SB

83

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: 1/23/91

HESS
FURTHER: Finance

Date of 5-Day Notice: 2/7/91
(in accordance with Uniform Rule 23)

DATE TURNED
INTO OFFICE: _____

L&C Committee considered SB 83

Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; efd.

and recommended:

[✓] **replace with** _____ **CS** SB 83 (L+C) [✓] **same title** [ ] **new title**

[ ] **attached amendment(s)**

[ ] _____ **letter of intent adopted**

[ ] **do pass**

[ ] **do not pass**

[ ] **no recommendation**

[✓] **individual recommendations**

[ ] **further referral to** _____

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:	Department(s)/Date:
[✓] fiscal note(s) ADMIN/4-3-91	[✓] zero fiscal note(s) ADMIN/2-13-91
	H+SS/2-13-91
[ ] appropriation-no fiscal note	[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Jim Duncan NO REC

Mike Halford NO REC

Trudi Reaves - NO REC

Chair: Signature and Recommendation

FISCAL NOTE

BILL NO. CSSB 83

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date: April 3, 1990
Title: An Act relating to the Alaska State Health Resources Authority

Department Affected: Administration
BRU: Health Resources Authority

Component: Health Resources Authority

Sponsor: Duncan
Requestor:

COMPONENT SERIAL NO. 6-4

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	155.5	163.3	171.4	180.0	189.0	198.5
TRAVEL	62.5	49.7	49.7	49.7	49.7	49.7
CONTRACTUAL	319.0	239.0	239.0	239.0	239.0	239.0
SUPPLIES	3.3	3.3	3.3	3.3	3.3	3.3
EQUIPMENT	33.3	1.0	1.0	1.0	1.0	1.0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	573.6	456.3	464.4	473.0	482.0	491.5
CAPITAL	0	0	0	0	0	0
REVENUE	0	547.6	557.3	567.7	578.4	589.8

FUNDING: (Thousands of dollars)

GENERAL FUND	573.6	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	456.3	464.4	473.0	482.0	491.5
TOTAL	0	0	0	0	0	0

POSITIONS

FULL-TIME:	3	3	3	3	3	3
PART-TIME:	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (attach a separate page if necessary.)

See attached analysis

Prepared By: Gary Bader
Division: Retirement and Benefits
Approved by Commissioner: Millett Keller
Agency: Department of Administration

Phone: 465-4460
Date: 4/2/91
Date: 4/2/91

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

Rev 10/90

Analysis: This bill creates the Alaska Health Resources Authority in the Department of Administration. This independent agency would have specific duties and powers as outlined including regulatory powers and authority to charge fees and establish reserves to cover the expenses of the Authority. The Authority shall be managed by a nine member board of directors appointed by the Governor.

Employing an Executive Director and additional staff as necessary, the Authority shall:

** issue recommendations on the effect of certificates of need under AS 18.07.071 effective immediately;

** by July 1, 1992, create provider reimbursement systems and utilization standards mandatory within the boundaries of municipalities with a population of 20,000 or more. Implementation must be complete by 12/31/93;

** after July 1, 1992, procure or provide through self insurance group health insurance pool for certain individuals, groups or employers; and

**after February 15, 1993, procure or provide through self insurance group health insurance for employers with 50 or fewer emplyees and who have been refused coverage by two carriers and have not provided insurance to its employees for a year.

The bill allows voluntary participation in the Authority's group plan that would be available after 7/1/92. It is assumed that the State would participate in this plan if the coverage could be provided less expensively than through the normal marketplace. It is expected that this bill will decrease the cost of health insurance since that is the charge to the Authority. Upon participation, a public entity or other employer would be required to continue participation unless granted a waiver by the Authority.

For purposes of this fiscal analysis, we have assumed that participation in the plan will be adequate to allow the Authority to charge sufficient administrative fees to support the entire operating costs of the Authority beginning in FY 93. These fees are shown as revenue on the fiscal note form and it is assumed that the amount collected will be 20% higher than the operating costs for the first five years in order to establish a reserve to cover continuing expenses. It is also assumed that staff salaries will increase 5% annually.

At the same time the fees are taken from insurance premiums paid by participating employers, it is assumed for purposes of this analysis, that there is a decrease in the overall health care expenditure in the state due to the cost containing influences of the Health Resource Authority. This decrease in expenditures resulting in annual savings has been estimated by other sources to be $132,723 in FY 93 and increasing to $1,066,318 by FY 96.

Personal Services

Executive Director (Range 26A, 12 mos.)	87.1	
Administrative Assistant II (14A, 12 mos.)	39.9	
Clerk Typist III (8B, 12 mos.)	28.5	
Total Personal Services		155.5

Travel

Assume 12 Board Meetings for FY 92 and 9 each year thereafter at an average cost of $400 per member per trip:

$475 X 9 members X 12 trips =	51.3	

Administrative travel for Director:

Board Meetings	$400 X 12 =	4.8	
Organizational Meetings	$600 X 12 =	7.2	
Total Travel			63.3

Contractual

Office space--500 sq. ft. @ $2.00 X 12 mos.=	12.0	
Telephone--$300 X 12 mos.=	3.6	
Courier Services--$220 X 12 mos.=	2.4	
Postage--$500 X 12 mos.=	6.0	
Printing, binding, transcription services=	15.0	
Professional Services Contract (s) which could include services such as: carrier surveys and analysis; provider data collection; provider meetings; financial and investment consulting; self vs fully insured analyses; and/or plan design and development=	280.0	
Total Contractual		319.0

Supplies

$500 per employee	1.5	
Software	1.8	
Total Supplies		3.3

Equipment

3 PCs and printer	15.0	
Phone system	2.6	
Photocopier	1.3	
Fax machine	1.8	
Office furniture:		
1 management unit	4.0	
2 support workstations	5.0	
3 chairs	1.2	
3 side chairs	.8	
2 file cabinets	.9	
bookcase	.1	
storage cabinet	.6	
Total Equipment		33.3

FISCAL NOTE

BILL NO. SB 83

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date:
Title: An Act relating to the Alaska State Health Resources Authority

Department Affected: Administration
BRU: Retirement and Benefits

Component: Retirement and Benefits

Sponsor: Duncan
Requestor:

COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	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	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS

FULL-TIME:	0	0	0	0	0	0
PART-TIME:	0	0	0	0	0	0
TEMPORARY:	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (attach a separate page if necessary.)

See Attached

Prepared By: Gary Bader
Division: Retirement and Benefits
Phone: 465-4460
Date:

Approved by Commissioner: Millett Keller
Agency: Department of Administration
Date: 2/13/91

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

Rev 10/90

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 83
Publish Date: 1/23/91

REQUEST: FISCAL NOTE

Revision Date:
Agency Affect: Health & Social Serivces
Title: Relating to the delivery, quality, and financing of health care
BRU: State Health Serivces
Sponsor: Duncan, Zharoff
Components: none
Requester: Labor and Commerce

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS

Full-Time		0				
Part-Time		0				
Temporary		0				

ANALYSIS: (attach a separate page if necessary)

No fiscal impact will occur in the immediate future. At the time that the Authority requires services from Division of Public Health, the Division will assess the Authority for those services

Prepared By: Alfred G. Zangri
Division: PUBLIC HEALTH
Phone: 465-3090
Date: 02/13/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Agency: HEALTH & SOCIAL SERVICES
Date: 2/13/91

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

STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION SB 83
PUBLISH DATE

FISCAL NOTE

REQUEST:
Revision Date: 3-18-91
Title: Alaska State Health Resources Authority
Sponsor: Senator Duncan

Affected Agency:
BRU:
Components:

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services			112.7	112.7			
Travel			40.4	40.4			
Contractual			145.3	145.3			
Supplies			3.5	3.5			
Equipment			21.0	1.0			
Land & Structures							
Grants, Claims							
Miscellaneous							
TOTAL OPERATING			322.9	302.9	*	*	*
CAPITAL							
REVENUE				122,723.	318,573.	642,677.	1,614,954.0

FUNDING: (THOUSANDS OF DOLLARS)

General Fund			322.9	302.9	*	*	*
Federal Fund							
Other							
TOTAL			322.9	302.9	*	*	*

POSITIONS:

Full-Time			2	2			
Part-Time							
Temporary							

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY) See pages 2 and 3 for budget detai

*After July 1, 1992, the Authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the Authority.

Prepared By: Dale Staley for Senator Jim Duncan Phone: 465-4766
Division: Date: 3-1-91

Approved By:
Agency: Date:

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

CONTINUATION OF FISCAL NOTE:

Senate Bill 83 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

Personal Services:

Executive Director Range 24A		
$5084 x 12 months = $60,008		
$60,008 x 37% benefits = $22,573		
Subtotal	$82,581	
Clerk Typist III Range 8B $1830		
$1830 x 12 months = $21,960		
$21960 x 37% benefits = $8,125		
Subtotal	$30,085	
Total Personal Services		$112,666

Travel:

It is anticipated there will be 6 meetings of the Health Care Resources Authority.		
6 meetings x 9 members = 54 airfares		
54 airfares x $436 = $23,544		
2 days per diem x 54 = 108		
108 days x $95 = $10,260		
Subtotal	$30,804	
Travel for Executive Director		
10 board meetings x $436 = $4,360		
2 meetings x 12 months x $436 = $5,232		
Subtotal	$ 9,592	
Total Travel		$ 40,396

CONTINUATION OF FISCAL NOTE:

SB 83

Contractual:

Office Space 500 sq. ft. x $1.75 = $875		
$875 x 12 months	$ 10,500	
Telephone $200 x 12 months	$ 2,400	
Postage $200 x 12 months	$ 2,400	
Advertising and printing	$ 5,000	
Professional Services Contract(s)	$125,000	
which may include:		
Rate Studies		
Utilization Research		
Financial Systems Analysis		
Total Contractional		$145,300

Supplies:

$1,000 per employee	$ 2,000	
Software	$ 1,500	
Total Supplies		$ 3,500

Equipment:

2 Desk top computers and a printer	$ 11,000	
Bookcases and file cabinets	$ 1,200	
Desk and chairs	$ 4,000	
Photocopier	$ 2,000	
Phone system	$ 800	
Miscellaneous	$ 2,000	
Total Equipment		$ 21,000

TOTAL OPERATING $322,862

REVENUE ASSUMPTIONS FOR SB 83

The revenue assumptions are based on the estimated 20% per year increase in the costs of medical care.

Understanding that this 20% per year figure may not be constant over a long period of time it is the target that SB 83 is aiming to reduce. This figure has been used in the following table to demonstrate the costs savings in Alaska resulting from the phased implementation of SB 83. Savings achieved by this phased implementation are calculated by the application of the formula in column B.

	A Health Care Expenditure w/o ASHRA	B FORMULA	C Health Care Expenditure With ASHRA	ANNUAL SAVINGS
FY 91	$1,929,000.0		NO ASHRA	00.0
FY 92	$2,315,520.0		NO ASHRA	00.0
FY 93	$2,778,624.0	20%@CPI, 80%@17%	$2,655,901.0	$ 122,723.0
FY 94	$3,334,348.0	30%@CPI, 70%@15%	$3,015,775.0	$ 318,573.0
FY 95	$4,001,218.0	40%@CPI, 60%@15%	$3,358,541.0	$ 642,677.0
FY 96	$4,801,462.0	40%@CPI, 60%@15%	$3,729,137.0	$ 1,072,325.0
FY 97	$5,761,754.0	40%@CPI, 60%@15%	$4,146,800.0	$ 1,614,954.0
FY 98	$6,914,105.0	50%@CPI, 50%@15%	$4,571,847.0	$ 2,342,258.0
FY 99	$8,296,926.0	50%@CPI, 50%@15%	$5,040,461.0	$ 3,256,465.0
FY 2000	$9,955,312,.0	50%@CPI, 50%@15%	$5,557,108.0	$ 4,398,204.0

NOTES:

A = FULL 20% ANNUAL MEDICAL INFLATION

B = EFFECTS OF ASHRA, CPI ESTIMATED AT 5% PER YEAR, REDUCED INFLATION AT 17% PER YEAR UNTIL 1994, 15% THEREAFTER.

C = TOTAL HEALTH CARE EXPENDITURE IN ALASKA AFTER ASHRA.

STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION SB 83
PUBLISH DATE

FISCAL NOTE

REQUEST:
Revision Date:
Title: Alaska State Health Resources Authority
Sponsor: Senator Duncan

Affected Agency:
BRU:
Components:

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services			112.7	112.7			
Travel			40.4	40.4			
Contractual			145.3	145.3			
Supplies			3.5	3.5			
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Land & Structures							
Grants, Claims							
Miscellaneous							
TOTAL OPERATING			322.9	302.9	*	*	*
CAPITAL							
REVENUE							

FUNDING: (THOUSANDS OF DOLLARS)

General Fund			322.9	302.9	*	*	*
Federal Fund							
Other							
TOTAL			322.9	302.9	*	*	*

POSITIONS:

Full-Time			2	2			
Part-Time							
Temporary							

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY) See pages 2 and 3 for budget detail

*After July 1, 1992, the Authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the Authority.

Prepared By: Dale Staley for Senator Jim Duncan Phone: 465-4766
Division: Date: 3-1-91

Approved By:
Agency: Date:

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

CONTINUATION OF FISCAL NOTE:

Senate Bill 83 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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SB 83

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Total Equipment		$ 21,000

TOTAL OPERATING $322,862

Alaska State Legislature

JAN 2 5 1991

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

MEMORANDUM

TO: Senator Drue Pearce, Chair
Senate Labor and Commerce Committee

FROM: Senator Jim Duncan

DATE: January 25, 1991

SUBJECT: Senate Bill 83, The Alaska State Health Resources Authority

I would like to request a few minutes of your time on January 30, 31 or February 1. Jeffrey Malek, Consultant to the Alaska State Health Care Cost Containment Task Force will be in Juneau those three days and I would like you to have an opportunity to talk to him about SB 83.

The Health Resources Authority created in SB 83 will help control the rate of increase in the cost of health care in Alaska. Mr. Malek has been working with the Task Force for the last 22 months. He is an expert in the health care field and has helped the Task Force make recommendations saving the State of Alaska more than $22 million in one year.

I would also appreciate it if you would consider having Mr. Malek make a presentation to the Senate Labor and Commerce Committee concerning the health care cost containment measures contained in SB 83. This will give you and your Committee the opportunity to ask question about the concepts proposed in SB 83 before it is comes up for a regular hearing.

Finally, I would like to request an early date for a formal hearing of SB 83 before the Senate Labor and Commerce Committee.

Thank you for your consideration and I look forward to your favorable response.

Alaska State Legislature

SENATOR JIM DUNCAN

P.O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR –
HEALTH, EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

SECTIONAL ANALYSIS

SENATE BILL NO. 83

"An Act creating the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for the residents of the state, and to the issuance of certificates of need; and providing for an effective date." By Senator Duncan.

Section 1. This section outlines the goals and objectives of the Alaska State Health Resources Authority in providing cost effective health insurance coverage for an expanded pool of employees.

Section 2 and 3. The authority has advisory responsibilities to the Department of Health and Social Services' certificate of need process. The responsibility is determination of group health insurance cost effects resulting from proposed new or expanded health facilities.

Section 4. is a new chapter establishing the Alaska State Health Resources Authority (ASHRA hereafter) and its powers, duties and requirements:

Sec. 4. Section 21.77.010. Requires ASHRA to establish a health care provider reimbursement system and utilization standards for eligible employees of the state, a municipality, or a school district, and other employers that apply to the authority. ASHRA must provide a group health insurance pool or pools for eligible state and local government employees as well as other employees that elect to participate.

Sec. 4. Section 21.77.015. It is provided that state agencies cooperate in the development of the health care provider reimbursement system and utilization standards and share relevant information.

Sec 4. Section 21.77.020. ASHRA has a nine member board of directors from various occupations serving staggered four year terms. Members are entitled to per diem and travel expenses and are subject to conflict of interest requirements in AS 39.50.

Sec 4. Section 21.77.030. ASHRA may exercise the powers granted to insurers as well as other general powers.

Sec. 4. Section 21.77.040. Duties of the ASHRA board include providing lowest cost comprehensive health insurance, annual reports to the governor and legislature on fiscal activities, and review of certificate of need applications under AS 18.07.041. Every third year a cost and benefit analysis of its insurance pool or pools is required.

Sec. 4. Section 21.77.050. ASHRA may employ an executive director and other staff it requires. It may contract for professional services. Employees of ASHRA are in the exempt service under AS 39.25.110.

Sec. 4. Section 21.77.060. ASHRA shall purchase group health insurance for eligible employees after July 1, 1992 or act as a self insurer. When purchasing group health insurance, ASHRA must comply with the State Procurement Code and re-bid at least once every five years.

Sec.4. Section 21.77.070. The Alaska State Health Resources Fund is created of funds appropriated by the legislature and collected premiums. The fund is managed and invested by the board.

Sec.4. Section 21.77.080. ASHRA shall provide that sufficient funds are available for the purposes of employee group health insurance.

Sec. 4. Section 21.77.090. A participant in group health insurance offered by ASHRA may obtain a waiver to opt out under certain conditions.

Sec. 4. Section 21.77.100. Definition section.

Section 5 and 6. Technical amendments.

Section 7. A special, March 1, 1992 report to the legislature is required of ASHRA describing the progress in establishing the health care provider reimbursement system and utilization standards.

Section 8. Effective date clause.

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

M E M O R A N D U M March 21, 1991

SUBJECT: Sectional analysis - CSSB 83(L&C) and CSSB 83( )

TO: Senator Drue Pearce

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of CSSB 83(L&C), with a comparison to CSSB 83( ) that reflects the changes made in the blank substitute:

Section 1 - Purpose.

The blank CS contains minor changes in paragraphs (1), (2) and (9), adds new paragraph (3), and deletes paragraph (8).

Section 2 - Requires certain certificate of need applications to be provided to the authority.

No change.

Section 3 - Provides that certain certificates of need may not be issued until the authority makes a determination regarding the effect of the certificate on group health insurance.

No change.

Section 4 - Requires the legislature to appropriate funds for the authority.

This section is now section 5 in the blank CS. Section 4 is a provision requiring an annual audit by the Legislative Budget and Audit Committee.

Section 5 - This provision places employees of the authority in the exempt service.

No change.

Section 6 - This provision subject the employees of the authority to the conflict of interest chapter AS 39.30.

No change.

Section 7 -

Sec. 44.87.010 - Creates the authority and requires establishment of a reimbursement system and utilization standards. Requires the state, a municipality, or a school district to use the reimbursement system and utilization standards. Allows other employers to participate with approval of the authority. Limits the authority's ability to establish group health insurance pools, to not earlier than July 1, 1992. Allows participation by an eligible state program.

The blank CS requires, by July 1, 1992, the creation and phased implementation of reimbursement systems and utilization standards established by the authority, within municipalities that have a population of 20,000 or more. Also, all reimbursement systems and utilization standards created within a municipality that has a population of 20,000 or more must be operational by December 31, 1993. Also, a requirement is imposed under subsection (c), that all health care providers or persons submitting a claim for services provided to a public employer or public employee, must use the reimbursement systems or utilization standards if established by the authority. Other employers may elect to use the reimbursement systems and utilization standards, if the use is approved by the authority. The blank CS also imposes new deadlines on the authority in (a)(1), requires new reimbursement components under (a)(2) and (3), and inserted paragraphs (a)(4) and (5). The blank CS also requires the authority to design a new health insurance program for certain employers who elect to participate, in subsections (e), (f) and (g). The authority is required to provide public notice and accept public comments under subsection (h).

Sec. 44.87.015 - Requires cooperation by state agencies.

No change.

Sec. 44.87.020 - Establishes the board and its organization.

No change.

Sec. 44.87.030 - Establishes the general powers of the authority.

No change.

Sec. 44.87.040 - Establishes the duties of the board, including requiring an annual report.

The blank CS adds paragraphs (5) - (9), that impose new duties on the board.

Sec. 44.87.050 - Provides for certain staff of the authority and for service contracts.

No change.

Sec. 44.87.060 - Gives the authority the power to procure insurance or to act as a self-insurer. Imposes certain requirements on the insurance obtained by the authority.

The blank CS rewrites subsection (a) to limit the authority to providing insurance for an individual or employer without insurance or with insurance that is more costly than could be provided by the authority. This section also adds a new subsection (b) that allows the authority to establish group insurance pools for employees who elect to participate, requires coverage for eligible employees and dependents, and requires employees who elect to participate to use the reimbursement systems and utilization standards established by the authority. This section also imposes new restrictions on when the authority can act as a self-insurer, in subsection (c) and (d), and allows creation of pools or subpools to track insurance costs, in subsection (e).

Sec. 44.87.070 - Creates a fund for the authority to expend to carry out duties imposed by this chapter.

No change.

Sec. 44.87.080 - Provides for the collection and investment of insurance premiums.

No change.

Sec. 44.87.090 - Allows participation by the state, a municipality or a school district in the group insurance provided by the authority. Requires participation after initial entry into the system, unless a waiver is granted. Sets out criteria for granting a waiver.

No change.

Sec. 44.87.100 - Definitions.

The blank CS contains two new definitions, of "full-time employee" and "public employer" and made minor changes in the definition of "reimbursement system".

Section 8 - Report.

No change.

Section 9 - Effective date.

No change.

MFF:pl
91-198.plm

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

M E M O R A N D U M March 20, 1991

SUBJECT: Sectional analysis - CSSB ~~305~~ 83 (L&C) and CSSB ~~305~~ 83 ( )

TO: Senator Drue Pearce

FROM: Michael F. Ford M. F.
Legislative Counsel

The following is a section by section analysis of CSSB 305(L&C), with a comparison to CSSB 305( ) that reflects the changes made in the blank substitute:

Section 1 - Purpose.

The blank CS contains minor changes in paragraphs (1), (2) and (9), adds new paragraph (3), and deletes paragraph (8).

Section 2 - Requires certain certificate of need applications to be provided to the authority.

No change.

Section 3 - Provides that certain certificates of need may not be issued until the authority makes a determination regarding the effect of the certificate on group health insurance.

No change.

Section 4 - Requires the legislature to appropriate funds for the authority.

This section is now section 5 in the blank CS. Section 4 is a provision requiring an annual audit by the Legislative Budget and Audit Committee.

Section 5 - This provision places employees of the authority in the exempt service.

No change.

Section 6 - This provision subject the employees of the authority to the conflict of interest chapter AS 39.30.

No change.

Section 7 -

Sec. 44.87.010 - Creates the authority and requires establishment of a reimbursement system and utilization standards. Requires the state, a municipality, or a school district to use the reimbursement system and utilization standards. Allows other employers to participate with approval of the authority. Limits the authority's ability to establish group health insurance pools, to not earlier than July 1, 1992. Allows participation by an eligible state program.

The blank CS requires, by July 1, 1992, the creation and phased implementation of reimbursement systems and utilization standards established by the authority, within certain municipalities. Also, all reimbursement systems and utilization standards must be operational by December 31, 1993. Also, a new requirement is imposed under subsection (c), that all health care providers or persons submitting a claim must use the reimbursement systems or utilization standards if established by the authority. The blank CS also imposes new deadlines on the authority in (a)(1), requires new reimbursement components under (a)(2) and (3), and inserted paragraphs (a)(4) and (5). The blank CS also requires the authority to design a new health insurance program for certain employers, in subsections (e), (f) and (g). The authority is required to provide public notice and accept public comments under subsection (h).

Sec. 44.87.015 - Requires cooperation by state agencies.

No change.

Sec. 44.87.020 - Establishes the board and its organization.

No change.

Sec. 44.87.030 - Establishes the general powers of the authority.

No change.

Sec. 44.87.040 - Establishes the duties of the board, including requiring an annual report.

The blank CS adds paragraphs (5) - (9), that impose new duties on the board.

Sec. 44.87.050 - Provides for certain staff of the authority and for service contracts.

No change.

Sec. 44.87.060 - Gives the authority the power to procure insurance or to act as a self-insurer. Imposes certain requirements on the insurance obtained by the authority.

The blank CS rewrites subsection (a) to limit the authority to providing insurance for an individual or employer without insurance or with insurance that is more costly than could be provided by the authority. This section also adds a new subsection (b) that allows the authority to establish group insurance pools for employees who elect to participate, imposes new restrictions on when the authority can act as a self-insurer, in subsection (c) and (d), and allows creation of pools or subpools to track insurance costs, in subsection (e).

Sec. 44.87.070 - Creates a fund for the authority to expend to carry out duties imposed by this chapter.

No change.

Sec. 44.87.080 - Provides for the collection and investment of insurance premiums.

No change.

Sec. 44.87.090 - Allows participation by the state, a municipality or a school district in the group insurance provided by the authority. Requires participation after initial entry into the system, unless a waiver is granted. Sets out criteria for granting a waiver.

No change.

Sec. 44.87.100 - Definitions.

The blank CS contains two new definitions, of "full-time employee" and "public employer" and made minor changes in the definition of "reimbursement system".

Section 8 - Report.

No change.

Section 9 - Effective date.

No change.

MFF:pl
91-181.plm

Alaska State Legislature

Senator Drue Pearce, Chair
Senator Virginia Collins, Vice Chair
Senator Dick Eliason
Senator Rick Halford
Senator Jay Kerttula

WHILE IN JUNEAU
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3844

3111 C STREET, SUITE 150
ANCHORAGE, ALASKA 99504
(907) 561-2018

SENATE LABOR AND COMMERCE COMMITTEE

TO: Mike Ford, Legal Counsel
Legal Services Division

FROM: Rod Mourant, Legislative Aide
Senate Labor & Commerce Committee

DATE: April 16, 1991

RE: SB 83

Mike, please draft a new committee substitute for the subject working from CSSB 83( ) dated 3/19/91, work draft 7-LS0305\D with the following changes:

Pg. 4, ln 31, insert after "United States census (;) as well as phased implementation of interested and eligible businesses of ~~twenty-five~~ 50 or fewer employees:"

Pg. 5, ln 2, insert a new section as follows:

"(2) the health care provider reimbursement systems and utilization standards required in 1 of this section are also required for communities with populations of less than 20,000, as reflected by the 1990 United States census, and shall be operational by July 1, 1995." Renumber accordingly.

Amend Pg. 5, ln 31 as follows:
"months; (and) or"

Amend Pg. 9, ln 19 as follows:
"The authority may not begin acting as a self-insurer under the plan until the legislature (has been in regular session for sixty calendar days) has ~~voted to~~ approved the self-insurance plan after the plan (was) has been submitted for approval by the Authority.

Amend Pg. 5, ln 12 as follows:
"(G) actual provider (cost) charges as of January 1, 1991;"

Amend Pg. 5 ln 13 as follows:

Insert additional components for the reimbursement systems as necessary to assure that the following concepts are addressed:

Advanced technology resulting in new equipment, staff & training.

Specialty training to expand or improve service.

Rate dispute resolution process & expense associated.

Uncollectible service expense.

Charity caseload modifier.

Long term elder care expense.

Employee expense because of competition with state employee compensation levels.

Specialist recruitment.

Capital costs.

Medicaid rates.

Alaska State Legislature

3111 C Street, Suite 150
Anchorage, Alaska 99503
(907) 561-2038

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-4993

Senator Drue Pearce
District G

TO: Members
Senate Labor & Commerce Committee

FROM: Senator Drue Pearce, Chair
Senate Labor & Commerce Committee

DATE: February 8, 1991

RE: Health Insurance Legislation

Gordon E. Evans, representative for the Health Insurance Association of America, asked that the enclosed material be distributed to committee members in preparation for hearings that the committee will be holding dealing with health insurance.

DP:rrm

Enclosure

Alaska State Legislature

3111 C Street, Suite 150
Anchorage, Alaska 99503
(907) 561-2038

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-4993

Senator Drue Pearce
District G

TO: Bruce Kendall, Legislative Liaison
Office Of the Governor

FROM: Senator Drue Pearce, ~~Chair~~
Senate Labor & Commerce Committee

DATE: February 8, 1991

RE: Senate Bill 83

The Senate Labor & Commerce Committee has scheduled Senate Bill 83, "Relating to the Alaska State Health Resources Authority; Relating to the Delivery, Quality and Financing of Health Care...", for a public hearing at 3:30 P.M. on Wednesday, February 13th, in the Beltz Room. Please forward a position paper and appropriate agency fiscal notes on this legislation.

Thank you for your cooperation.

DP:rrm

DUNCAN —

PROSPECTIVELY —

EFFORT + TIME

VISIT

LISTED IN BILL

* "ACTUAL PROVIDER CHARGES"

~~USUAL RATES~~

COLLINS — MODIFIERS BG J

#.

TECHNOLOGY

SPECIALTY TRAINING (EXPERTISE)

NEW EQUIPMENT

NEW EQUIPMENT TRAINING

* PROVISION TO REQUEST FEE/RATE REVIEW

LIABILITY INSURANCE

SUPPLY COSTS (TRANSPORTATION)

UNCOLLECTIBLES MODIFIERS

CLARITY CASES

LONG TERM ELDER CARE

RATE DISPUTES

EMPLOYER SANCTIONS

SPECIALIST RECRUITMENT

CAPITAL COSTS

MEDICAID RATES

BASE YEAR SHOULD NOT BE 1989.

From the desk of:
Rod Mourant
Senator Drue Pearce's Office
P.O. Box V
Juneau, AK 99811
Capitol, Room 101
(907) 465-4993

3/22

8-10 BUTRO

HI CARL TRL CONF SCHRAMM

PARKS HIAA

1025 CONNECTICUT AVE NW

D C 20036

202 - 223 - 7800

SB 83

-- the report recommends fixing fees for all providers--This assumes there is excess profit and revenue in the health care system. How much? In what areas? By imposing a fee schedule how much would the one expect by way of immediate savings and total cost reductions? Would such a pricing scheme effect the viability of facilities and providers; could it result in the closure of facilities?

-- If the purpose of the reimbursement system is to nullify cost shifting, then all this does is shift costs from employers to the providers themselves, or to those remaining employers who do not opt into the system; this offers no real solution, but rather a further passing of the buck.

-- the report identifies inefficient delivery systems, overbuilt facilities, and system waste as primary culprits in rising health care costs--What specifically are the inefficiencies, Which particuar facilities are overbuilt? What is theexact nature of the waste?

-- The report also speaks of establishing utilization monitoring. Most public and private employer groups have instituted utilization management in the form of precertification requirements for inpatient care and, less frequently for outpatient care. Are these programs considered substandard? too lenient? Years of effort by insurers and third party-payors have gone into testing and developing these programs--does the authority expect to be able to significantly improve upon these results? Also, "appropriate" utilization must be determined to some degree on a case by case basis, taking into account the patients specific medical circumstances. How would the authority administer such a program, or would it rather just adopt a cookie-cutter approach?

-- Also to the extent insurers and other payors were required to adopt such standards, there would be significant cost, particularly for smaller insurers.

