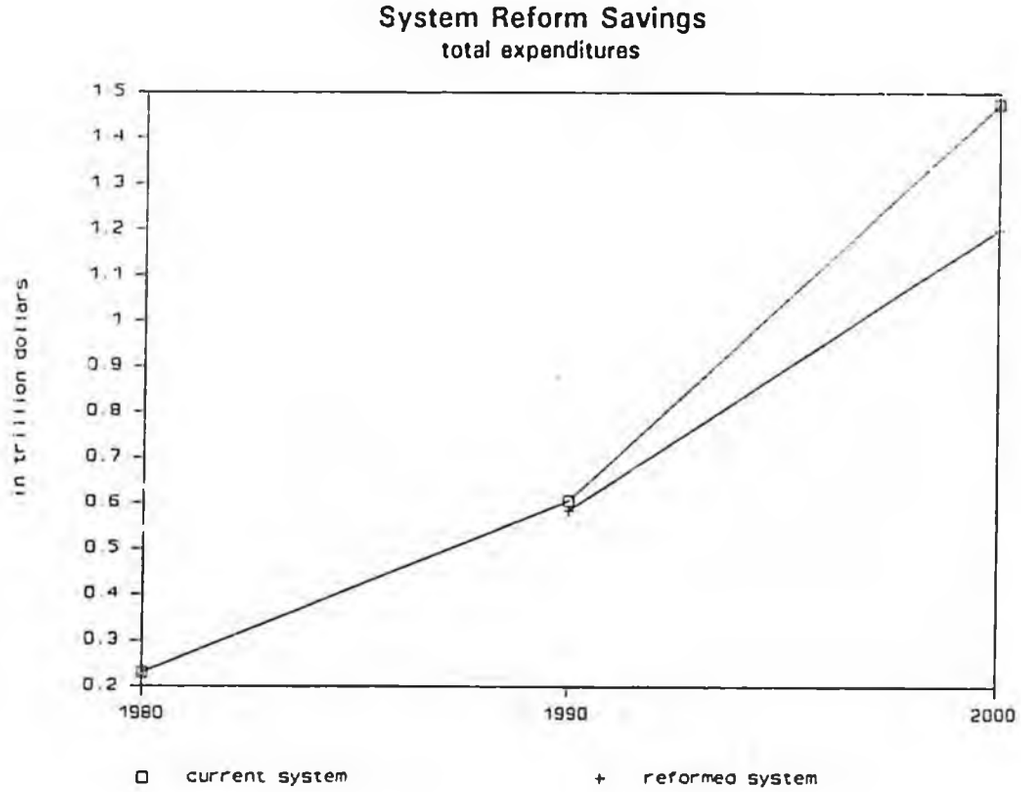
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

- The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion.

- By holding provider fees and rates to a 6.6% annual rate of per capita growth (about one and one-half times general inflation) $245.7 billion can be saved by the year 2000. This can be accomplished by expanding reforms in the Medicare program to our entire health care system.

♦ Administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high costs of private insurance administration. Additional savings may be possible from reduced provider overhead costs associated with billing.

The following tables present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.



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9. Lewin/ICF estimate using the Health Benefits Simulation Model.

10. Committee on Ways and Means, op. cit., p. 238.

11. National Leadership Commission on Health Care, **For the Health of a Nation**, Washington, D.C., January 1989, p. T.A. III-2.

12. Johns Hopkins Center for Hospital Finance and Management, **A Study of the Cost Effectiveness of Medicare Waivers and Efficiency of State All-Payer Hospital Payment Systems**, 1987. Maryland, Massachusetts, New Jersey and New York have had all-payer hospital rate-setting systems. Maryland is the only state that currently has such a system. In the other states, hospitals preferred to be paid under Medicare's DRG system; other payers are still subject to rate-setting.

13. Maryland Health Services Cost Review Commission, Fiscal Year 1989 Report.

14. Maryland data is included from 1974 to 1985. New Jersey data is included from 1980 to 1985. Massachusetts and New York are included from 1982 to 1985.

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COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES
BY STATE UNDER ALTERNATIVE POLICIES IN 2000
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	22,667,039	389,069	(3,805,249)	(629,995)	18,620,864	(4,046,175)
ALASKA	3,228,864	52,890	(534,023)	(134,503)	2,613,223	(515,640)
ARIZONA	23,306,882	313,035	(3,866,095)	(835,211)	18,918,612	(4,388,270)
ARKANSAS	11,097,073	193,713	(1,867,838)	(282,744)	9,140,204	(1,956,868)
CALIFORNIA	223,595,772	3,283,773	(37,113,065)	(8,154,865)	181,611,615	(41,984,157)
COLORADO	18,819,641	328,250	(3,119,607)	(762,585)	15,265,699	(3,553,942)
CONNECTICUT	20,996,403	354,133	(3,463,197)	(940,296)	16,947,048	(4,049,355)
DELAWARE	4,138,620	60,393	(691,154)	(125,720)	3,382,140	(756,480)
DISTRICT OF COLUMBIA	3,500,076	67,223	(593,286)	(70,790)	2,903,224	(596,852)
FLORIDA	90,060,126	1,210,959	(15,089,001)	(2,344,533)	73,837,551	(16,222,576)
GEORGIA	37,733,919	538,227	(6,309,527)	(1,097,148)	30,875,471	(6,858,448)
HAWAII	7,653,634	109,434	(1,262,304)	(323,721)	6,177,043	(1,476,590)
IDAHO	3,959,138	71,591	(659,214)	(145,671)	3,225,845	(733,294)
ILLINOIS	69,779,254	1,240,749	(11,547,728)	(2,963,833)	56,508,442	(13,270,812)
INDIANA	28,504,460	497,770	(4,717,173)	(1,201,718)	23,083,338	(5,421,122)
IOWA	13,620,316	271,924	(2,257,420)	(588,209)	11,046,611	(2,573,704)
KANSAS	14,677,643	257,370	(2,425,163)	(642,393)	11,867,457	(2,810,186)
KENTUCKY	15,737,895	291,848	(2,649,529)	(414,825)	12,965,388	(2,772,507)
LOUISIANA	20,590,574	410,813	(3,475,688)	(517,528)	17,008,171	(3,582,403)
MAINE	6,645,638	105,620	(1,099,393)	(272,017)	5,379,847	(1,265,790)
MARYLAND	31,074,629	458,792	(5,196,582)	(907,527)	25,429,311	(5,645,318)
MASSACHUSETTS	42,436,773	725,588	(7,030,106)	(1,730,655)	34,401,601	(8,035,173)
MICHIGAN	54,691,321	967,289	(9,055,599)	(2,289,721)	44,313,290	(10,378,031)
MINNESOTA	25,755,773	429,535	(4,239,365)	(1,200,744)	20,745,199	(5,010,574)
MISSISSIPPI	11,044,767	193,386	(1,860,928)	(270,833)	9,106,391	(1,938,375)
MISSOURI	31,946,064	536,740	(5,284,951)	(1,336,112)	25,861,740	(6,084,324)
MONTANA	3,486,657	69,350	(583,844)	(115,140)	2,857,023	(629,634)
NEBRASKA	8,580,707	159,869	(1,417,323)	(387,626)	6,935,627	(1,645,080)
NEVADA	8,837,119	112,469	(1,458,356)	(354,811)	7,136,421	(1,700,698)
NEW HAMPSHIRE	6,351,711	85,896	(1,045,852)	(273,909)	5,117,846	(1,233,865)
NEW JERSEY	42,383,428	701,136	(7,014,626)	(1,744,086)	34,325,852	(8,057,576)
NEW MEXICO	7,076,082	112,592	(1,179,766)	(235,763)	5,773,146	(1,302,936)
NEW YORK	115,121,894	2,064,813	(19,206,482)	(3,993,908)	93,986,317	(21,135,578)
NORTH CAROLINA	32,183,511	489,202	(5,377,481)	(960,695)	26,314,536	(5,868,975)
NORTH DAKOTA	3,606,280	73,636	(599,931)	(144,244)	2,935,741	(670,539)
OHIO	61,941,308	1,100,776	(10,267,317)	(2,531,973)	50,242,794	(11,698,514)
OKLAHOMA	14,232,334	293,934	(2,400,143)	(381,102)	11,745,023	(2,487,311)
OREGON	15,269,405	258,617	(2,537,250)	(574,818)	12,415,954	(2,853,451)
PENNSYLVANIA	69,555,852	1,237,755	(11,558,415)	(2,674,454)	56,560,738	(12,995,113)
RHODE ISLAND	6,448,659	109,254	(1,070,219)	(250,613)	5,237,081	(1,211,578)
SOUTH CAROLINA	15,222,478	239,954	(2,544,917)	(464,043)	12,453,472	(2,769,006)
SOUTH DAKOTA	3,773,731	67,320	(625,132)	(156,856)	3,059,063	(714,667)
TENNESSEE	27,908,735	456,767	(4,683,098)	(765,810)	22,916,594	(4,992,141)
TEXAS	88,910,873	1,544,835	(14,903,874)	(2,620,198)	72,931,636	(15,979,237)
UTAH	7,493,526	123,948	(1,238,664)	(317,448)	6,061,362	(1,432,164)
VERMONT	2,753,403	43,861	(454,743)	(117,254)	2,225,268	(528,135)
VIRGINIA	34,364,026	507,109	(5,735,435)	(1,069,528)	28,066,172	(6,297,854)
WASHINGTON	27,295,859	429,823	(4,533,675)	(1,006,614)	22,185,394	(5,110,465)
WEST VIRGINIA	7,844,814	165,857	(1,325,762)	(197,336)	6,487,573	(1,357,240)
WISCONSIN	26,967,967	480,209	(4,460,714)	(1,159,098)	21,828,364	(5,139,603)
WYOMING	1,634,548	36,516	(272,443)	(65,427)	1,333,192	(301,354)
TOTAL	$1,476,507,197	$24,325,619	($245,708,644)	($52,756,656)	$1,202,367,516	(274,139,681)

a/ Savings computed on the basis of total health spending under Universal Access
SOURCE: Lewin/ICF estimates

COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES
BY STATE UNDER ALTERNATIVE POLICIES IN 1990
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	9,522,402	194,638	(178,794)	(257,894)	9,270,352	(252,050)
ALASKA	1,242,929	26,459	(23,357)	(50,932)	1,195,100	(47,830)
ARIZONA	8,105,810	156,601	(152,028)	(291,921)	7,818,461	(287,348)
ARKANSAS	4,706,750	96,908	(88,387)	(121,620)	4,593,652	(113,099)
CALIFORNIA	84,754,469	1,642,760	(1,589,709)	(3,117,188)	81,690,332	(3,064,137)
COLORADO	8,045,268	164,212	(151,054)	(325,362)	7,733,064	(312,204)
CONNECTICUT	8,815,608	177,163	(165,471)	(405,325)	8,422,175	(393,633)
DELAWARE	1,547,100	30,213	(29,023)	(47,620)	1,500,670	(46,430)
DISTRICT OF COLUMBIA	1,559,131	33,630	(29,307)	(31,931)	1,531,523	(27,608)
FLORIDA	31,411,102	605,802	(589,111)	(840,263)	30,587,530	(823,572)
GEORGIA	13,669,245	269,257	(256,468)	(395,572)	13,286,461	(382,784)
HAWAII	2,797,343	54,746	(52,478)	(117,620)	2,681,991	(115,352)
IDAHO	1,748,435	35,815	(32,830)	(64,245)	1,687,175	(61,260)
ILLINOIS	30,597,883	620,704	(574,422)	(1,343,072)	29,301,094	(1,296,789)
INDIANA	12,362,662	249,017	(232,055)	(532,810)	11,846,815	(515,847)
IOWA	6,615,476	136,034	(124,228)	(294,600)	6,332,683	(282,794)
KANSAS	6,426,779	128,754	(120,622)	(289,497)	6,145,414	(281,365)
KENTUCKY	7,021,825	146,002	(131,888)	(186,001)	6,849,938	(171,888)
LOUISIANA	9,545,115	205,516	(179,412)	(240,437)	9,330,783	(214,332)
MAINE	2,687,926	52,838	(50,430)	(112,449)	2,577,885	(110,041)
MARYLAND	11,627,792	229,518	(218,175)	(342,905)	11,296,230	(331,562)
MASSACHUSETTS	17,947,477	362,987	(336,913)	(753,437)	17,220,115	(727,362)
MICHIGAN	23,874,781	483,902	(448,200)	(1,031,175)	22,879,307	(995,473)
MINNESOTA	10,857,061	214,882	(203,724)	(514,127)	10,354,092	(502,969)
MISSISSIPPI	4,638,528	96,744	(87,129)	(114,055)	4,534,088	(104,439)
MISSOURI	13,373,361	268,513	(251,010)	(578,860)	12,812,003	(561,358)
MONTANA	1,641,223	34,694	(30,837)	(53,992)	1,591,087	(50,136)
NEBRASKA	3,933,640	79,977	(73,851)	(181,791)	3,757,975	(175,664)
NEVADA	3,115,213	56,264	(58,355)	(125,858)	2,987,264	(127,949)
NEW HAMPSHIRE	2,258,658	42,971	(42,350)	(99,597)	2,159,682	(98,976)
NEW JERSEY	17,368,763	350,755	(326,039)	(735,990)	16,657,489	(711,274)
NEW MEXICO	2,757,688	56,326	(51,778)	(91,096)	2,671,140	(86,547)
NEW YORK	50,354,750	1,032,956	(945,534)	(1,792,954)	48,649,219	(1,705,532)
NORTH CAROLINA	12,259,381	244,731	(230,076)	(370,230)	11,897,807	(361,574)
NORTH DAKOTA	1,751,185	36,838	(32,900)	(71,797)	1,683,326	(67,859)
OHIO	27,193,403	550,681	(510,491)	(1,146,344)	26,087,249	(1,106,154)
OKLAHOMA	6,824,669	147,045	(128,280)	(184,441)	6,658,993	(165,676)
OREGON	6,523,595	129,377	(122,415)	(246,256)	6,284,301	(239,294)
PENNSYLVANIA	30,541,650	619,207	(573,360)	(1,221,936)	29,365,561	(1,176,089)
RHODE ISLAND	2,701,187	54,656	(50,708)	(107,859)	2,597,276	(103,911)
SOUTH CAROLINA	6,011,186	120,041	(112,815)	(183,631)	5,834,781	(176,405)
SOUTH DAKOTA	1,662,251	33,678	(31,205)	(70,916)	1,593,808	(68,443)
TENNESSEE	11,328,956	228,505	(212,657)	(314,445)	11,030,359	(298,597)
TEXAS	37,380,724	772,828	(702,025)	(1,111,317)	36,340,210	(1,040,514)
UTAH	3,085,385	62,007	(57,912)	(129,926)	2,959,554	(125,831)
VERMONT	1,117,014	21,942	(20,957)	(48,544)	1,069,456	(47,558)
VIRGINIA	12,931,845	253,690	(242,614)	(404,510)	12,538,410	(393,434)
WASHINGTON	11,084,596	215,026	(207,913)	(408,369)	10,683,339	(401,257)
WEST VIRGINIA	3,846,712	82,973	(72,306)	(97,342)	3,760,037	(86,675)
WISCONSIN	11,980,357	240,232	(224,859)	(528,175)	11,467,555	(512,802)
WYOMING	821,858	18,268	(15,458)	(32,805)	791,862	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(22,177,039)	584,596,673	(21,381,674)

a/ Savings computed on the basis of total health spending under Universal Access
SOURCE: Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

In this analysis we developed estimates of total health expenditures in each state by source of payment in 1980 and 1987. We also developed projections of future health expenditures by state in selected years under current policy and alternative health care financing scenarios. This appendix describes the methods used to develop these estimates.

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1987 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

- Direct payments by households.
- Employer health insurance payments.
- Payments by other private sources.
- Medicare payments.
- State Medicaid expenditures.
- Federal Medicaid expenditures.
- Payments by other public sources.

State-level data on Medicare and Medicaid spending were obtained from the Health Care Financing Administration (HCFA). However, information on other health care expenditures by state and local governments is largely unavailable from existing data sources. Data on health spending by households and employers are also unavailable at the state level.

Due to the lack of state-level health expenditures data, we estimated state spending using techniques that reflect the unique socio-economic composition of the population in each state. We developed these estimates for 1980 and 1987 using the following three steps:

- **Develop First Stage estimates.** We estimated total expenditures by source of payment based upon the socio-economic composition of the population in each state. The Lewin/ICF Health Benefits Simulation Model (HBSM) was used to estimate per-capita health spending for each source of payment by age, income, geographic region, and health insurance status. Using these per capita health spending estimates, we estimated total health spending in each state based upon state-level data on the distribution of persons by age, income, and insured status as reported in the Current Population Survey (CPS) for 1980 and 1987.

- **Adjust First Stage Estimates to Replicate Known Totals By State.** We then adjusted the first stage estimates to reflect the following known control totals for 1980 and 1987:

  -- Medicare spending by state.
  -- Federal Medicaid spending by state.
  -- State Medicaid spending.

  In addition, we adjusted total health spending to reflect HCFA estimates of relative differences in per-capita health spending by state in 1982.

- **Adjust Second Stage Estimates to Replicate HCFA Estimates of National Health Spending by Source of Payment.** The state-level health spending estimates developed in the second stage were adjusted to replicate HCFA estimates of national health spending by source of payment.

B. PROJECTIONS OF HEALTH SPENDING IN FUTURE YEARS UNDER ALTERNATIVE SCENARIOS

In the second task we developed projections of total health spending in each state under alternative health care financing strategies. Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

We then developed estimates of total health spending by state under three policy scenarios. These policy scenarios are described below.

Scenario #1

In the first scenario we developed estimates of national health spending under a universal health plan that emphasized a pluralistic health insurance system. We assumed

that, under this scenario, all individuals would be covered under a benefits package similar to that recommended by the Pepper Commission with the exception that prescription drugs would be covered.

Under this scenario, we estimate that there will be an initial increase in health spending in 1990 as previously uninsured persons become covered under a health plan. The increase in health spending was allocated across states in proportion to the number of uninsured in each state. (Estimates of uninsured persons by state are also provided as part of this study.) For purposes of estimating the administrative costs of insurance under this scenario, we assumed that 1) all workers and dependents would become covered under private employer health insurance where administrative costs average about 15 percent of benefit payments, and 2) all non-workers would become covered under a public plan where administrative costs average about three percent of benefit payments.

Scenario #2

In the second scenario we assumed that all persons in the United States would become covered under a unitary payer system. We assumed that the unitary plan would have patient cost sharing similar to that under the Pepper Commission proposal ($250 deductible for a single person, $500 per family, 20% copayments for hospital, physician and lab services, with an out-of-pocket limit of $3,000 per individual or family). Under this scenario, we estimated the savings due to reduced insurance administrative overhead charges under a unitary payer system.

We assumed that the shift to the unitary payer would result in substantial savings in administrative costs due to the elimination of insurer profits and marketing costs and the simplification of claims processing and other general administrative functions. We estimated these administrative savings by assuming that persons who were privately insured in Scenario #1 would be shifted to a unitary payer where administrative overhead

charges are assumed to be the same as in the current Medicare program. For privately insured persons we assumed that this would reduce administrative charges from 15 percent of benefit payments to less than 3 percent.

Scenario #3

We also estimated total health spending in 1990 and 2000 assuming cost controls were implemented. HCFA estimates that per capita health spending will increase by about 8.6 percent per year through 2000. To illustrate the potential impact of cost controls, we estimated health expenditures in 2000 assuming the growth in spending is reduced to 6.6 percent annually.

The purpose of these estimates is to show the potential savings that could be achieved by slowing the projected rate of growth in health spending. These estimates are intended to be illustrative and should not be interpreted as estimates of the savings arising under any particular cost containment program.

EMERGENCY!

Rising Health Costs in America 1980 - 1990 - 2000

A Families USA Foundation Report

in Cooperation with

Citizen Action

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

October 1990

Health care costs in the United States have risen dramatically, far outpacing economic growth, general inflation, and families' incomes. These spiraling health costs are creating an emergency -- a crisis of affordability for consumers, government, labor, and business. Families are paying more in premiums, deductibles and co-payments while often seeing their benefits shrink. Employers faced with double digit premium increases now find that health care costs consume nearly 94% of net profits.[1] Rising costs have also resulted in a growing number of Americans without adequate health coverage, or none at all.

This report examines the magnitude of the health care cost crisis by providing data on health spending and the uninsured during the 1980s and projections of what the United States will be spending by the end of the 1990s should the status quo continue in our health care system. Information on health care costs and numbers of uninsured are provided on a state-by-state and national basis. This is the first time state-based data on health care expenditures has been available since 1982, when the Health Care Financing Administration stopped providing it.

The magnitude of health care cost increases over the 1980s indicates why there is serious interest in health care reform. This interest has been increasing among both state and federal legislators.

THE 1980s: RISING COSTS

During the last decade, health care costs have risen at rates far exceeding the consumer price index. Between 1980 and 1989 the average annual increase in the consumer price index was 4.7%. Health care spending increases averaged 10.4% during this same period. An increasing portion of every family budget has been going to pay for health care since skyrocketing health costs have dwarfed wage increases. Annual earnings increased 4% per year, on average, since 1980.

National health care spending more than doubled between 1980 and 1990, jumping from $230 billion to $606 billion. American consumers pay directly for over 25% of this huge health care bill through out-of-pocket payments. Although many public and private health plans have responded to these cost increases with a variety of cost control initiatives, these efforts have been piecemeal and have not succeeded in holding down system-wide costs.

- Per capita spending increased 139% from 1980 to 1990, rising from $1,016 to $2,425 per person in 1990.

- From 1980 to 1990 overall health care spending in the United States more than doubled, increasing by 163%, from $230 billion to $606 billion.

- Spending for employer-based health insurance premiums increased 164% in the past decade, from $66 billion to $174 billion.

- An increasing portion of every family's budget is going to pay for health care as shown by the 157% rise in out-of-pocket spending from 1980 to 1990 (excluding the cost of employee premium contributions), from $63 billion to $162 billion.

- State government spending for Medicaid increased 156% between 1980 and 1990, from $10.7 billion to $27.4 billion.

- Massachusetts ($3,031), California ($2,894), New York ($2,818), Nevada ($2,757) and Rhode Island ($2,707) have the highest levels of per capita health spending in 1990. South Carolina ($1,689), Idaho ($1,726), Mississippi ($1,751), Wyoming ($1,756) and Utah ($1,784) have the lowest levels of per capita health spending in 1990.

- In Arizona (160.7%), Alaska (157.2%), Florida (152.3%), New Mexico (152.2%) and Maine (150%) per capita health expenditures increased at least 150% from 1980 to 1990.