-- My understanding is that the Authority would likely adopt the Medicare RBRVS as its physician payment system. Can in fact the Medicare system be bought and utilized by others, is it a turnkey system available to other entities? If not, they it would seem that the cost to develop such a payment system from the ground up would be prohibitive.

•• How would phase two result in savings? Given that it would need to accomodate any number of plan arrangements due to collective bargaining, etc. The 1-31-90 Task force report indicates that State of Alaska plan expenses (p.20) were under 7% not including interest offsets. Assuming that plan expenses for other employer plans are similar, how much savings in terms of economy of scale is anticipated?

•• the Bill indicates that pooling will be voluntary, why then does the Bill indicate that that the Authority will "evaluate the need for mandatory participation in the group health insurance offered by the authority?

Jan Meisels
HIAA
(818) 991-6817
How does she call in to just listen?
(MON. Meeting)

Dr. Robert Crittenden
Office of the Governor
State of Washington
Dr. Office 202-624-2449

John M. Colmers
Health Services Cost Review
Commission
Baltimore, Maryland
301-764-2605

JOHN
COLMERS

DIR HLTH SVC COST
REV COMM'N
MARYLAND

303-764-2605

DR. ROBERT
CRITTENDEN

SPEC ASST TO GOV.

WASH ST.

206-586-4048
WORKS W
GARDEN

PLUS ADDRESSES ON INSURERS

SB 83 WORKSESSION TELECONFERENCE

ON LINE:

JAN MEISELS OF HIAA - LISTEN ONLY

DR. ROBERT CRITTEDEN, SPEC ASST TO GOVERNOR GARDNER OF WASH.

JOHN COLMERS, DIR HLTH SVC COST REVIEW COMMISSION OF MARYLAND

DR. JACK METER OF HIAA

SB 83
MODIFIERS FOR RATE & UTILIZATION SYSTEMS

From testimony at March 22 hearing:

Advanced technology:
- New equipment
- New staff
- Staff training

Specialty training to improve or expand service
Rate dispute resolution procedure expense
Uncollectible services
Charity caseload
Long term elder care
Competitive in-state salary level
Specialist recruitment
Excessive in-state capital improvement cost
Medicaid rate changes
Base year is too long ago

SB 83 AMENDMENTS

1) HAVE SMALL BUSINESSES COME ONLINE AT SAME TIME AS STATE & 3 MUNIS.

2) REQUIRE OUTLYING AREAS TO BE BROUGHT ONLINE AT A DATE CERTAIN IN THE FUTURE.

3) PG 5 LN 31 CHANGE [AND] TO <u>OR</u> .

4) PG 9 LN 19 - 21 CHANGE TO <u>REQUIRE</u> APPROVAL.

5) PG 5 SEC (B)(2) ADD ADDITIONAL CRITERIA TO RATE AND UTILIZATION STANDARDS.

6) PG 5 LN 12 DELETE [COST] INSERT <u>CHARGES</u>.

SB 83 MODIFIERS

Pg. 5 Sec 8 (b)(2)

Modifiers mentioned in 3/22 testimony

Advanced technology resulting in new equipment, staff & training
Speciality training to expand or improve service
Rate dispute resolution process & expense associated
Uncollectible service expenses
Charity caseload modifier
Long term elder care expense
Employee salary because of state
Specialist recruitment
Capital costs
Medicaide rate
Base year change

1. Concern about whether the Authority belongs in Title 21, the insurance statutes, or Title 44, where most other authorities are established, has been expressed by Bergstrom at H&SS and, off-the-record, Reed Stoops for AEtna and, off-the-record, Dave Walsh, Div of Insurance.

2. Concern about the authority setting rates that would force membership growth has been expressed by Reed Stoops, off-the-record again, for AEtna; Gordon Evans for Health Insurance Association of America.

3. HIAA also expresses concern over definition of employer, which somehow is divided down to the level of bargaining unit.

4. HIAA also has concern about ability to get out of pool.

5. Walsh, still off-the-record, suggests that if the authority chooses to self-insure, it should be exempt from state regulatory authority to avoid conflict between agencies.

requires certificate of need evaluation
establishes an authority
gives authority access to state info
Board of directors is 1 or 2 of the following:
- exec branch
- labor organizations
- school districts
- municipalities
- private sector employer
- health care provider

exempt service or contracts
bid purchase or self insurance
establishes State Health Resources Fund with approps & premiums
once enrolled an entity can only withdraw with board approval

SB 83 Railroad Questions - MARK HICKEY

What rates apply to employees stationed out side of the country, out side of the state?

What is the relationship between this plan and SBS?

What is the relationship of this plan to the long term supplemental coverage system the railroad enjoys?

Philosophically, they railroad believes this to be bad public policy.

Oppose rate setting and utilization standards.

Believe the formation of reduced payments for medical services will result in cost transfer by providers and the spiral will continue until all belong.

Rod,

Dr. Tuckerman

Strongly oposses SB83!!

Do we need to take addresses of these people? Send them the form letter thanking them for calling in and expressing their opinion?

(907) 276-2811
2841 Debarr Rd.
Anchorage, AK 99508

Introduction of SB 83

"An act creating the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for the residents of the state, and to the issuance of certificates of need; and providing for an effective date."

This legislation has received referrals to the Senate Labor & Commerce; Health, Education & Social Services and Finance Committees.

Similar legislation, SB 254, "An act relating to group health insurance and to health care provided by the state, and providing for an effective date", was sponsored by Senators Duncan and Kerttula last session. That legislation restricted participation to employees of the public sector only. It passed the Senate 18 to 1 and stalled in the House Finance Committee last year.

SB 83 allows public sector, as well as private sector, employers to participate. And, like SB 254, it allows the State Health Resources Authority to purchase coverage plans for participating employers or self-insure.

SB 83
MODIFIERS FOR RATE & UTILIZATION SYSTEMS

FROM TESTIMONY AT MARCH 22 HEARING:

ADVANCED TECHNOLOGY: need for
- NEW EQUIPMENT
- NEW STAFF
- STAFF TRAINING

SPECIALTY TRAINING TO IMPROVE OR EXPAND SERVICE
RATE DISPUTE RESOLUTION PROCEDURE EXPENSE
UNCOLLECTIBLE SERVICES
CHARITY CASELOAD
LONG TERM ELDER CARE
COMPETITIVE IN-STATE SALARY LEVEL
SPECIALIST RECRUITMENT
EXCESSIVE IN-STATE CAPITAL IMPROVEMENT COST
MEDICAID RATE CHANGES
(BASE YEAR IS TOO LONG AGO?)

March 18, 1991

Drue -

Re: SB83 Continuing Saga

I had asked Dale Staley of Duncan's office for a list of the amendments that you and he had agreed to. I never got them.

The next time I asked, Dale said the list included the amendments you had agreed to as well as some others that Duncan felt should be included. I never got the list.

Sunday, 3/17, Staley gave me the attached amendment draft and said that it replaced "some" of Duncan's original amendment number 3. (The committee had a package of four amendments from Duncan that were never acted on.)

This morning I asked for the "draft amendments" again and was told by Staley that what the committee would be receiving is a draft blank CS not individual amendments.

I have requested from Staley a side-by-side sectional comparing the draft blank CS with the original legislation. He indicated that "might take time and when did we need it?" I reminded him that the bill is scheduled to be heard on Friday and that it would be nice to be able to understand the changes prior to that hearing.

Rod

Let's talk about Friday hearing.

March 7, 1991

Ruth Lurie
Law Department
Great West Life
8515 E. Orchard Road
Anglewood, CO 80111

Dear Ms. Lurie:

As I mentioned to you in our telephone conversation today, the Senate Labor & Commerce Committee has heard Senate Bill 83, An act relating to the Alaska State Health Authority, on three occasions.

I have enclosed the minutes, which are paraphrased not verbatim, of those three meetings.

If I can be of further assistance, let me know.

Sincerely,

Rod R. Mourant
Legislative Aide

February 28, 1991

Brenda -

Enclosed is a copy of Senate Bill 83.

On friday, the meeting starts at 3:30 P.M. You should call collect 562-2882 and ask for the "Bridge Operator" and identify yourself.

On monday, the meeting is scheduled for the same time. Call collect 562-2867.

If you wish to testify just let the moderator know.

Thanks for your interest and I wish you well.

Rod

FAX TRANSMITTAL MEMO

TO: BRENDA TRUMBLE

DEPT: FAX #: 755-2511

FROM: ROD MOURANT PHONE: 465-3844

CO: SEN PEARCE FAX #: 463-5352

NO. OF PAGES 9

Post-it "brand fax transmittal memo 7671

February 7, 1991

Drue -

Harlan Knudson, lobbyist for AK State Hospital & Nursing Home Assoc, would like Sen L&C to consider holding a teleconference on SB 83 at a future hearing. He believes Humana, Providence and Fairbanks would be interested in participating.

Rod

February 7, 1991

Drue -

SB 83 -

Met with Reed Stoops today. Off the record, because they, Aetna, are the current state contract holder and don't want to loose it, they oppose the legislation. Their concerns center on rate setting. He claimed that the rates set by the authority apply to all public employees whether they're in the system or not. They also had a concern with the same authority that's setting the rates being the same authority that either purchases the coverage or self insures being the same authority that processes all claims. They also worry that the authority will set rates so low that providers will charge non-participates higher rates that will force more employers to join which will drive rates up for non-participants until everyone joins. The ultimate in socialized medicine will result.

Also spoke with Dave Walsh. Again, it was off the record because the administration has not taken a position as yet but Millet Keller seems to be supportive of the legislation. Dave does have two technical concerns with the legislation. The first is that the statutory language is being placed in Title 21, the Insurance section, rather than in Title 44, the State Government section. (AIDEA, Muni Bond Bank, AEA, CFAB were all Title 44.) He has no real problem with a health resources authority whose role is to reduce health insurance costs. The second concern is that if the authority chooses to self insure, it should be exempt from state regulation rather than regulated as the bill now provides. This would prevent disagreements between the authority and the regulating agency resulting in administrative resolution of disagreements. If they were exempted from state regulation, the regulatory role would be filled by the legislature and the public. If the authority did not self insure, there would be no problem.

REED

4/86

Health Care Cost Containment Task Force Report
February, 1991

Problems ① The list of factors responsible for the high cost of Health Care (page 5) is simply a laundry list of factors, which is frequently mentioned in reports and news articles around the country. The report should have investigated each of these as they pertain to Alaska and to determine which are major causes as opposed to incidental. The only information in the report which sheds any light on this is the survey response. A copy of the survey is enclosed. The survey is poorly written, and the return rate was very low. To my knowledge, it was not sent to individual doctors. I have no doubt that the survey information has no statistical significance due to these problems. (Ask Malik for a list of everyone who was sent a survey, and a list of who returned the survey.

② Without assessing a ranking the causes of high health care costs, it is difficult to recommend a justify a solution a solutions. The report should have prioritized the causes from greatest to smallest, discussed alternative ways to address the greatest problems, and recommended the best solution, giving reasons why it was selected over other possible solutions. You will find none of this analysis in the report.

(3) One would assume that the cost of health care in Alaska would be compared to the cost in other States ~~to~~ to give a relative idea of the problem here. You will find little, if any, ~~data~~ comparative cost or expenditure data in the report.

(4) There is no discussion about solutions proposed and tried in other States to evaluate the successes and failures of various approaches. (with the exception of an attached article). This is another obvious deficiency in the report.

(5) Given the endorsement of a mandated provider rate schedule and utilization standards, one would expect some discussion of the way this as worked in other States which have tried it (i.e. Ct, MA, NY, N.J, MD, WA.). Again, nothing.

(6) I don't believe that the number of uninsured in Alaska (99,000) or the cost of projected increases in health care costs found in the Executive Summary are credible. Last year, the estimate of uninsured was (45,000). You should ask Dalen for the back up for both claims.

(7) If Norris says that the scope of the study was too limited to get 1-6, ask how much he received for the last two years of his contract. (I believe it was ~~Norris~~ $100,000/yr).

SB 83 AMENDMENTS

1) HAVE SMALL BUSINESSES COME ONLINE AT SAME TIME AS STATE & 3 MUNIS.

2) REQUIRE OUTLYING AREAS TO BE BROUGHT ONLINE AT A DATE CERTAIN IN THE FUTURE. Dec 31, 1994. - DUNCAN ASKED 1995

3) PG 5 LN 31 CHANGE [AND] TO <u>OR</u> .

4) PG 9 LN 19 - 21 CHANGE TO <u>REQUIRE</u> APPROVAL.

5) PG 5 SEC (B)(2) ADD ADDITIONAL CRITERIA TO RATE AND UTILIZATION STANDARDS.

6) PG 5 LN 12 DELETE [COST] INSERT <u>CHARGES</u>.

Page 5, alter line 14:

Insert new subsections to read:

"( ) Analyze the Alaska population that is uninsured or underinsured for health care."

"( ) Provide recommendations to the Legislature no later than February 15, 1992, for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health for all Alaskans, and report on annually on its progress."

"( ) Provide recommendations to the Legislature no later than February 15, 1993, for the design of a program with alternatives including liability and financing alterative to provide health care insurance to Alaska residents who:

(a) are not covered by health insurance, and

(b) have been refused health insurance coverage by two or more health insurance carriers in the last twelve months, or

(c) have been deemed uninsurable for health coverage, or

(d) are unable to pay for basic health care protection and do not qualify for any other health care protection program or plan.

Change "employer" in the definitions to "Public Employer" and write a definition for "Private Employer" as all other.

1) have small businesses come on line at same time

MAURICE

2) require outlying areas be brought in at same date certain (delayed)

- check w/ insurance companies on this one.

3) p5, line 31 change and to or

4) p9, lines 19-21 change to require approval.

5) p5, section (b)(2) -. additions to list? (were suggested at hearing)

plus reword (G) to not be cost - there has to be some profit. CHARGES

AMENDMENT

CSSB-83 AMENDMENT SERIES III

(placement from CSSB 83L&C)

PAGE 3 LINE 29

REPLACE

Post-It™ brand fax transmittal memo 7671 | # of pages ▸ 1

To	From
Co.	Co.
Dept.	Phone #
Fax #	Fax #

(b) THE AUTHORITY SHALL BY JULY 1, 1992, CREATE AND BEGIN A PHASED IMPLEMENTATION OF STATEWIDE GEOGRAPHIC SPECIFIC HEALTH CARE PROVIDER REIMBURSEMENT SYSTEMS,AND UTILIZATION STANDARDS.
NO LATER THAN DECEMBER 31,1993 THE AUTHORITY SHALL HAVE OPERATIONAL REIMBURSEMENT SYSTEMS AND UTILIZATION STANDARDS FOR HEALTH PROCEDURES PERFORMED WITHIN THE BOUNDARIES OF AN INCORPORATED MUNICIPALITY OR BOROUGH WITH A POPULATION BASE IN EXCESS OF 20,000 AS DETERMINED BY THE 1990 US CENSUS REPORT.
All reimbursement schedules and utilization standards considered necessary by the authority shall be operational by June 30, 1995.
THE AUTHORITY SHALL ESTABLISH THE REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS PROSPECTIVELY, UTILIZING THE THE MOST ACCURATE INFORMATION AVAILABLE TO THE AUTHORITY USING DEFINED RELIABLE COMPONENTS, THE DEFINED COMPONENTS FOR THE REIMBURSEMENT SYSTEM SHALL INCLUDE BUT ARE NOT LIMITED TO:
1.EFFORT AND TIME BY PROVIDER(E&T),
2.FACILITIES AND PRACTICE EXPENSE(FPE),
3.PROFESSIONAL LIABILITY INSURANCE (PLI),
4.GEOGRAPHIC MODIFIER (GEO),
5.AVAILABILITY OF SERVICES MODIFIER (ASM),
6.UNCOMPENSATED CARE NET COST(UCNC).
7.ACTUAL PROVIDER COST AS OF JANUARY 1 1991(APC);

THE AUTHORITY SHALL FURTHER DEFINE THE COMPONENTS AND ASSIGN RELATIVE WEIGHTING TO EACH COMPONENT
THE AUTHORITY WILL PUBLISH NO LATER THAN JULY 1,1992 AND UPDATE ANNUALLY A GUIDE FOR HEALTH CARE PROVIDERS, INSURERS AND PARTICIPANTS THAT DESCRIBES THE SCHEDULES AND STANDARDS SYSTEMS ALONG WITH AN EXPLANATION OF HOW TO UTILIZE THE SCHEDULES AND STANDARDS

All Providers and claims payor shall use these health care provider reimbursement schedules and utilization standards when billing for services provided to public employers or public employees and private employers may elect to use these schedules and standards by application to the authority.

THE AUTHORITY AS SOON AS FEASIBLE, SHALL ESTABLISH HEALTH CARE QUALITY,UTILIZATION, PROVIDER COST/ BILLING INFORMATION AND DATA COLLECTION PARAMETERS INCLUDING REPORTING PROCEDURES, IN COOPERATION WITH REPRESENTATIVES OF THE HEALTH CARE PROVIDER AND INSURANCE COMMUNITY, ONCE ESTABLISHED ALL HEALTH CARE PROVIDERS AND INSURERS OPERATING IN THE STATE SHALL COMPLY WITH THE HEALTH CARE INFORMATION AND DATA REPORTING PROCEDURES.

REPLACE"PROCURE OR PROVIDE" WITH:

PROCURE OR WHEN PROCUREMENT OF INSURANCE IS NOT REDLY OR ECONOMICALLY AVAILABLE, PROVIDE [redacted]

REPLACE SEC44.87.060 PROCUREMENT OF INSURANCE

(a) THE AUTHORITY MAY AFTER JULY 1,1992 BEGIN THE PROCUREMENT OF A COMPREHENSIVE GROUP HEALTH INSURANCE PROGRAM FOR INDIVIDUALS, GROUPS OF INDIVIDUALS OR EMPLOYERS THAT THE AUTHORITY DETERMINES DO NOT HAVE HEALTH INSURANCE OR FOR WHOM HEALTH INSURANCE COULD BE MORE COST EFFECTIVE IF PROCURED BY THE AUTHORITY. THE AUTHORITY MAY ALSO HEALTH INSURANCE TO EMPLOYERS WHO ELECT TO PARTICIPATE IN THE GROUP HEALTH INSURANCE [redacted] BY THE AUTHORITY; EMPLOYER GROUP HEALTH INSURANCE MAY INCLUDE COVERAGE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS;

Provided or Procured

THE AUTHORITY MAY NOT PROVIDE OR ACT AS A SELF INSURING ENTITY UNTIL THERE IS SUBMITED A REQUEST FOR PROPOSAL TO LICENSED HEALTH INSURANCE CARRIERS IN THE STATE THAT ARE DEEMED BY THE AUTHORITY QUALIFIED TO PROVIDE THE DESIRED BENEFITS AND MEET THE SPECIFICATIONS OUTLINED IN THE REQUEST FOR PROPOSAL.

IF AFTER AND ONLY AFTER THIS REQUEST FOR PROPOSAL PROCESS HAS BEEN COMPLETED THE AUTHORITY DETERMINES THAT THE DESIRED COVERAGES OR BENEFITS ARE NOT REDLY AVAILABLE AND OR THE AUTHORITY CAN PROVIDE THE DESIRED COVERAGES AND BENEFITS AT A LOWER COST PER ELIGIBLE PERSON,CAN THE AUTHORITY SUBMIT ITS PLAN TO THE LEGISLATURE TO ACT AS A PROVIDER OF COVERAGE OR BENEFITS.

" THE AUTHORITY WHEN PROCURING OR PROVIDING INSURANCE MAY, CREATE POOLS OR SUB POOLS OF PARTICIPANTS TO ACCURATELY TRACK PREMIUM, EXPERIENCE AND EXPOSURE BY CATAGORY, THE AUTHORITY MAY ALSO EMPLOY RISK SHARING MECHANISIMS TO LIMIT THE AUTHORITIES OR PARTICIPANTS TOTAL EXPOSURE AND PREMIUM CLAIM VOLATILITY

February 15,

" NOT LATER THAN [redacted] 1993 THE AUTHORITY SHALL DESIGN AND PROCURE OR PROVIDE A BASIC HEALTH INSURANCE PROGRAM FOR ALASKA EMPLOYERS WHO ELECT TO PARTICIPATE AND WHO:

a. HAVE FIFTY OR LESS EMPLOYEES and,

b. WHO HAVE BEEN REFUSED COVERAGE BY TWO OR MORE HEALTH INSURANCE CARRIERS.IN THE LAST TWELVE MONTHS AND

c.EMPLOYERS WHO HAVE NOT PROVIDED HEALTH INSURANCE COVERAGE TO THEIR EMPLOYEES IN THE LAST TWELVE MONTHS.

d. THIS PLAN SHALL EMPHASIZE PREVENTATIVE AND PROTECTIVE HEALTH SERVICES

e. THIS PLAN WILL BE EXEMPT FROM MANDATED COVERAGE PROVISIONS OUTLINED IN SEC---- EXCEPT WHERE THE AUTHORITY DEEMS IT APPROPRIATE AND MORE COST EFFECTIVE TO OFFER CERTAIN COVERAGES..

f. THE AUTHORITY WILL SUBMIT RECOMMENDATIONS TO THE LEGISLATURE FOR CONSIDERATION.A WAY TO PROVIDE FINANCIAL INCENTIVES FOR EMPLOYERS TO PROVIDE HEALTH PROTECTION FOR THEIR EMPLOYEES AND DEPENDENTS.

g. THE PLAN MUST HAVE PROVISIONS TO STREAMLINE MARKETING,PAYMENT OF CLAIMS TO PROVIDERS/PARTICIPANTS, AND ADMINISTRATION

h. THE PLAN MUST INCLUDE HEALTH CARE COST MANAGEMENT PROVISIONS AND USE THE PROVIDER REIMBURSEMENT SYSTEM AND UTILIZATION UTILIZATION STANDARDS OUTLINED IN SEC.--

i. THE AUTHORITY MAY UTILIZE ALASKA LICENSED INSURANCE AGENTS/BROKERS TO ASSIST IN THE MARKETING AND SERVICING OF THIS PLAN

7-LS0305\G.1
Ford
02/28/91

AMENDMENT

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE

TO: CSSB 83(L&C)

Page 6, after line 11:

Insert a new subsection to read:

"(c) If the authority elects to act as a self-insurer, the authority shall submit a plan of the intended insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer until 60 days after the authority submits the intended plan of insurance to the legislature."

7-LS0305\G.2
Ford
02/28/91

AMENDMENT

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE

TO: CSSB 83(L&C)

Page 2, after line 31:

Insert a new bill section to read:

"* **Sec. 4.** AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident

employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority."

Renumber the following bill sections accordingly.

7-LS0305\G.3
Ford
03/01/91

AMENDMENT

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE

TO: CSSB 83(L&C)

Page 3, line 29:

Delete "implementation of a"

Insert "a phased implementation of a statewide geographic specific"

Page 3, line 30, after "standards.":

Insert "The authority shall establish the reimbursement system and utilization standards prospectively utilizing the most accurate information available to the authority regarding defined reliable components of the reimbursement system and utilization standards. By July 1, 1993, the authority shall establish and operate at least 50 percent of the reimbursement system and utilization standards. By June 30, 1994, the authority shall complete establishment and implementation of the reimbursement system and utilization standards."

Page 4, after line 13:

Insert a new subsection to read:

"(e) At least 60 days before implementing a phase of the reimbursement system and utilization standards, the authority shall provide public notice and accept public comments on that phase of the reimbursement system and utilization standards."

Page 5, line 23, after "(4)":

Insert "establish a grievance procedure to resolve disputes between the authority and participants;

(5)"

Page 6, line 3:

Delete "obtain"

Insert "procure or provide"

Page 6, line 7:

Delete "obtain"

Insert "procure or provide"

7-LS0305\G.4
Ford
02/28/91

AMENDMENT

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE

TO: CSSB 83(L&C)

Page 1, lines 6 - 11:

Delete all material and insert:

"(1) by July 1, 1992, create and begin a phased implementation of statewide geographic specific health care provider reimbursement systems and utilization standards;

(2) after July 1, 1992, begin the procurement or provision of a comprehensive group health insurance program for individuals, groups of individuals, or employers that the authority determines do not have health insurance or for whom health insurance could be more cost effective if offered by the authority to employers who elect to participate; the authority may also procure or provide health insurance to employers who elect to participate in the group health insurance offered by the authority; employer group health insurance may include coverage for eligible employees and dependents;

(3) assure financial protection for participants and beneficiaries, provide equitable payment to health care providers, and slow the increase in health care expenditures;"

Reletter the following paragraphs accordingly.

Page 2, line 11:

Delete "offered"

Insert "procured or provided"

Page 2, line 13:

Delete "evaluate the need for group health insurance for residents of the state who are"

Insert "continue to evaluate and where feasible offer a health insurance program for those sectors of the state that remain"

7-LS0305\J
Ford
4/18/91

CS FOR SENATE BILL NO. 83 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY
Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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

*** Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin a phased implementation of geographic specific health care provider reimbursement systems and utilization standards;

(2) after July 1. 1992, begin the procurement or provision of a comprehensive group health insurance program for individuals, groups of individuals, or employers that the authority determines do not have health insurance or for employers who elect to have the authority procure or provide insurance on the employer's behalf; employer group health insurance may include coverage for eligible employees and dependents;

(3) assure financial protection for participants and beneficiaries, provide equitable payment to health care providers, and slow the increase in health care expenditures;

(4) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(5) maintain efficient provider reimbursement systems to reduce the administrative cost to providers who are serving employees of participants;

(6) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(7) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(8) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the reimbursement systems and utilization standards offered by the authority; and

(9) continue to evaluate and where feasible offer a health insurance program for those sectors of the state that remain uninsured or underinsured.

* **Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

* **Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska State Health Resources Authority regarding the effect of the**

certificate of need on the cost of group health insurance.

*** Sec. 4.** AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority.

*** Sec. 5.** AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

[New Text Underlined; DELETED TEXT BRACKETED]

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

* **Sec. 6.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* **Sec. 7.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 44.87).

* **Sec. 8.** AS 44 is amended by adding a new chapter to read:

CHAPTER 87. STATE INSURANCE AUTHORITY.

Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall

(1) by July 1, 1992, create and begin a phased implementation of geographic specific health care provider reimbursement systems and utilization standards (A) within the boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990 United States census and (B) for interested and eligible businesses that have 50 or fewer

employees; the health care provider reimbursement systems and utilization standards required under this paragraph shall be in operation by December 31, 1993;

(2) create and begin a phased implementation of geographic specific health care provider reimbursement systems and utilization standards within the boundaries of communities that have a population of less than 20,000 as reflected by the 1990 United States census; the health care provider reimbursement systems and utilization standards required under this paragraph shall be in operation by July 1, 1995;

(3) establish the reimbursement systems and utilization standards prospectively utilizing the most accurate information available to the authority regarding defined reliable components of the reimbursement systems and utilization standards; components for the reimbursement systems must include but are not limited to

(A) effort and time by provider;

(B) technological advances resulting in new equipment, staff, or training;

(C) facilities and practice expense;

(D) training as a specialist that expands or improves service;

(E) professional liability insurance;

(F) resolution of rate disputes and associated expenses;

(G) geographic modifier;

(H) uncollectible debt expenses;

(I) availability of services modifier;

(J) charity caseload modifier;

(K) uncompensated care net cost;

(L) long-term elder care expenses;

(M) employee expenses resulting from competition with state employee salaries;

(N) specialist recruitment expenses;

(O) capital costs;

(P) Medicaid rates;

(Q) actual provider charges as of January 1, 1991;

(4) assign relative weight to each component specified in (3) of this subsection and may further define each component;

(5) publish, not later than July 1, 1992, a guide for health care providers, insurers, and participants that describes and explains how to use the reimbursement systems and utilization standards;

(6) establish health care information and data reporting procedures; the procedures shall be established in cooperation with health care providers and insurers.

(c) A health care provider and a person paying a claim shall use the health care provider reimbursement systems and utilization standards established by the authority when billing for services provided to a public employer or a public employee. Other employers may elect to use the reimbursement systems and utilization standards, if the use is approved by the authority.

(d) Upon application by an employer or an eligible state program, the authority may, beginning July 1, 1992, allow the employer or the eligible state program to participate in a group health insurance pool established by the authority.

(e) Not later than February 15, 1993, the authority shall design and procure or provide a basic health insurance program for employers who elect to participate and who have

(1) 50 or fewer full-time employees;

(2) been refused coverage by two or more health insurance carriers in the last 12 months; or

(3) not provided health insurance coverage to their employees in the last 12 months.

(f) A plan required under (e) of this section

(1) must emphasize preventative and protective health services;

(2) must include provisions to streamline marketing and payment of claims to providers and participants;

(3) must include the reimbursement systems and utilization standards described in (b) of this section;

(4) may utilize insurance agents or brokers licensed in this state to assist in the marketing and servicing of the plan.

(g) The authority shall submit recommendations to the legislature for providing financial incentives for employers to provide health protection for their employees and dependents.

(h) At least 60 days before implementing a phase of the reimbursement systems and utilization standards, the authority shall provide public notice and accept public comments on that

phase of the reimbursement systems and utilization standards.

Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement systems and utilization standards established by the authority, including sharing relevant information.

Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 44.87.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under AS 21;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) establish a grievance procedure to resolve disputes between the authority and participants;

(5) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority;

(6) analyze the health care needs of the state population that is uninsured or underinsured;

(7) provide recommendations to the legislature not later than February 15, 1992, for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health insurance for all state residents; the recommendations must be updated each year;

(8) provide recommendations to the legislature not later than February 15, 1993, for the design of a program with alternatives including liability and financing alternatives to provide health care insurance to state residents who

(A) are not covered by health insurance;

(B) have been refused health insurance coverage by two or more health insurance carriers in the last 12 months;

(C) have been considered uninsurable for health coverage; or

(D) are unable to pay for basic health care protection and do not qualify for any other health care protection program or plan;

(9) beginning January 1, 1994, periodically review and update the reimbursement systems and utilization standards established by the authority, and evaluate the need for

[DELETED TEXT BRACKETED]

reimbursement systems and utilization standards in other areas of the state.

Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance covering an individual or an employer that the authority determines does not have health insurance or for whom health insurance could be more cost effective if procured by the authority. The authority may procure or, if procurement of insurance is not economically feasible, provide group health insurance to employers who elect to participate. Group health insurance may include coverage for eligible employees and dependents. The authority shall procure the insurance from an insurer authorized to transact business in the state under AS 21.09, or the authority may elect to act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee and the authority complies with (c) of this section.

(b) The authority, no earlier than July 1, 1992, may establish a group health insurance pool or pools of eligible employers that elect to participate in the group health insurance obtained by the authority. Coverage provided under this subsection must include eligible employees and dependents. Employers that elect to participate shall use the reimbursement systems and utilization standards established by the authority.

(c) Except when acting as a self-insurer, the authority shall procure or provide group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

(d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals

for the required coverage from insurers licensed in this state to offer health insurance. If after the proposal process has been completed, the authority determines that the desired coverage or benefits are not available from insurers licensed in this state or the authority can provide the desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan of the intended self-insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted by the authority.

(e) The authority, when procuring or providing insurance, may create pools or subpools of participants to accurately track premium, experience, and exposure by category. The authority may employ risk sharing mechanisms to limit the total exposure and premium claim volatility of the authority or a participant.

Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state, municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage

matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 44.87.900. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "full-time employee" means a person who works 30 or more hours in a week;

(8) "fund" means the Alaska state health resources fund;

(9) "group health insurance" means coverage that may include medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(10) "health care provider" has the meaning given in AS 21.88.900;

(11) "municipality" includes a public corporation established by a municipality;

(12) "participant" means a person who participates in the group health insurance procured or provided by the authority;

(13) "reimbursement systems" means systems or methods that streamline or result in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs,

and availability of services;

(14) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(15) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 9.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement systems and utilization standards.

* **Sec. 10.** This Act takes effect immediately under AS 01.10.070(c).

7-LS0305\D
Ford
3/19/91

ADOPTED

CS FOR SENATE BILL NO. 83 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY
Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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

* **Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin a phased implementation of geographic specific health care provider reimbursement systems and utilization standards;

(2) after July 1, 1992, begin the procurement or provision of a comprehensive group health insurance program for individuals, groups of individuals, or employers that the authority determines do not have health insurance or for employers who elect to have the authority procure or provide insurance on the employer's behalf; employer group health insurance may include coverage for eligible employees and dependents;

(3) assure financial protection for participants and beneficiaries, provide equitable payment to health care providers, and slow the increase in health care expenditures;

NEW WORK [DELETED TEXT BRACKETED]

(4) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(5) maintain efficient provider reimbursement systems to reduce the administrative cost to providers who are serving employees of participants;

(6) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(7) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(8) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the reimbursement systems and utilization standards offered by the authority; and

(9) continue to evaluate and where feasible offer a health insurance program for those sectors of the state that remain uninsured or underinsured.

*** Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

*** Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determin[illegible]n from the Alaska State Health Resources Authority regarding the effect of the**

certificate of need on the cost of group health insurance.

* **Sec. 4.** AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority.

* **Sec. 5.** AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

*** Sec. 6.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

*** Sec. 7.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 44.87).

*** Sec. 8.** AS 44 is amended by adding a new chapter to read:

CHAPTER 87. STATE INSURANCE AUTHORITY.

Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall

(1) by July 1, 1992, create and begin a phased implementation of geographic specific health care provider reimbursement systems and utilization standards within the boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990 United States census; the health care provider reimbursement systems and utilization standards

EXPENDITURES IN THIS AREA

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required under this paragraph shall be in operation by December 31, 1993;

(2) establish the reimbursement systems and utilization standards prospectively utilizing the most accurate information available to the authority regarding defined reliable components of the reimbursement systems and utilization standards; components for the reimbursement systems must include but are not limited to

(A) effort and time by provider;

(B) facilities and practice expense;

(C) professional liability insurance;

(D) geographic modifier;

(E) availability of services modifier; WHAT ABOUT UPGRADES

(F) uncompensated care net cost;

CHANGES → (G) actual provider ~~cost~~ as of January 1, 1991;

(3) assign relative weight to each component specified in (2) of this subsection and may further define each component;

(4) publish, not later than July 1, 1992, a guide for health care providers, insurers, and participants that describes and explains how to use the reimbursement systems and utilization standards;

(5) establish health care information and data reporting procedures; the procedures shall be established in cooperation with health care providers and insurers.

(c) A health care provider and a person paying a claim shall use the health care provider reimbursement systems and utilization standards established by the authority when billing for services provided to a public employer or a public employee. Other employers may elect to use the reimbursement systems and utilization standards, if the use is approved by the authority.

(d) Upon application by an employer or an eligible state program, the author[illegible]ay beginning July 1, 1992, allow the employer or the eligible state program to participate in health insurance pool established by the authority.

(e) Not later than February 15, 1993, the authority shall design and procure or provide a basic health insurance program for employers who elect to participate and who have

(1) 50 or fewer full-time employees;

(2) been refused coverage by two or more health insurance carriers in the last 12 months; and

(3) not provided health insurance coverage to their employees in the last 12 months.

(f) A plan required under (e) of this section

(1) must emphasize preventative and protective health services;

(2) must include provisions to streamline marketing and payment of claims to providers and participants;

(3) must include the reimbursement systems and utilization standards described in (b) of this section;

(4) may utilize insurance agents or brokers licensed in this state to assist in the marketing and servicing of the plan.

(g) The authority shall submit recommendations to the legislature for providing financial incentives for employers to provide health protection for their employees and dependents.

(h) At least 60 days before implementing a phase of the reimbursement systems and utilization standards, the authority shall provide public notice and accept public comments on that phase of the reimbursement systems and utilization standards.

Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement systems and utilization standards established by the authority, including sharing relevant information.

Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

WHAT ABOUT INSURANCE INDUSTRY

(b) Members of the board serve staggered terms of four years. The board shall elect

from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 44.87.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under AS 21;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) establish a grievance procedure to resolve disputes between the authority and participants;

(5) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority;

(6) analyze the health care needs of the state population that is uninsured or underinsured;

(7) provide recommendations to the legislature not later than February 15, 1992,

for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health insurance for all state residents; the recommendations must be updated each year;

(8) provide recommendations to the legislature not later than February 15, 1993, for the design of a program with alternatives including liability and financing alternatives to provide health care insurance to state residents who

(A) are not covered by health insurance;

(B) have been refused health insurance coverage by two or more health insurance carriers in the last 12 months;

(C) have been considered uninsurable for health coverage; or

(D) are unable to pay for basic health care protection and do not qualify for any other health care protection program or plan;

(9) beginning January 1, 1994, periodically review and update the reimbursement systems and utilization standards established by the authority, and evaluate the need for reimbursement systems and utilization standards in other areas of the state.

Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance covering an individual or an employer that the authority determines does not have health insurance or for whom health insurance could be more cost effective if procured by the authority. The authority may procure or, if procurement of insurance is not economically feasible, provide group health insurance to employers who elect to participate. Group health insurance may include coverage for eligible employees and dependents. The authority shall procure the insurance from an insurer authorized to transact business in the state under AS 21.09, or the

authority may elect to act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee and the authority complies with (c) of this section.

(b) The authority, no earlier than July 1, 1992, may establish a group health insurance pool or pools of eligible employers that elect to participate in the group health insurance obtained by the authority. Coverage provided under this subsection must include eligible employees and dependents. Employers that elect to participate shall use the reimbursement systems and utilization standards established by the authority.

(c) Except when acting as a self-insurer, the authority shall procure or provide group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

(d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals for the required coverage from insurers licensed in this state to offer health insurance. If after the proposal process has been completed, the authority determines that the desired coverage or benefits are not available from insurers licensed in this state or the authority can provide the desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan of the intended self-insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer under the plan until the legislature has been in regular session for 60 calendar days after the plan was submitted.

(e) The authority, when procuring or providing insurance, may create pools or subpools of participants to accurately track premium, experience, and exposure by category. The authority may employ risk sharing mechanisms to limit the total exposure and premium claim volatility of the authority or a participant.

Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the

authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state, municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 44.87.900. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining

unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "full-time employee" means a person who works 30 or more hours in a week;

(8) "fund" means the Alaska state health resources fund;

(9) "group health insurance" means coverage that may include medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(10) "health care provider" has the meaning given in AS 21.88.900;

(11) "municipality" includes a public corporation established by a municipality;

(12) "participant" means a person who participates in the group health insurance procured or provided by the authority;

DELETE (13) "public employer" means the state, a municipality, a district, or a public corporation of the state created within a principal executive department;

(14) "reimbursement systems" means systems or methods that streamline or result in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(15) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(16) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 9.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement systems and utilization standards.

* **Sec. 10.** This Act takes effect immediately under AS 01.10.070(c).

unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "full-time employee" means a person who works 30 or more hours in a week;

(8) "fund" means the Alaska state health resources fund;

(9) "group health insurance" means coverage that may include medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(10) "health care provider" has the meaning given in AS 21.88.900;

(11) "municipality" includes a public corporation established by a municipality;

(12) "participant" means a person who participates in the group health insurance procured or provided by the authority;

(13) "reimbursement systems" means systems or methods that streamline or result in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(14) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(15) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 9.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement systems and utilization standards.

* **Sec. 10.** This Act takes effect immediately under AS 01.10.070(c).

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Ford
2/28/91

CS FOR SENATE BILL NO. 83 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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

* Section 1. PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin implementation of a statewide health care provider reimbursement system and utilization standards;

(2) after July 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, other employers in the state who elect to participate, and all eligible employees of the state, a municipality, a school district, or other employer in the state who elect to participate in the group insurance offered by the Alaska State Health Resources Authority;

(3) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(4) maintain an efficient provider reimbursement system to reduce the administrative cost

New Text Underlined [DELETED TEXT BRACKETED]

to providers who are serving employees of participants;

(5) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority;

(8) evaluate the need for mandatory participation in the group health insurance offered by the authority; and

(9) evaluate the need for group health insurance for residents of the state who are uninsured or underinsured.

* **Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

* **Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska State Health Resources Authority regarding the effect of the certificate of need on the cost of group health insurance.**

* Sec. 4. AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

* Sec. 5. AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* Sec. 6. AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 44.87).

* Sec. 7. AS 44 is amended by adding a new chapter to read:

CHAPTER 87. STATE INSURANCE AUTHORITY.

Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall, by July 1, 1992, establish and begin implementation of a health care provider reimbursement system and utilization standards. The state, a municipality, or a school district shall use the health care provider reimbursement system and utilization standards

established by the authority for eligible employees of the state, a municipality, or a school district. With the approval of the authority, other employers in the state may use the health care provider reimbursement system and utilization standards established by the authority.

(c) The authority shall, no earlier than July 1, 1992, establish a group health insurance pool or pools of eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance pool provided by the authority. Employees of other groups that elect to participate shall use the reimbursement system and utilization standards established by the authority.

(d) Upon application by an eligible state program, the authority may, beginning July 1, 1992, allow the eligible state program to participate in the group health insurance pool provided by the authority.

Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement system and utilization standards established by the authority, including sharing relevant information.

Sec. 44.87.020. BOARD OF DIRECTORS: ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for

boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 44.87.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under AS 21;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority.

Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings,

studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees of an employer that has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

(b) Except when acting as a self-insurer, the authority shall obtain group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state, municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage

matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 44.87.100. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "fund" means the Alaska state health resources fund;

(8) "group health insurance" means coverage that may include life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(9) "municipality" includes a public corporation established by a municipality;

(10) "participant" means the state, a municipality, a district, or other employer in the state;

(11) "reimbursement system" means a system or method that streamlines or results in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 8.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement system and utilization standards.

* **Sec. 9.** This Act takes effect immediately under AS 01.10.070(c).

1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION

Division Labor Relations **Bill Number** CSSB 83

Bill Title Act relating to the Alaska State Health Resources Authority

Position Statement: Explain briefly what bill does, its impacts and Department's position, i.e., a) support, b) do not support, c) neutral or d) oppose.

We oppose this legislation for budgetary reasons.

This bill would establish the Alaska State Health Resources Authority as a nonprofit incorporated legal entity, within the Department of Administration; the authority is to be managed by nine (9) uncompensated directors appointed by the Governor.

The Alaska State Health Resources Authority would be charged with three (3) primary responsibilities:

1. Issuing recommendations on the effect of certificates of need (AS 18.07.071) on group insurance costs, effective immediately.

2. By July 1, 1992, implement a health care provider reimbursement system and utilization standards; these are mandatory for all public employers and may be voluntarily utilized by other employers.

3. By July 1, 1992, establish a voluntary health insurance pool designed to purchase or provide affordable health insurance.

State agencies involved in health care/health insurance are to cooperate in developing the reimbursement system and utilization standards, through the sharing of information. The authority is to report its progress to the legislature by March 1, 1992, and annually thereafter.

While we support the objectives proposed in this legislation, we must oppose the bill's proposed effective dates because immediate implementation will increase our FY 92 operating budget beyond the level we believe appropriate. The bill is otherwise meritorious. We believe the bill should be given budgetary support in FY 93, along with a cost reduction justification offset.

APPROVED:

Director Bruce Cummings **Division** Labor Relations

Signature Bruce Cummings **Date** 4/1/91

Commissioner Millett Keller

Signature Millett Keller **Date** 4/3/91

(For more information, call Barbara Pritchett 465-2200) Rev. 01/28/91

LEGPP.FRM
9/8/PP/0431272.kp/1

1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION

Division Retirement and Benefits **Bill Number** SB 83

Bill Title An Act relating to the Alaska State Health Resources Authority...

Position Statement: **Explain briefly what bill does, its impacts and Departments' position, i.e. a) support, b) do not support, c) neutral or d) oppose.**

This bill creates an Authority within the Department of Administration managed by a Board of Directors. By July 1992, the Authority will create utilization standards and reimbursement systems that will be used by participating groups on a statewide basis. After July 1992, the Authority will provide group health insurance to various public employers throughout the State should they choose to elect to participate.

The bill does not require the State to participate in the insurance pool. The State may elect to do so. It is anticipated the Division of Retirement and Benefits would continue to perform similar administrative functions regarding the health plan, whether the State decided to participate in the pool or not.

Since the bill has no clear adverse impact on this division and could provide more accessible and more affordable health insurance coverage for employers, the Department supports this bill.

APPROVED:

Director Gary M. Bader **Division** Retirement and Benefits

Signature [signature] **Date** Februrary 12, 1991

Commissioner Millett Keller

Signature [signature] **Date** 2/13/91

(For more information, call Barbara Pritchett 465-2200) Rev. 1/91

1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION

Division Labor Relations **Bill Number** SB 83

Bill Title Act relating to the Alaska State Health Resources Authority

Position Statement: Explain briefly what bill does, its impacts and Department's position, i.e., a) support, b) do not support, c) neutral or d) oppose.

This bill would establish the Alaska State Health Resources Authority as a nonprofit incorporated legal entity, within the Department of Administration; the authority is to be managed by nine (9) uncompensated directors appointed by the Governor.

The Alaska State Health Resources Authority would be charged with three (3) primary responsibilities:

1. Issuing recommendations on the effect of certificates of need (AS 18.07.071) on group insurance costs, effective immediately.

2. By July 1, 1992, implement a health care provider reimbursement system and utilization standards; these are mandatory for all public employers and may be voluntarily utilized by other employers.

3. By July 1, 1992, establish a voluntary health insurance pool designed to purchase or provide affordable health insurance.

State agencies involved in health care/health insurance are to cooperate in developing the reimbursement system and utilization standards, through the sharing of information. The authority is to report its progress to the legislature by March 1, 1992, and annually thereafter.

We support this legislation as a potential vehicle to curb escalating health care/health insurance costs. However, we recognize that the bill may require technical amendments for clarity or to improve organizational efficiency (e.g., statutory placement of authority, frequency and nature of reports to legislature, etc.). We do not anticipate any change in position as a result of such amendment, but will modify our position as necessary on bill substitutes.

APPROVED:

Director Bruce Cummings **Division** Labor Relations

Signature Bruce Cummings **Date** 2/13/91

Commissioner Millett Keller

Signature Millett Keller for BHL **Date** 2/13/91

(For more information, call Barbara Pritchett 465-2200) Rev. 01/28/91

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9/8/PP/0431272.kp/1

MEMORANDUM

State of Alaska

TO: Senator Drue Pearce
Chairperson
Senate Labor & Commerce Committee
Alaska State Senate

DATE: March 1, 1991

FILE NO.:

TELEPHONE NO.: (907) 465-2515

SUBJECT: CSSB 83

THRU:

FROM: Dave Walsh
Director
Division of Insurance
Department of Commerce
and Economic Development

We have reviewed the following documents and they appear to respond to the points and concerns noted in the February 22, 1991 Position Paper from the Department of Commerce and Economic Development attached. The reviewed documents are:

CS for Senate Bill No. 83 (L&C)	Work Draft 7-LS0305\G, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.1, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.2, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.3, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.4, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft Page 3 Line 29, Ford, no date

STATE OF ALASKA

FEB 25 1991

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500

February 25, 1991

Honorable Drue Pearce
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Pearce:

Please accept this letter as a formal retraction of the position paper on SB 83 dated 2/19/91. The most current position paper, dated 2/22/91, is attached.

The original bill analysis was not affected.

Please excuse our ignorance on this procedure. If the Department of Commerce and Economic Development can be of any assistance to you in the future, please do not hesitate to ask.

Sincerely,

Larry Galloway
Special Assistant

LG/wfd4188W-1
.22591a
Enclosure
cc: Senator Jim Duncan

what, pray tell, u he apologizing for?

Call + say everyone who gives in to Jim only reinforces his behavior!

Larry works for Hickel ..... not Duncan - and their philosophies are so different he should be careful about letting Jim scare him.

03-M:LH

Department of Commerce & Economic Development / POSITION PAPER

SB 83: "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

This department is in favor of this legislation with the changes noted below.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

The department recommends the following changes to SB 83.

1. Move Section 4 of the bill from Title 21 to another title.

   This would avoid conflict with the content and purpose of Title 21. Title 21 is designed for the regulation of the business of insurance. Section 4, on the other hand, is designed for the purchase or provision of coverage. These two roles tend to be in conflict with each other. Further, Title 21 is administered and regulated within the Department of Commerce and Economic Development while Section 4 is an authority administered under the Department of Administration.

2. Eliminate regulatory oversight of the authority by the Division of Insurance.

   The regulation of one agency in the executive branch by another agency in the executive branch is not workable. The potential for interagency squabbles is substantially increased and other conditions beyond the regulatory scheme may control and prevail. This arises if the authority elects to become a direct provider of coverage. To a large extent, that should be part of the responsibility of the authority Board of Directors.

3. Provide for legislative oversight of any move to provider status.

   If the authority elects to become a direct provider of coverage, it basically enters an area that has been a subject for private enterprise. Such a move must, therefore, be subject to a process that assures that conditions warrant such a move. This should be done only after appropriate hearings on the specific move and the Legislature has had an opportunity to review the proposal.

4. Expand the report required in page 4 to include complaints against the authority as an element for review.

   The fiscal activities of the authority are a reasonable measure of the financial activities and rate activities of the authority. An equally important activity is one that deals with how the authority treats those it serves. Complaints are one measure of a firm's success in its relations with the public. It should also serve to let the authority and the Legislature know how the public perceives the authority and the coverage it provides.

5. Change the cost-benefit analysis to biannual rather than triannual.

   A greater frequency of cost-benefit analysis is desirable. A two-year period would assure that each Legislature has an opportunity to see and review such information. The three-year approach would skip every other Legislature.

Spec. Asst. II

Glenn A. Olds, Commissioner

Date: 2-22-91

GAO/DK/dgl8929D
022291b

Department of Commerce & Economic Development / POSITION PAPER

SB 83: "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

This department is not in favor of this legislation as presently written.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

We believe that this legislation effectively puts the state in the insurance business as either an agent or as an insurer. It will adversely impact competition, and tends to create a monopoly either way. If the authority further concentrates insurance coverage in a single insurer as an agent or elects to become an insurer itself, other private insurers will be unable to continue to provide coverage at a reasonable expense level, thus resulting in higher costs of coverage. The remaining market will be too small to support more than a very few insurers, thus limiting choice and competition. It is unlikely they will be able to compete with the state.

The legislation will adversely impact insurance agents currently making a living at selling health insurance. No data is available to quantify this impact.

- Move AS 21 provisions to another title.
- Expand the report required in page 4 to include complaints as an element for review.
- Change the cost-benefit analysis to biannual rather than triannual.
- Provide for legislative oversight of any move to provider status.
- Eliminate regulatory oversight of the Authority by the Division of Insurance.

Spec. Ass't II

Glenn A. Olds, Commissioner

Date: 2-19-91

GAO/DK/dgl8929D
021591a

Department of Commerce & Economic Development / POSITION PAPER

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- Provide for legislative oversight of any move to provider status.
- Eliminate regulatory oversight of the Authority by the Division of Insurance.

Spec. Asst II

Glenn A. Olds, Commissioner

Date: 2-19-91

GAO/DK/dgl8929D
021591a

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

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JUL 05 1991

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.

APR 1 5 1991

Health Access & Cost Containment Council

April 12, 1991

Honorable Drue Pearce
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

RE: Senate Bill 83

Dear Senator Pearce:

The Alaska Hospitals & Nursing Homes Association, the Alaska Hospital Council, and the Alaska Medical Association have joined together to address the issues of health care cost and access.

Part of our effort has been the analysis of Senate Bill 83. (enclosed)
But more important, we offer our Council as a resource to the legislature on these complex and serious issues.

The Council will continue to meet over the summer with experts and participants alike, in an attempt to assist the legislature in solving these problems.

Sincerely,

Ray Schalow

Alaska Hospital Council · Alaska Hospitals & Nursing Homes Association · Alaska State Medical Association
4107 Laurel Street, Anchorage, Alaska 99508 (907) 562-2662 · FAX (907) 561-2063

Health Access & Cost Containment Council

POSITION PAPER
in re: SB 83
by
Joint Health Access and Cost Containment Council
Alaska Hospital & Nursing Home Association
Alaska Hospital Council
Alaska State Medical Association

We do not support Senate Bill 83, and would like to lay out the reasons for our opposition in a joint response by our three organizations, representing Alaska's hospitals, nursing homes and physicians. Our comments concern both the Health Care Cost Containment Task Force Report (or, HCCC Report) to the 17th Legislature, and its outgrowth legislation, SB 83.

We share a deep concern about the crisis of the uninsured and the increasing costs of health care. We have formed a working group to deal with the issues, the Joint Health Access and Cost Containment Council. Health care providers represented by this Council are committed to help solve the problem of ensuring access to health care for all Alaskans; we are equally committed to help find ways to contain health care costs and maximize effectiveness of health care dollars. In our judgment, SB 83 does not adequately address either of these broad commitments.

Before we comment on Senate Bill 83, we must first review the Health Care Cost Containment Task Force Report of February 1991 on which SB 83 is based. The report's major contentions are that Alaska health care costs are skyrocketing, and will be almost $10 billion by the year 2000; and that, the cause of this inflation is provider charges. SB 83 consequently proposes a reduction of those charges as the primary method of controlling health care expenditures. It also proposes, without saying how, to establish utilization standards to reduce the volume of services.

The HCCC Report is so poorly done that it is difficult to critique without redoing all the work. Throughout the report, statements are made without adequate data, sources are not referenced, the method selected for multiple data "adjustments" is not specified, the questionnaires used and the response rates are not shown. The report has an obvious slant, driven by alarmist costs for the year 2000, extrapolated from scanty data using unstated statistical methodology. *Since these projections are central to the HCCC Report's conclusions, it is imperative that the methodology used by fully revealed and completely justified.*

Alaska Hospital Council · Alaska Hospitals & Nursing Homes Association · Alaska State Medical Association
4107 Laurel Street, Anchorage, Alaska 99508 (907) 562-2662 · FAX (907) 561-2063

The projections seem to have been made by taking the rate of increase from a single year --1979-80-- and projecting forward for 20 years of compounded increases. However, the rate of increase on which the projections are based is in marked disagreement with the health care cost inflation rate given by the U.S. Bureau of Labor Statistics in the Consumer Price Index (CPI) for 1985-89. (See attached). These CPI figures actually show that the rate of increase in Anchorage is approximately one-half that shown in the Task Force's Report. It also shows that Alaska's rate is in line with the rate of medical inflation nationwide. *In fact, as the CPI shows, Alaska's rates in the recent past have increased more slowly than U.S. rates.*

The report fails to address other Alaska-specific factors impinging on cost increases. For example, during the 1970's and 1980's Alaska medicine was intent on catching up with the rest of the country in order to create the medical and technological infrastructure already in place elsewhere in the United States. In response to strong public demand, the health care community built coronary and intensive care units, developed an adequate emergency medical services and transport system, built newborn and pediatric intensive care units, acquired CT scanners and so on. Further the state greatly expanded the Pioneer Home system, nursing homes and schools, public health nursing and village aide programs; and thereby created increased expectations in rural and bush Alaska for high quality local services. These represented huge capital outlays and have clearly driven the costs of medical care upwards in Alaska.

Had these expenditures not been made, Alaskans would now be complaining loudly that our medical system is backward and inadequate, and that we need to spend the money immediately to improve it. *The money was spent, and it should have been spent--Alaska was a medically underdeveloped territory. These expenditures severely skew the Alaska cost increase curve.* The skewing is not automatically bad--it's just a reality of what it costs to cease being a medical backwater of Seattle. As the CPI figures show, now that we have made our initial investment, our rate of cost increases has slowed to keep step with the rest of the nation.

One of the most significant developments in health care insurance costs in Alaska is almost completely ignored by the HCCC Report: namely, that $20 million was saved in 1990-91 for state employee health insurance expenditures without any legislation at all and without the development of a huge state bureaucracy. During this period, some common modes of controlling costs were instituted: pre-admission review, effective case management and some increase in employee financial participation. Yet the report fails to take this decrease into account in making its alarmist extrapolations about state employee health costs in the year 2000. In fact, if we use the report's simplistic projection model, and take the very latest percentage change in rates, then project it linearly forward to 2000, we find predicted health care costs for 2000 *lower* than those of 1990! *An unlikely event, but the result of simplistic statistical modeling.*

The HCCC Report only gives lip service to other factors impinging on health care cost increases, even though these overshadow by far the effect of provider charges. Some of these other factors include: ever-growing social expectations -- and patient demands -- for the full use of every resource on every problem, coupled with capital-intensive technological breakthroughs; professional liability and defensive medicine issues; the huge resources spent to preserve life born too soon and to put off death for the mortally ill; and the unanticipated and massive health care expenditures resulting from the AIDS, violence and cocaine epidemics. These are all given only perfunctory attention, even though we providers see these as the real drivers of health care costs increases.

Purported to be a response to the problems identified in the HCCC Report, SB 83 does not meaningfully address the problem the Task Force identified as highest priority: the paramount question of access to care for the uninsured and underinsured. This is surprising, since the HCCC Report claims growth in this group from 40,000 to 90,000 in the last few years. And furthermore, publicity about SB 83 implies that the bill addresses this problem. In fact, SB 83 specifies neither how nor when this group will have health insurance, only that the problem will be addressed after July 1, 1992.

Despite the report's stated interest in reducing cost shifting, SB 83 will actually exacerbate the problem. It will further erode access and quality of care by further jeopardizing the economic viability of Alaska's rural hospitals. Already, many of these hospitals are serving a small number of patients, and barely make ends meet. Rural physicians depend on the existence of rural hospitals and nursing homes for a substantial part of their practice activity. Every patient without insurance generates costs for the hospitals and physicians, which are either included in charges to other patients who can pay, or are taken as losses by the hospitals and physicians.

The pool of employees covered under SB 83's Health Resources Authority (HRA) would be the last major group which can help bear the costs of care for the uninsured. *Medicaid and Medicare reimbursement already is at or below real cost.* If the HRA lowers the rate it pays for care of its beneficiaries, the costs for taking care of the uninsured cannot be passed along to others, nor made to vanish. The costs will be there, and will increase the losses taken by the hospitals, and by the physicians. The losses will reduce the margin of free care which health care providers will be able to provide to those with no resources, or even tip the fragile balance of financial viability of small hospitals and their physicians. These obviously make the problem of access even worse.

The HCCC Report's reference to the importance of controlling the costs of defensive medicine is ignored in SB 83. There is nothing in the way of tort reform, or any other solution. Some individual physicians are paying more than $100,000 a year for professional liability insurance. A family practitioner who agrees to deliver babies may pay more than $1000 per baby delivered for the obstetrical portion of his/her malpractice insurance. Some authorities estimate that the cost of medical care is inflated by as much as one-third by defensive medicine, which is further encouraged with each huge judgement or settlement. And the spiral of medical costs continues upwards.

The heart of SB 83 is fixing provider charges and establishing "utilization standards." Careful historical analysis of the establishment of fee schedules reveals almost nothing but failures. The establishment of fee ceilings invariably results in further inflationary pressures, as the ceiling automatically becomes the new "floor" which all providers will automatically charge, even those whose charges were originally lower than the ceiling. *We have cited source articles in our bibliography.* The establishment, maintenance and periodic revision of a fee schedule is a complex and costly undertaking, requiring a sizeable bureaucracy.

Our experience with fee schedules has been unpleasant. Fee schedules under other programs which at first appeared fair, and based on fair market rates, increasingly have become provider's-cost-based, and then payor's-budget-based, and so paper-laden, complicated and slow that no payment is sometimes better than the costs of collection. Fee schedules exacerbate access to care because some providers choose not to participate.

What would the establishment and implementation of utilization standards really mean? First, there currently *are* no generally accepted standards -- medicine is not an exact science. Some work has begun in this area, but it is early and largely untested. Second, assuming that such standards can be developed, then a bureaucracy must be established and hired to implement and enforce them. Due process for beneficiaries and providers must be developed and maintained. A large professional and paralegal bureaucracy will have to be established, which will likely cost more to sustain than whatever minimal savings may be realized.

Finally, SB 83 creates a government-run insurance bureau, whether or not the state actually gets into the direct insurance business of receiving premiums, reviewing claims, and making payments.

In short, SB 83 certainly will create a large bureaucracy and in our opinion is unlikely to reduce the cost of medical care in Alaska at all.

Health care providers in Alaska oppose SB 83. So what do we support?

* First, and foremost, we support and pledge to continue our participation in the establishment of a coherent health policy for Alaska. This must address access to health care as one of the basics. It must set goals for health status and spell out the skeleton of a health care system to which federal, state, and local government programs, as well as private health care providers can contribute. How can we know whether we have succeeded if we don't know where we are trying to go?

* Secondly, we support a high quality analysis of the Alaska health care system, using standardized methodology and uniform medical data. The discrepancies between the HCCC Task Force Report and our analysis must be resolved prior to the adoption of any legislation enacting changes.

* Third, we support watchful analysis and thoughtful observation of other state and federal proposed solutions to the problem of providing health care to all Americans at reasonable cost. We are a small state and can ill-afford to be out "on point" when larger states with more resources have been unable as yet to demonstrate a successful solution.

* Fourth, we support continued implementation of those cost-saving measures which have been demonstrated to reduce cost *without* increased regulation or the creation of state bureaucracies -- measures such as those which have already reduced the increase in health care insurance costs for state employees by $20 million in FY 1990 and frozen them in place for FY 1991.

* Fifth, we support immediate and concrete measures to deal with Alaska's uninsured that could include the establishment of basic medical benefits packages, mandated risk pooling for currently uninsurable individuals, and state subsidies of premiums for certain individuals.

* And finally, we support a mechanism that provides a forum for cooperation, dialogue and consensus among all levels of government, business, the uninsured, providers, Natives, and the general public.