Although all states experienced health care spending increases well above the consumer price index, there is high variation in spending among states. This variation is generally explained by the following kinds of factors: demographics (especially the proportion of a state's population that is either women of child-bearing age, or older men and women); the numbers of uninsured persons in a state (uninsured persons consume about one-third less health care than insured persons); the environmental conditions in a state (these can cause deteriorating health); the number and type of health care facilities and providers in a state (this will cause individuals to travel into or out of a state to get health care); the practice patterns of providers in state (the use of hospital inpatient care and surgical procedures varies greatly among geographic areas), and historical levels of spending in a state.

THE 1980s: DECLINING ACCESS

Dramatic increases in health care spending have not resulted in more Americans having access to better care. Despite the high price tag of our health care system, millions of Americans are without any health insurance, public or private. The number of uninsured Americans has grown during the 1980s.[2] State-by-state data on

numbers of uninsured persons show variation in the growth or decline of uninsured persons. Reasons for this state variation are diverse. In some instances, an aging population means that a growing portion of the state's residents have become eligible for Medicare. The composition of a state's economy can also influence the number of uninsured, as particular industries are more or less likely to offer employer coverage. Other factors, such as a state's Medicaid eligibility level, income levels, and economic well-being, also influence the number of uninsured.

- Over 13% of Americans, almost 32 million, were uninsured on any given day in 1988.

- The number of uninsured Americans has increased 30%, from 24.5 million persons in 1980 to 31.8 million persons in 1988 (the most recent year for which published statistics are available).

- 28% of U.S. residents, 63 million people, lacked health insurance for at least a month during the 28 month period ending May 1987, according to the Census Bureau.

- New Mexico (22.8%), Arkansas (21.8%), Texas (21.4%), Florida (18.4%), Oklahoma (18%), Mississippi (17.9%), Arizona (17.7%), Nevada (17.3%), Louisiana (17.3%) and California (17.2%) had the highest percentages of uninsured persons as of 1988.

- Nevada (86.7%), Kentucky (68.9%), Florida (62%), Texas (59.5%) California (57.7%), Alaska (57.2%), and Oregon (52.6%) all saw the number of uninsured persons in the state increase by more than 50% from 1980 to 1988.

Who are these uninsured persons? Young adults are the most likely to lack insurance. Twenty-seven percent of persons 18-24 lack insurance.[3] These are individuals who are likely to be in entry-level jobs and to be too old to qualify as dependents of other family members. Twenty-eight percent of the uninsured are children. Forty-two percent of the nation's uninsured live in the South.

Five out of eight uninsured persons are employed or are dependents of employed persons. Just over half of uninsured workers are employed by firms with less than 25 employees.

Why has the number of uninsured persons increased? One of the major reasons is a reduction in the number of individuals and their families covered by employment-

related insurance. In recent years there has been an increase in the number of persons employed in businesses that don't offer health insurance, or offer inadequate or unaffordable insurance.[4]

Health care inflation and competition in the small group insurance market have combined to make health insurance increasingly unaffordable for small businesses, their employees and their dependents. In order to hold premiums and benefit payments down and attract customers, insurers have been engaging in a number of practices that have had the effect of increasing the number of uninsured, or underinsured persons, who work in small businesses or are dependents of these workers. These practices include: denying coverage to certain, high-risk individuals within small groups; denying coverage to entire small groups considered to be high risk; and denying coverage for pre-existing conditions, such as diabetes or asthma.[5]

Analysis of the nonelderly population shows that an additional 13 percent of the nonelderly, 20 million persons, are underinsured -- at risk of spending more than 10 percent of their income on health care.[6] Since the elderly spend an estimated 18% of their incomes on health care on average, including the elderly would add many millions to the number of underinsured.[7]

When small businesses do get insurance, the insurance companies establish the premiums based on "experience-rating" -- the practice of basing premiums solely on the experience of the specific group, rather than establishing a "community-rating" for the larger community as a whole. Premiums set on the basis of experience-rating, rather than community rating, are more unstable and rise quickly.

One of the ways employers have responded to escalating premiums is by charging employees a greater share of the premiums. The percentage of employees paying $100 or more a month for family health insurance rose from 5 percent in 1986 to 16 percent in 1988. Average employee payments for individual coverage rose 32 percent between 1988 and 1989.[8] These increased cost demands on employees result in employees, especially low-wage employees, declining health insurance because it is unaffordable.

A vicious cycle of higher costs and declining access was set in motion during the 1980s. Uninsured persons often forego cost effective preventive care and, when they seek care, do so at costly hospital emergency rooms instead of physicians' offices. To cover the cost of treating the uninsured, hospitals raise their rates to privately-insured patients and insurance premiums go up. Cost-shifting due to uncompensated care and the lack of insurance offered by some employers accounts for approximately

27% of employer health care costs. In the face of rising premiums, more employers chose not to offer coverage at all, ultimately increasing the costs of coverage for those who remain insured.

THE 1990s: A $1.5 TRILLION ANNUAL HEALTH CARE BILL

The huge increase in outlays for health care during the 1980s pales in comparison to what this country will spend by the year 2000 should the status quo continue with our health care system. Absent fundamental change, consumers, employers and governments can expect a $1.47 trillion annual health care bill by the year 2000.

- By 2000, health care spending will rise to $5,515 per person, an increase of 443% from 1980.
- From 1980 to 2000, overall health care spending will be six and one-half times higher.
- Employers and employees will have to absorb a 529% increase from 1980 to 2000, from $66 billion to $412 billion for employer-based health coverage.
- Families will experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from $63 billion to $386 billion, not counting the employee share of health insurance premiums.
- By the year 2000, state governments can expect to see a 480% increase in Medicaid expenditures, from 1980 spending levels of $11 billion to $62 billion in 2000.
- In the 1980-2000 period, per capita spending will increase fastest in Arizona (493%), Alaska (485%), New Mexico (473.9%), Florida (473.7%), Maine (468.5%), North Dakota (467.6%) and Washington (466%).

Clearly, health care spending of the magnitude described above presents a crisis of affordability for every family, for the American economy, and for government. The data in this report illustrates the need for fundamental reform of our health care system. Unless the United States takes bold action now, all Americans will suffer a declining standard of health care and a declining standard of living as a result of the increasing burden of health care costs.

ENDNOTES

1. Katherine R. Levit, Mark S. Freeland and Daniel Waldo, "Health spending and ability to pay: Business, individuals and government," **Health Care Financing Review**, Spring 1989, p. 9.

2. The estimates in this report are based on the most recent data from the Census Bureau. These estimates, 31.8 million persons nationally, are lower than previous estimates of approximately 37 million uninsured persons because the Census Bureau now asks if uninsured persons are covered by insurance form someone not living in the household, e.g. a noncustodial parent.

3. Unless otherwise noted, data are the results of analysis by Lewin/ICF, Inc.

4. See **A Call for Action**, The Pepper Commission, The U.S. Bipartisan Commission on Comprehensive Health Care, Final Report, September 1990, p. 23-6.

5. These practices are described in "The Crisis in Health Insurance," **Consumer Reports**, August 1990, p. 533-7.

6. Jack Needleman, Judith Arnold, John Sheils and Lawrence S. Lewin, "The Health Care Financing System and the Uninsured," submitted to the Office of Research, Health Care Financing Administration, Department of Health and Human Services, April 4, 1990. The Joint Economic Committee estimates the number of the underinsured at 70 million. See **Medical Alert**, a staff report of the Subcommittee on Education and Health of the Joint Economic Committee, October 1989.

7. Committee Analysis, Select Committee on Aging, U.S. House of Representatives, October 26, 1988.

8. United States Department of Labor, Bureau of Labor Statistics, **News**, (Washington, D.C., USDL 90-160, March 30, 1990).

Table 1

PER CAPITA HEALTH SPENDING
1980 - 2000

STATE	1980	1990	% Change 1980-1990	% Change Rank	2000	% Change 1980-2000
ALABAMA	924	2,286	147.4%	13	5,201	462.8%
ALASKA	921	2,367	157.2%	2	5,390	485.5%
ARIZONA	848	2,211	160.7%	1	5,031	493.0%
ARKANSAS	844	1,944	130.4%	46	4,423	424.1%
CALIFORNIA	1,186	2,894	143.9%	17	6,584	454.9%
COLORADO	996	2,415	142.5%	20	5,496	451.8%
CONNECTICUT	1,148	2,699	135.2%	39	6,136	434.7%
DELAWARE	960	2,268	136.3%	36	5,160	437.6%
DISTRICT OF COLUMBIA	1,241	2,586	108.4%	51	5,882	374.1%
FLORIDA	962	2,427	152.3%	3	5,520	473.7%
GEORGIA	883	2,072	134.7%	40	4,714	434.0%
HAWAII	993	2,469	148.5%	9	5,619	465.6%
IDAHO	708	1,726	143.9%	18	3,928	455.0%
ILLINOIS	1,093	2,619	139.6%	29	5,953	444.6%
INDIANA	919	2,201	139.4%	30	5,004	444.3%
IOWA	993	2,351	136.6%	35	5,343	437.9%
KANSAS	1,057	2,548	141.1%	22	5,792	448.0%
KENTUCKY	806	1,875	132.5%	43	4,266	429.1%
LOUISIANA	940	2,185	132.4%	44	4,972	428.9%
MAINE	870	2,175	150.0%	5	4,945	468.5%
MARYLAND	1,041	2,436	134.1%	42	5,541	432.5%
MASSACHUSETTS	1,284	3,031	136.0%	38	6,890	436.5%
MICHIGAN	1,097	2,569	134.3%	41	5,840	432.5%
MINNESOTA	1,110	2,480	123.4%	49	5,641	408.1%
MISSISSIPPI	759	1,751	130.6%	45	3,984	424.6%
MISSOURI	1,033	2,568	148.6%	8	5,837	465.1%
MONTANA	859	2,059	139.7%	27	4,686	445.6%
NEBRASKA	1,016	2,452	141.4%	21	5,576	448.8%
NEVADA	1,109	2,757	148.5%	10	6,272	465.3%
NEW HAMPSHIRE	813	1,981	143.6%	19	4,505	453.8%
NEW JERSEY	930	2,224	139.2%	32	5,056	443.8%
NEW MEXICO	711	1,792	152.2%	4	4,078	473.9%
NEW YORK	1,257	2,818	124.2%	48	6,408	409.8%
NORTH CAROLINA	773	1,833	137.1%	34	4,170	439.5%
NORTH DAKOTA	1,066	2,661	149.7%	6	6,051	467.6%
[illegible]	1,039	2,493	140.0%	26	5,667	445.6%
[illegible]HOMA	906	2,139	136.2%	37	4,867	437.3%
[illegible]EGON	940	2,312	146.0%	15	5,260	459.8%
PENNSYLVANIA	1,021	2,536	148.3%	11	5,763	464.2%
RHODE ISLAND	1,184	2,707	128.6%	47	6,153	419.7%
SOUTH CAROLINA	706	1,689	139.2%	31	3,842	444.4%
SOUTH DAKOTA	952	2,322	144.0%	16	5,278	454.7%
TENNESSEE	952	2,262	137.7%	33	5,145	440.8%
TEXAS	915	2,192	139.7%	28	4,987	445.3%
UTAH	741	1,784	140.8%	23	4,062	448.0%
VERMONT	815	1,956	140.1%	25	4,448	445.9%
VIRGINIA	863	2,076	140.5%	24	4,724	447.2%
WASHINGTON	929	2,311	148.7%	7	5,258	466.0%
WEST VIRGINIA	843	2,088	147.6%	12	4,752	463.4%
WISCONSIN	1,097	2,449	123.2%	50	5,507	407.3%
WYOMING	714	1,756	146.1%	14	3,998	460.0%
TOTAL	$1,016	$2,425	138.7%		$5,515	442.8%