For all of the reasons cited in previous pages, the Joint Health Access and Cost Containment Council and its constituent organizations representing Alaska's hospitals, nursing homes and physicians, respectfully request that the legislature not pass Senate Bill 83. We stand willing and ready to assist in whatever way we can with a thoughtful, careful analysis of Alaska's health needs and its current health system. We believe that the broadest base of agreement possible is the place to start, and that sound public policy will more certainly follow if we agree where we are trying to go.

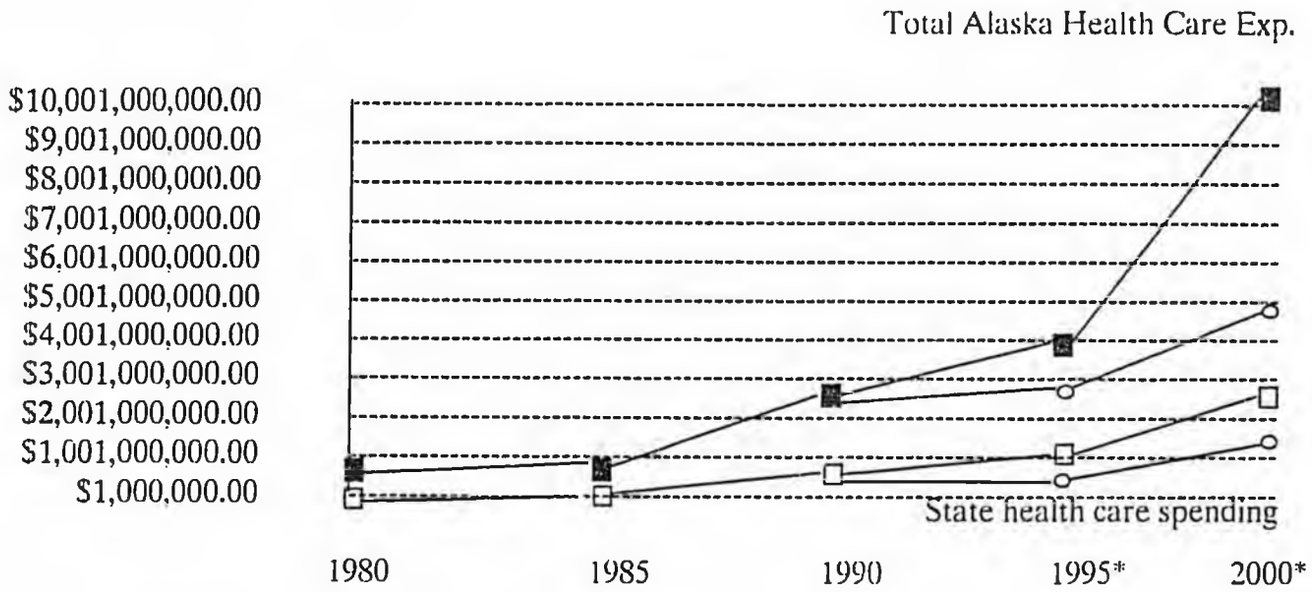
Respectfully submitted on behalf of the Joint Health Access and Cost Containment Council.

April 12, 1991

Health Cost Containment Task Force Exhibit

Source - Noble Lowndes

This exhibit demonstrates the rise in health care spending in Alaska from 1980 through the year 2000.



■ Illustrates total health care expenditures in Alaska

1980 = $576. million, 1985 = $852. million. 1990 = $1.608 billion
1995 = $4.0 billion*, 2000 = $10.0 billion*

□ Illustrates health care spending by the State

1980 = $75. million, 1985 = $175. million. 1990 = $350 million
1995 = $1.068 billion*, 2000 = $3.26 billion*

○ Revised to reflect corrected rate of increase

* estimate

Health Access & Cost Containment Council

January 9, 1992

The Honorable Jim Duncan & Johnny Ellis
Co-Chair
Health Resources & Access Task Force
P.O. Box Y
Juneau, Alaska 99811

Gentlemen:

The Alaska Physician/Hospital Health Access and Cost Containment Council (APHHACCC) looks forward to presenting and discussing with you on January 9, the following:

A) A proposed "Comprehensive Health Insurance and Payment Reform Act of 1992" (CHIPRA), and

B) The APHHACCC comparison of CHIPRA with SB 83, the Alaska Health Resources Authority Act.

We strongly urge you to support legislation that reflects the Task Force's combined concerns in simultaneously assuring access to care for all Alaskans and fiscal responsibility.

Please keep in mind that the current CHIPRA proposal is the work of the council's members and administrators. It needs your review and input, and it needs the review and input of health providers around the state. Working together, we can achieve meaningful health care reform in Alaska.

Sincerely,

Jennifer Christian, M.D.
Co-Chair, APHHACCC

Alaska Hospital Council · Alaska Hospitals & Nursing Homes Association · Alaska State Medical Association
4107 Laurel Street, Anchorage, Alaska 99508 (907) 562-2662 · FAX (907) 561-2063

Health Access & Cost Containment Council

THE COMPREHENSIVE HEALTH INSURANCE AND PAYMENT REFORM ACT OF 1992 (CHIPRA): AN OUTLINE FOR MODEL HEALTH CARE REFORM LEGISLATION

JANUARY 6, 1992

DRAFT

I: INTRODUCTION: The Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA) establishes access by the people of Alaska to a program of basic health care benefits that utilizes market forces to restrain spiralling costs. CHIPRA creates an insurance pool and a broad-based preferred provider organization through which providers agree to discount fees to pool members. Creation of the PPO is predicated upon fundamental tort reform, prompt payment of claims, uniformity of utilization review standards and use of a standard health claims form.

CHIPRA does not replace existing insurance programs, which remain free to compete with CHIPRA policies in the marketplace. CHIPRA can be utilized by the currently insured as well as by the uninsured and uninsurable. Small businesses may also participate.

Participation in the insurance pool is open to individuals and groups of employees on an elective basis. A single premium structure, based on sex and age, will be mandated regardless of group size. Funding will be by a combination of individual contributions, use of the Permanent Fund dividend on a sliding-scale based on income, and by a sales tax on the purchase of products associated with a high risk of disease or injury. A special tax on companies selling health insurance in Alaska but not offering CHIPRA policies is included as an additional revenue enhancement option. Insurance policies will be sold by private insurance agents or, in the case of large employee groups, can be purchased directly from the carrier. Any carrier may offer, and any insurance agent market CHIPRA policies, in much the same fashion that Alaska lending institutions market home mortgages sponsored by the Alaska Housing Finance Corporation in competition with traditional mortgage instruments.

CHIPRA's coverage provisions contain strong financial incentives for promoting preventive health services.

Alaska Hospital Council · Alaska Hospitals & Nursing Homes Association · Alaska State Medical Association
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A reimbursement and benefits review commission is established in order to negotiate fee discounts; recommend and publish reasonable, voluntary reimbursement schedules; publish a list of services or procedures that are not covered by the program; establish a set of uniform utilization review standards; and set payment ceilings for providers who increase charges in excess of the annual rate of increase of the Consumer Price Index, unless such increases can be justified to the Commission. Publication of the reimbursement schedule, coupled with mandatory disclosure of individual provider fee schedules upon patient request, will exert potent market pressures to eliminate "outlier" fees.

II: PROVISIONS

A. CREATION OF A REIMBURSEMENT AND BENEFITS REVIEW COMMISSION:

An independent commission shall be established and shall, on a defined, regular basis: review and amend the basic health benefits package; negotiate the provider discount; establish and publish a voluntary fee schedule for procedures; review and define non-covered services; review and define inefficacious services; establish a uniform set of utilization review standards; and collect, review and evaluate data on the performance and effectiveness of the program. The Commission shall be empowered (and funded) to hire nationally recognized expert consultants to assist it in these determinations. The results of these determinations shall be published and distributed to all Permanent Fund dividend recipients on an annual basis, along with the Permanent Fund dividend application.

Should the rate of increase in some providers' charges exceed the rate of increase of the Consumer Price Index for the most recent 12-month period, the Commission shall be authorized to invoke limiting charge levels on the providers involved, unless the increases can be justified to the Commission. This provision applies equally to individual and institutional providers.

The Commission shall consist of two representatives of each of the following interest groups: hospitals, physicians, employers, the health insurance industry and the public. Method of selection, terms of appointment, salaries, supporting staff and means of enforcing its decisions are to be defined.

B. DEFINITION OF HEALTH BENEFITS PLAN:

A basic but comprehensive health plan would be defined and adopted. The waiting period for pre-existing conditions shall not exceed one year. The plan shall be defined as the covered services currently provided to State of Alaska retirees, modified as follows:

1. Basic inpatient and outpatient services are covered according to the scope of coverage defined below. These include indicated laboratory and radiological studies.
2. The deductible and co-insurance shall be waived for approved routine preventive services to adults and for prenatal, well-baby and well-child care. Limits shall be imposed on the number of "waivered" services per calendar year.
3. Non-covered services:
   a: Dental care other than emergency extractions and repair of trauma.
   b: Corrective lenses other than after ocular surgery or for conditions other than myopia, hyperopia, presbyopia and regular astigmatism.
   c: Cosmetic surgery other than for major congenital deformities, trauma, cancer and related conditions.
   d: Inpatient care for substance abuse, other than for the immediate, life-threatening consequences thereof (lifetime benefit of one covered inpatient recreational drug overdose episode).
   e: Experimental treatments or procedures.
   f: Chiropractic services.
   g: Homeopathic and naturopathic services.
   h: Treatments or procedures defined by the Reimbursement and Benefits Review Commission as inefficacious or of doubtful value for the preservation of or improvement in the quality of life.

C. SCOPE OF COVERAGE: A deductible of $1000 per participant per year shall apply, with a maximum out-of-pocket limit of $5,000 per family. The plan will pay 80% of the balance after the deductible has been met. The deductible and co-insurance shall be on sliding scale for those receiving other low-income benefits and shall be waived for approved routine preventive care for adults and for routine prenatal and well-baby and well-child care. An annual limit shall be established for these "waivered" services. Participants may opt for lower deductibles and co-insurance, but the costs of such additional premiums shall be borne by the participant and/or the employer, and not by the pool. There will be a lifetime annual benefit limit of $1,000,000 per subscriber.

D. CREATION OF INSURANCE POOL AND PREFERRED PROVIDER ORGANIZATION; PAYMENT OF PREMIUMS; ELIGIBILITY:

1. An insurance pool is created to obtain coverage for its members at an initial discount of 5% below providers' charges to the Alaska Medicaid program for 1991. A participating provider may not collect more than 95% of such charges from all sources. New providers will be reimbursed at 95% of the average 1991 Alaska Medicaid charges for their geographic areas.
2. Individuals, employees and groups of employees are eligible to participate.

3. There shall be a waiting period of no more than one year for pre-existing conditions. Premiums will be based on age and sex, (no experience rating) although discounts shall be granted to non-smokers.
4. Premiums may be paid by a combination of employee/employer contributions, individual payments, or assignment of all or part of the Permanent Fund dividend. A sales tax on the purchase of products associated with a high risk of disease or injury shall be levied if actuarial studies or experience with the program reveal a shortfall. A tax may also be levied on companies selling health insurance in Alaska who do not offer policies under the CHIPRA program.
5. Any person wishing to participate in the program must be eligible to receive a Permanent Fund dividend.
6. All insurance carriers must pay, deny or challenge in writing claims within 15 working days of receipt by the all-payor claims clearing house (cf. item M), with interest penalties payable thereafter, provided the claim form is fully completed.

E. PROVIDER CHARGES: Providers shall maintain a single fee or charge schedule for services, except when separate schedules are a requirement of law or regulation, or when separate schedules are negotiated with an entity (not an individual or a family) purchasing or contracting for health services to a population group. This (these) schedule(s) shall be made available upon request to members of the group(s) to which they apply.

F. GENERAL HEALTH INSURANCE PROVISIONS (for CHIPRA and non-CHIPRA policies). All health insurance carriers doing business in Alaska shall:

1. Accept the 1992 revised HCFA 1500 form as the standard form for all claims.
2. Adopt the utilization review standards as defined by the Reimbursement and Benefits Review Commission.
3. Adhere to the same standards for claims payment as CHIPRA participants.

G: MEDICAL LIABILITY REFORM: Based on the uniform standards for medical malpractice cases outlined in the Health Equity and Access Improvement Act of 1991, central elements of malpractice reform under CHIPRA shall be:

1. Expedited medical malpractice settlements
2. Alternative dispute resolution,
3. Mandatory periodic payments of awards,
4. Caps on non-economic damages,
5. Limitation on attorney fees.
6. Several liability for non-economic damages
7. Uniform statute of limitations.
8. Protection for certain high-risk specialties (e.g., obstetrics).

H: STANDARDIZED UTILIZATION REVIEW MONITORING SYSTEM: All hospitals with a bed capacity in excess of 100 would be required to establish a multidisciplinary team whose purpose is to implement a utilization and outcome oriented approach to hospitalization, based on uniform guidelines established by the Commission. The hospital will provide annual reporting data to the Commission. The hospital will be at risk financially for prescribed standards of utilization and will be prohibited from billing any third party or patient for defined excess utilization. Third party utilization will be eliminated for large hospitals under this approach.

I: EMPLOYER PROVIDED COVERAGE: All employers having five or more full-time employees would be required to provide basic health insurance coverage to employees and their dependents through the basic health plan pool if they are not already providing other health insurance with the same basic benefits. Employers already providing other insurance may switch to a CHIPRA policy; differences in deductibles, co-insurance, etc. (if any) will then have to be settled between employer and employees on the same basis as any change in employee benefits.

J: COMPLIANCE BY ALL STATE AND FEDERAL AGENCIES: All federal and state agencies who are providing health care in Alaska shall comply with the same rules and regulations that apply to the private sector. This includes licensure and certificates of need, as examples. The intent of this provision is to begin the process of levelling the playing field as the Commission attempts to reduce rate of increase in health care spending.

K: CERTIFICATE OF NEED REFORM: The certificate of need law will be amended to require *all* institutional providers of health services to be in compliance with it.

L: HOSPITAL PRICE REVIEW: All hospitals will be required to submit annual rate information. The information will be in a prescribed format and will enable the Commission to measure the actual increase in rates proposed. Any hospital increasing its rates faster than the CPI must request a rate review hearing before the Commission. The results of the review will be made available to the public, in sufficient detail and clarity to justify the increase. An appeal mechanism shall be established.

M: ALL PAYOR CLAIMS CLEARING HOUSE: All claims for services provided under all insurance programs doing business in the state shall be submitted [electronically] to a single claims paying clearing house. The clearing house will process claims and remit payment within 15 days of entry into the system. In addition, the clearing house shall abstract claims data for routine submission to the Commission. Insurance companies operating in the state will bear the cost of the clearing house and will be prohibited from incorporating the costs into the group rating process.

N: MEDICAID ELIGIBILITY TECHNICIANS: All hospitals with more than 100 beds will be required to employ eligibility technicians for the purpose of providing assistance to the population; the technicians shall be deputized by the state to make eligibility determinations for Medicaid and GRM. The hospital will be required to adhere to all state requirements in the conduct of this activity. The intent of this provision is to provide greater access to the Medicaid and GRM programs, possibly increasing the number of enrollees and reducing the uninsured population.

O: LICENSURE: All institutional health care providers determined by the authority to be essential to the cost efficiency of the health care system will be required to obtain a state license. The state will establish minimum licensure standards for each type of institutional health care provider, and will require evidence that the provider, prior to being granted a new or renewal license, has conformed to the applicable certificate of need laws.

HEALTH ACCESS AND COST CONTAINMENT COUNCIL (HACCC)
JANUARY 4, 1992

COMPARISON OF HACCC'S COMPREHENSIVE HEALTH INSURANCE AND PAYMENT REFORM ACT (CHIPRA) WITH SB83

OVERVIEW: Health care reform is rapidly becoming the leading political issue in the U.S. Costs are growing rapidly. Many Americans are afraid to change jobs for fear of losing their coverage. Still others, as many as 37 million, are uninsured, and fear financial ruin in the event of a serious illness or injury. In Alaska, however, according to recent opinion polls, health care does not yet occupy first place. The purpose of HACCC's proposal, known as the Comprehensive Health Insurance and Payment Reform Act of 1992 (or CHIPRA) is to embark on comprehensive health care reform now, rather than when health care has reached true crisis proportions in Alaska as it already has elsewhere in the country. CHIPRA is based partly on previous legislative initiatives and on the recommendations of various work groups and task forces. CHIPRA assumes that all the participants in the health care debate will be willing to address objectively the multitude of problems that exist and be willing to achieve a workable compromise.

The HACCC's proposal is truly comprehensive, whereas SB83 represents a fragmented approach that deals only with provider price control and utilization review standards, mandated for a single segment of the already-insured: State employees. SB83 addresses real insurance reform, as well as the issue of coverage for all Alaskans other than State and other public employees on a "might do" basis. *In other words, SB83 mandates limited reforms only for services to public employees, while reform for services to everyone else, even limited reform, is contingent upon unspecified conditions.* The likelihood is that none of SB83's provisions will ever be applied to other Alaskans.

SB83 has been vigorously promoted as dealing with the uninsured, yet a careful reading of the bill reveals that this unfortunate part of our population is, in fact, left in the political never-never land of "maybe." To use the uninsured as a banner behind which to rally support for SB83, while in fact giving them little more than a political promise to perhaps do something in the future is less than forthright.

CHIPRA, on the other hand, makes the uninsured, underinsured and uninsurable its first priority. The Council believes that their needs take priority over the needs of State employees who already have more-than-adequate coverage. State employees are neither at risk of losing their health benefits nor of being financially ruined by illness or injury.

CHIPRA also provides insurance relief to small business as an integral part of its program, whereas SB83 addresses the needs of small business, like those of the uninsured, as a lower priority, to be accomplished only on a conditional basis.

What follows is a comparison of the two proposals detail by detail in tabular form.

CHIPRA	SB83
UNDERLYING PURPOSE:	
Comprehensive health care reform affecting all Alaskans, universal access, market-based price controls. CHIPRA advocates system-wide reform, with individualized price controls and utilization review standards being only two facets of a solution to a very complex problem.	Implementation of government price controls and utilization review standards for health services to public employees. SB83 advocates price controls as a precursor to system-wide reform, which the bill does not address.
WHAT IS PROPOSED:	
CHIPRA proposes comprehensive health care, health insurance, utilization review, provider payment and tort reform affecting *all* Alaskans. In so doing it assures universal access to a basic health benefits package. The second major difference between CHIPRA and SB83 is that CHIPRA provides coverage for the uninsured, underinsured and uninsurable as an essential element, not as a contingency to be addressed after the costs of insurance for State employees is controlled. State employees already have excellent health insurance, for which they pay no part of the premium. A third difference is that CHIPRA provides relief for small businesses as another essential element, not as a contingency	SB83 proposes control of provider reimbursements, insurance reform and imposition of an additional utilization review system only for State of Alaska and other public employees. Extension of reforms to others is purely discretionary. It does not assure universal access. In fact, the "must do" sections of the bill deal only with "public employees" and their dependents. Everything else is a "maybe." (Sec. 8, ¶c-e).
BASIC PRINCIPLES OF HEALTH CARE REFORM:	
CHIPRA defines a set of basic principles as an essential element in health care reform, as follows:	SB83 offers no clear definition of principles. This is a critical omission in any plan to reform the health care system.

CHIPRA	SB83
ACCESS: Each Alaskan should have access to high quality basic health care, defined later in the proposal.	
CHOICE: Consumers should have free choice of providers	
RESPONSIBILITY: Consumers must take responsibility for their lifestyle choices and be aware of the costs of these choices. Any health care reform must provide incentives to avoid abusive life styles and to obtain preventive care.	
COST SHARING: Consumers should share in meeting some of the costs of health care.	
MARKET ENVIRONMENT: A free market environment, with appropriate restraints on cost increases, allows alternative approaches and stimulates innovation, research and competition.	
CAPITALIZATION: Adequate capitalization of the health care delivery system must be assured	
STANDARDS: Covered services must be based on scientifically based, nationally recognized standards of acceptability and efficacy.	
PREVENTION: Successful reform must provide tangible financial incentives for seeking and obtaining preventive care	
DEFINITION OF BENEFITS PACKAGE:	
CHIPRA defines a basic health care benefits package. It says up front what is and is not covered.	No definition of a basic health care benefits package is provided.

CHIPRA	SB83
ELIGIBILITY:	
All Alaskans who qualify for the Permanent Fund dividend.	Only "public employees" and their dependents. "Other employers may elect to use the reimbursement system and utilization review standards, if the use is approved by the authority."
THE UNINSURED & SMALL BUSINESSES:	
CHIPRA provides coverage for the uninsured, underinsured and uninsurable as a first step. This provides true universal access. CHIPRA provides affordable insurance to small businesses as an essential ingredient of true health system reform.	The Health Authority "*may* begin to procure" insurance after July, 1, 1992 for the uninsured and for those not falling into the category of public employees. This provision leaves everyone outside the public sector--including the uninsured and small businesses--to the vicissitudes of political and budgetary contingencies. In other words, SB83's first priority is to takes care of the needs of those who already have excellent health insurance.
MEDICAL LIABILITY REFORM:	
CHIPRA mandates comprehensive tort reform as an essential element of health care delivery reform.	SB83 not only does nothing to reform medical liability, it actually *reinforces* the current liability system by factoring the costs of malpractice insurance into the new reimbursement system.
FUNDING:	
CHIPRA has a specific funding mechanism, utilizing a combination of the Permanent Fund Dividend program, employer and individual contributions, and a new sales tax on the purchase of products associated with a high risk of disease or injury.	SB83 has no specific funding provision. It mentions "potential savings if approximately 135,000 [public employees and dependents] participate" in the program. Monies for supporting the new State bureaucracy, the Alaska State Health Resources Authority, will be appropriated by the legislature.

CHIPRA	SB83
CREATION OF A NEW STATE BUREAUCRACY:	
CHIPRA creates a Reimbursement and Benefits Review Commission. Its membership will be from the public, insurance industry, providers and employers. On a regular basis it shall publish a voluntary fee schedule which shall be readily available to consumers; negotiate and renegotiate provider discounts; review and redefine, if necessary, covered and non-covered services and establish a unitary utilization review program for all health insurance programs in the state. The Commission will be authorized to fix fees should they rise faster than the Consumer Price Index. Even including staff, the Commission's size will be limited.	SB83 creates the Alaska State Health Authority (ASHRA) within the Department of Administration. It will develop and implement a fee schedule and utilization review standards that apply only to its beneficiaries. It has the authority to act as self-insurer, which gives it the potential for becoming a truly enormous bureaucracy. SB83's approach adheres to the philosophy that government can fix any problem, and that more and bigger government is better. No provision is made for publishing and disseminating the ASHRA fee schedule.
PROVIDER PAYMENT REFORM:	
Under CHIPRA each provider would be required to maintain a single, uniform fee schedule for all patients, initially defined as that provider's fees charged to the Alaska Medicaid program in 1991. The fee schedule would be available to patients upon request. Reimbursements under the CHIPRA insurance program would be at a negotiated discount from this fee schedule, initially set at 5%, but renegotiable annually. Should the rate of increase in some providers' charges exceed the rate of increase of the Consumer Price Index (CPI) for the most recent 12-month period, limiting charge levels will be imposed on the providers involved unless the rate of increase can be justified.	The insurance pool created by SB83 would set a standard fee schedule for all providers, by geographic area. There is no provision for negotiation or appeal of ASHRA's decisions. SB83, while citing economy of scale in purchasing group health insurance--a market mechanism--mandates complete government setting of provider reimbursements, with not even a token involvement of providers. A 60 day public comment period is provided initially, but there is no provision for future comments, much less negotiations. Even national health programs, such as Canada's, provide for regular negotiations with providers.

CHIPRA	SB83
The rate of increase in charges by institutional providers will be subject to a similar mechanism if the rate exceeds the increase in the CPI.	SB83 contains no provision for a uniform charge schedule nor for mandatory availability of the schedule upon patient request.
PROVIDER DATA REPORTING:	
CHIPRA and SB 83 are in agreement on the need for more information. CHIPRA wants data to judge efficacy of services and to restrain increases in costs.	CHIPRA and SB 83 are in agreement on the need for more information. But SB83's language suggests that ASHRA will utilize data as a sanctioning mechanism rather than as an equitable evaluation tool.
UTILIZATION REVIEW:	
CHIPRA mandates a single utilization review program for *all* health insurers doing business in Alaska. This would replace the current multitude of different, and sometimes contradictory utilization review programs.	SB83 introduces a new set of utilization review standards, *in addition to* all those already in place in the state.
BROAD INSURANCE REFORM:	
CHIPRA mandates community rating and ends exclusions for pre-existing conditions under its insurance programs; mandates the use of a single claim form for *all* insurers in the state; and speeds up processing of claims by imposing penalties for late payment on *all* insurers.	SB83's reforms apply only to public sector employees and their dependents. No mention is made of community rating, exclusion of pre-exisiting conditions, or a standard claims form.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

FOR IMMEDIATE RELEASE:
January 9, 1992

Contact: Harlan Knudson
Juneau 586-1790

A coalition of Alaska physicians and health care facilities has proposed a reform packages aimed at providing universal health coverage in the state.

The Health Access & Cost Containment Council, which includes representatives of the Alaska State Medical Association and the Alaska State Hospital & Nursing Home Association, has been working on the reform package for almost a year. Its proposal was unveiled today before the state's Health Resources and Access Task Force meeting in Juneau.

"We feel this plan offers Alaskans what they need most -- accessible, affordable, basic health insurance coverage," said Dr. Jennifer Christian, Anchorage, co-chair of the council.

"This proposal makes the uninsured, underinsured and uninsurable its first priority; other proposals have no concrete provision for uninsured Alaskans," said Dr. Christian.

Key parts of the Comprehensive Health Insurance and Payment Reform Act of 1992 (or CHIPRA) are formation of a reimbursement and benefits review commission to review fees charged by physicians, hospitals and other health providers.

The physicians' plan would be open to Alaskans with pre-existing conditions, and for all businesses employing three or more people. CHIPRA provides a basic plan for all Alaskans, enabling employers to build on the plan to maintain current levels of

(More)

coverage if they are higher than the basic plan. CHIPRA provides affordable insurance to small businesses as an essential ingredient of true health system reform. Eligibility would be based on qualifications for the Permanent Fund Dividend.

Funding for this pool would come from individual contributions, a portion of the Permanent Fund Dividend based on income, sales taxes on products associated with a high risk of disease or injury, and contributions from insurance companies and other providers.

CHIPRA promotes preventive care by fully covering routine preventive care, such as well baby check-ups.

The bill would require hospitals to have a single price or charge schedule for all patients, CHIPRA and otherwise.

Other parts of the proposal include an annual hospital price review, and a medical liability reform package which incorporates alternative dispute resolutions, expedited medical malpractice settlements and other concepts which have been introduced in national reform proposals. It streamlines claims processing by creation of both a single claim form to be used statewide, and a central claims clearing house.

"It's important to realize that, in order to arrive at this proposal, all of those in the arena of health care had to give up something," said Dr. Christian. "Hospitals and physicians will submit to control of the rates they may charge, and limit rate increases to consumer price index levels or face penalties; employers may have some additional costs. Community rather than employee group-rating will be required of insurance companies."

"But the end result is well worth it, and we hope that by seeking compromises from everyone, we have a workable package that will be approved by the Legislature."

# # # #

HIAA

Health Insurance Association of America

April 8, 1991

Senator Drue Pearce
Chairperson, Senate Labor and Commerce Committee
Alaska State Senate
P.O. Box V
State Capitol
Juneau, Alaska 99811

By facsimile

Dear Senator Pearce:

Gordon Evans has relayed to me your request for HIAA input on the impact of several proposed amendments to SB 83. HIAA is opposed to SB 83 and we do not believe the proposed amendments improve the bill, in fact several of the proposed amendments intensifies our opposition toward the bill. The following is our interpretation of the impact of the proposed amendments. The working draft dated March 19 was used as the basis of the areas to be discussed.

1. Page 1, lines 6-7 Phased-in geographic specific health care provider reimbursement systems and utilization standards.

HIAA is unable to give you the specific dates for each of the phased-in geographic regions, and the impact on the different Alaskan regions. The impact on the provider communities would be best obtained from the provider organizations themselves. However, the impact on the insurance companies which would be required to use these systems for their Alaskan policyholders would be substantial. Each insurance company has invested millions of dollars in their own systems. Requiring an Alaskan-unique reimbursement and utilization systems to be implemented will require major modifications to the various systems resulting in substantial financial investments.

2. Page 5 lines 6-12 Components that the reimbursement systems must include as a minimum.

Subsections (A), (B), (C), (D) and (G) are all part of the proposed Medicare Resource-based Relative Value System (RBRVS). To the best of our knowledge subsections (E)--availability of the services modifier--and (F) uncompensated care net cost are not included in the program being developed by HCFA. The creation of an Alaskan-unique system, i.e. variation from the Medicare RBRVS will further delay the implementation time, not only for the Authority but also for insurance companies which will be required to modify their computer reimbursement and utilization systems. A minimum of 12 months will be required for the modifications once

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the Authority develops the system and disseminates the information. This time frame may well be inadequate for many small and medium sized companies. The RBRVS has 7,000 different procedures for which values must be assessed. If these are to vary by geographic regions this will require multiplying the 7,000 procedures by the number of different regions. We are still uninformed as to the number of geographic regions Medicare plans to have nationwide, let alone the number of regions planned for Alaska, either by HCFA or by the Authority.

I believe the intent of SB 83 is to set rates and utilization standards for all health care providers, not just physicians and hospitals. The RBRVS does not cover providers other than physicians. If the Authority is to set rates for allied health practitioners, i.e., chiropractors, dentists, podiatrists, psychologists, etc. this will take additional time and an immense effort by the Authority staff.

The RBRVS is supposed to begin phased-in implementation as of January 1, 1992. The five-year phased-in approach is based on phasing in the Medicare fee schedule from the current payment system over a period of time to soften the impact of the different reimbursement approach. The phase-in is not based on geography, i.e. urban areas before rural areas. The final regulations were expected to be published in the Federal Register on April 1. As of the date of this letter the regulations were not published. In addition, the Physician Payment Review Commission annual report to Congress was also supposed to be available by April 1 as it is to be based on the final regulations. This report has also not been released. For additional information on the RBRVS and Physician Payment Review Commission I have attached a copy of an HIAA 1990 descriptive bulletin to our members.

3. Page 5, line 31 The Authority's authority to design and procure or provide a basic health insurance program.

There are major negative implications of making the Authority's authority additive by allowing it to design and procure or provide a basic health insurance program for employers who elect to participate and (1) who have 50 or fewer full-time employees; (2) have been refused coverage by two or more health insurance carriers within the past 12 months; and (changing to or) (3) have not provided health insurance coverage to their employees in the past 12 months. The additive effect makes the Authority's area of responsibility all that more encompassing as any one of the three conditions need to be met rather than all three as originally proposed. This puts the Authority in direct competition with the private insurance market.