SOURCE: Lewin/ICF estimates

Table 2

TOTAL HEALTH SPENDING
1980 - 2000
(in thousands of dollars)

STATE	1980	1990	% Change 1980-1990	Rank	2000	% Change 1980-2000
ALABAMA	3,598,838	9,522,402	164.6%	21	22,667,039	529.8%
ALASKA	370,082	1,242,929	235.9%	3	3,228,864	772.5%
ARIZONA	2,305,619	8,105,810	251.6%	1	23,306,832	910.9%
ARKANSAS	1,929,340	4,706,750	144.0%	37	11,097,073	475.2%
CALIFORNIA	28,080,581	84,754,469	201.8%	5	223,595,772	696.3%
COLORADO	2,878,913	8,045,268	179.5%	14	18,819,641	553.7%
CONNECTICUT	3,536,669	8,815,808	147.2%	32	20,996,403	488.7%
DELAWARE	570,197	1,547,100	171.3%	17	4,138,620	625.8%
DISTRICT OF COLUMBIA	791,551	1,559,131	97.0%	51	3,500,076	342.2%
FLORIDA	9,376,859	31,411,102	235.0%	4	90,060,126	860.5%
GEORGIA	4,822,254	13,669,245	183.5%	12	37,733,919	682.5%
HAWAII	958,674	2,797,343	191.8%	8	7,653,634	698.4%
IDAHO	668,050	1,748,435	161.7%	24	3,959,138	492.6%
ILLINOIS	12,489,958	30,597,883	145.0%	35	69,779,254	458.7%
INDIANA	5,047,369	12,362,662	144.9%	36	28,504,460	464.7%
IOWA	2,894,898	6,615,476	128.5%	49	13,620,316	370.5%
KANSAS	2,498,938	6,426,779	157.2%	26	14,677,643	487.4%
KENTUCKY	2,951,766	7,021,825	137.9%	45	15,737,895	433.2%
LOUISIANA	3,954,402	9,545,115	141.4%	42	20,590,574	420.7%
MAINE	978,536	2,687,926	174.7%	15	6,645,638	579.1%
MARYLAND	4,388,016	11,627,792	165.0%	20	31,074,629	608.2%
MASSACHUSETTS	7,367,870	17,947,477	143.6%	38	42,436,773	476.0%
MICHIGAN	10,158,071	23,874,781	135.0%	46	54,691,321	438.4%
MINNESOTA	4,525,259	10,857,061	139.9%	44	25,755,773	469.2%
MISSISSIPPI	1,914,580	4,638,528	142.3%	41	11,044,767	476.9%
MISSOURI	5,079,283	13,373,361	163.3%	23	31,946,064	528.9%
MONTANA	676,015	1,641,223	142.8%	39	3,486,657	415.8%
NEBRASKA	1,595,143	3,933,640	146.6%	33	8,580,707	437.9%
NEVADA	887,542	3,115,213	251.0%	2	8,837,119	895.7%
NEW HAMPSHIRE	749,188	2,258,658	201.5%	6	6,351,711	747.8%
NEW JERSEY	6,848,103	17,368,763	153.6%	27	42,383,428	518.9%
NEW MEXICO	925,932	2,757,688	197.8%	7	7,076,082	664.2%
NEW YORK	22,066,936	50,354,750	128.2%	50	115,121,894	421.7%
NORTH CAROLINA	4,546,873	12,259,381	169.6%	18	32,183,511	607.8%
NORTH DAKOTA	696,115	1,751,185	151.6%	30	3,606,280	418.1%
OHIO	11,215,407	27,193,403	142.5%	40	61,941,308	452.3%
OKLAHOMA	2,740,186	6,824,669	149.1%	31	14,232,334	419.4%
OREGON	2,474,037	6,523,595	163.7%	22	15,269,405	517.2%
PENNSYLVANIA	12,117,790	30,541,650	152.0%	29	69,555,852	474.0%
RHODE ISLAND	1,121,337	2,701,187	140.9%	43	6,448,659	475.1%
SOUTH CAROLINA	2,203,405	6,011,186	172.8%	16	15,222,478	590.9%
SOUTH DAKOTA	657,535	1,662,251	152.8%	28	3,773,731	473.9%
TENNESSEE	4,368,396	11,328,956	159.3%	25	27,908,735	538.9%
TEXAS	13,012,429	37,380,724	187.3%	10	88,910,873	583.3%
UTAH	1,082,735	3,085,385	185.0%	11	7,493,526	592.1%
VERMONT	416,395	1,117,014	168.3%	19	2,753,403	561.2%
VIRGINIA	4,615,580	12,931,845	180.2%	13	34,364,026	644.5%
WASHINGTON	3,836,548	11,084,596	188.8%	9	27,295,859	611.1%
WEST VIRGINIA	1,644,557	3,846,712	133.9%	47	7,844,814	377.0%
WISCONSIN	5,164,568	11,980,357	132.0%	48	26,967,967	422.2%
WYOMING	335,414	821,858	145.0%	34	1,634,546	387.3%
TOTAL	$230,166,741	$605,978,347	163.3%		$1,476,507,197	541.5%

SOURCE: Lewin/ICF estimates

Table 3a

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 a/
(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER SPONSORED	NON GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	1,137,579	756,469	186,631	44,044	77,669	193,143	551,715	651,587	3,598,838	924
ALASKA	88,948	121,467	7,286	6,155	13,720	13,720	17,773	101,013	370,082	921
ARIZONA	582,995	698,587	72,743	36,635	NA	NA	328,804	585,855	2,305,619	849
ARKANSAS	582,892	369,379	86,883	23,012	65,441	175,772	300,770	325,184	1,929,340	844
CALIFORNIA	6,111,415	7,281,598	710,178	370,271	1,401,953	1,401,953	4,164,002	6,639,211	28,080,581	1,186
COLORADO	695,272	933,532	74,885	43,390	87,470	99,272	302,454	642,638	2,878,913	996
CONNECTICUT	1,026,949	1,228,813	238,910	43,829	179,702	179,702	611,034	57,729	3,566,669	1,148
DELAWARE	168,160	136,750	28,466	5,787	23,279	23,279	87,529	98,949	570,197	952
DISTRICT OF COLUMBIA	168,707	123,705	28,275	6,661	86,588	86,588	148,616	142,410	791,551	1,241
FLORIDA	2,814,989	1,778,637	478,882	96,866	165,422	237,456	2,153,010	1,651,597	9,376,859	962
GEORGIA	1,499,191	1,132,191	233,268	54,378	157,967	317,264	614,894	813,100	4,822,254	883
HAWAII	217,889	277,774	24,639	12,659	49,435	49,435	92,413	234,429	958,674	993
IDAHO	157,700	192,682	18,680	9,178	18,331	35,112	83,928	172,443	686,050	709
ILLINOIS	3,400,615	4,201,372	906,180	222,739	612,487	612,487	2,339,686	194,392	12,489,958	1,093
INDIANA	1,497,890	1,805,812	411,938	97,491	155,513	208,516	754,790	115,419	5,047,369	919
IOWA	817,145	979,140	238,551	51,426	102,750	133,838	486,426	85,621	2,894,898	993
KANSAS	674,088	796,112	204,462	42,979	96,399	111,000	443,405	130,491	2,498,936	1,057
KENTUCKY	945,732	738,292	181,148	31,508	97,004	208,798	397,782	373,522	2,951,788	808
LOUISIANA	1,198,552	880,118	196,340	40,451	133,052	293,670	470,671	741,550	3,954,402	940
MAINE	284,943	280,438	77,439	13,382	41,117	93,828	179,001	8,389	978,536	870
MARYLAND	1,286,977	1,149,042	211,012	46,508	164,234	164,234	698,873	667,138	4,388,016	1,041
MASSACHUSETTS	1,961,518	2,207,911	437,646	88,910	500,501	538,807	1,529,777	104,800	7,367,870	1,284
MICHIGAN	2,648,628	3,441,020	718,157	159,462	550,719	550,719	1,771,676	317,690	10,158,071	1,097
MINNESOTA	1,243,181	1,498,322	301,198	83,258	269,169	337,814	704,635	27,881	4,525,259	1,110
MISSISSIPPI	619,332	410,989	0	23,328	48,684	168,171	281,274	262,076	1,914,580	759
MISSOURI	1,482,558	1,652,437	436,857	98,288	120,224	183,065	1,006,024	99,831	5,079,283	1,033
MONTANA	158,707	182,422	19,068	9,501	22,871	41,158	73,442	168,847	676,015	859
NEBRASKA	469,733	532,375	134,464	30,893	47,389	64,430	260,572	55,287	1,595,143	1,016
NEVADA	202,680	261,305	22,759	12,294	23,073	23,073	112,798	229,561	887,542	1,109
NEW HAMPSHIRE	227,069	260,611	53,749	9,906	28,738	45,157	107,879	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,160	458,158	85,935	388,438	388,438	1,146,073	92,675	6,840,103	930
NEW MEXICO	228,563	248,079	25,581	14,411	22,378	49,875	91,184	247,833	925,932	711
NEW YORK	5,502,085	6,045,460	1,304,282	248,347	2,334,327	2,334,327	4,012,129	285,980	22,066,936	1,257
NORTH CAROLINA	1,443,006	1,100,169	227,200	52,419	133,398	278,833	576,692	729,155	4,546,873	773
NORTH DAKOTA	199,350	223,808	59,960	13,989	18,628	29,678	120,945	29,759	696,115	1,068
OHIO	3,218,536	4,009,617	954,293	190,723	373,505	458,355	1,818,967	191,410	11,215,407	1,039
OKLAHOMA	840,211	581,953	139,726	28,583	99,177	173,587	433,308	443,642	2,740,188	906
OREGON	558,453	705,573	68,503	33,498	81,525	102,339	319,286	604,859	2,474,037	940
PENNSYLVANIA	3,486,617	3,967,694	860,052	161,365	487,881	599,683	2,385,775	168,722	12,117,790	1,021
RHODE ISLAND	291,130	358,994	72,062	12,411	69,551	95,300	204,278	17,604	1,121,337	1,184
SOUTH CAROLINA	883,690	437,942	95,613	25,117	77,334	189,059	230,513	484,138	2,203,405	706
SOUTH DAKOTA	202,638	199,249	58,778	15,537	17,815	38,808	99,529	25,381	657,535	952
TENNESSEE	1,377,091	1,038,889	226,380	45,904	119,232	270,798	629,946	662,156	4,368,396	952
TEXAS	4,244,744	3,070,355	632,707	159,455	419,882	588,238	1,878,299	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	26,122	55,887	79,516	268,814	1,082,735	741
VERMONT	119,592	133,428	29,474	5,360	19,259	41,687	83,594	4,002	416,395	815
VIRGINIA	1,402,784	1,123,908	234,835	46,655	160,351	208,611	593,181	845,275	4,615,580	863
WASHINGTON	852,112	1,071,822	99,177	52,104	169,065	169,065	400,188	1,025,015	3,838,548	929
WEST VIRGINIA	551,141	396,291	89,965	18,220	34,764	71,711	252,528	229,937	1,644,557	843
WISCONSIN	1,349,249	1,765,318	391,282	78,756	296,468	408,568	822,555	52,372	5,164,568	1,097
WYOMING	78,091	108,783	8,364	4,876	7,400	7,400	32,597	87,905	335,414	714
TOTAL	$63,140,884	$65,626,957	$12,946,686	$3,123,818	$10,697,188	$13,147,306	$37,246,701	$24,228,100	$230,166,741	$1,016

a/ Includes personal health expenditures and administrative costs
b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: LewinACF estimates