The purpose of SB 242, HIAA's small group market reform proposal is to assure that small employers will no longer be denied access to coverage. With SB 242 no employer, even those

with high risk employees would be denied access to the private insurance market. Under Section 21.55.120 guaranteed issue carriers would insure these higher risk groups and would have a private not-for-profit reinsurance mechanism standing behind it. Any small employer group who went to a non-guaranteed issue carrier, and it did not want to insure the group, they are required to provide the employer with the list of the guaranteed-issue carriers, produced by the board of the Small Employer Health Reinsurance Association (section 21.55.030). Nationally, two-third's of the uninsured are employed by or are a dependent of someone employed by an employer with 25 or fewer full-time employees. We would assume this would be the same or greater for Alaska. SB 242 is structured for employers with 25 or fewer employees. To keep the cost of these small employer plans affordable, SB 242 includes various provisions for rate bands allowing for specific maximum variance from the individual insurance company's midpoint as well as variances between industries and year-to-year increases (section 21.55.050). To further make the health plans affordable SB 242 also includes various cost containment provisions, including a provision allowing the plans not to include any state imposed mandated coverages or providers except for those included in the Act; and prevents any impediments to managed care components within the small employer health plan.

4. Page 9 lines 19-21. Legislative affirmation prior to the Authority becoming the provider of insurance.

We are encouraged by the amendment requiring the legislature to affirmatively approve any proposal by the Authority prior to its becoming the provider of insurance. However, the concept of the state becoming the insurer is one we strongly oppose whether or not the legislature gives prior approval. We strongly believe the private insurance sector can do a better job than another state bureaucracy to provide accessible, affordable, quality, health coverage to the people of Alaska. SB 242 is the better vehicle to achieve that objective.

I hope these comments are of assistance to you. If I may be of any further assistance please do not hesitate to contact me.

Sincerely,

Jan Andrea Meisels

Jan Andrea Meisels
State Affairs Associate

JAM/bhs

cc: Gordon Evans

attachment

HIAA

Health Insurance Association of America

INSURANCE, MANAGED CARE AND PROVIDER RELATIONS BULLETIN

#2-90 - March 23, 1990 **MEDICAL RELATIONS**

PHYSICIAN PAYMENT REFORM LEGISLATION

SUMMARY

As part of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), Congress enacted comprehensive reform of Medicare physician payment. The reform includes four components that are interrelated both politically and substantively.

- Medicare's reasonable charge method of determining payment amounts will be replaced by a resource-based fee schedule in 1992.
- To provide financial protection to beneficiaries, the cumbersome and complex system of maximum actual allowable charge (MAAC) limits will be replaced by a uniform charge limit that is a percentage of the fee schedule amount.
- The fee schedule conversion factor, which attaches dollar amounts to relative values, will be updated on the basis of Medicare Volume Performances Standards (MVPS).
- Finally, the legislation created a program for research on effectiveness of medical services and development and dissemination of practice guidelines and a new Agency for Health Care Policy and Research (AHCPR) to administer it.

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MEDICARE FEE SCHEDULE

In January 1992, the Medicare program will begin to replace the current payment system that bases fees on what physicians charge with a fee schedule that reflects the resources used in efficiently providing services to patients. That policy is intended to realign payments that, under a charge-based system, have come to overvalue most surgical and technical procedures relative to visits and consultations. Over a five-year transition period, the fee schedule will play an increasingly important role in determining what physicians are paid.

Relative Value Scale

The relative value scale (RVS) indicates the value of each service relative to other services. The RVS is translated into a schedule of fees when it is multiplied by a dollar conversion factor and a geographic adjustment factor that indicates how fees should vary from one locality to another. The fee schedule does not include specialty differentials.

The resource basis of the Medicare Fee Schedule is embodied in the relative value scale. The RVS will have three cost components: "physician work" that reflects the time and intensity of the physician's effort in providing a service; a "practice expense" that includes costs such as office rent, salaries, equipment and supplies; and "malpractice" that reflects professional liability premium expenses. While the proportion of a relative value represented by each component varies by service, on average physician work accounts for slightly more than half the relative value.

Coding

When physicians submit claims for payment from the Medicare program, they use a system of codes to describe the services they provided. The use of these codes by both the Medicare carriers who process the claims and physicians who file them has varied widely. Differences in the interpretation of codes theoretically can be accommodated under the current charge-based system since it is possible for fees to vary to reflect those differences. But a fee schedule places different requirements on the coding system. With a single relative value assigned to each service nationally, coding definitions must be standardized and widely understood so that codes are applied uniformly by all who use them.

Two areas that have been particularly problematic are standardizing coding policies for surgical procedures and clarifying the definitions of codes used for physician visits and consultations. The legislation recognizes the need for coding reform by calling for HHS to develop a uniform coding system. It specifies that payment for surgical procedures should reflect a global service definition that encompasses pre- and post-operative services. It also instructs HHS to establish a coding structure for visits and consultations that allows for accurate assignment

of relative values, especially with regard to time spent, in the fee schedule. Within this framework, Congress has left the design of the coding policies to HHS, directing the Department to consult with the Physician Payment Review Commission (PPRC).

In addition to analyzing data from the Hasio study and conducting its own survey of physicians, the PPRC has relied heavily on consensus panels of surgeons and medical directors of Medicare carriers, to develop recommendations for coding reform. Over the next year, it will continue its work to apply that definition to each surgical procedure and to assign relative work values that accurately reflect the policy.

Recently, the PPRC, in collaboration with the American Medical Association, began a consensus process involving physicians, insurers, other health professionals and consumers to take up the issues raised in the legislation about reforming the coding system for office visits and consultation. The Commission expects to draw on this work in consulting with HHS and in developing recommendations to Congress.

Transition to the Medicare Fee Schedule

The legislation calls for a five-year transition from the current payment system to the Medicare Fee Schedule, the first step of which is particularly significant. Fees for services in a locality whose 1991 payments, as defined by the legislation, are within 15 percent of the fee schedule will shift to the fee schedule amounts in that first step.

For services whose payments do not move to the fee schedule in the first year, the remaining differences between their recognized payment amounts during the transition and the fee schedule amount will be reduced by 25 percent in 1993, 33 percent in 1994 and 50 percent in 1995. In 1996, all payments will be based on the fee schedule.

Conversion Factor

In the first year of the transition, the conversion factor is to be set so that estimated expenditures under the fee schedule for 1992 equal estimates of what expenditures would have been if the current payment system had continued. Assumptions made about physicians' responses to these changes will be a key factor in determining what the conversion factor will be. The research upon which to make these assumptions is limited. Available studies do suggest, however, that the impact on physicians from both increases and reductions in fees will be partially offset by changes in the volume of services.

In subsequent years, the fee schedule will be adjusted for inflation and other factors through annual updates. The Medicare Volume Performance Standard policy described below outlines the factors to be considered and the process for updating fees.

BENEFICIARY FINANCIAL PROTECTION

Medicare has always allowed physicians to charge patients more than the approved Medicare payment amount--often called "balance billing." The payment reform legislation continues that policy, while placing stricter and clearer limits on what physicians can charge. The policy standardizes the percentage by which charges can exceed the fee schedule amount, replacing a complicated system of physician-specific charge limits know as maximum allowable actual charges (MAACs). In 1991, physicians will no longer be able to charge patients more than 125 percent of the Medicare fee. This will decline to 120 percent in 1992 and 115 percent in 1993 and thereafter.

This policy is expected to reduce the number and size of balance bills substantially.

MEDICARE VOLUME PERFORMANCE STANDARDS (MVPS)

The MVPS policy is the major component of the payment reform to address the problem of aggregate costs. The fee schedule conversion factor will be updated on the basis of how expenditure increases compared to a previously determined goal. This policy draws heavily on the expenditure target (ET) proposal developed by the PPRC.

MVPS policy expresses Congress' determination to slow the growth of expenditures to an affordable rate. By basing fee updates on how expenditure growth compares to a target, the medical profession is given a collective incentive to constrain costs. While these incentives are not intended to influence the decisions of individual practitioners directly, they are likely to spur physician organizations, such as the American Medical Association, national specialty societies, and state medical associations, to focus on cost containment.

The MVPS will be the federal government's principal tool to control aggregate spending on physician services in Medicare. Once a specific target for the rate of increase in expenditures is adopted, fee increases two years later will be adjusted up or down. The ability to set a target does not imply long-term control over costs, however. If expenditure growth is slowed more through reduced fee updates than through slower growth in service volume, the increasing divergence between Medicare fee levels and those of private insurers could limit the federal government's ability to control growth in spending without compromises of access to care.

The specifics of the MVPS policy are complex because Congress decided to leave very little discretion to HHS in the implementation of the policy. The legislation calls for the Congress to make annual decisions on the performance standard (the target rate of increase in expenditures) and on the conversion factor update. But leaving these decisions to Congress requires provisions about concerning what will happen if Congress does not

act. Thus, the legislation contains a series of formulas that HHS will use to determine the standard and the update if Congress does not specify it each year.

While those who drafted the legislation envision that Congress will act each year, the default formulas are very important. First, they signal Congress' current thinking about the appropriate level of the performance standard and how the subsequent conversion factor update will depend on it. Second, the presence of a default option will influence deliberations as various parties weigh potential options in comparison to the default formulas.

A number of significant decisions about MVPS were left for the future. One concerns whether there should be subnational performance standards and updates. The legislation takes a step in this direction by calling for HHS to recommend a separate standard each year for surgery, but the default formulas specify only national standards and updates. A separate performance standard has a theoretical advantage of providing additional impetus to surgical specialty societies to contain costs, but it risks causing the relative values between surgery and other services to diverge from the resource basis of the fee schedule. In addition, the ability to set differential performance standards in an objective manner is questionable. While the legislation provides an avenue to move to subnational performance standards based on type of service, the key decisions will be made in 1990 or 1991.

Performance standards could be set at the state level as well. State standards would emphasize the role of state-level organizations.

RESEARCH AND DISSEMINATION TO IMPROVE CLINICAL PRACTICE

The third component of the payment reform legislation expanded federal support and dissemination of health care research. It established the Agency for Health Care Policy and Research (AHCPR) and gave it a broad charge to conduct and support research on the quality, appropriateness, effectiveness and cost of health care services, and to use the results of this research to promote improvements in clinical practice and in the organization, financing and delivery of health care services.

The new agency, a component of the Public Health Service that reports directly to the Secretary of Health and Human Services, assumes the responsibilities of the National Center for Health Services Research and Health Care Technology Assessment (NCHSR), which was abolished. While many of the programs are similar to those carried out by NCHSR, the scope is greater, the funding higher and the emphasis different. Effectiveness and outcomes research are more prominent, and there is a specific program to develop and analyze large clinical data bases such as those generated through Medicare claims. There is much greater emphasis on disseminating information generated through research on

clinical practice, especially a program to develop and disseminate practice guidelines, clinical standards, review criteria and performance measures. The attached bulletin describes in detail the new agency's activities.

IMPLICATIONS OF THE REFORM

If the payment reform were to be described in one phrase, it might be "rationalization" of fee-for-service practice. The fee schedule seeks to rationalize the pattern of payment by making incentives to physicians more neutral. For example, physicians now have financial incentives to perform procedures rather than to provide evaluation and management services and to specialize in the more procedurally-oriented components of medicine. With payment based on relative resources, physicians do not have an economic incentive to go in one direction or the other.

Effectiveness and outcomes research generate a second force to rationalize care. As understanding of effective and appropriate practice increases, it can be translated into medical practice guidelines. While most physicians will respond to this opportunity to improve their practices, education will be reinforced by utilization and quality review using improved criteria. Utilization review will also provide a financial incentive to eliminate medically unnecessary or inappropriate services. Volume performance standards provide the government some measure of control over outlays and give the medical profession a collective incentive to take steps to increase the appropriateness of medical practice.

The reform attempts to enable fee-for-service medicine to continue by diminishing its tendency to significantly increase costs. Rather than engineer a 180-degree change in incentives to physicians, as capitation for all Medicare beneficiaries would, the reform seeks to stimulate increased professional activity to define efficient medical practice and encourage physicians to practice that way. Administrative activities, such as utilization review, are used as reinforcement.

While the orientation of the reform is toward improving fee-for-service care, it does not discourage alternative delivery systems, such as HMOs, which will continue to compete with fee-for-service and benefit from the effectiveness research and practice guidelines. The competition between fee-for-service and HMO payment will continue, based on factors such as which sector can do a better job of controlling costs in a manner that satisfies both patients and physicians.

While some believe that the reform provisions are revolutionary, many aspects of the policy are logical extensions of policy changes enacted over the past five years. For example, departures form charge-based relative values began in 1986 with reductions in payment for cataract surgery. Restrictions on physician charges began in 1984 when charges were frozen along with Medicare payments.

Basing fee updates on comparisons of expenditure increases with what is judged affordable has been pursued on an ad hoc basis ever since. A number of specialty societies have developed and disseminated practice guidelines. The payment reform policy builds on these relatively fragmented efforts by combining them and pursuing them with greater determination and purpose.

Implementation of these policies over the next few years will require effort as well as further policy decisions. While major decisions about fee schedule have been made, much analysis remains to be done, MVPS policy is the least developed. Congress will not only have to confront issues such as subnational targets but is likely to hear disparate advice from private payers concerning how MVPS affects them and whether the fee schedule and MVPS should apply to their payment policies.

Cost shifting to private insurers is likely to occur. However, its impact may not be severe because insurers will be able to anticipate the phase-in of the RBRVS system by adopting parts of the relative value scale or the whole package, and tightening utilization review and management programs by using practice guidelines to define and identify appropriate care for policyholders.

* * * * * *

For further information, contact:

Joel E. Miller, Deputy Director
Insurance, Managed Care and Provider Relations Division
(202) 223-7836

GORDON EVANS

SB 83/HB 71 - State Health Insurance Pool. Introduced 1/23 by Duncan and Zharoff, SB 83 is intended to implement recommendations of the Health Care Cost Containment Task Force (HB 71, the House version, was introduced on 1/24 by Representative Boyer and Navarre). The bill would create an Alaska State Health Resources Authority to provide the "lowest cost comprehensive health insurance" on a group basis, report annually on its activities, and review certificates of need for new or expanded health facilities.

The legislation would:

1. Create an independent state corporation, the Alaska State Health Resources Authority, with a board of nine members appointed by the Governor with at least one but no more than two members representing: the executive branch, labor organizations, school districts, municipalities, private sector employers and health care providers;

2. Require the authority to establish mandatory "health care provider reimbursement system and utilization standards" for the state, municipalities, and school districts by July 1, 1992;

3. Require the authority, "no earlier than July 1, 1992," to establish a group health insurance pool to provide health insurance to eligible employees of the state, a municipality, or a school district if the employer has elected to participate; the authority may provide health insurance to other (private) employers if they elect to participate and use the reimbursement and utilization standards; and

4. Require that if the state, municipality, district or other employer elects to participate in the group insurance coverage, then it must continue to participate unless a waiver is granted by the authority; a waiver may be granted if the employer can document by a time certain that it can match the "minimum benefit and financial standards set by the authority."

The intent of the legislation is to address a significant problem faced by many employers, including municipalities - the growing cost of health care and insurance for their employees. The Task Force, as stated in its draft report, found that:

- Health care expenditures in Alaska have increased 157.2 percent over the last 10 years, the second highest in the nation.

- The health care expenditures portion of the State of Alaska budget is the fastest-growing component of the whole budget, $385.5 million in FY 90 and, at this pace, will exceed $2 billion in FY 95.

- The number of uninsured residents in Alaska has increased at an alarming rate to an estimated 90,000 uninsured residents, representing 16.5 percent of the total population in Alaska.

- The cost of providing health coverage for state employees and their dependents has been reduced and stabilized at $385.00 for FY 90 and 91.

Some concerns:

1. **Mandatory payment and utilization schedules:** Although participation in the health insurance pool is not required, use of payment and utilization schedules for medical procedures, etc. set by the authority is. This means presumably that the state will provide a list of doctors, hospitals, and insurers which agree to the rates set by the state. If you use one of these for medical services, you will be fully reimbursed up to the limits of your coverage. The legislation does speak to setting the rates based on "geographic regions, actual provider costs and availability of service."

Even with the estimated potential of 135,000 employees, is the pool large enough to affect the cost of care? Are there enough health care providers to make them want to participate?

2. **Alternatives:** What is the impact on municipalities and their ability to negotiate with a private insurer if the rates are set by the state but they elect not to participate in the state system? How does the system set up in the legislation affect collective bargaining? Will the "minimum benefit and financial standards" negotiated meet the needs and the budgets of all potential employers that do or want to participate, using the current state health benefits as an example?

3. **Representation:** Why does the definition of "employer" include "a collective bargaining unit"? The legislation states that the Board of the authority shall be made up of representatives of the executive branch, municipalities, school districts etc. but it does not specify "employers" versus "employees."

4. **Getting out of the pool:** What is the timeline to "match" the state program when applying for a waiver? Can an employer get an "apples to apples" quote? Should there not be the provision (added to the legislation last year at our request) to at least allow an employer to get out of the pool if it could no longer provide <u>any</u> health care benefit?

HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unbeknownst to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

Health Insurance Association of America

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SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.



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SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1990

(1) **Typical Employer**[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate which amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

Low Risk Employer - While a second employer has similar demographic, area and industrial composition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

(3) **High Risk Employer** - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1991

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1990 to 1991) is 12 percent.

(4) **Typical Employer** - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1990 and submitted major claims. From 1990 to 1991, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be nc more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

(5) **High Risk Employer** - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1991 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1991 mid-point rate of $224), which amounts to an increase from 1990 to 1991 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer

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[1] By "typical" we mean a small employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

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October 1990

STATE OF MARYLAND

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HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

February 15, 1991

Ms. Jan Meisels
HIAA
6052 Hackers Lane
Agoura Hills, California 91301

Dear Jan:

Enclosed, as requested, is a copy of the Annual Disclosure Report released by the Commission at its February 6, 1991 public meeting. You have also asked for information regarding the budget of the Commission. The proposed FY92 budget for the Commission is $1,885,385. Health General Article Section 19-207.1 authorizes the Commission to include two-thirds of this budget amount in the rates approved by the Commission. Hospitals collect this money from the payors and reimburse the state annually.

Should you have any additional questions, please feel free to contact me.

Sincerely,

John M. Colmers
Executive Director

enc.

generalkmeisels

TTY for The Deaf
Baltimore Area 383-7555
D.C. Metro Area 565-0451

THE AMERICAN HOSPITAL ASSOCIATION

AHA Hospital Statistics

A Comprehensive Summary of U.S. Hospitals

1990-1991

AHA

Table **5C** (Continued) Alaska

Utilization, Personnel, and Finances in States

Excludes AHA nonregistered hospitals (see Table 14, page 230).

CLASSIFICATION	HOSPITALS	BEDS	ADMISSIONS	INPATIENT DAYS	ADJUSTED PATIENT DAYS	OCCUPANCY, percent	AVERAGE DAILY CENSUS	ADJUSTED AVERAGE DAILY CENSUS	AVERAGE STAY, days	SURGICAL OPERATIONS	OUTPATIENT VISITS			NEWBORNS	
											Emergency	Other	Total	Bassinets	Births
ALASKA	27	1,932	57,630	399,539		52.4	1,012			37,224	220,076	1,024,160	1,244,236	207	10,537
6-24 beds	6	110	2,567	14,883		36.4	40			1,459	13,750	75,315	89,065	25	52
25-49	8	274	6,712	46,161		46.0	126			2,714	32,517	138,493	171,010	33	1,35
50-99	8	551	18,536	100,622		50.1	275			9,628	85,067	516,172	601,239	69	3,07
100-199	3	419	11,272	100,734		65.9	276			11,004	29,808	219,074	248,882	33	2,04
200-299	1	238	6,210	31,614		36.6	87			5,314	24,253	43,294	67,547	18	1,32
300-399	1	340	12,303	75,619		60.9	207			7,075	34,681	31,812	66,493	24	2,24
400-499	0	0	0	0		00.0	0			0	0	0	0	0	0
500 or more	0	0	0	0		00.0	0			0	0	0	0	0	0
Psychiatric	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Hospitals	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Institutions for mentally retarded	0	0	0	0		00.0	0			0	0	0	0	0	0
General	24	1,658	55,483	302,448		49.9	828			37,224	219,245	1,017,865	1,237,110	207	10,53
Hospitals	24	1,658	55,483	302,448		49.9	828			37,224	219,245	1,017,865	1,237,110	207	10,53
Hospital units of institutions	0	0	0	0		00.0	0			0	0	0	0	0	0
TB and other respiratory diseases	0	0	0	0		00.0	0			0	0	0	0	0	0
Obstetrics and gynecology	0	0	0	0		00.0	0			0	0	0	0	0	0
Eye, ear, nose, and throat	0	0	0	0		00.0	0			0	0	0	0	0	0
Rehabilitation	0	0	0	0		00.0	0			0	0	0	0	0	0
Orthopedic	0	0	0	0		00.0	0			0	0	0	0	0	0
Chronic disease	0	0	0	0		00.0	0			0	0	0	0	0	0
All other	0	0	0	0		00.0	0			0	0	0	0	0	0
Federal	7	395	16,712	77,299		53.4	211			10,801	67,243	726,861	814,104	74	3,088
Psychiatric	0	0	0	0		00.0	0			0	0	0	0	0	0
General and other special	7	395	16,712	77,299		53.4	211			10,801	67,243	726,861	814,104	74	3,088
Nonfederal	20	1,537	40,918	297,334		52.5	801			26,423	132,833	297,299	430,132	133	7,447
Psychiatric	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Hospitals	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Institutions for mentally retarded	0	0	0	0		00.0	0			0	0	0	0	0	0
TB and other respiratory diseases	0	0	0	0		00.0	0			0	0	0	0	0	0
Long term general and other special	0	0	0	0		00.0	0			0	0	0	0	0	0
Short-term general and other special	17	1,263	38,771	225,149		48.9	617			26,423	132,002	291,004	423,006	133	7,447
Hospital units of institutions	0	0	0	0		00.0	0			0	0	0	0	0	0
Community hospitals*	17	1,263	38,771	225,149	310,393	48.9	617	850	5.8	26,423	132,002	291,004	423,006	133	7,447
6-24 beds	4	80	1,157	10,665	16,939	36.3	29	46	9.2	915	3,462	15,574	19,036	18	336
25-49	5	209	5,019	36,926	61,926	48.3	101	171	7.4	1,820	19,634	57,319	76,953	37	1,114
50-99	6	275	9,458	48,825	69,454	48.7	134	190	5.8	4,300	37,002	50,975	87,977	25	1,309
100-199	1	121	5,584	29,500	30,839	48.8	59	84	3.9	6,398	17,970	92,030	110,000	18	1,119
200-299	1	238	6,210	31,614	38,414	36.6	87	105	5.1	5,314	24,253	43,294	67,547	18	1,325
300-399	1	340	12,303	75,619	92,871	60.9	207	254	6.1	7,075	34,681	31,812	66,493	24	2,244
400-499	0	0	0	0	0	00.0	0	0	0.0	0	0	0	0	0	0
500 or more	0	0	0	0	0	00.0	0	0	0.0	0	0	0	0	0	0
Nongovernment not-for-profit	6	780	26,836	156,136	218,930	54.9	426	599	5.8	18,389	92,534	211,740	304,274	75	5,070
Investor-owned (for profit)	1	238	6,210	31,614	38,414	36.6	87	105	5.1	5,314	24,253	43,294	67,547	18	1,325
State and local government	8	245	5,725	37,399	53,049	41.6	107	146	6.5	2,720	15,215	35,970	51,185	40	1,052

Table 44 through 60, pages 14 through 17

Table 5C (Continued) Alaska

CLASSIFICATION	FULL-TIME EQUIVALENT PERSONNEL					FULL-TIME EQUIVALENT TRAINEES			EXPENSES						
									LABOR				TOTAL		
	Physicians and Dentists	Registered Nurses	Licensed Practical Nurses	Other Salaried Personnel	Total Personnel	Medical and Dental Residents	Other Trainees	Total Trainees	Payroll (in thousands)	Employee Benefits (in thousands)	Total (in thousands)	Percent of Total	Amount (in thousands)	Adjusted, per Admission	Adjusted, per Inpatient Day
ALASKA	256	1,451	217	4,390	6,314	7	15	22	$ 213,275	$ 42,665	$ 255,940	57.3	$ 446,996		
6-24 beds	27	70	13	282	392	3	0	3	10,171	1,851	12,023	60.7	19,796		
25-49	26	166	23	595	810	1	0	1	23,646	4,539	28,185	59.2	47,637		
50-99	123	357	94	1,438	2,012	2	0	2	58,196	10,560	68,756	64.0	107,396		
100-199	79	371	31	833	1,314	0	15	15	51,055	9,971	61,026	65.8	92,697		
200-299	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997		
300-399	0	360	26	912	1,298	0	0	0	46,721	10,728	57,449	51.1	112,464		
400-499	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
500 or more	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Psychiatric	10	105	7	360	492	0	0	0	14,498	4,215	18,713	61.9	30,238		
Hospitals	10	105	7	360	482	0	0	0	14,498	4,215	18,713	61.9	30,238		
Institutions for mentally retarded	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
General	246	1,346	210	4,030	5,832	7	15	22	198,777	38,450	237,227	56.9	416,748		
Hospitals	246	1,346	210	4,030	5,832	7	15	22	198,777	38,450	237,227	56.9	416,748		
Hospital units of institutions	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
TB and other respiratory diseases	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Obstetrics and gynecology	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Eye, ear, nose, and throat	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Orthopedic	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Chronic disease	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
All other	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Federal	218	404	83	1,437	2,142	5	15	20	67,533	10,099	77,632	72.1	107,629		
Psychiatric	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
General and other special	218	404	83	1,437	2,142	5	15	20	67,533	10,099	77,632	72.1	107,629		
Nonfederal	38	1,047	134	2,953	4,172	2	0	2	145,742	32,566	178,307	52.5	339,357		
Psychiatric	10	105	7	360	482	0	0	0	14,498	4,215	18,713	61.9	30,238		
Hospitals	10	105	7	350	487	0	0	0	14,498	4,215	18,713	61.9	30,238		
Institutions for mentally retarded	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
TB and other respiratory diseases	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Long term general and other special	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Short term general and other special	28	942	127	2,593	3,690	2	0	2	131,244	28,351	159,595	51.6	309,119		
Hospital units of institutions	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Community hospitals*	28	942	127	2,593	3,690	2	0	2	131,244	28,351	159,595	51.6	309,119	$5,858.53	$ 995.90
6-24 beds	0	41	7	130	178	0	0	0	5,207	1,021	6,228	57.4	10,856	5,687.19	640.89
25-49	7	127	18	279	531	1	0	1	16,464	3,549	20,013	56.4	35,483	4,437.05	573.06
50-99	20	375	34	550	779	0	0	0	22,529	4,485	27,014	55.1	49,008	4,007.51	705.62
100-199	0	112	12	292	416	0	0	0	16,807	3,553	20,360	59.4	34,307	4,282.57	1,112.46
200-299	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997	8,678.47	1,744.08
300-399	0	360	26	912	1,298	0	0	0	46,721	10,728	57,449	51.1	112,464	7,429.25	1,711.62
400-499	0	0	0	0	0	0	0	0	0	0	0	0.0	0	0.00	0.00
500 or more	0	0	0	0	0	0	0	0	0	0	0	0.0	0	0.00	0.00
Nongovernment not-for-profit	27	710	65	1,876	2,678	1	0	1	90,674	19,616	110,290	53.6	205,720	5,563.90	939.66
Investor owned (for-profit)	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997	8,678.47	1,744.08
State and local government	0	195	32	387	524	0	0	0	17,084	3,719	20,804	57.1	36,403	4,415.68	686.21

*For information on community hospitals that includes nursing home-type data, refer to Hospital Units columns in tables 4A through 4D, pages 14 through 17.

(continued on next page)

STATE OF MARYLAND

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HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

PRESS RELEASE

For the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 8.70% in Maryland last year, while the national average was 8.96%. Based on these figures, Marylanders saved an estimated $5.3 million in hospital costs in 1990.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1990 it was 8.11% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $1.1 billion in 1990 alone.

While hospital costs per admission rose 8.7%, hospital charges per admission rose 10.04%. Hospitals' uncompensated care rose in 1990 from approximately $246 million or 7.8% of revenue to $271.9 million or 7.7% of revenue. (See Chart 2).

TTY for the Deaf
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Hospital profits decreased from $78.3 million in 1989 to $67.0 million in 1990. (See Chart 3). Nineteen hospitals (Memorial at Cumberland, Key Medical Center, Franklin Square, Frederick, GBMC, Good Samaritan, Harbor Medical Center, Holy Cross, Johns Hopkins, Johns Hopkins Oncology, Peninsula General, Physician Memorial, Sacred Heart, St. Agnes, St. Joseph's, Sinai, Suburban, University and Washington Adventist) had profits exceeding $2,000,000, while two hospitals (Homewood Medical Center and AMI Doctors Hospital) had losses exceeding $2 million. In total, 42 acute hospitals showed profits while 12 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Hospital profits fell slightly despite an increase in revenue per admission of 10.04% compared to an 8.24% increase in revenue per admission the previous year. Simultaneous with the release of this disclosure statement, the Commission released the second annual report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. The Commission modified the rate system last year by tying continued growth to the ability of the system to match the rate of growth in hospital costs nationally. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access. Our ability to continue this program will depend on the joint response of the Commission, the hospitals, and the payers to respond to the challenges of continued cost containment, particularly for

Medicare cases."

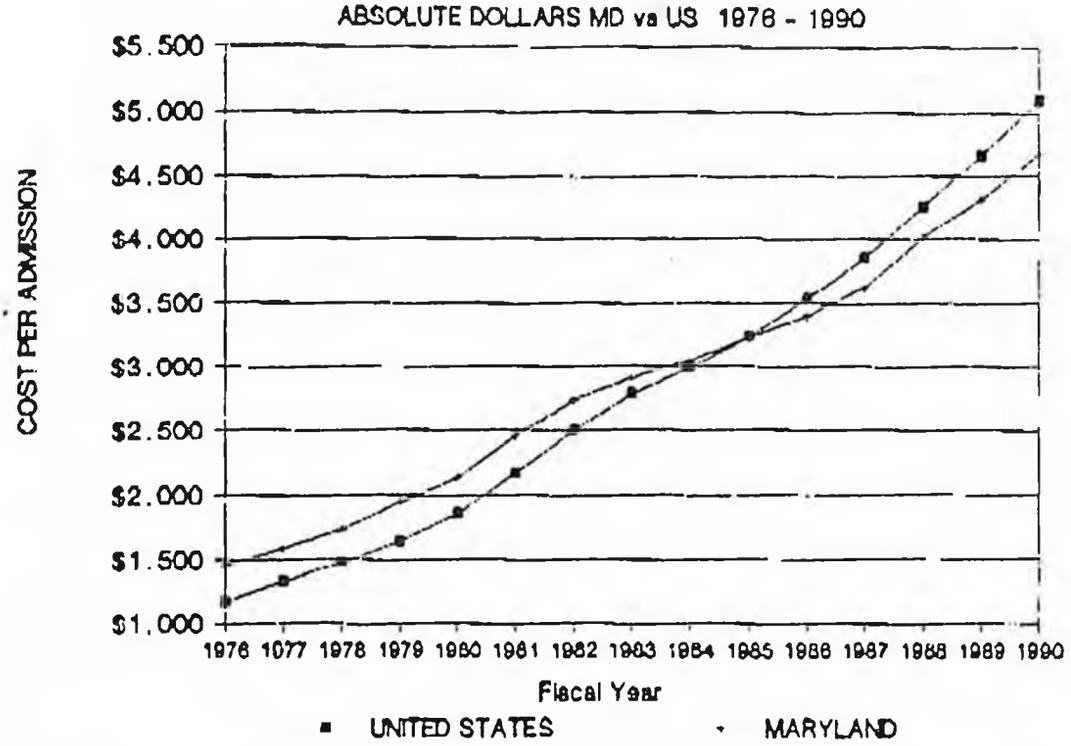
Net patient revenue increased by 11.53% as the combined result of a 1.00% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 84,695 or 1.9%.

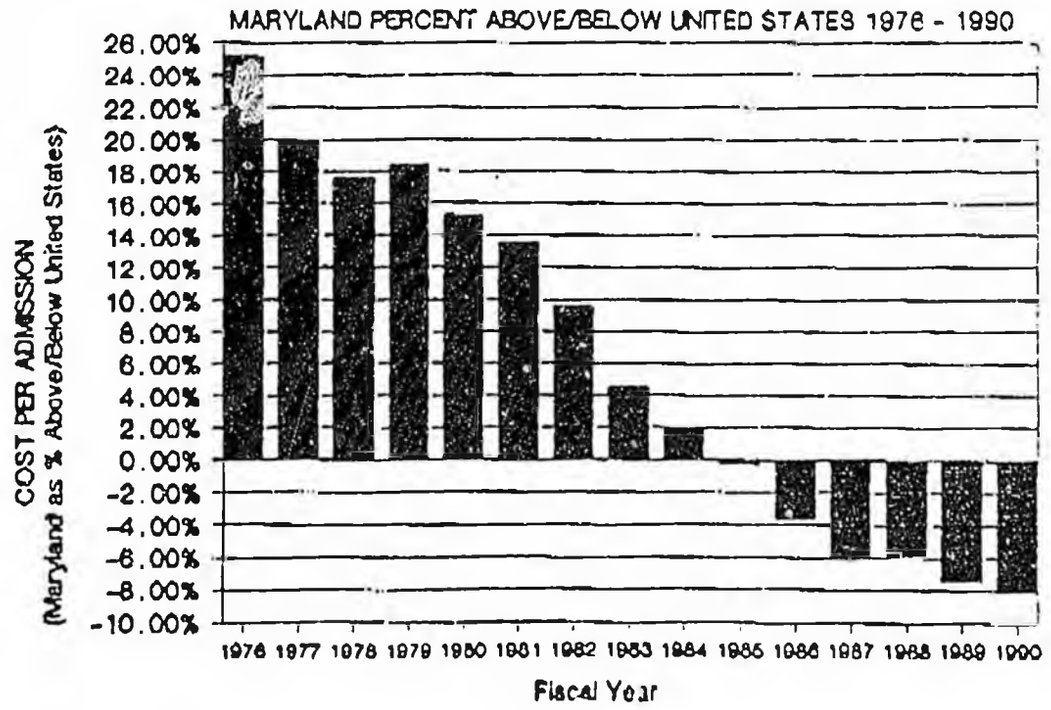
Hospital uncompensated care increased in absolute terms but decreased in relative terms in FY 1990. Total hospital uncompensated care rose to $271.9 million, an increase of 10.51% over the previous year. This represents 7.72% of gross patient revenue, a slight decrease from the 7.79% experienced the previous year.

Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 8.11% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1
COMPARISON - COST PER ADMISSION

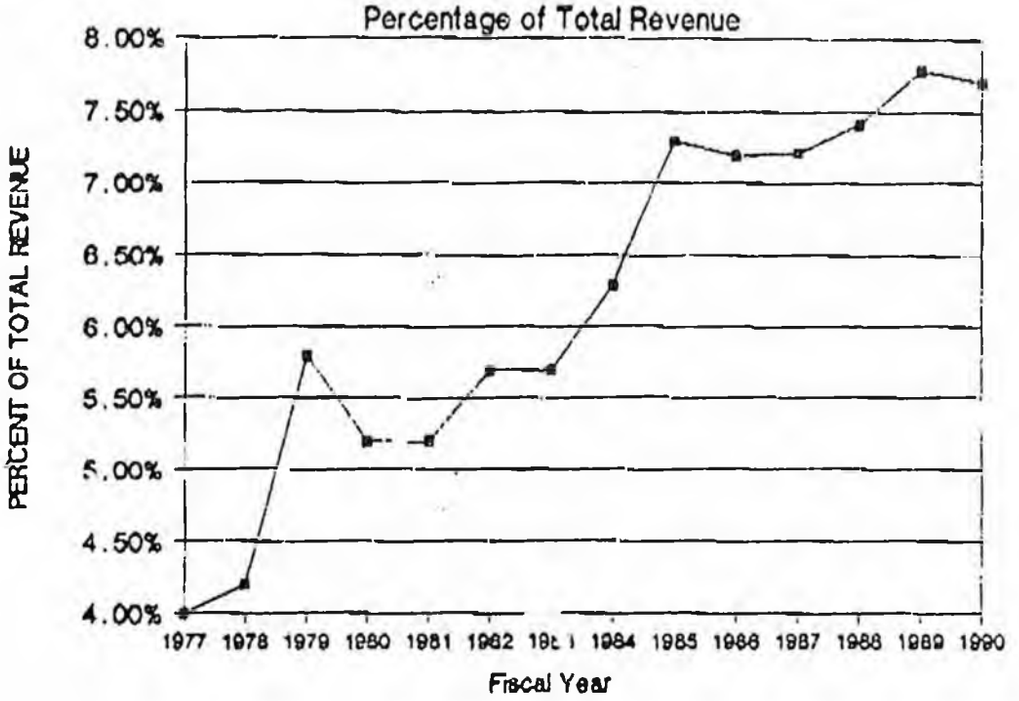


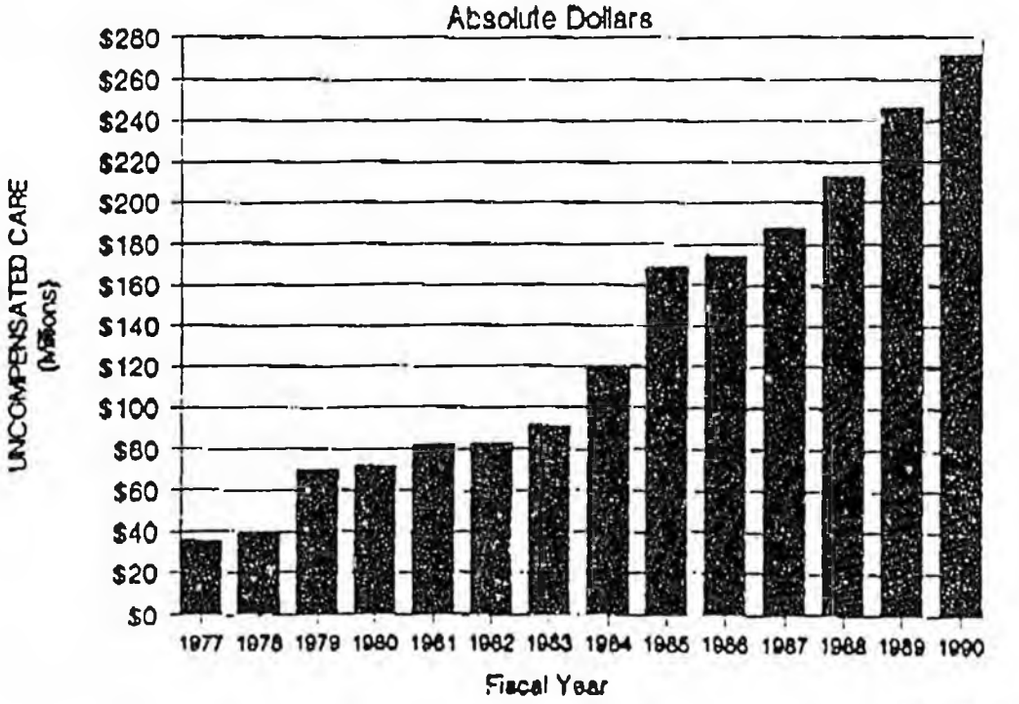


Source HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1990

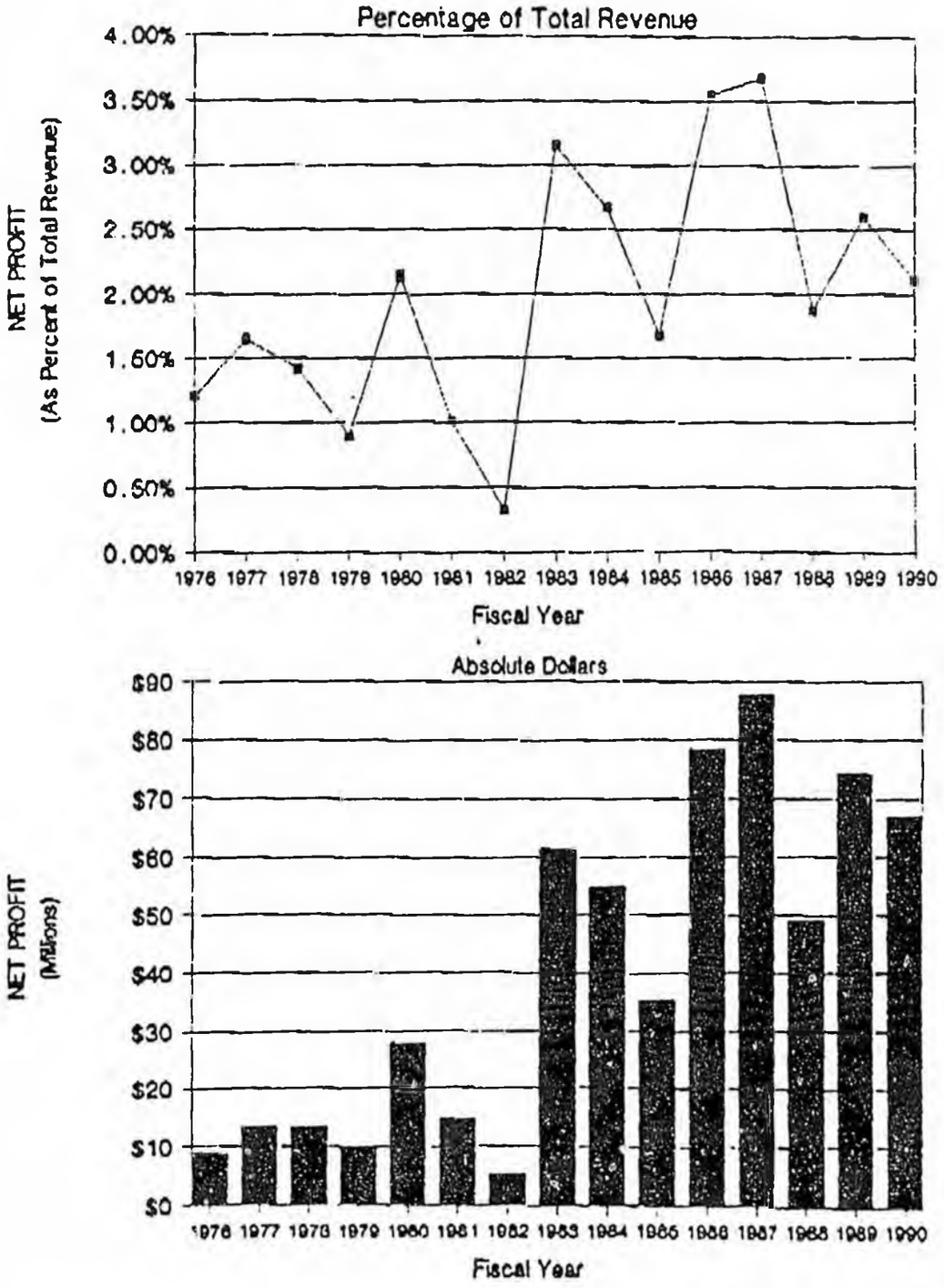




Source HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1990



Source HSCRC Annual Disclosure Reports

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 22, 1991

Senator Drue Pearce
P.O. Box V
Juneau, Alaska 99811

Dear Senator Pearce:

In preparation for the hearing on SB 83 at 3:30 p.m. Friday, March 22, Senator Duncan has been good enough to share with us his proposed committee substitute bill dated March 19.

Hospitals greatly appreciate Senator Duncan's attempt to work with them, and the efforts in the proposed committee substitute bill to provide a more timely process to the implementation of a hospital/physician rate system.

We still have these concerns with SB 83 and the proposed committee substitute:

1. Insurance pooling is needed now, not in 1993. It should be administered by the Division of Insurance, provide coverage for the uninsurable, as well as individuals and small employers, and a basic health plan should be adopted that reduces health insurance costs.

2. SB 83, and the proposed committee substitute, provides a major buyer of health care the right to set the rates they will pay for that care. This will save money for public employees, but increase costs (through cost shifting) to other buyers of health care.

3. The certificate of needs provisions in CSSB 83 are unnecessary, duplicate the work of the Department of Health & Social Services, and will add to the time and cost it takes a facility to receive the CON.

4. There is still no realistic fiscal note on CSSB 83. The Medicaid Rate Advisory Commission, setting rates for less than 30 hospitals and nursing homes spends over $600,000 per year.

Enacting insurance pooling legislation this session will deal with the issue of the uninsurable and those without insurance. It will take the best efforts of the Task Force on Health Care Resources and Access (SCR 10) to bring us equitable and realistic solutions to controlling health care costs for all Alaskans.

Sincerely,

Harlan R. Knudson
President/CEO

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ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

Rod

March 15, 1991

Senator Drue Pearce, Chair
Senate Labor & Commerce Committee
Attn: Rod Mourant
P.O. Box V
Juneau, AK 99811

Dear Senator Pearce:

We greatly appreciate the early notice of the hearing on SB 83, creating the Alaska Health Care Authority for 3:30 p.m. Friday, March 22.

Hospitals in the following communities would appreciate being included in the teleconference: Soldotna, Cordova, Fairbanks, Dillingham, Ketchikan, Kodiak, Anchorage, Seward, Sitka, Homer, Valdez, Wrangell.

This Association continues to seriously question whether or not SB 83 will have a positive impact on controlling health care costs. We believe you will hear from health providors and businesses that the results will more than likely be the shifting of public employee health costs to the other buyers of health care.

Another concern is the administrative and legal costs of a state reimbursement system. We are hopeful there will be a hard look at the fiscal note for SB 83 on March 22. We are asking Senator Collins to help in requesting data from the Department of Health & Social Services on the cost of administering the Medicaid Rate Advisory Commission. The 1992 budget request is over $700,000 and that does not include the cost of several lawsuits and the appeals process.

Thank you very much for your very careful review of this very major piece of health care legislation.

Sincerely,

Harlan R. Knudson
President/CEO

P.S. This Association has spent close to $100,000.00 during the past eighteen months in a lawsuit with the Department over a very arbitrary cap on long term care rates by the Medicaid Rate Advisory Commission.

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ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

February 25, 1991
Alaska State Hospitals & Nursing Homes
Contact: Harlan Knudson, President, 586-1790, Juneau

FACT SHEET FOR RESPONSE TO:
*** The State of Alaska's Health Care Cost Containment Task Force Report**
and
*** Senate Bill No. 83 (HB No. 71), a bill creating the Alaska State Health Resources Authority.**

Introduction:

The Health Care Cost Containment Task Force Report was released this February. The task force was formed originally to consider ways to cut the cost to the state of providing health insurance for its employees. Its duties were extended last year to cover all uninsured and under-insured Alaskans.

The report's major recommendation is creation of the Alaska State Health Resources Authority, as described by legislation sponsored by Sen. Jim Duncan (D-Juneau). The authority would set up a rate and reimbursement payment schedule for health care providers in Alaska, and dictate that schedule be followed by all public employers. It would also allow establishment of insurance pools by groups of smaller employers in search of available and affordable health insurance.

Hospital concerns with the task force and its recommended legislation:

* The task force's view of health care was extremely limited -- there was no representation from the business community, health providers or consumers on the task force. **All its members, but one union representative, were state employees or legislators.**

* There is little hard data to back up the task force report's findings. For example, it cites "overbuilt health care facilities" as one reason for the increasing cost of health care, but **fails to indentify one facility that it considers overbuilt.**

* Much of the hard data is does provide is questionable at best. **There is no analysis of its statement that Alaska health care costs have been increasing at 20 percent for the last five years.** Even if correct, this figure is influenced by such factors as the increase in health care provided in the state, instead of outside the state, and an increase in the number of people eligible for Medicaid because of new federal guidelines.

* The U.S. Dept. of Labor, in fact, has released data on the Anchorage consumer price index showing medical care to have among the smallest increases of any cost-of-living component between the

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second half of 1989 and the second half of 1990. (Medical care showed a 4.2 percent increase; motor fuel was 21 percent, food was 5.9 percent and the consumer price increase overall was 7 percent.)

* There is no analysis of the report's conclusion that there are 90,000 uninsured and underinsured, or that that number will increase to 25 percent of Alaska's population by the year 2000. While we recognize there is an increase in the number of uninsured and underinsured, it is essential that that figure be as accurate as possible before it is used to drive changes to the health care delivery system.

* There is no acknowledgement given of the vast improvement in medical care and delivery in Alaska in recent years, or of cost-saving measures taken by hospitals. These include flexible staff scheduling, group purchasing of supplies and a marked emphasis on outpatient, versus inpatient care.

* There is no acknowlegement of the costs hospitals can't control, but must deal with. These include the cost of fuel oil, wages driven by staff shortages and renovation and maintainence of facilities.

Why we like Senate Concurrent Resolution No. 10 and House Concurrent Resolution No. 5, legislation also introduced by task force members.

* They acknowledge and address the problem of the uninsured and underinsured, an issue all health care providers in Alaska struggle with daily.

* They recommend collecting the information needed to deal with this problem including uniform medical data from health care providers and opens the door to addressing the individual responsibility of every citizen to help control health costs.

* While the basis (the whereas portion) of the legislation is bassed on unsubstantiated data, the resolutions would, for the first time, provide Alaska policy makers with the necessary information to establish a fair and equitable program or programs to control health costs while assuring all Alaskans have access to health care.

* They recommend creation of a Health Resources and Access Task Force -- a group drawn from a broad representation of interests that would delve more thoroughly into the issue of health care costs and access.
* They bring a cross-section of Alaskans, including legislators, members of the administration, health consumers, private employers, health care providers and organized labor to the table to resolve a major issue facing every state in the nation -- controlling costs while assuring all citizens access to care.

# # #

FEB 2 5 1991

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

February 22, 1991

Senator Drue Pearce
Chair, Labor & Commerce Committee
P. O. Box V
Juneau, AK 99811

RE: SB 83

Dear Senator Pearce:

The Alaska State Hospital & Nursing Home Association would like to recommend that the report of the Health Care Cost Containment Task Force, along with SB 83, recommended by that Task Force be referred to the proposed Health Resources and Access Task Force. (SCR 10)

SB 83 is opposed in its current form because it creates yet another untried, undefined payment system for hospitals, and physicians. Simply telling hospitals and doctors what you will pay for their services will escalate shifting the costs of health care to other payors (if there are any left) and do nothing to improve access to care or control the overall cost of care.

The Task Force on Cost Containment was a public employee task force that did a good job in addressing state employee health costs and controlling those costs. It also opened the door to the serious problem of those who do not have health insurance. But, any long range solutions must be developed by a cross section of our provider, legislative, consumer community. This is done under SCR 10.

Sincerely,

Harlan R. Knudson
President/CEO

HRK/ma

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Ray Gillespie
Gillespie & Associates
Lobbying & Governmental Affairs

Reg - fyi
Leep

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November 14, 1990

The Honorable Drue Pearce
Alaska State Senate
3111 "C" Street, Suite 535
Anchorage, Alaska 99503

Re: SB 550, Certification of Utilization Review Providers

Dear ~~Senator Pearce~~ Drue:

As the Task Force begins to draft its report to the legislature, I would like to take this opportunity to share thoughts on certification/accreditation of utilization review providers (SB 550).

As you know, the Task Force has taken testimony from numerous health providers that standardization of utilization review is necessary given the proliferation of review firms. This type of legislation helps ensure that utilization review firms do not unfairly restrict access to medical care, promotes uniformity of review standards, paperwork and procedures with which health care providers must deal, and promotes cooperation between the providers and the review organizations. In addition, legislation such as SB 550 tends to protect the rights of the patient and ensure that private review agents are fully qualified to perform the utilization review. In addition it ensures confidentiality of patient medical records.

At least 10 states have enacted legislation regulating the practice of private utilization review agents. In the past year alone, Georgia, Kentucky, Maryland, Mississippi, South Carolina and Virginia have enacted such legislation. Typically the legislation requires companies conducting utilization review to obtain a certification either from the State Department of Health or the Commissioner of Insurance. Generally, in order to be certified, a utilization review firm must submit certain information to show:

1. the critera and procedures used in evaluating hospital and medical care;

2. the type and qualifications of personnel performing utilization review;

3. procedures and policies ensuring that a private review agent is reasonably accessible to patients and providers during normal business hours;

4. submit policies and procedures ensuring the applicable state and federal laws protecting confidentiality are followed; and

5. procedures that ensures providers may seek reconsideration of adverse decisions.

Please consider this information and the testimony provided to the Task Force concerning the need for utilization review legislation. Should you need other or further information or have questions concerning SB 550, please feel free to call upon me.

Again, we urge the Task Force to seriously consider a favorable recommendation to the Legislature for utilization review legislation such as SB 550.

Sincerely,

Raymond A. Gillespie

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

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February 11, 1991

To: **Senator Pearce, Chair**
Members, Senate Labor and Commerce Committee

Re: **SB 83;** *"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."*

NEA-Alaska supports and encourages your favorable consideration of SB 83. It represents a sound and viable alternative to the cost, quality, and utilization of health care services, especially as it may pertain to public school district employees.

Currently, school district employees are covered by a variety of health care plans with a broad range of benefits at differing levels of premium costs.

Many districts are disadvantaged in their ability to maximize benefit coverages at reasonable costs and have seen these costs increase at alarming rates in recent years.

Access to utilization standards, more efficient administrative and provider reimbursement systems, and the opportunity for reducing premium costs and for improving benefits through participation in expanded group pools represents substantial opportunity for employers and employees alike.

Implementation of the provisions in SB 83 is a critical step if we are to effectively deal with health care costs in Alaska.

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: Senator Duncan

ALASKA STATE EMPLOYEES ASSOCIATION

AFSCME Local 52, AFL-CIO

February 11, 1991

Hon. Jim Duncan, State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

On behalf of the Alaska State Employees Association and its 9,000 members statewide, I want to thank you for introducing Senate Bill 83, which seeks to establish an Alaska State Health Resources Authority to help cap the state's increasing health care costs.

As you know from your experience with the Alaska Health Care Cost Containment Task Force, health care costs to Alaskans exceeded $1.5 billion in 1989 and have been rising at a rate of more than 20% each of the past five years. These cost increases have concommittantly increased the costs of health insurance premiums for all Alaskan employers, including the State of Alaska, making it more and more difficult for them to continue health care coverage for their employees.

Clearly, something needs to be done to bring down or, at the very least, check Alaska's spiraling health care costs and SB 83 takes the right approach.

For its part, ASEA/AFSCME Local 52 has agreed to a defined contribution to health care costs in its collective bargaining agreement with the state, but this is only a step in what should be a comprehensive attept to contain costs throughout Alaska.

Furthermore, SB 83 makes inherently good public policy. Such an approach benefits union's, such as ASEA, by mitigating their health care costs; it benefits the State by lowering its operating costs; and it benefits private sector employers by reducing their cost of doing business with the state.

Again, my thanks to you and your colleagues on the Health Care Cost Containment Task Force for tackling a complex, difficult and controversial subject.

Respectfully yours,

Buddy Maupin

Buddy Maupin, Business Manager
ASEA/AFSCME Local 52, AFL-CIO

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MANO FREY
Executive President

February 27, 1991

Senator Jim Duncan
P.O. Box V
Juneau, AK. 99811

Dear Senator Duncan:

On Thursday, February 21, the Executive Board of the Alaska AFL-CIO voted its unanimous support for SB-83, a measure introduced to decelerate the cost spiral of health care for Alaskans.

The unchecked increases in health care costs is of grave concern to all Alaskans. It has priced insurance right out of the market for many small businesses, resulting in a drastic increase in the percentage of uninsured/ underinsured citizens. This in turn has dumped a greater proportion of the costs on those of us who are fortunate enough to enjoy comprehensive insurance coverage. Alaskans can no longer afford to leave this problem unresolved.

SB-83 is the most comprehensive, reasonable, and effective legislation we have ever seen introduced in this area. It would provide a long-term policy rather than a short-term fix.

With regard to health care cost containment and access questions, all too often public officials are quick to agree that someone else should do something about it. The Alaska AFL-CIO applauds your leadership in the field of health care quality and access through your introduction of SB-83 and urges its passage.

Yours in Progress,

Mano Frey
President

MAR 14 19

Hi!

I had fun
with this!
Thanks for dinner -
Love you!

John

my doctor

good grief!

fyi -
then keep
hidden

NORTHWEST MEDICAL
PROFESSIONAL CORPORATION
2841 DeBarr Road, Suite 22 • Anchorage, Alaska 99508
Phone: (907) 276-6301

Vernon A. Cates, M.D.
General Practice
John W. Gerster, M.D.
Internal Medicine
Robert D. Hanek, M.D.
Family Practice
Alexandor T. Baskous, M.D.
Family Practice

11-Mar-91

To: Editor, The Anchorage Times

I can't believe it! Senator Jim Duncan has once again demonstrated the short-sightedness of the petty little bureaucratic mind. His idea to solve the increasing costs of medical care is to simply create another commission so that the State Government can set all the rates. Price controls do not work! What, you think milk costs too much? Why, let's just pass a law saying that Carrs cannot charge more than 10¢ a quart. Flying outside is too expensive? We'll just pass a law that Alaska Airlines cannot charge more than 10$ to fly to Seattle. Do you really think that shortly there would be any more milk or airlines in Alaska? Sen. Duncan flunks Economics I: In a free society, prices are determined by costs, not fiat, and health care is no different. East Germany has been the perfect example that government-controlled prices do not work. Can you really imagine the Alaska Legislature, that paragon of fiscal responsibility, knowing more about prices than the free market economy? Health Care is expensive for three reasons: the stratospheric explosion of expensive technology, the boom in malpractice insurance costs, and the perception that everyone is entitled to a perfect outcome. It's a little like the public insisting that every auto manufacturer make only Rolls-Royces and wondering why they are so expensive. We have the best Rolls-Royce of medical care in the world, but no one wants to pay for it. Let us ask the legislature to work on the roots of the problem in meaningful insurance and tort reform, and not embark on this ill-advised experiment in Northland Socialism.

John W. Gerster M.D.

JWG/hs

OLIVER M. KORSHIN, M.D.
6920 CROOKED TREE DRIVE
ANCHORAGE, ALASKA 99516
907-346-1946

MAR 2 8 1991

March 22, 1991

Drue Pearce, Chairman
Senate Labor and Commerce Committee
P.O. Box V
Juneau, Alaska 99811

Dear Senator Pearce:

This is a personal note to accompany my written testimony on SB 83.

Of course I remember that you are a patient of mine. It's been at least two years, and you're due for a follow-up!

A number of us were at a disadvantage at the hearing because Senator Duncan had made major changes to the bill which we could not fully absorb because we had not been aware of them until hearing time. Of course, our prepared testimony was based on the earlier version.

Nonetheless, the revisions, as I understand them, don't alter the fact that the primary purpose of the bill is to establish a fee schedule for health providers and to develop and implement utilization standards. Better minds than Senator Duncan's have tried to do the same and have consistently failed to control rising costs, because rising costs aren't driven by inflation in provider charges, but by other, more potent factors discussed both in the Task Force report and in my testimony.

It's like having an elevator stuck on the top floor of a highrise, and you're on the ground floor trying to get it to come down. You can't find the right button, but the fire alarm is handy, so you pull that. You'll get some immediate and spectacular results—the occupants will flee the building, the sprinklers may go off and the fire engines will arrive, but the elevator will stay on the top floor.

I trust you and the members of the committee have all actually read the Health Care Cost Containment Task Force report. I know you were on the Task Force, so I'm probably treading on thin ice here. It's not just that the report is poorly done, it's *so* poorly done that it's embarrassing. It looks like a high school junior effort at best; it surely doesn't reflect the workings of a powerful intellect or one well-versed on the issues of health care delivery or health economics. But it's done with a word processor on a laser printer, so it's immediately "acceptable," I suppose.

What did the State actually pay its consultant to produce that report? You should ask for your money back, as the product is so flimsy and reflects poorly on the mem-

bership and efforts of the task force. As I said in my testimony, the least prestigious scientific journal would not even consider such a report. As physicians, we are accustomed to much more rigorous presentation and analysis of data than what the Task Force's consultant has produced.

Anyway, I hope the bill is defeated. I'd be grateful for anything you can do to help.

Best regards,

Oliver Korshin

enclosure

TESTIMONY ON SB 83
MARCH 22, 1991

OLIVER M. KORSHIN, M.D.
ANCHORAGE, ALASKA

I'm an ophthalmologist engaged in solo private practice here in Anchorage for the last five years. Prior to that, I worked 17 years for the U. S. Public Health Service; eleven of those years I spent as a medical care administrator, part of that time in the Medicare program. So I'm intimately familiar with the workings of the health care bureaucracy, both from the bureaucrat's and provider's standpoint. I'm also representing the Alaska State Medical Association today. So that I don't keep you in suspense, I am here to tell you that Alaska's physicians oppose SB 83, and request it be defeated.

Now, to take a step in a positive direction, I must also tell you that Alaska's physicians are committed to help solving the problem of ensuring access to health care for all Alaskans. We are equally committed to help find ways to reduce health care costs and maximize effectiveness of health care dollars.

We do not believe that SB 83 adequately addresses either of these broad commitments. Specific proposals which do deal with them will be presented at the end of this testimony.