Table 3b

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/
(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	2,814,760	2,012,389	416,532	101,705	183,013	425,482	1,932,843	1,655,817	9,522,402	2,286
ALASKA	329,687	427,212	29,864	24,057	60,360	60,360	80,357	231,034	1,242,929	2,367
ARIZONA	1,972,363	2,379,617	240,868	137,174	222,669	367,652	1,367,192	1,418,276	8,105,810	2,211
ARKANSAS	1,449,372	892,449	198,921	57,525	103,797	292,830	980,607	721,250	4,706,750	1,944
CALIFORNIA	20,379,570	25,640,378	2,335,173	1,471,282	3,574,078	3,574,078	14,653,732	12,926,177	84,754,469	2 894
COLORADO	2,097,807	2,670,571	263,730	139,260	304,439	304,439	959,276	1,295,747	8,045,268	2,415
CONNECTICUT	2,278,555	3,303,221	432,925	92,800	514,939	514,939	1,578,669	99,760	8,815,808	2,699
DELAWARE	454,368	365,183	70,128	14,539	68,058	68,058	291,765	218,999	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,188	50,262	11,181	182,516	344,[illegible]	[illegible]	228,817	1,559,131	2,586
FLORIDA	9,375,203	6,218,476	1,396,780	322,[illegible]	878,583	1,125,484	8,083,[illegible]07	4,010,590	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,638	124,588	489,424	952,179	2,22[illegible]39	2,301,976	13,669,245	2,072
HAWAII	697,628	966,101	96,984	48,022	102,084	106,251	29[illegible]352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,196	28,238	48,178	109,063	238,416	305,267	1,748,435	1,726
ILLINOIS	8,208,698	10,348,102	1,806,653	532,709	1,231,633	1,231,633	6,719,023	519,434	30,597,883	2,619
INDIANA	3,382,637	3,988,394	816,531	228,316	481,451	813,468	2,204,733	447,133	12,362,662	2,201
IOWA	1,834,062	2,218,841	448,816	115,314	247,922	355,295	1,345,839	45,288	6,815,478	2,351
KANSAS	1,772,719	2,218,335	415,780	100,640	220,379	220,379	1,287,848	190,689	6,426,779	2,548
KENTUCKY	1,947,743	1,418,857	270,882	67,343	254,106	599,458	1,233,765	1,229,672	7,021,825	1,875
LOUISIANA	2,547,782	1,822,033	352,995	96,280	345,188	608,634	1,741,606	2,030,597	9,545,115	2,185
MAINE	689,728	882,374	149,985	29,898	128,635	284,450	480,731	62,124	2,687,920	2,175
MARYLAND	3,169,204	2,674,955	484,561	99,774	541,404	541,404	2,178,431	1,958,060	11,627,792	2 436
MASSACHUSETTS	4 443,792	6,173,324	748,868	195,223	1,239,474	1,239,474	3,827,313	280,008	17,947,477	3,031
MICHIGAN	6,085,418	7,977,976	1,391,031	372,097	1,001,688	1,316,760	5,159,240	570,371	23,874,781	2,569
MINNESOTA	3,032,352	4,004,588	672,128	180,038	659,881	758,225	1,408,019	144,050	10,857,061	2,480
MISSISSIPPI	1,319,923	849,242	177,033	51,154	111,948	408,809	827,081	895,339	4,638,528	1,751
MISSOURI	3,643,381	4,398,101	845,312	224,843	355,821	547,738	3,055,508	302,658	13,373,361	2,568
MONTANA	383,483	438,546	46,226	25,273	57,205	112,948	241,279	336,263	1,641,223	2,059
NEBRASKA	1,132,890	1,361,739	285,541	70,028	128,525	171,137	668,770	115,011	3,933,640	2,452
NEVADA	807,751	1,033,508	98,602	56,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,660	107,811	33,381	97,620	118,939	370,959	48,364	2,258,658	1,981
NEW JERSEY	4,545,827	6,011,019	741,459	200,122	1,042,327	1,042,327	3,501,694	283,989	17,368,763	2,224
NEW MEXICO	705,891	728,428	92,220	49,890	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,881	14,346,795	2,020,635	569,890	5,288,300	5,288,300	10,274,890	825,078	50,354,750	2,818
NORTH CAROLINA	3,808,151	2,855,434	567,966	130,692	378,718	850,088	1,957,921	1,712,411	12,259,381	1,833
NORTH DAKOTA	442,809	540,478	111,059	26,699	86,967	108,809	350,419	85,946	1,751,185	2,661
OHIO	6,966,974	8,754,357	1,645,671	429,028	1,244,280	1,739,605	5,855,967	557,522	27,193,403	2,493
OKLAHOMA	2,026,546	1,379,606	288,712	76,027	204,947	400,883	1,278,850	1,081,298	6,824,669	2,139
OREGON	1,657,140	2,007,536	207,895	110,855	171,645	274,649	986,019	1,106,958	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	365,577	1,248,011	1,835,583	7,748,007	375,838	30,541,650	2,538
RHODE ISLAND	704,349	853,513	135,007	30,385	173,508	223,809	531,628	48,997	2,701,187	2,707
SOUTH CAROLINA	1,809,716	1,401,609	269,561	63,523	160,028	428,154	889,168	991,426	6,011,186	1,689
SOUTH DAKOTA	469,323	532,487	106,789	30,642	51,118	107,733	320,442	43,718	1,662,251	2 122
TENNESSEE	3,284,049	2,385,982	493,952	110,504	341,451	804,357	2,185,868	1,742,697	11,328,958	2,282
TEXAS	11,992,115	8,477,215	1,555,624	465,330	1,145,085	1,320,848	6,584,259	5,840,450	37,380,724	2,192
UTAH	777,208	1,095,590	80,021	51,752	65,018	172,449	318,184	525,181	3,085,385	1,784
VERMONT	323,045	381,043	64,236	13,292	47,486	96,873	172,612	18,629	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,548	469,473	532,390	2,061,361	2,160,846	12,931,845	2,076
WASHINGTON	2,613,628	3,348,969	321,777	188,957	567,419	568,783	1,556,885	1,918,178	11,084,596	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	280,771	720,922	743,573	3,848,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	168,823	526,448	713,420	2,258,999	379,584	11,980,357	2,449
WYOMING	206,156	269,578	26,328	13,894	19,865	19,865	107,370	158,705	821,658	1,758
TOTAL	$161,810,653	$174,125,101	$27,063,851	$8,308,703	$27,397,885	$34,258,738	$116,277,024	$56,730,394	$605,978,347	$2,425

a/ Includes personal health expenditures and administrative costs
b/ Does not include employee share of premiums for employer-sponsored insurance These payments are included in the 'Employer-Sponsored' column

SOURCE: Lewin/ICF estimates

Table 3c

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 a/

(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
					STATE	FEDERAL				
ALABAMA	6,587,653	4,706,531	976,883	267,896	387,825	960,063	5,375,234	3,424,954	22,667,039	5,201
ALASKA	865,609	1,121,008	78,581	71,054	152,806	152,806	250,751	536,159	3,228,864	5,330
ARIZONA	5,810,602	6,764,398	606,598	436,907	610,678	1,008,299	4,621,770	3,565,631	23,306,882	5,031
ARKANSAS	3,349,186	2,060,831	460,622	149,517	231,246	652,384	2,720,302	1,472,984	11,097,073	4,423
CALIFORNIA	53,007,530	66,644,841	6,086,483	4,304,439	8,982,640	8,982,640	45,912,880	29,714,318	223,595,772	6,584
COLORADO	4,691,263	6,222,417	616,798	365,225	684,360	684,360	2,685,710	2,670,108	18,819,641	5,496
CONNECTICUT	5,271,870	7,637,346	1,003,744	241,508	1,148,658	1,148,658	4,340,830	203,993	20,996,403	6,139
DELAWARE	1,195,017	959,790	184,826	43,011	167,503	167,503	911,917	509,052	4,138,620	5,160
DISTRICT OF COLUMBIA	704,048	529,771	111,169	27,784	388,391	388,391	804,558	445,965	3,500,076	5,882
FLORIDA	28,031,662	17,254,594	3,886,487	1,006,793	2,351,978	3,012,935	26,673,673	9,842,004	90,060,126	5,520
GEORGIA	10,852,590	8,320,811	1,565,419	383,629	1,291,755	2,513,120	7,237,055	5,569,541	37,733,919	4,714
HAWAII	1,910,550	2,643,972	266,159	147,929	269,540	280,542	961,238	1,173,704	7,653,634	5,619
IDAHO	993,703	1,184,244	120,221	71,828	104,758	237,141	638,985	608,459	3,959,138	3,928
ILLINOIS	18,024,960	22,707,029	3,975,387	1,315,734	2,607,418	2,607,418	17,533,255	1,008,052	69,779,254	5,953
INDIANA	7,587,956	8,940,608	1,835,468	576,081	1,041,239	1,759,298	5,877,353	886,461	28,504,460	5,004
IOWA	3,643,891	4,405,316	893,501	257,698	474,894	680,566	3,177,848	86,542	13,620,316	5,343
KANSAS	3,916,623	4,897,773	920,558	250,103	469,432	469,432	3,381,372	372,350	14,877,643	5,792
KENTUCKY	4,324,250	3,147,873	602,648	160,169	543,906	1,283,120	3,255,128	2,412,801	15,737,895	4,268
LOUISIANA	5,456,366	3,899,393	757,556	231,930	712,733	1,258,887	4,432,487	3,843,422	20,590,574	4,972
MAINE	1,663,097	2,126,142	362,405	81,089	299,039	661,265	1,320,211	132,390	6,645,638	4,945
MARYLAND	8,357,708	7,049,413	1,227,679	295,958	1,378,536	1,378,536	6,827,112	4,563,688	31,074,029	5,541
MASSACHUSETTS	10,176,490	14,127,420	1,718,518	502,868	2,738,599	2,738,599	8,871,559	566,719	42,436,773	6,890
MICHIGAN	13,152,128	17,623,526	3,081,357	925,199	2,135,251	2,808,318	10,553,224	1,114,322	54,691,321	5,840
MINNESOTA	7,051,420	9,305,818	1,566,223	470,911	1,478,930	1,695,420	3,891,005	296,049	25,755,773	5,641
MISSISSIPPI	3,116,442	2,003,742	418,860	135,852	254,833	926,041	2,320,679	1,868,319	11,044,767	3,984
MISSOURI	8,368,592	10,095,144	1,945,672	580,906	787,968	1,212,866	8,340,413	814,402	31,946,064	5,837
MONTANA	813,087	929,192	98,216	60,273	118,938	230,688	607,947	630,119	3,486,957	4,686
NEBRASKA	2,403,868	2,887,461	607,149	167,136	282,930	350,103	1,886,381	215,683	8,580,707	5,578
NEVADA	2,264,610	2,695,540	277,016	179,109	193,513	193,513	1,627,012	1,206,717	8,837,119	6,272
NEW HAMPSHIRE	1,867,766	2,188,757	265,910	102,842	257,810	314,084	1,207,467	117,076	6,351,711	4,505
NEW JERSEY	10,737,775	14,188,913	1,755,065	531,709	2,373,749	2,373,749	9,829,603	592,866	42,383,428	5,058
NEW MEXICO	1,814,472	1,871,107	211,785	144,264	218,600	480,760	1,053,827	1,283,266	7,076,082	4,078
NEW YORK	28,052,821	31,813,339	4,493,114	1,422,407	11,313,588	11,313,588	27,094,850	1,618,092	115,121,804	6,408
NORTH CAROLINA	9,878,126	7,405,800	1,477,120	381,519	847,619	2,127,070	8,038,653	3,927,803	32,183,511	4,170
NORTH DAKOTA	885,467	1,080,024	222,543	60,052	167,663	205,918	832,722	151,892	3,606,280	6,051
OHIO	15,316,195	19,232,268	3,625,387	1,080,889	2,637,267	3,087,115	15,298,954	1,083,233	61,941,308	5,667
OKLAHOMA	4,165,518	2,833,706	590,559	175,776	584,502	794,040	3,123,838	1,964,314	14,232,334	4,867
OREGON	3,846,838	4,657,015	483,608	289,452	384,153	614,685	2,722,592	2,271,062	15,269,405	5,260
PENNSYLVANIA	17,430,559	20,877,038	3,490,750	896,713	2,623,883	3,438,693	20,073,866	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,360	499,658	1,462,951	100,253	6,448,659	6,153
SOUTH CAROLINA	4,503,474	3,524,182	679,663	179,781	388,200	1,033,778	2,658,719	2,204,679	15,222,478	3,842
SOUTH DAKOTA	1,032,399	1,170,535	235,401	75,818	108,414	228,484	837,887	84,893	3,773,731	5,278
TENNESSEE	7,962,737	5,732,759	1,200,168	301,378	788,197	1,880,317	8,298,723	3,734,453	27,900,735	5,145
TEXAS	28,125,731	19,868,305	3,656,995	1,227,572	2,589,258	2,988,233	16,351,490	12,106,189	88,910,873	4,987
UTAH	1,889,913	2,662,266	194,991	141,549	152,431	404,292	819,416	1,128,669	7,493,526	4,062
VERMONT	777,694	916,691	154,965	35,992	110,215	224,379	493,830	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	363,799	1,192,047	1,351,801	6,451,550	5,029,566	34,364,026	4,724
WASHINGTON	6,406,052	8,197,810	790,328	520,941	1,340,850	1,344,072	4,540,641	4,155,168	27,295,859	5,258
WEST VIRGINIA	2,216,108	1,441,469	344,513	78,170	201,945	507,362	1,728,984	1,328,244	7,844,814	4,752
WISCONSIN	6,803,691	8,886,593	1,653,258	409,690	1,109,502	1,503,550	5,868,345	733,339	28,967,967	5,567
WYOMING	409,029	534,489	52,346	31,230	37,999	37,999	253,161	278,293	1,634,548	3,998
TOTAL	$385,931,868	$412,369,109	$63,755,912	$22,246,107	$62,147,543	$77,766,646	$328,079,658	$124,210,355	$1,476,507,197	$5,515