SB 83 is based in large measure on the Health Care Cost Containment Task Force Report of February 1991. So, to discuss SB 83, one must first review the Task Force report. The report identifies a number of "contributing factors" to health care cost inflation, but its underlying thesis, completely unsupported by hard data, is that the principal cause of the inflation is spiralling provider charges. SB 83 consequently proposes a reduction of those charges as the principal method of controlling health care expenditures. It also proposes, without saying how, to establish "utilization standards" to reduce the volume of services.

The report itself is so poorly done that it is difficult to critique without redoing all the work. The sources of the data are not referenced, the questionnaires used are not shown, the response rates to the questionnaires are not given, nor is the statistical methodology of projecting the alarmist costs for the year 2000 described. *As*

these projections are central to the plan's conclusions, and therefore to the raison d'être *for SB 83, it is imperative that the methodology used be fully revealed and completely justified.* To all appearances, the projections seem to have been made by simply taking the very latest rate of increase and assuming that this will hold unabated for the next ten years. That is rather like projecting that the Dow Jones Average will hit 17,910 by December 31 because it was 2900 on January 1 and rose 18% in January alone.

These simplistic cost projections are presented with all the calculated zeal of a burglar alarm salesman trying to frighten homeowners into buying a home security system by reciting residential crime figures. One four-point graph even purports to project health care expenditures in Alaska in 2000 "without ASHRA[1] " and with the "impact of ASHRA," as if a health authority that doesn't even exist yet, whose bureaucratic complexities and costs have not yet even been determined, much less projected forward nine years, were a mathematical variable that can be factored into an equation or a graph, or as if ASHRA were some sort of secret toothpaste ingredient that will make teeth "twice as white." Finally, a few obligatory and lackluster testimonials from interested constituent groups and organizations are appended supporting the Task Force's mission.

No medical journal would accept such a poorly done article purporting that a given treatment is effective for a given disease. And the legislature shouldn't buy SB 83's "cure" for containing health costs based on this Task Force report. It would be like buying "Engine Overhaul in a Can" based on ad copy in a J. C. Whitney catalogue.

The report fails to address other Alaska-specific factors impinging on cost increases. For example, during the 1970's and 1980's Alaska medicine was playing a serious game of catch-up with respect to the rest of the country in order to create the medical-technological infrastructure taken for granted elsewhere in the United States during those decades. This meant building coronary and intensive care units, developing an adequate emergency medical services and transport system, building newborn and pediatric intensive care units, acquiring CT scanners and so on. These represented huge capital outlays and have clearly driven the costs of medical care upwards in Alaska. Had these expenditures *not* been made, Alaskans would now be complaining loudly that our medical system is backward and inadequate, and that we need to spend lots of money right away to improve it. So of course lots of money was spent, and it *should* have been spent—Alaska was medically unde-

[1] Alaska State Health Resources Authority

veloped territory. These expenditures severely skewed the Alaska cost increase curve and make comparison with other states, which started from a more sophisticated infrastructure, a precarious affair. This skewing is not automatically bad—it's just a reality of what it costs to cease being a medical backwater of Seattle.

One of most important significant developments in health care costs in Alaska, however, is almost glossed over by the report: namely, that $20 million was saved in 1990-91 for state employee health expenditures *without any legislation at all and without the development of a huge state bureaucracy.* This was probably done by effective care management and preadmission review—by now accepted modes of controlling costs. Yet the report fails to take this decrease into consideration in making its alarmist extrapolations about state employee health costs in the year 2000. In fact, using the report's simplistic projection methodology of taking the very latest percentage increase in rates and projecting it linearly forward to 2000, the $20 million savings would result in *lower* costs in 2000 than in 1990. At any rate, the report's authors chose to downplay both the savings and their implications, because they don't harmonize with their preconceptions that doctors and hospitals are the main culprits for the health care cost crisis.

And the report gives only lip service to the other factors impinging on health care cost increases, even though these overshadow by far the effect of provider charges. Ever-growing expectations and demands for the instant availability of high-tech medicine, coupled with spiralling technology; the problem of the *overinsured,* the malpractice/defensive medicine issue; the fact that huge resources are spent during the first and last few weeks of life; the massive health care expenditures mandated by the AIDS and cocaine epidemics—these are all given only perfunctory attention.

Finally, the Task Force report is so full of grammatical and punctuation errors, verbatim repetition of entire paragraphs, misspellings and so on, that it raises the question of the author's depth of preparation and underlying competence to buttress facts in support of a coherent thesis. Substantial state funds were apparently spent to hire someone, supposedly an expert in the field of health care delivery and health economics, who had many months to devote to the report's preparation and writing. The report's almost juvenile quality makes us wonder at the care and skill employed in researching and analyzing the data on which the report's conclusions are based.

Now to the bill: SB 83 does not even address the problems the Task Force identified as those of highest priority, and instead concentrates on reducing fees and creating

utilization standards. Regarding the paramount question of the uninsured and underinsured, the bill proposes merely to "evaluate the need" for health insurance for these individuals. This is surprising, as the report loudly protests that the ranks of these unfortunate people have jumped from 40,000 or 50,000 to 90,000 in a few short years. So it's clear that this issue is only being used as a smoke screen—the bill's authors really aren't concerned with the uninsured or underinsured right now. They wish to protect the job perks of their constituents—the *overinsured* state employees.

SB 83 places the burden of cost control exclusively on the shoulders of providers, with no provision to restrict or reduce consumer demand by streamlining benefits, increasing deductibles or co-insurance rates. In other words, it doesn't address at all the problems of *overinsurance.* It looks like a bill to protect the Cadillac benefits, 1960's-level deductibles and minimal co-insurance rates of state employes, who appear to be the principal constituents of the bill's authors, as well as the bill's principal beneficiaries.

Despite all the lip service given in the report to improving access, the bill utterly fails to propose anything at all in this regard. It is, as we said, silent on the issue of the uninsured except to "evaluate" their needs. It would seem that 90,000 uninsured or underinsured Alaskans constitute the real crisis, not whether state employees can continue to have $100 deductible health insurance policies, be hospitalized for 30 days to break their cigarette habit (or their kid's habit), or get one pair of eyeglasses a year whether or not they need them.

Despite the report's stated interest in reducing cost-shifting, SB 83 will exacerbate the problem, and it will further erode the continued access and quality of care by jeopardizing hospitals' ability to operate or even to remain open, in the case of Alaska's smaller hospitals.

Despite the report's reference to the importance of controlling the costs of defensive medicine—estimated by some authorities to constitute as much as *one-third* of all health care costs—SB 83 proposes nothing in the way of tort reform. Some providers are paying more than $100,000 a year for professional liability insurance; defensive medicine intensifies throughout the medical community with each huge judgement or settlement, and the spiral of medical costs continues upwards.

Now to get to the heart of the bill—the fixing of provider charges and the establishment of "utilization standards." Any careful historical analysis of the estab-

lishment of fee schedules reveals almost nothing but failures. In fact, the establishment of fee ceilings invariably results in further inflationary pressures, as the ceiling automatically becomes the new "floor" which all providers will automatically charge, even those whose charges were originally lower than the ceiling. I refer you to the work of Alain Enthoven and other eminent health economists. And the establishment, maintenance and revision of a fee schedule is a complex and costly undertaking, requiring a sizeable bureaucracy. Many refinements and exceptions will be necessary. Reviews, denials and appeals will have to be dealt with, and this doesn't take into account what will be needed if the state actually starts writing its own insurance—an option provided by SB 83.

Regarding the establishment and implementation of utilization standards, what does this really mean? First, there *are* no generally accepted standards—medicine is not an exact science. Second, assuming that such standards do exist, or can be defined by 1992, then a bureaucracy must be established and hired to implement and enforce these standards. Such a bureaucracy must obtain the services of skilled individuals, possessing at least a nursing degree. And legitimate exceptions to standards *always* arise, and with great frequency: the patient with hypertension is "allowed" three visits a year to the doctor, but this particular patient has an unusual and uncontrollable form of hypertension, and needs monthly visits. A hospital stay must be extended because of complications. A way to obtain legitimate exceptions to the standard must be available, which predicates creation of a review mechanism. An appeals process must also be established for reviews that are denied, and so on.

All this requires a higher level staff to review the applications for exceptions and the appeals of denials, and this means obtaining the services of general physicians, specialists and even subspecialists. Due process for beneficiaries and providers must be developed and maintained—after all, this is a government program. In short order, a large professional and paralegal bureaucracy will have been established, which, as health economists will point out, often costs more to sustain than whatever savings—if any—may be realized.

When these standards are applied to hospital care, the costs of applying, reviewing, enforcing and modifying them becomes astronomical, as whole patient charts must be abstracted and computerized.

Finally, one of our central criticisms of SB 83 is that it creates a government-run insurance bureau, whether or not the state actually gets into the direct insurance

business of receiving premiums, reviewing claims, making payments and so forth. In 1965 another legislative body, the U. S. Congress, created a government insurance program—Medicare, the crown jewel of the Great Society package of legislation. It established a government agency, called the Bureau of Health Insurance, to establish payment rates, review and control the utilization of services and purchase insurance for its beneficiaries at the lowest possible cost. But not even the Congress made SB 83's mistake of actually giving the government the option to run the insurance program directly—it contracted with private insurance companies, known as fiscal intermediaries, to handle claims and pay out benefits.

Even with the contracting mechanism, the Bureau of Health Insurance had grown so large that within a decade it could no longer be contained within the massive Social Security Administration, and so a new, separate bureaucracy was created—the Health Care Financing Administration (HCFA).

By 1990 HCFA and its various insurance and non-insurance contractors (who perform utilization review and quality of care review functions) had become one the largest, most complex and costliest of all the Federal bureaucracies, and one that is thoroughly loathed by beneficiaries, providers and legislators alike. And costs were not—and still are not—controlled. Nor was the volume of services curtailed, but instead has continued to grow unabated. And all the dollars sunk into this gigantic bureaucracy are no longer available for providing services to patients.

The authorizing legislation for Medicare, HCFA, and the burgeoning mandated utilization review and cost containment mechanisms now occupy thousands of pages, with many more thousands of pages of regulations. The documentation is as complex as the Internal Revenue Code and its regulations. Don't take my word for it—request all the Medicare amendments to Title XVIII of the Social Security Act, and the regulations, wait for the cartons to arrive and see for yourselves. I know firsthand, because my first job as a federal physician in 1968 was as a consultant to the then infant Medicare program, and even then it was a highly complex program which resisted efforts to be effectively administered.

Medicare has proven to be a social, political, bureaucratic and fiscal tar baby for legislators, taxpayers, old people and providers alike. Americans over 65 are now paying a larger percentage of their income on health care than before Medicare existed. Is this what Alaska wants to duplicate? We don't think so. SB 83 will grow (it's already increased from eight to eleven pages in just a few days), and so will the bu-

reaucracy it creates, and it won't reduce the costs of medical care in Alaska by one dime.

SB 83 would ultimately create the same kind of monster, helpless bureaucracy as Medicare. And it's not only that the dead hand of bureaucracy will blight any part of the medical care system it grasps, (think of your last visit to a VA hospital)—it's also a very expensive proposition. The authors of SB 83 haven't yet calculated the costs, or, if they have, they haven't yet shared them with the public. The important difference between SB 83 and Medicare, as far the the Alaska legislature is concerned, is that *you'll* be appropriating money for it, not the federal government, and *you'll* be grappling with it at every legislative session for the next 50 years.

SB 83 is poor legislation based on an almost childishly crafted report, and poor legislation is worse than no legislation. Don't pass it.

Organized medicine in Alaska doesn't support this bill. We don't want to end on such a negative note. So what *do* we support?

- We support establishment of a coherent health care policy for Alaska—we don't have one.

- We support a complete redoing of the Health Care Containment Task Force report based on professional—not amateur—analysis of the health care situation in Alaska, with standardized, above-board and even-handed methodology and with the full cooperation of physicians and hospitals in supplying data. Hire a team of respected health care economists from a leading university or public policy think tank.

- We support watchful analysis and observation of other states' and national proposed solutions to the problem of providing equitable health care to all Americans at reasonable cost. We are a small state and can ill-afford to be out "on point" when larger states with more resources—intellectual, fiscal and infrastructure—have been unable as yet to demonstrate a successful solution.

- We support full implementation of those current cost-saving measures which have been demonstrated to reduce cost *without* legislation or the creation of state bureaucracies—measures such as those which have already reduced health care costs for state employees by $20 million in FY 1990 and frozen them in place for FY 1991.

- And finally, we support immediate and concrete measures to deal with Alaska's uninsured and underinsured through the establishment of streamlined benefits packages, care management systems, mandated risk pooling for currently uninsurable individuals and state subsidies of premiums for certain individuals. SB 73 and SB 74, by Senator Kerttula, contain such provisions.

Thank you.

ADDENDUM

When I arrived to give this testimony at the Anchorage Legislative Information Office, Senator Duncan was in the middle of reading a new substitute for the bill, which contained "substantial changes." The substitute was telefaxed to Anchorage about an hour later, and could not be adequately reviewed before the testimony. These changes mostly have to do with (1) stressing the need to contract with a private insurance company before allowing the state to become an insurer; (2) introducing a cost-based methodology for arriving at the fee schedule, (a virtual copy of the as-yet untried Resource Based Relative Value System cost methodology being phased in by Medicare in 1992); and (3) implementing (rather than evaluating the need for) an insurance scheme for the underinsured and uninsured by 1993.

These changes don't alter the basic character of the bill, nor our objections to it. Senator Duncan told the hearing that by these changes he was moving the issue of the uninsured "off the back burner." Perhaps he's moved it to the front of the stove, but it's clearly still on slow simmer.

The "improved" SB 83 now seems to blend old SB 83 with facets of Senator Kerttula's SB 73 and SB 74, which deal exclusively with the underinsured, uninsured and uninsurable and which I support. The result is an unwieldy hybrid or omnibus bill, which, in trying to become all things to all people, will result in an even more complex and unworkable bureaucracy under the auspices of the proposed Health Resources Authority.

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SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

March 22,1991

Dear Senator Pearce,

I wish to note that I am opposed to Senate Bill 83 which would create the Alaska Health Care Authority and Reimbursement System. My colleagues in health care and I truly wish to work with Senator Duncan in resolving the state's health care needs. We recognize and accept that all parties must be willing to make concessions and compromises for the good of all our citizens.

Basically, our concerns are not with the concepts of SB83 but with the prioritization - or order - in which it proposes change. The bill essentially places the problem of the uninsured on the back burner. I believe, however, that unless this issue is addressed it will be the Achilles heel in all other attempts to solve the puzzles of the health care delivery system.

Historic attempts at health care reform in the U.S. indicate the dilemma cannot be solved a <u>piece at at time</u>. All aspects must be addressed simultaneously.

SCR10 calls for a task force which would include <u>all</u> the players in the delivery system - Legislature/Business/Insurance and Providers. I would support this legislation. It provides an opportunity for all concerned to develop a solution.

I would be happy to talk with you further on these issues.

Sincerely,

Sister Dona Taylor
Administrator

Table 1

Consumer Price Index – Urban Consumers
All Items and Selected Components
U.S. & Alaska

Year	All Items				All Items Less Shelter				Housing		Medical		Food & Beverage	
	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average
1960	29.6		34.4											
1965	31.5	6.4%	35.3	2.6%										
1970	38.8	23.2	41.1	16.4										
1975	53.8	38.7	57.1	38.8										
1980	82.4	53.2	86.5	48.7	82.9		84.7		81.1	85.9	74.9	76.6	88.7	89.7
1981	90.9	10.3	92.4	6.8	91.0	9.8%	92.0	8.6%	90.4	92.5	82.8	86.9	93.6	94.3
1982	96.5	6.2	97.4	5.4	96.2	5.7	96.3	4.7	96.9	98.2	92.5	94.8	97.3	97.2
1983	99.6	3.2	99.2	1.8	99.8	3.7	99.9	3.7	99.5	99.0	100.6	99.7	99.5	99.7
1984	103.9	4.3	103.3	4.1	103.9	4.1	103.8	3.9	103.6	102.7	106.8	105.5	103.2	103.2
1985	107.6	3.6	105.8	2.4	107.0	3.0	107.5	3.6	107.7	103.0	113.5	110.9	105.6	106.2
1986	109.6	1.9	107.8	1.9	108.0	0.9	111.2	3.4	110.9	102.6	122.0	127.8	109.1	110.6
1987	113.6	3.6	108.2	0.4	112.6	3.3	115.1	3.5	114.2	97.5	130.1	137.0	113.5	113.1
1988	118.3	4.1	108.6	0.4	115.9	3.9	117.8	2.3	116.5	95.4	138.6	145.6	118.2	113.8
1989	124.0	4.8	111.7	2.9	121.6	4.9	122.3	3.8	123.0	96.3	149.3	7.0 154.4	7.6 124.9	117.2
1st half 1988	116.8		108.4		114.4		117.0		117.2	95.8	136.5	143.0	116.5	113.5
1st half 1989	122.7	5.1	110.9	2.3	120.4	5.2	121.4	3.6	121.7	95.8	146.3	9.8 153.1	10.1 123.6	116.4
1st half 1990	128.7	4.9	116.9	5.4	126.2	4.8	126.5	4.2	128.6	102.2	159.1	12.8 160.1	7.0 131.0	122.5

Notes: The most current Consumer Price Index data available for Alaska is for the first half of 1990.
For comparability, data for the first half of 1988 and 1989 are given to show the percentage change over the year.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

MAR 2 6 1991
Ales

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

MEMORANDUM

TO: SENATE LABOR AND COMMERCE COMMITTEE MEMBERS

FROM: SENATOR JIM DUNCAN
PRIME SPONSOR SENATE BILL 83

DATE: MARCH 25, 1991

SUBJECT: SENATE BILL 83

Please find attached a letter from Dr. Mike Beirne, M.D. concerning SB 83 and SB 84. I am sure you will recognize Dr. Beirne not only as an Anchorage physician but also as a former legislator.

I wanted you to have this information about a provider and a consumers group supporting the concepts proposed in SB 83.

Health Consumers Of Alaska, Inc.
P.O. Box 91539
Anchorage, Ak. 99509
(907) 277-6219

Senator Jim Duncan
AK. State Legislature
Pouch V
Juneau, Ak. 99801

3-18-91

Testimony SB 83+84

Dear Senator Duncan,

This letter is a follow up on The Public opinion message of support sent to you last week. I also talked directly with your staff and offered to provide testimony by members as well as by myself.

Truly your efforts to help control the ever escalating prices of Health care services are sincerely appreciated. The present condition is unacceptable to the Public and to the health consumers.

We all recognize I'm sure that there is no single cause for the rapid price increases; on the other hand, some of the causes are more outstanding than others and need to be dealt with now. The providers are simply not entitled to raise prices without adequate justification, and this would be the responsability of a price review board or authority. The consumer would not be required to pay for errors by the management of the provider organization.

While we may all agree that we have many fine providers in Alaska, and in my opinion we certainly do, none the less we should not hesitate to express concern about high prices and their causes. A check and balance system is absolutely necessary in our opinion.

We want to expressly thank you for having the courage to confront the problem, for demanding a solution, and then for offering a realistic solution.

We have reviewed your Bills. We have heard " the tree fall in the forest" We stand ready to work with you in any way we can.

Sincerely,

Dr. Mike Beirne, M.D.
President

The Health Consumers Of Alaska is an Alaskan non-profit corporation organized in 1987. An informed consumer is our goal.

APR 2 1991

4421 E. Huffman Road
Anchorage, AK 99516
March 27, 1991

Senator Dru Pearce
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Senator Pearce:

I'm deeply concerned that Alaska Senate Bill 83, sponsored by Juneau Senator Jim Duncan, is the wrong approach for solving the problems of access and rising cost of health care. These problems are complex and require careful study before we embark upon a set of solutions that could bring even greater turmoil to our already troubled health care system.

For example, the Duncan proposal would impose price controls on services. Providers would be limited to what they could charge. On the surface, this may sound like a good idea, but over a period of time, the quality of services will surely decline and many health care professionals will relocate to places where their earnings potential is not controlled by government. Since the program is voluntary for private employers, the bill does nothing to improve access for the thousands of individuals who cannot afford health insurance.

The proposal also calls for creation of a state government agency to administer a government authorized insurance program. Not only does the insurance pool arrangement described in the bill have several financial and underwriting difficulties, it will mean additional cost for taxpayers of the state.

I believe a better option would be to improve upon our existing public/private system rather than creating an expansive government bureaucracy. Yes, we all would like to stop the rapid escalation of health care cost, but Duncan's approach won't work!

Very truly yours,

Ronald J. Trevithick

APR 1 6 1991

NORTH SLOPE BOROUGH

OFFICE OF THE MAYOR

P.O. Box 69
Barrow, Alaska 99723

Phone: 907-852-2611

Jeslie Kaleak, Sr., Mayor

April 10, 1991

Senator Drue Pearce
Chairperson, Labor & Commerce Committee
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Pearce,

I recently received a letter from Senator Duncan, along with its enclosures of the Alaska State Health Care Cost Containment Task Force Report and the drafts of the associated House and Senate Bills, requesting my support for certain pieces of legislation he is sponsoring. More specifically, the bills are SB 83 & 84. I want to commend the members of the Task Force for their hard work in attempting to find solutions to the overwhelming problem of health care cost containment.

After lengthy review by myself and my staff, I feel it is necessary to draw your attention to some of our primary concerns regarding the proposed legislation. The specific areas of concern include, but are not limited to, 1) Procurement of Coverage, 2) Administration of Coverage, 3) Pricing of Coverage and Cost of the Program, 4) Provider Rate Setting, 5) Eligibility Criteria, 6) Definition of Group Health Insurance, 7) Certificates of Need, and, 8) Evaluation of need for <u>mandatory</u> participation. Until these concerns are specifically addressed, the North Slope Borough cannot support the proposed legislation. In fact, we find the bills both unacceptable and unnecessary.

1) **Procurement of Coverage**: It is unclear in the legislation as to the Alaska State Health Resources Authority's actual ability to contract with insurers, the number of insurers or consultants it would contract with, and how the costs of such services would be distributed to the participants. We are curious as to who will do, and when will, a cost-benefit analysis be completed with respect to the costs of procuring and maintaining a state-sponsored healthcare authority?

2) **Administration of Coverage**: The legislation is also unclear with regard to who would administer insurance claims. It appears to give the

Health Resources Authority the power to administer claims but it is unlikely this would occur, even if the state elects to self-insure. The state of Alaska has seen several private insurance carriers attempt to maintain local claims processing office. Economics has proved this venture to be a costly undertaking. The metropolitan areas of Anchorage, Fairbanks and Juneau cannot seem to maintain a large enough, or skilled enough, pool of labor to efficiently process a large number of claim transactions. We offer as examples Aetna and Travelers who both found it not cost effective to maintain local claims adjudication offices.

In addition, we understand that the Health Authority would have the power to administer the plan eligibility and implementation, and utilization standards, but, the Health Authority does not possess the information to do so. The three insurance carriers who do most of the business in the state have spent several years establishing their databases. Utilization standards are often considered proprietary information, not for sale or outside use. How would the Health Authority overcome this problem?

3) **Pricing of Coverage and Cost of the Program**: The bills are not clear with respect to how exactly coverage would be priced for the participants. Under the proposed bills, SB 83 and HB 71, the Health Authority would establish a pool or pools of eligible employees, for the purposes of providing health coverage. It is not stated whether this eligibility definition would involve the use of community rating for the group or groups, or, whether groups would be specifically established based upon risk categories.

If Alaska's state pool becomes solely high risk health insurance, the costs associated with this program will be extremely high. As rates increase due to poor risks, the pool will be left only with the least healthy of the population as they must accept all applicants in the absence of pre-existing exclusions. High losses associated with this will be paid by the carrier(s) or, in the worst case, by the state if the Authority elects to self insure. Without a reinsurance mechanism, carriers will leave, or never participate in, this market because they cannot afford these types of expected high losses.

Also, even without high losses, the establishment and administration of the program will be costly for the state. Current budget projections for Alaska predict deficits in future years. In addition, the Alaska economy is an unstable one which cannot count on a consistent level of income from year to year.

4) **Provider Rate Setting**: Experience in six states which utilize a statewide hospital rate setting system (CT, MA, NY, NJ, MD, WA) has shown

that between 1980 and 1989, states with rate setting arrangements have no clear cost advantage over states without rate setting. In fact, in recent years, some rate setting states have experienced growth rates for hospital costs in excess of the national average. For example, in 1988, five out of six rate setting states had growth rates for costs per admission above the national growth rate; in 1989 three of the six states had growth rates 2-6 percent above the national average.

The rate setting system used in Maryland is often cited as one which has been successful at consistently controlling hospital costs. Between 1980 and 1989, Maryland was the only one of the six rate setting states which had a cost per admission growth rate below the national average for every year. However, the spread between Maryland's rate of growth and that for the nation has significantly narrowed in recent years. More importantly, on a per capita basis, in 1988 Maryland had a higher percentage increase in its costs than the average for either the five other regulated states or the national average.

Alaska, which is not currently a regulated state, has had a rate of growth for hospital costs which is not out of line with that for the regulated states over the past ten years. In 1989, Alaska's per admission hospital costs rose almost five percent less than the national average, and were between 2 and 11 percent lower than any of the six regulated states, including Maryland. The North Slope Borough has experienced per hospital admission costs between 4 and 9 percent below those of the six regulated states.

5) **Eligibility Criteria**: The proposed legislation is not clear in the area of defining who is eligible for the state's coverage or what criteria would be used to determine eligibility. If current eligibility language from either employers or insurers is used, the problems of "uninsured", "underinsured", and "uninsurable" individuals remain unaddressed. These people will continue to fall outside of the affordable health care providing arena. All public employers appear to be eligible (along with all employees of this group); other (i.e., private) employers (or their employees) can elect to join the pool (or use only the rate setting and utilization standards), yet no more specific criteria (i.e., pre-existing conditions language) is given.

Because of the vagueness of the definition of "eligible", we are prone to believe that ***adverse selection*** will occur. If the state allows all employer groups or any of their employees to join the pool, only the high risk individuals or groups will elect this coverage. The ramifications of this language will create a pool with a similar demographic cross section to that of COBRA participants. Small employers will act in their own best interest

and sign up their unhealthy (i.e., high risk) employees for the pool when they need coverage and then withdraw them (take them out of the pool, back to their own plan) when they get healthy. Even if coverage is not community rated, this would be a problem since there are no pre-existing exclusions included in this Bill, thus, all could sign up.

If the plan is community rated, adverse selection poses a more severe problem. State employees pose no selection problems since all will join, not just the high risk cases. Under pure community rating, state employees will face much higher rates since the bad risks from the private employers will drive up rates for all. If coverage is not community rated, rates will still need to be higher since the good risks will need to subsidize the bad.

6) **Definition of Group Health Insurance:** Senate Bill 83 and House Bill 71 define group health insurance as including " life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority". We are very concerned that these bills do not address life insurance and accidental death and dismemberment coverages when discussing rate setting and administration. The North Slope Borough has better-than-average life and AD&D experience and would undoubtedly see additional benefit cost increases.

7) **Certificates of Need:** With respect to the requirement of Certificates of Need, Sec. 3, SB 84, and the definition of a "health care facility" in, Sec. 16, SB 84, we will need some additional clarification. As you may know, the North Slope Borough and several of the other rural Borough's have municipal powers in the Health area.

We have a Health Department that has satellite health aide facilities in each of our eight villages and the two primary urban centers, Fairbanks and Anchorage. The definitions of a health care facility and the requirements for Certificates of Need could greatly affect the services this department provides to our entirely rural population. In fact, the requirement of Need Certificates justifying an addition of services in the rural areas could be very restrictive. Such a requirement will also affect our only hospital, the Barrow Public Health Service Hospital. Adding services in an area that has few or no services currently can only save us money in the short and long run.

8) **Evaluation of need for <u>mandatory</u> participation:** Requiring participation of public entities in the group health insurance offerings of the Alaska State Health Resources Authority would cost the North Slope Borough a great deal of money in both the long- and short-term.

If group insurance costs were mandated at the rate the state currently spends for health care, the North Slope Borough would immediately find its health care costs increase approximately 35%, or, $1,000,000 per year. If coverage is not mandated, but remains voluntary, and since all public and private employers and employees are permitted to use the rate setting agreement, those who choose not to would have costs shifted onto them. (This scenario is unlikely unless the state allows only those in the pool (or puts some other condition on the use of the rate setting) to use the rate setting arrangement.) It appears that either way costs will increase for us, but, they will increase the least with a completely voluntary participation clause for public entities.

Also, given that all providers would have the state set rates for them, hospitals would lose a substantial amount of revenue, thus reducing the dollars available to purchase new equipment, hire skilled physicians, etc. Between the services the Borough currently provides, those services that PHS provides, and our exempt status under the IHC Act, we could only see cost increases through mandated participation.

Senator Pearce, we do realize that health care cost containment is one of the primary issues that both the public and private sectors must work together on for solutions. We again acknowledge the hard work the Task Force has put into their report and thank you for including us in your informational search. Please feel free to contact my office if you need clarification of any of our concerns, or have any comments regarding our information.

Sincerely,

Jeslie Kaleak, Sr.
Mayor

cc: Rep. Eileen MacLean
Sen. Al Adam
Sen. Collins, Vice-Chairman L & C
Sen. Eliason
Sen. Halford
Sen. Kerttula

APR 2

3531 West 31st Avenue
Anchorage, Alaska 99517

April 20th, 1991

Senator Drue Pearce
P.O. Box V
Juneau, Alaska 99811

Dear Drue,

As an agent involved in insurance sales, I have almost daily contact with Alaskans who are either unable to afford health insurance or, because of a disqualifying condition, can not get coverage at any price.

It will not be news to you that the health care system in this country is in crisis. Periodically, we hear leaders in the health care and insurance industries (and politicians of all flavors) making noises about doing something about it. To date, I see no progress nor any prospects for progress. The health care providers blame the insurance industry and insurance people blame the medical profession. The pot is kept boiling by union demands and by frequent government action to shift the costs of federal and state health programs to the private sector.

In my opinion, nothing constructive will be achieved until government, medical, insurance, union and business people meet to decide what each can contribute to control the spiralling costs of health care. I believe that unilateral efforts by these parties to solve the problems are doomed to failure.

The National Association of Life Underwriters published a special edition of the Life Association News in February. Its focus is on The Health Care Crisis and I am enclosing a copy for you. I hope you will find it informative.

Sincerely,

Frank Keen

MAY 8 1991

PEDIATRIC CONSULTANTS OF ALASKA, INC.

Clinton B. Lillibridge, M.D., F.A.A.P.

April 21, 1991

Senator Drue Pearce
Chairman
Labor and Commerce Committee
Alaska State Legislature
Pouch V
Juneau, AK 99811

RE: **Senate Bill 83**

Dear Senator Pearce:

Let me tell you why Senate Bill 83 will not provide cost containment.