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates

Table 4

ESTIMATED NUMBER OF UNINSURED PERSONS

STATE	1980 NUMBER a/	1980 % OF STATE POP	1980 RANK b/	1988 NUMBER c/	1988 % OF STATE POP	1988 RANK b/	PERCENT CHANGE
ALABAMA	560,052	14.4%	9	615,680	15.1%	15	9.9%
ALASKA	54,655	13.6%	11	85,903	15.8%	13	57.2%
ARIZONA	449,151	16.5%	2	608,444	17.7%	7	35.5%
ARKANSAS	372,852	16.3%	3	519,163	21.8%	2	39.2%
CALIFORNIA	3,004,160	12.7%	14	4,737,675	17.2%	10	57.7%
COLORADO	371,701	12.9%	13	428,555	13.0%	22	15.3%
CONNECTICUT	193,401	6.2%	50	186,011	5.8%	51	-3.8%
DELAWARE	53,621	9.0%	36	65,178	10.2%	34	21.6%
DISTRICT OF COLUMBIA	97,916	15.3%	6	97,659	15.7%	14	-0.3%
FLORIDA	1,358,123	13.9%	10	2,199,960	18.4%	4	62.0%
GEORGIA	672,080	12.3%	17	788,513	12.6%	25	17.3%
HAWAII	78,539	8.1%	43	87,669	8.1%	42	11.6%
IDAHO	115,174	12.2%	18	165,419	16.4%	11	43.6%
ILLINOIS	1,078,105	9.4%	32	1,164,471	10.1%	35	8.0%
INDIANA	538,413	9.8%	30	751,116	13.6%	21	39.5%
IOWA	244,302	8.4%	41	222,017	7.9%	44	-9.1%
KANSAS	172,575	7.3%	48	257,374	10.4%	33	49.1%
KENTUCKY	328,638	9.0%	37	555,113	14.9%	16	68.9%
LOUISIANA	522,790	12.4%	16	778,919	17.3%	9	49.0%
MAINE	127,156	11.3%	22	92,123	7.8%	45	-27.6%
MARYLAND	382,164	9.1%	35	430,254	9.5%	38	12.6%
MASSACHUSETTS	493,906	8.6%	39	424,868	7.3%	48	-14.0%
MICHIGAN	604,488	6.5%	49	756,414	8.2%	41	25.1%
MINNESOTA	350,485	8.6%	40	282,003	6.6%	50	-19.5%
MISSISSIPPI	378,740	15.0%	8	472,365	17.9%	6	24.7%
MISSOURI	511,424	10.4%	26	533,342	10.5%	32	4.3%
MONTANA	120,046	15.3%	7	129,258	15.9%	12	7.7%
NEBRASKA	147,733	9.4%	33	168,268	10.5%	31	13.9%
NEVADA	92,188	11.5%	20	172,097	17.3%	8	86.7%
NEW HAMPSHIRE	70,854	7.7%	46	105,203	9.9%	36	48.5%
NEW JERSEY	688,699	9.4%	34	638,403	8.3%	40	-7.3%
NEW MEXICO	245,114	18.8%	1	345,509	22.8%	1	41.0%
NEW YORK	1,656,634	9.4%	31	2,049,755	11.5%	28	23.7%
NORTH CAROLINA	668,728	11.4%	21	883,308	13.8%	20	32.1%
NORTH DAKOTA	52,615	8.1%	45	50,447	7.5%	47	-4.1%
OHIO	872,119	8.1%	44	1,031,230	9.6%	37	18.2%
OKLAHOMA	399,994	13.2%	12	592,995	18.0%	5	48.3%
OREGON	260,217	9.9%	29	397,160	14.6%	18	52.6%
PENNSYLVANIA	981,113	8.3%	42	949,608	8.0%	43	-3.2%
RHODE ISLAND	72,422	7.6%	47	71,051	7.2%	49	-1.9%
SOUTH CAROLINA	493,006	15.8%	5	406,552	11.9%	26	-17.5%
SOUTH DAKOTA	86,842	12.6%	15	104,051	14.7%	17	19.8%
TENNESSEE	536,142	11.7%	19	687,400	14.2%	19	28.2%
TEXAS	2,270,337	16.0%	4	3,621,720	21.4%	3	59.5%
UTAH	146,561	10.0%	28	198,706	11.7%	27	35.6%
VERMONT	52,373	10.2%	27	50,256	9.2%	39	-4.0%
VIRGINIA	473,667	8.9%	38	637,029	10.8%	30	34.5%
WASHINGTON	457,440	11.1%	24	579,781	12.8%	24	26.7%
WEST VIRGINIA	217,640	11.2%	23	245,160	12.9%	23	12.6%
WISCONSIN	273,431	5.9%	51	361,781	7.6%	46	32.3%
WYOMING	50,687	10.8%	25	54,968	10.9%	29	8.4%
TOTAL	24,501,212	10.8%		31,837,904	13.1%		29.9%

a/ Based upon March 1980 Current Population Surveys (CPS) estimates adjusted to reflect changes in survey design implemented in the March 1988 CPS

b/ Based upon percent uninsured

c/ Based upon March 1988 CPS data

SOURCE Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

By:

Lewin/ICF
a division of Health & Sciences International, Inc.

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

In this analysis we developed estimates of total health expenditures in each state by source of payment in 1980 and 1987. We also developed projections of future health expenditures by state in selected years under current policy and alternative health care financing scenarios. This appendix describes the methods used to develop these estimates.

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1986 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

- Direct payments by households.
- Employer health insurance payments.
- Payments by other private sources.
- Medicare payments.
- State Medicaid expenditures.
- Federal Medicaid expenditures.
- Payments by other public sources.

State-level data on Medicare and Medicaid spending were obtained from the Health Care Financing Administration (HCFA). However, information on other health care expenditures by state and local governments in largely unavailable from existing data sources. Data on health spending by households and employers are also unavailable at the state level.

Due to the lack of state-level health expenditures data, we estimated state spending using techniques that reflect the unique socio-economic composition of the population in each state. We developed these estimates for 1980 and 1987 using the following three steps:

- **Develop First Stage estimates.** We estimated total expenditures by source of payment based upon the socio-economic composition of the population in each state. The Lewin/ICF Health Benefits Simulation Model (HBSM) was used to estimate per-capita health spending for each source of payment by age, income, geographic region, and health insurance status. Using these per capita health spending estimates, we estimated total health spending in each state based upon state-level data on the distribution of persons by age, income, and insured status as reported in the Current Population Survey (CPS) for 1980 and 1987.

- **Adjust First Stage Estimates to Replicate Known Totals By State.** We then adjusted the first stage estimates to reflect the following known control totals for 1980 and 1987:

  -- Medicare spending by state.
  -- Federal Medicaid spending by state.
  -- State Medicaid spending.

  In addition, we adjusted total health spending to reflect HCFA estimates of relative differences in per-capita health spending by state in 1982.

- **Adjust Second Stage Estimates to Replicate HCFA Estimates of National Health Spending by Source of Payment.** The state-level health spending estimates developed in the second stage were adjusted to replicate HCFA estimates of national health spending by source of payment.

These steps were performed separately to develop estimates for 1980 and 1987.

Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

ADDITIONAL TABLES

Sources of Payment for Personal Health Expenditures 1980, 1990, 2000

Percentage Distribution

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1900 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	31.0 %	21.0 %	5.2 %	1.2 %	2.2 %	5.4 %	15.3 %	18.1 %	100.0%
ALASKA	24.0	32.8	2.0	1.7	3.7	3.7	4.8	27.3	100.0
ARIZONA	25.3	30.3	3.2	1.8	0.0	0.0	14.3	25.4	100.0
ARKANSAS	30.2	19.1	4.5	1.2	3.4	9.1	15.6	16.9	100.0
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.6	23.6	100.0
COLORADO	24.2	32.4	2.6	1.5	3.0	3.4	10.5	22.3	100.0
CONNECTICUT	28.6	34.5	6.7	1.2	5.0	5.0	17.1	1.6	100.0
DELAWARE	28.5	24.0	5.0	1.0	4.1	4.1	15.4	17.0	100.0
DISTRICT OF COLUMBIA	21.3	15.6	3.6	0.8	10.9	10.8	16.6	16.0	100.0
FLORIDA	30.0	19.0	5.1	1.0	1.8	2.5	23.0	17.6	100.0
GEORGIA	31.1	23.5	4.8	1.1	3.3	6.6	12.8	16.9	100.0
HAWAII	22.7	29.0	2.6	1.3	5.2	5.2	9.6	24.5	100.0
IDAHO	23.6	28.6	2.6	1.4	2.7	5.3	9.6	25.6	100.0
ILLINOIS	27.2	33.6	7.3	1.6	4.9	4.9	16.7	1.6	100.0
INDIANA	29.7	35.6	6.2	1.9	3.1	4.1	15.0	2.3	100.0
IOWA	28.2	33.6	6.2	1.6	3.5	4.6	16.6	3.0	100.0
KANSAS	27.0	31.9	6.2	1.7	3.9	4.4	17.7	5.2	100.0
KENTUCKY	32.0	25.0	5.5	1.1	3.3	7.0	13.5	12.7	100.0
LOUISIANA	30.3	22.3	5.0	1.0	3.4	7.4	11.9	18.6	100.0
MAINE	29.1	28.7	7.9	1.4	4.2	9.6	16.3	0.9	100.0
MARYLAND	29.3	28.2	4.6	1.1	3.7	3.7	15.9	15.2	100.0
MASSACHUSETTS	26.6	30.0	5.9	1.2	6.6	7.3	20.6	1.4	100.0
MICHIGAN	26.1	33.9	7.1	1.6	5.4	5.4	17.4	3.1	100.0
MINNESOTA	27.5	33.1	6.0	1.6	5.9	7.5	15.6	0.6	100.0
MISSISSIPPI	32.3	21.5	0.0	1.2	2.5	6.6	14.7	13.7	100.0
MISSOURI	29.2	32.5	6.6	1.9	2.4	3.6	19.6	2.0	100.0
MONTANA	23.5	27.0	2.6	1.4	3.4	6.1	10.9	25.0	100.0
NEBRASKA	29.4	33.4	6.4	1.9	3.0	4.0	16.3	3.5	100.0
NEVADA	22.6	29.4	2.6	1.4	2.6	2.0	12.7	25.9	100.0
NEW HAMPSHIRE	30.3	34.6	7.2	1.3	3.6	6.0	14.4	2.1	100.0
NEW JERSEY	27.9	34.6	6.7	1.3	5.7	5.7	16.7	1.4	100.0
NEW MEXICO	24.7	26.6	2.6	1.6	2.4	5.4	9.6	26.6	100.0
NEW YORK	24.9	27.4	5.9	1.1	10.6	10.6	16.2	1.3	100.0
NORTH CAROLINA	31.7	24.3	5.0	1.2	2.9	6.1	12.7	16.0	100.0
NORTH DAKOTA	28.6	32.2	6.6	2.0	2.7	4.3	17.4	4.3	100.0
OHIO	28.7	35.6	6.5	1.7	3.3	4.1	16.2	1.7	100.0
OKLAHOMA	30.7	21.2	3.1	1.0	3.6	6.3	15.6	16.2	100.0
OREGON	22.6	26.5	2.6	1.4	3.3	4.1	12.9	24.4	100.0
PENNSYLVANIA	26.6	32.7	7.1	1.3	4.0	4.9	19.7	1.4	100.0
RHODE ISLAND	26.0	32.0	6.4	1.1	6.2	6.5	16.2	1.6	100.0
SOUTH CAROLINA	30.1	19.9	4.3	1.1	3.5	6.6	10.5	22.0	100.0
SOUTH DAKOTA	30.6	30.3	6.9	2.4	2.7	5.9	15.1	3.9	100.0
TENNESSEE	31.5	23.7	5.2	1.1	2.7	6.2	14.4	15.2	100.0
TEXAS	32.6	23.6	4.0	1.2	3.2	4.5	14.4	15.5	100.0
UTAH	24.2	32.1	2.7	1.4	2.4	5.1	7.3	24.6	100.0
VERMONT	26.7	32.0	7.1	1.3	4.6	10.0	15.3	1.0	100.0
VIRGINIA	30.4	24.4	5.1	1.0	3.5	4.5	12.9	18.3	100.0
WASHINGTON	22.2	27.9	2.6	1.4	4.4	4.4	10.4	26.7	100.0
WEST VIRGINIA	33.5	24.1	5.5	1.1	2.1	4.4	15.4	14.0	100.0
WISCONSIN	26.1	34.2	7.6	1.5	5.7	7.0	15.9	1.0	100.0
WYOMING	23.3	32.4	2.5	1.5	2.2	2.2	9.7	26.2	100.0
TOTAL	27.4 %	28.5 %	5.8 %	1.4 %	4.6 %	5.7 %	16.2 %	10.5 %	100.0%

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	29.6 %	21.1 %	4.4 %	1.1 %	1.7 %	4.5 %	20.3 %	17.4 %	100.0%
ALASKA	28.5	34.4	2.4	1.9	4.9	4.9	6.5	16.6	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	16.9	17.5	100.0
ARKANSAS	30.6	19.0	4.2	1.2	2.2	6.2	21.0	15.3	100.0
CALIFORNIA	24.0	30.3	2.6	1.7	4.2	4.2	17.5	15.3	100.0
COLORADO	26.1	33.2	3.3	1.7	3.6	3.6	12.0	16.1	100.0
CONNECTICUT	25.6	37.5	4.9	1.1	5.6	5.6	17.9	1.1	100.0
DELAWARE	29.4	23.6	4.5	0.9	4.3	4.3	16.6	14.2	100.0
DISTRICT OF COLUMBIA	20.5	15.4	3.2	0.7	11.7	11.7	22.1	14.7	100.0
FLORIDA	28.6	19.6	4.4	1.0	2.6	3.6	25.7	12.6	100.0
GEORGIA	29.0	22.3	4.2	0.9	3.6	7.0	16.3	16.6	100.0
HAWAII	24.9	34.5	3.5	1.7	3.6	3.6	10.6	17.3	100.0
IDAHO	25.2	30.1	3.0	1.6	2.6	6.2	13.6	17.5	100.0
ILLINOIS	26.6	33.6	5.9	1.7	4.0	4.0	22.0	1.7	100.0
INDIANA	27.4	32.3	6.6	1.6	3.9	6.6	17.6	3.6	100.0
IOWA	27.7	33.5	6.6	1.7	3.7	5.4	20.3	0.7	100.0
KANSAS	27.6	34.5	6.5	1.6	3.4	3.4	20.0	3.0	100.0
KENTUCKY	27.7	20.2	3.9	1.0	3.6	6.5	17.6	17.5	100.0
LOUISIANA	26.7	19.1	3.7	1.0	3.6	6.4	16.2	21.3	100.0
MAINE	25.7	32.6	5.6	1.1	4.6	10.6	17.1	2.3	100.0
MARYLAND	27.3	23.0	4.0	0.9	4.7	4.7	16.7	16.6	100.0
MASSACHUSETTS	24.6	34.4	4.2	1.1	6.9	6.9	20.2	1.6	100.0
MICHIGAN	25.5	33.4	5.6	1.6	4.2	5.5	21.6	2.4	100.0
MINNESOTA	27.9	36.9	6.2	1.7	6.1	7.0	13.0	1.3	100.0
MISSISSIPPI	26.5	16.3	3.6	1.1	2.4	6.6	17.6	19.3	100.0
MISSOURI	27.2	32.9	6.3	1.7	2.7	4.1	22.6	2.3	100.0
MONTANA	23.4	26.7	2.6	1.5	3.5	6.9	14.7	20.5	100.0
NEBRASKA	26.6	34.6	7.3	1.6	3.3	4.4	17.0	2.9	100.0
NEVADA	25.9	33.2	3.2	1.6	2.3	2.3	15.7	15.6	100.0
NEW HAMPSHIRE	30.2	35.4	4.6	1.5	4.3	5.3	16.4	2.1	100.0
NEW JERSEY	26.2	34.6	4.3	1.2	6.0	6.0	20.2	1.6	100.0
NEW MEXICO	25.6	26.4	3.0	1.6	3.2	7.0	12.5	20.5	100.0
NEW YORK	23.3	26.5	4.0	1.1	10.5	10.5	20.4	1.6	100.0
NORTH CAROLINA	31.0	23.3	4.6	1.1	3.1	6.9	16.0	14.0	100.0
NORTH DAKOTA	25.3	30.9	6.3	1.5	5.0	6.1	20.0	4.9	100.0
OHIO	25.6	32.2	6.1	1.6	4.6	6.4	21.5	2.1	100.0
OKLAHOMA	29.7	20.2	4.2	1.1	4.3	5.9	16.7	15.6	100.0
OREGON	25.4	30.6	3.2	1.7	2.6	4.2	15.1	17.0	100.0
PENNSYLVANIA	26.2	31.4	5.2	1.2	4.1	5.4	25.4	1.2	100.0
RHODE ISLAND	26.1	31.6	5.0	1.1	6.4	6.3	19.7	1.6	100.0
SOUTH CAROLINA	30.1	23.3	4.5	1.1	2.7	7.1	14.6	16.5	100.0
SOUTH DAKOTA	28.2	32.0	6.4	1.6	3.1	6.5	19.3	2.6	100.0
TENNESSEE	29.0	20.9	4.4	1.0	3.0	7.1	19.3	15.4	100.0
TEXAS	32.1	22.7	4.2	1.2	3.1	3.5	17.6	15.6	100.0
UTAH	25.2	35.5	2.6	1.7	2.1	5.6	10.3	17.0	100.0
VERMONT	26.6	34.1	5.6	1.2	4.3	6.7	15.5	1.7	100.0
VIRGINIA	30.1	24.1	4.4	1.0	3.6	4.1	15.0	16.7	100.0
WASHINGTON	23.6	30.2	2.9	1.7	5.1	5.1	14.1	17.3	100.0
WEST VIRGINIA	26.5	16.6	4.4	0.9	2.7	6.6	16.7	19.3	100.0
WISCONSIN	26.0	34.0	6.3	1.4	4.4	6.0	16.9	3.2	100.0
WYOMING	25.1	32.6	3.2	1.7	2.4	2.4	13.1	19.3	100.0
TOTAL	26.7 %	26.7 %	4.5 %	1.4 %	4.5 %	5.7 %	19.2 %	9.4 %	100.0%

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	29.1 %	20.8 %	4.3 %	1.2 %	1.8 %	4.2 %	23.7 %	15.1 %	100.0%
ALASKA	26.8	34.7	2.4	2.2	4.7	4.7	7.8	11.8	100.0
ARIZONA	24.1	29.0	2.9	1.9	2.8	4.3	19.8	15.3	100.0
ARKANSAS	30.2	18.6	4.2	1.3	2.1	5.8	24.5	13.3	100.0
CALIFORNIA	23.7	29.8	2.7	1.9	4.0	4.0	20.5	13.3	100.0
COLORADO	28.0	33.1	3.3	1.9	3.8	3.8	14.3	14.2	100.0
CONNECTICUT	25.1	36.4	4.8	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	28.9	23.2	4.5	1.0	4.0	4.0	22.0	12.3	100.0
DISTRICT OF COLUMBIA	20.1	15.1	3.2	0.8	11.1	11.1	25.8	12.7	100.0
FLORIDA	28.9	19.2	4.3	1.1	2.6	3.3	29.8	10.9	100.0
GEORGIA	28.8	22.1	4.1	1.0	3.4	6.7	19.2	14.8	100.0
HAWAII	25.0	34.5	3.5	1.9	3.5	3.7	12.6	15.3	100.0
IDAHO	25.1	29.9	3.0	1.8	2.8	6.0	16.1	15.4	100.0
ILLINOIS	25.8	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	28.8	31.4	6.4	2.0	3.7	6.2	20.8	3.1	100.0
IOWA	28.8	32.3	6.6	1.9	3.5	5.0	23.3	0.6	100.0
KANSAS	28.7	33.4	6.3	1.7	3.2	3.2	23.0	2.5	100.0
KENTUCKY	27.5	20.0	3.8	1.1	3.5	6.2	20.7	15.3	100.0
LOUISIANA	28.5	18.9	3.7	1.1	3.5	6.1	21.5	18.7	100.0
MAINE	25.0	32.0	5.5	1.2	4.5	10.0	19.8	2.0	100.0
MARYLAND	28.9	22.7	4.0	1.0	4.4	4.4	22.0	14.7	100.0
MASSACHUSETTS	24.0	33.3	4.0	1.2	6.4	6.4	23.3	1.3	100.0
MICHIGAN	24.6	32.2	5.6	1.7	3.9	5.1	24.8	2.0	100.0
MINNESOTA	27.4	36.1	6.1	1.8	5.7	6.6	15.1	1.1	100.0
MISSISSIPPI	28.2	18.1	3.8	1.2	2.3	8.4	21.0	16.9	100.0
MISSOURI	28.2	31.6	6.1	1.8	2.5	3.8	26.1	1.8	100.0
MONTANA	23.3	26.6	2.8	1.7	3.4	6.6	17.4	18.1	100.0
NEBRASKA	28.0	33.7	7.1	1.8	3.1	4.1	19.7	2.5	100.0
NEVADA	25.6	32.8	3.1	2.0	2.2	2.2	18.4	13.7	100.0
NEW HAMPSHIRE	29.4	34.5	4.7	1.6	4.1	4.9	19.0	1.8	100.0
NEW JERSEY	25.3	33.5	4.1	1.3	5.6	5.6	23.2	1.4	100.0
NEW MEXICO	25.6	28.4	3.0	2.0	3.1	6.8	14.9	16.1	100.0
NEW YORK	22.8	27.6	3.9	1.2	9.8	9.8	23.5	1.4	100.0
NORTH CAROLINA	30.7	23.0	4.6	1.2	2.9	6.6	18.8	12.2	100.0
NORTH DAKOTA	24.6	29.9	6.2	1.7	4.6	5.7	23.1	4.2	100.0
OHIO	24.7	31.0	5.9	1.7	4.3	6.0	24.7	1.7	100.0
OKLAHOMA	29.3	19.9	4.1	1.2	4.1	5.8	21.9	13.8	100.0
OREGON	25.2	30.5	3.2	1.9	2.5	4.0	17.8	14.9	100.0
PENNSYLVANIA	25.1	30.0	5.0	1.3	3.8	4.9	28.9	1.0	100.0
RHODE ISLAND	25.3	30.6	4.9	1.2	6.0	7.7	22.7	1.6	100.0
SOUTH CAROLINA	29.9	23.2	4.5	1.2	2.8	6.6	17.5	14.5	100.0
SOUTH DAKOTA	27.4	31.0	6.2	2.0	2.9	6.1	22.2	2.3	100.0
TENNESSEE	28.5	20.5	4.3	1.1	2.9	6.7	22.6	13.4	100.0
TEXAS	31.6	22.3	4.1	1.4	2.9	3.4	20.6	13.6	100.0
UTAH	25.2	35.5	2.6	1.9	2.0	5.4	12.3	15.1	100.0
VERMONT	28.2	33.3	5.6	1.3	4.0	6.1	17.9	1.4	100.0
VIRGINIA	29.6	23.9	4.4	1.1	3.5	3.9	18.6	14.8	100.0
WASHINGTON	23.5	30.0	2.9	1.9	4.9	4.9	16.6	15.2	100.0
WEST VIRGINIA	28.2	18.4	4.4	1.0	2.6	6.5	22.0	16.9	100.0
WISCONSIN	25.2	33.0	6.1	1.5	4.1	5.6	21.8	2.7	100.0
WYOMING	25.0	32.7	3.2	1.9	2.3	2.3	15.5	17.0	100.0
TOTAL	28.1 %	27.9 %	4.3 %	1.5 %	4.2 %	5.3 %	22.2 %	6.4 %	100.0%

a/ Includes personal health expenditures and administrative costs

b/ Does not include employee share of premiums for employer sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates

Jack Lindsey → Oct 11 – New Eng. Journal of Medicine

For the Health of a Nation

by Henry Simmons, M.D., from the Report of the National Leadership Commission on Health Care

The National Leadership Commission on Health Care identified four major problems in our health care system and proposed a major restructuring of the nation's health care system to resolve them. The commission's proposal provides universal access to a basic level of health services; it controls escalating costs through use of economic leverage in the purchase of care, financing and systems reforms, economic incentives including cost sharing, and practice guidelines to encourage appropriate care and eliminate unnecessary care. The commission believes that reducing unnecessary procedures will help contain costs and improve the quality of health care. Its malpractice reform recommendations will also help contain costs and improve quality.

The commission agreed on a vision of a better health care system in the twenty-first century, one that promotes preventive care and healthy lifestyles, and established an innovative, efficient health care system. The system would encourage personal responsibility for choosing good health and appropriate treatment, support a strong doctor-patient relationship, and establish and utilize a public-private partnership to control costs, assure universal access, and improve the quality of care.

Problems with the Current Health Care System

America's health care system is in crisis. Costs are out of control, millions of Americans face difficulty gaining access to needed care, there is a malpractice crisis, and there are serious problems in the quality and appropriateness of much of the medical care being rendered. These problems are interrelated, systemic, and growing worse. It seems clear that they cannot be solved without a long-term, comprehensive strategy. Awareness of these problems has led to a strong shift in public attitudes to broad dissatisfaction with our health care system.

The rate of health care cost escalation is of major concern to both government and the private sector. Unless we act soon to change America's health care system, by the year 2000 the United States could be spending a quarter of the GNP—$2.5 trillion—on health care. That number is more than double the federal government's entire budget for 1990. It is also $1 trillion more than recent estimates for U.S. spending on health care at the turn of the century. National health care spending of $2.5 trillion translates to almost $10,000 per year for every man, woman, and child in this country.

Government is concerned because it is increasingly clear that the federal deficit and rising health care costs are inextricably intertwined. Business and labor are concerned because rising health care costs are now considered a major threat to industry's economic viability and its ability to compete and to provide jobs. The American people are concerned because more and more of the costs are borne directly by individuals, and there is no end in sight.

A systemic problem of this magnitude cannot be solved with a piecemeal strategy. Nor can it be solved by any one segment of society, including government, alone. We all share some of the blame for this complex societal problem, and therefore we share the responsibility for resolving the problem. Costs must be contained, quality and access must be assured, the malpractice problem must be resolved, and, to the extent possible, the American system of freedom of choice, "pluralism," and competition must be preserved. But this will not be possible without comprehensive, long-term structural reform. Such reforms will require creation of a new public-private partnership and a coordinated effort of business, labor, government, providers, insurers, and consumers. Otherwise, costs and problems will only be shifted, and our situation will grow more severe, to the detriment of all.

The growing seriousness of the problems and public concerns have combined to create a new opportunity and need for effecting major change in our health care system. There is now a clear and compelling case for comprehensive reform.

Summary of the Commission's Proposal

The National Leadership Commission on Health Care's final report, *For the Health of a Nation: A Shared Responsibility*, proposes a major restructuring of the nation's health care system. The central feature of the commission's proposal is the notion that none of the problems besetting the nation's health care system—lack of access for millions, poor quality, inefficiency, soaring costs, and a malpractice insurance crisis—can be solved in isolation. The problems are interconnected; the solution must also be. The plan is based on seven fundamental principles and has four interrelated parts—a universal access proposal, a national quality improvement initiative, a cost containment strategy, and a malpractice reform package.

Fundamental Principles of the Commission's Proposal

The commission's proposal is based on seven fundamental principles.

1. *Principle of Universal Access.* There should be no financial barrier separating Americans in need of health care from access to care.
2. *Principle of Fair Compensation.* Every provider of health services in America should be adequately compensated for services rendered to patients.
3. *Principle of Clinical and Economic Freedom.* To the maximum extent possible, without unduly compromising other important principles, health policy ought to restore clinical freedom in rendering health services and economic freedom in financing these services, within the context of adequate countervailing market power from those who ultimately pay for health care in America.
4. *Principle of Shared Responsibility.* Financial responsibility for health care for those too poor to afford it should be shared by government, individuals, and employers.
5. *Principle of Individual Responsibility.* To help achieve the goal of universal access to health care, the individual has a duty to have adequate insurance coverage for himself or herself and dependents.
6. *Principle of Basic Benefits Guarantee.* The design of a basic package of health service benefits to which all Americans should have reliable access is ultimately a federal responsibility.
7. *Principle of a Strong Doctor-Patient Relationship.* Any health care system should foster the goal of protecting the integrity of the doctor-patient relationship.

In light of the federal deficit, the commission proposes building upon the American tradition of providing private health insurance through the workplace. The proposal is designed to encourage continued extensive reliance on that approach, without mandating that employers provide such coverage. The commission also noted that universal access could be funded out of general revenues.

The Commission's Proposal

The Universal Access (UNAC) Plan. UNAC would provide universal access to basic health care for all Americans without insurance. Medicaid recipients would become part of this program. There would be an incentive for more employers to offer health insurance to employees, since both would pay a fee to UNAC if employees were not offered insurance. Financing for this public program would be paid for through a health insurance premium of 0.6 percent of income up to the social security maximum, paid by everyone with incomes over 150 percent of the federal poverty level and their employers, with special provisions for new and small businesses and part-time workers. The funds would be collected nationally; the UNAC program would be administered in a decentralized fashion by the states.

A National Quality Improvement Initiative. This provision would improve the quality, appropriateness, and efficiency of care by establishing a national program of increased technology assessment and outcomes research that would result in national practice guidelines for all the major procedures. Since seventy major procedures account for about half of our total national health expenditures, this is an important way to eliminate unnecessary care. Up to $500 million a year from the UNAC funds would support this ongoing program, designed to assess technology, develop guidelines and standards, and compare new procedures, as they become available, with those already in use.

A Cost Containment Strategy. The elimination of much unnecessary care could potentially cut back up to 20 percent to 30 percent of all procedures performed today. UNAC will have economic leverage, because it will negotiate payment rates for 60 million to 70 million people. Under UNAC, cost shifting of charity care will end and there will be greater inter-employer equity. UNAC will also encourage intervention. The new ability through research and guidelines to make more informed purchasing decisions, combined with cost sharing, will increase individual responsibility. The commission called for increased use of organized systems of care, such as PPOs, by private employers and for physician payment reform with expenditure targets.

A Malpractice Reform Package. This six-part proposal, based on successful programs in some states, calls for strict criteria for expert witnesses; strengthened standards of negligence; punitive damages limited to a grave dereliction of professional responsibility with damages going to the state; limited contingency fees; a fast track through the court system for malpractice cases; and increased use of arbitration. If the states do not move expeditiously to make these changes, there should be consideration of federal preemption of state malpractice laws.

NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

AT&T
Amalgamated Clothing and Textile Workers Union
American Academy of Pediatrics
American Association of Retired Persons
American College of Physicians
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Nurses' Association, Inc.
Ameritech
Association of Academic Health Centers
Association of Minority Health Professional Schools
Bell Atlantic
BellSouth
Bethlehem Steel
Chrysler Motors Corporation
Communications Workers of America
DuPont
Eastman Kodak
Equifax
Families USA Foundation
Ford Motor Company
General Electric
Georgia-Pacific Corporation
W.R.Grace & Co.
International Association of Machinists and Aerospace Workers
International Brotherhood of Electrical Workers
International Union of Electrical Workers
Lincoln Telephone & Telegraph Co.
Lockheed Corporation
Meredith Corporation
National Leadership Commission on Health Care
National Small Business United
Northern Telecom Limited
Northwest Airlines
NYNEX Corporation
Pacific Gas & Electric
Pacific Telesis Group
Pioneer Seed
Rochester Telephone Corporation
Rubbermaid
Service Employees International Union
W.C.Smith Inc.
Southern California Edison Company
Southwestern Bell Telephone
3M
Time Warner Inc.
U S WEST
United Steelworkers of America
United Way of America
Westinghouse Electric Corporation
Weyerhaeuser Company
Xerox Corporation

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