Approximately 90 percent of my billing is for overhead. My hourly room pay is $15.73. Many other pediatricians, family physicians, and internists have a similar high overhead rate. To regulate costs downward requires reducing salaries for nurses, reducing the amount paid to lawyers, dropping medical liability insurance, not paying rent, or other utilities. NINETY PERCENT OF EVERY DOLLAR PAID TO OFFICES GOES TO THE COMMUNITY. SIMPLY CUTTING PROFESSIONAL FEES WILL HAVE SEVERE EFFECTS THROUGHOUT THE COMMUNITY.

Sincerely,

CLINTON B. LILLIBRIDGE, M.D.
Pediatric Gastroenterologist

CBL/bw

COMMUNITY
CHIROPRACTIC CLINIC

550 EAST TUDOR ROAD
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 562-5366



Dear Senator Pearce,

Again, I would like to thank you for taking the time to visit with us the other day. It was very enjoyable to meet you and we are very happy to support you. Enclosed, please find a couple of pamphlets illustrating the effectiveness and cost effectiveness of Chiropractic versus Medical care for the treatment of musculo-skeletal injuries (the most common type of injury). Also please remember that while Chiropractic is indeed better and cheaper, we also do not expose our patients to the risks of drugs or surgeries. An added benefit of conservative care.

If you have any questions or would like to chat about this a bit, I'll be glad to be available at your convenience.

Hoping you have a successful and enjoyable session.

Most Truly Yours,

David Mulholland D.C.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
INFORMATIONAL SURVEY

BACKROUND

This survey is designed to give the Health Care Cost Containment Task Force additional insight into the complexities of health care delivery and associated costs to Alaskans. This information will be supplemented by public testimony from interested parties later this year.

PLEASE DESCRIBE YOUR PRACTICE :

1. Scope and Specialties of your practice: _____
   _____

2. Year started_____

3. Organizational structure (Corp., Sub. S, Non-Profit, etc.)
   _____

4. Total Number Of Employees_____, Full-Time_____,
   Part-Time _____, Seasonal _____, Other _____

5. Your position _____

EMPLOYEE BENEFITS

6. Does your firm offer health insurance to employees and their dependents? _____

6a. If so, of the total number of employees listed above, how many are covered ? _____, Are any groups not covered ? _____

6b. Which categories? (part-time, seasonal, etc.)_____
   _____

7. Is your health plan provided by an insurance company? _____

7a. If so, which company?_____ how long ? _____

EMPLOYEE BENEFITS CONT.

8. How much are your monthly health insurance premiums?

	1990	1985	1980
Single -	$		
Family-	$		

9. How much do your employees pay towards the cost?

Single- $

Family- $

10. Please describe your health plan?

Annual deductible $ _____

Co-payment percentage _____

Lifetime maximum benefit $_____

Chiropractic benefit limit $ _____

Psychiatric benefit $ _____

Substance abuse limit $ _____

Well child care coverage ? _____

Prescription drug card ?_____

Vision care coverage? _____

Dental coverage ? _____

11. Which of the following health care management techniques have you included in your health plan ?

_____ Preferred provider networks

_____ Pre-certification for hospital stays

_____ Pre-admission testing

_____ Outpatient surgeries

__ ___ Utilization review

_____ Benefit plan changes

_____ Others - Please list _____
_____
_____
_____

12. Which of these have been **most effective** in containing your health care costs? _____
_____
_____

13. Which of these have been **least effective** in containing your health care costs?_____
_____
_____

14. What do you think is the biggest contributor to the rapidly rising health care costs in Alaska ?

_____

_____

_____ _____

15. What suggestions do you have for the Task Force that could help slow medical inflation in Alaska? _____

_____

_____

_____

16. What percentage of your practice/service is providing care to :

Medicare Recipients _____
Medicade Recipients _____
State Employees _____
Federal Employees _____
Uninsured/underinsured _____

17a. How much medical care/service did you provide during 1989 for which you were not reimbursed $_____

17b. What percentage is this of your total practice/service_____%

17c. Approximately how has 17a and 17b changed since 1985?

a. +/- _____%
b. +/- _____%

18. How much have your fees/rates increased :

1989 to 1990 _____%
1985 to 1990 _____%
1980 to 1990 _____%

19. What would you say is the major contributor (s)to increases in your cost of providing health care to Alaskans _____

_____

_____

_____

_____

_____

20.. Would you be interested in testifying before the Health Care Cost Containment Task Force on this issue? ____

If so, Please furnish the following information:

NAME:_____

TITLE:__ _____

REPRESENTING:_____

ADDRESS:_____

_____

_____

THANK YOU FOR YOUR TIME AND INFORMATION. PLEASE FORWARD COMPLETED SURVEY IN THE ENVELOPE PROVIDED.

FINDINGS

The results support the findings of many of the earlier studies of workers' compensation claims: When compared with standard medical care, chiropractic care evidences greater cost-effectiveness in the management of work-related back injuries.

1. The specific findings from the present study that support this conclusion are: The duration of temporary total disability represented by the average length of the com-pensation period, and the indemnity payments for work days lost, were substantially less for claimants treated by chiropractors compared with those treated by medical doctors. In the group of claimants that excluded surgery patients, the period of disability was 48.7 percent shorter for chiropractic patients; for the claimant group that included patients who underwent surgery, the duration of disability was 51.3 percent shorter for chiropractic patients. Interestingly, the magnitude of the difference in duration of disability between patients of chiropractors and medical doctors is similar to that found by other investigators.

2. The average cost of chiropractic physician services and prescribed procedures was significantly less than the corresponding cost for medical doctors. In both claimant groups analyzed in this study, the cost of chiropractors' services and prescribed procedures was over 50 percent less than that of medical doctors (55.3 percent less in claimant group A and 58.8 percent less in claimant group B).

3. Claimants treated by medical doctors were hospitalized at a much higher rate than claimants treated by chiropractors and incurred significant additional costs due to hospitalization services. Only 20.3 percent of chiropractic patients in each claimant group were hospitalized; 51.3 percent of medical patients in claimant group A and 52.2 percent of medical patients, coupled with a higher average cost of hospitalization, resulted in a substantial impact on the overall cost of care attributable to medical doctors.

4. The estimated average total cost of care, computed across all major categories of treatment costs, was substantially higher for medical patients compared with chiropractors' patients: 83.8 percent higher in the claimant group that excluded surgery patients and 95.3 percent higher in the claimant group that included surgery patients. The present study's methodology, in accounting for the total treatment costs of *managing* a work-related back injury, more accurately reflects the cost-effectiveness of chiropractic care over standard medical care.

The study confirms the findings of earlier literature: the chiropractic approach to the management of work-related back injuries and illnesses minimizes the impact of such injuries on prolonged absence from work and excessive treatment costs.

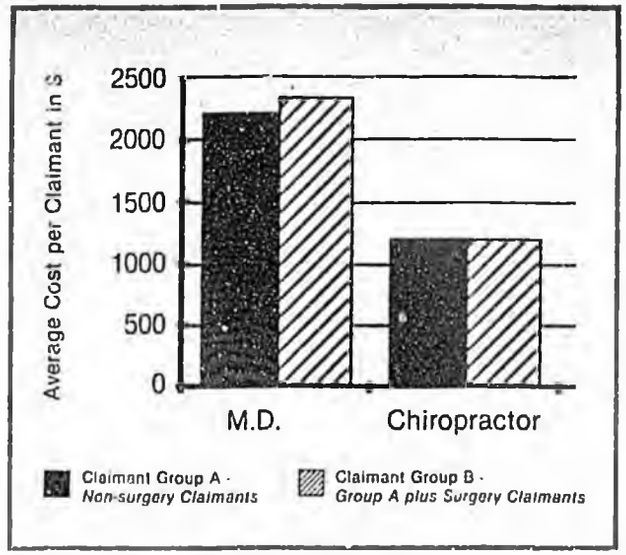


Figure 5. Estimated Total Cost Of Care

ACKNOWLEDGEMENTS

Permission to print the highlights of the Florida report has been granted to the American Chiropractic Association by the Foundation for Chiropractic Education and Research, Publisher. All rights reserved. No part of this pamphlet or the original report may be reproduced, used, stored in a retrieval system, or transcribed, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without the prior written permission of the publisher. Copyright 1988.

For more information, contact: Foundation for Chiropractic Education and Research, 1701 Clarendon Boulevard, Arlington, Virginia 22209.

COMMUNITY CHIROPRACTIC CLINIC

Commission On Insurance
American Chiropractic Association
1701 Clarendon Boulevard • Arlington, VA 22209

Printed in the United States of America

CHIROPRACTIC VERSUS MEDICAL CARE

A Cost Analysis of Disability and Treatment for Back-Related Workers' Compensation Cases.



HIGHLIGHTS OF THE FLORIDA REPORT

A STUDY DESIGNED TO SHOW THE TOTAL COST OF MANAGEMENT OF A CLAIMANT'S TREATMENT

Presented here are some of the highlights of the Florida report. The statistics summarized in the report were compiled by the Office of Medical Services, Florida Division of Workers' Compensation, at the request of the Foundation for Chiropractic Education and Research. The statistics were compiled during the period April-June, 1988. The complete report is available by writing to either the Foundation for Chiropractic Education and Research or the American Chiropractic Association (addresses are given on the back of this folder.)

The annual cost of work-related injuries is a major concern within the health-care profession. Work-related injuries translate into costs not only for treatment and rehabilitation, but costs to employers and insurance carriers for work days lost. Health-care researchers have paid particular attention to workers' compensation claims for back-related injuries, which are one of the most disabling types of injuries.

Because of the debilitating nature of most back injuries, researchers continue to analyze the efficacy and cost-effectiveness of alternate treatment approaches. In light of chiropractic's unique focus on the treatment of the neuromusculoskeletal system and, specifically, the spine, comparisons in workers' compensation literature are often made between chiropractic care and standard medical care.

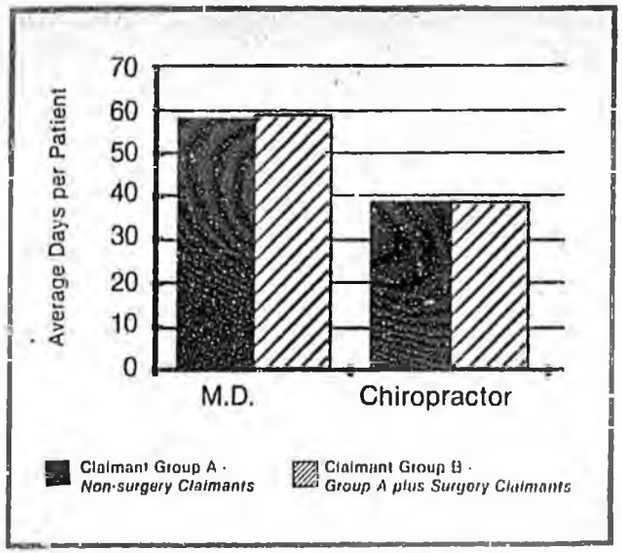


Figure 1. Length Of Compensation Period

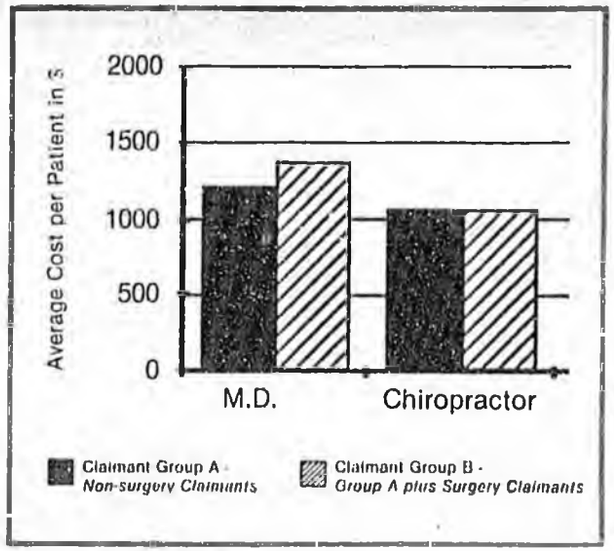


Figure 3. Hospital Services' Costs

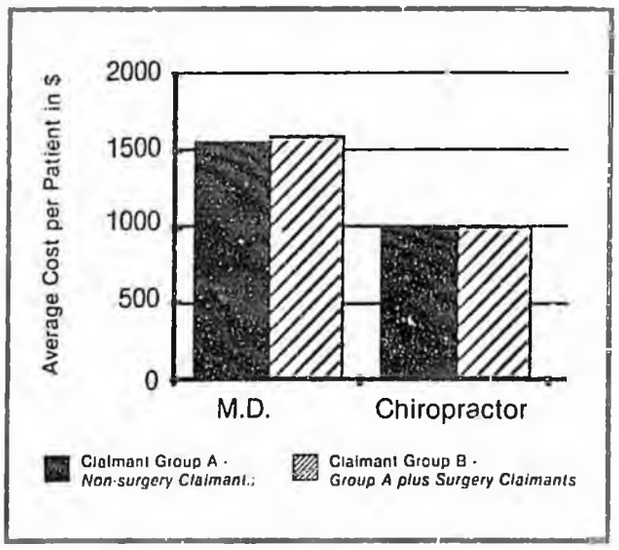


Figure 2. Physician And Prescribed Services' Costs

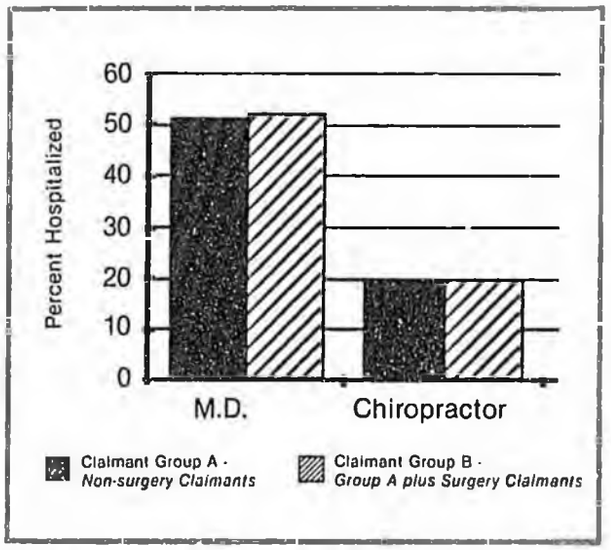


Figure 4. Percent Hospitalized Of All Closed Cases

The purpose of the Florida report is to compare chiropractic and medical care for back-related injuries and illnesses stemming from closed workers' compensation claims. The comparative analysis covers the following major variables: duration of disability; cost of indemnity payments for work days lost; cost of all physician services and physician prescribed procedures (such as occupational and physical therapy and radiological examinations and interpretations); cost of hospital services and procedures, both in-patient and out-patient costs; drug and supply costs; transportation costs; and miscellaneous treatment costs.

F.Y.I.®

A Bulletin for ALEC Leaders
About State, Federal and Local Issues

February 22, 1991

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HEALTH CARE

Three States Confront Universal Health Care: Proponents of Canadian-style universal health care are mounting major efforts in three states, California, Minnesota, and Missouri. Action in these states over the next few weeks may be vital to averting the enactment of such costly and dangerous socialist-style health care system.

In California, Senator Nicholas Petris has introduced legislation, SB 36, that would establish a one-payor universal health care system for all Californians. The government-funded and operated system would provide coverage for a comprehensive package of medical benefits, including hospitalization, preventive care, primary and tertiary care for acute and chronic conditions, rehabilitative care, long-term care, mental health services, dental care, and prescription drugs. Provider rates would be set by the state and all capitol expenditures subject to state control. The program would be funded through a 10% gross payroll tax on all employers (the tax would be phased in over three years for certain small businesses), a 2% tax on gross wages for employees and the self-employed, an unspecified tax on gross receipts, and an increase in the tax on unearned income.

Only slightly less dangerous is legislation, AB 14, by Assemblyman Bert Margolin, powerful Chairman of the Assembly Committee on Insurance. Assemblyman Margolin's proposal would establish a "play or pay" mandate for insurers, similar to Massachusetts failed universal health care law. All employers, regardless of size, would be required to provide qualifying health insurance coverage for all employees working more than 25 hours per week and their dependents. Companies with more than 50 employees that fail to comply will be assessed a "contribution" equal to the highest annual premium charged in the geographic area for group coverage. Employers with less than 50 workers would have to pay an 8% gross payroll tax. Employees of small businesses would be subject to a 2% tax on wages. Qualifying insurance plans must cover hospitalization and attendant services, radiology and other diagnostic services, physician visits, pap smears and mammograms, sterilization, comprehensive maternity and perinatal care, emergency care, reconstructive surgery, preventive care for minors, prescription drugs, and certain mental health services. Qualifying plans would be severely restricted in their ability to require cost-sharing and deductibles could be no more than $250 annually per individual or $500 annually per family.

In Minnesota, new Governor Arne Carlson, in a stunning about-face, now indicates he may not oppose a universal health care program being pushed by Representative Paul Ogren. That legislation, HF 2, is based on recommendations of the Minnesota Health Care Access Commission. Under the proposal the state would establish a basic health care package, to be offered through existing health maintenance organizations (HMO's) and preferred provider organizations (PPO's). The benefit package would include preventive, primary, and outpatient care, prescription drugs, mental health care, and chemical dependency care. Limits on physician visits and hospitalization benefits would be imposed to hold down costs. The state would subsidize purchase of the new insurance through a sliding scale based on family income. The total cost of the program is estimated to exceed $290 million per year. Governor Carlson had said the state could not afford such a program. However, the Governor now says that at least a pilot program would be acceptable.

Missouri legislators are nearing a vote on Representative Gail Chatfield's $6 billion per year proposal for a one-payor universal health care system. That legislation, H 28, has been the subject of a carefully orchestrated campaign by organized labor and other liberal special interests. A vote could come as early as next week.

For additional information, contact Michael Tanner, Director of ALEC's Task Force on Health Care, at (202) 547-4646.

TAX AND FISCAL POLICY

Balanced Budget Amendment Rescission Fails key Vote in New Hampshire: Despite a well coordinated effort to convince New Hampshire legislators to reverse the state's long-held position for fiscal discipline in the federal budget process, the House State-Federal Relations Committee, Chaired by ALEC member, Representative Garret Cowenhoven, recently voted 10-5 against passage of a resolution (HCR 1) to rescind the state's call for a

limited constitutional convention to *propose* a federal balanced budget amendment. New Hampshire is one of twenty-nine states with an effective resolution calling on the Congress to either *propose* a federal balanced budget amendment or to convene a limited constitutional convention to *propose* such an amendment.

Groups supporting the rescission effort in New Hampshire, featuring an amazing cross-section of left- and right-wing extremists -- labor unions, social-welfare spending advocates, the John Birch Society, and Liberty Lobby -- continue to spread the discredited argument that a constitutional convention could not be limited to *proposing* a balanced budget amendment, and that it would somehow develop into a "runaway" convention that could scrap the Bill of Rights and lead to a host of other changes in our form of government. Fortunately, the vast majority of legislators in New Hampshire have read the U.S. Constitution, as well as numerous other historical documents and in-depth studies on Article V and the process for amending the Constitution. Legislators in New Hampshire also realize that Congress is unlikely to *propose* a balanced budget amendment unless and until the requisite number of states (34) exercise their Constitutional prerogative for such an amendment.

The rescission resolution in New Hampshire now goes to the full House of Representatives. However, in the weake of the vote by the State-Federal Relations Committee, it is unlikely that the resolution will pass. The rescission effort also faces strong bipartisan opposition by Legislative Leaders in the state, including ALEC members, House Speaker Harold Burns and Representative Beverly Rodeschin, and by U.S. Congressman Dick Swett.

Similar rescission efforts have been launched so far this year in Idaho, Kansas (HCR 5010), Nebraska (LR 2), South Carolina (H 3353, 3365, S 606, S 611) and Utah (HJR 8).

ALEC supports a federal balanced budget amendment and the unquestionable right of the states under Article V of the U.S. Constitution to call for a constitutional convention to *propose* a balanced budget amendment. ALEC does not take this issue lightly. However, the numerous safeguards built into the amending process are quite clear and distinct. In addition, a *proposed* amendment, either from Congress or a convention, does not become part of the Constitution until it is ***ratified*** by 38 states.

For more information, contact Duane A. Parde, Director of ALEC's Task Force on Tax & Fiscal Policy, at (202) 547-4646, or Senator....

ALEC to Host California Budget Reform Workshop: On Wednesday, March 13, ALEC will sponsor a California Budget Reform Workshop. The Workshop, being held at the request of ALEC State Chairman, Senator Bill Leonard, will address such issues as the effects of mandating and earmarking on state budgets, privatization, and solutions to budget problems from other states. Speakers will include Larry McCarthy, President of the California Taxpayers Association; Steven Haywood, Director of the Claremont Institute's Golden State Project; Wendell Cox, nationally known consultant on public transportation policy; Representative

Joseph Petrilli, Majority Leader of the Delaware House of Representatives and Chairman of ALEC's Task Force on Tax and Fiscal Policy; ALEC National Chairman, Delegate Ellen R. Sauerbrey, Minority Leader of the Maryland House of Delegates; and Senator Kelly Mader, Chairman of the Wyoming Senate Appropriations Committee.

For additional information, contact Senator Leonard at (?16) 445-3688, or Duane Parde, Director of ALEC's Task Force on Tax and Fiscal Policy, at (202) 547-4646.

BANKING AND FINANCIAL SERVICES

Credit Cards Face Increased Regulation: Credit cards have been the focus of a plethora of bills in the current session. Legislation setting interest rate caps for credit card purchases has been introduced in Arizona, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, Texas, and West Virginia. States continue to try to cap interest rates despite overwhelming evidence that such action results in reducing credit availability to minorities and low-income people.

In an interesting counterpoint, six states (Maine, New Hampshire, New Jersey, New York, Rhode Island, and South Carolina) have introduced legislation to establish a state-sponsored credit card. Revenue generated would be used for a variety of purposes, including educational financial aid and environmental projects.

There have also been a flurry of privacy bills introduced which prohibit the use of credit cards as required identification for check cashing. States introducing this type of privacy bill include Arizona, Connecticut, Georgia, Illinois, Indiana, Massachusetts, Minnesota, North Dakota, New Hampshire, New Jersey, Ohio, Oklahoma, South Carolina, Tennessee, Wisconsin, and West Virginia. In conjunction with this issue of privacy, the following states have introduced bills which prohibit a vendor from requiring the credit card holder's telephone number as a condition of sale: Arizona, Connecticut, Delaware, Georgia, Minnesota, New Hampshire, Pennsylvania, Texas, and Washington.

For additional information, contact Patricia Finn, Director of ALEC's Task Force on Banking and Financial Services, at (202) 547-4646.

ENVIRONMENT

Crossborder Transit of Wastes Triggers Civil War Among States: The controversy over out-of-state waste disposal has flared anew recently after several U.S. District Court decisions finding state barriers to crossborder waste disposal an unconstitutional infringement on interstate commerce. Battles between the states are raging in three areas; hazardous waste disposal, low-level radioactive waste disposal, and solid waste disposal.

Hazardous Waste

The controversy over interstate hazardous waste erupted after the North Carolina Council of State (composed of the state's top elected officials) vetoed the construction of a regional hazardous waste incinerator in Butner. The move violated commitments made to other southern states which signed a regional hazardous waste disposal pact with North Carolina in late 1989. Alabama and South Carolina quickly retaliated by banning North Carolina waste from their disposal facilities and recycling centers as of January 1. The move by Alabama and South Carolina (the destination for 71 million pounds of North Carolina's hazardous waste, 64 percent of all hazardous waste shipped out of North Carolina annually) forced hundreds of businesses to store wastes on-site until new contract could be negotiated with facilities in other states. Meanwhile, Tennessee and Kentucky, the other two signatories to the regional pact, indicated that disposal facilities in their states could not be counted on to meet capacity assurances required of North Carolina by the federal government.

A federal district court judge on January 11, however, ruled that several of South Carolina's laws restricting out-of-state hazardous waste disposal were unconstitutional infringements on interstate commerce (*Hazardous Waste Treatment Council v. State of South Carolina, et al, DC SC, No. 3:90-14020-0, 1/11/91*). A similar decision was reached by federal courts last summer, which rejected a ban of certain out-of-state wastes enacted by Alabama. Given the scarcity of case law in this area, these two rulings set a potentially strong precedent and should give pause to those states contemplating similar prohibitions. Both Alabama and South Carolina are appealing these rulings to federal district courts.

In the meantime, South Carolina has threatened to sue the EPA if it fails to penalize North Carolina for its lack of a federally approved hazardous waste management plan. EPA indicated this month that it would likely draft a "tiered" enforcement program out of reluctance to impose harsh penalties mandated under federal law.

The Comprehensive Environmental Response, Compensation & Liability Act (CERCLA) requires that states adopt plans (subject to EPA approval) ensuring 20 years of future capacity for the disposal of all generated hazardous waste. Failure by states to adopt an approved plan could lead to the cutoff of federal "Superfund" cleanup assistance. North Carolina is the home of 22 contaminated sites eligible for Superfund assistance. Analysts estimate that approximately $286 million will be necessary to clean-up these sites in order to meet federal standards.

Other states which are challenging the interstate disposal of hazardous wastes included Louisiana, which has enacted stringent taxes on out-of-state hazardous waste, and New York, which has proposed to modify private disposal licenses in order to set limits on the amount of out-of-state hazardous waste that a facility may accept legally.

The National Solid Waste Management Association recently reported that all states export some hazardous waste to out-of-state facilities and all but two states (Alaska and Montana) received some out-of-state hazardous waste for disposal. Approximately 35 states are net exporters of waste, while 15 states are net importers of waste. Of the 236 million tons of hazardous waste generated each year, however, 96 percent is treated or disposed of at the industrial facility which generated the waste.

Low-Level Radioactive Waste

The controversy over low-level radioactive waste disposal is similar to that regarding hazardous waste. The 1985 Low-Level Radioactive Waste Policy Amendments Act require states to assume responsibility for providing either by itself or in cooperation with other states for the disposal of Class A, B & C low-level radioactive waste. Most of this waste is generated by electric utilities, other industry, government, and university and medical research by-products such as diagnostic and treatment procedures. This waste typically includes contaminated towels, mops, gloves and protective clothing, machinery parts, laboratory equipment, animal carcasses, and various liquids.

Since 1985, most states have chosen to form regional compacts, with one state designated to provide for disposal. Yet little progress has been made in facility siting -- only 3 disposal facilities exist (those in South Carolina, Nevada, and Washington) to handle 1.4 million cubic feet of waste annually. Only Illinois, Nebraska, California, and Texas, and Washington are making progress (albeit slow and amidst serious political opposition) in siting new facilities, leading many analysts to believe that when the three existing facilities close in January, 1993, the nation will face a serious capacity crunch that could devastate certain industries.

New York, one of the few states not part of a regional compact, filed suit against the federal government last year, arguing that the original Low-Level Radioactive Waste Act of 1980 is constitutional because it requires states to take title to privately-generated waste that it did not generate.

State officials which host the three existing disposal facilities are frustrated at the lack of progress by many states in meeting federal mandates for disposal capacity and are prepared to exercise authority to bar interstate disposal of radioactive waste granted them by the 1985 Act. Nevada, South Carolina, and Washington last November prohibited the disposal of radioactive waste generated in Michigan (the designated host state for a facility in the midwest compact). In response, generators of Michigan radioactive waste filed suit against the three states and the state attorney general filed suit against other members of the midwest regional compact (Indiana, Iowa, Minnesota, Missouri, Ohio, and Wisconsin). Michigan argues that these states are not forthcoming with promised financial assistance in the state's search for an acceptable site.

Michigan may be the first of many states excluded from disposal rights in the near future. Washington, South Carolina, and Nevada have similarly warned Massachusetts and New Jersey this month that, unless those states speed up their own siting process, they to will be prohibited from using the nation's only three low level radioactive waste disposal sites. In the meantime, Washington has unilaterally prohibited the disposal of radioactive waste generated in Rhode Island, Vermont, New Hampshire, Puerto Rico, and Washington, D.C.

Solid Waste

The ongoing controversy regarding interstate solid waste disposal recently came to a head over Indiana's recently adopted House Enrolled Act 1240.

The Indiana statute would (1) require transporters of interstate waste to certify the origin and non-hazardous content of the solid waste based upon inspections by officials in the state where the trash originated, and (2) mandate that out-of-state waste disposal fees equal the fee for dumping the waste at a site closest to the waste's point of origin minus the fee actually charged for disposal by the Indiana disposal facility.

A U.S. District Court, however, ruled on December 27 that both provisions of the bill violate the commerce clause of the U.S. Constitution (*Government Suppliers Consolidating Services Inc. v. Indiana*, DC SInd, No. IP 90-303-C, 12/27/90). Although Indiana argued that the law was an attempt to protect the health and safety of its citizens, the court found that that no such evidence existed to prove that it would do so and that, moreover, was more interested in economic protectionism and political posturing. A similar ruling was issued last summer regarding the unconstitutionality of an Alabama waste ban statute.

Arkansas, Delaware, Ohio, Michigan, Wisconsin, Montana, and Rhode Island have similar provisions on the books which restrict the disposal of out-of-state waste and are thus subject to legal challenge.

An October, 1990 report issued by the National Solid Waste Management Association found that only 8 percent of the nation's solid waste is transported for disposal across state lines, and that 83 percent of all such shipments are either between contiguous states or states in nearby, non-contiguous regional wastesheds. All told, fully 38 states are both importers and exporters of solid waste, 5 states are exporters only, 4 states and importers only, and 1 state (Montana) is neither.

Clearly, a political Lebanon is being waged between states who have enshrined NIMBY -- Not-In-My-Back-Yard -- as the central objective of all state waste policy. This is not only destructive economically (waste flows to the cheapest disposal fees and thus ensures affordable disposal) but environmentally as well. Waste should be disposed of in the most environmentally sensible facility available, regardless of location. Statutes which close down disposal options will increase costs to the economy and in many cases direct wastes to obsolete facilities for lack of better recourse. Finally, small communities willing to host such facilities are unduly penalized by limiting the means by which they can build-up their tax base and provide local jobs. State legislators would be well-advised to resist the political temptation afforded by such policies and pursue a balanced waste agenda that protects the environment and the economy.

For further information, contact Jerry Taylor, director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202) 547-4646.

<u>CONEG Falls Apart Over Packaging Restrictions</u>: The Coalition of Northeast Governors (CONEG) fragmented last month when environmental groups pulled-out of the Coalition's Source Reduction Council (SRC) over protests that anti-packaging efforts were being stalled by lack of political commitment by the Governors and procedural changes in the organization's operating procedures. CONEG is composed of state executives, individual businesses, trade associations, and environmental

groups charged with reaching consensus recommendations on various solid waste policy issues.

CONEG gained national notoriety last year when it issued model toxics-in-packaging legislation that was subsequently adopted by 8 states, thus becoming a *de facto* national standard. Yet CONEG's Source Reduction Council was charged with a more ambitious agenda which included sweeping product regulations. Although business interests were dubious about SRC's direction, they believed that yet-another attempt at "dialogue" and "consensus building" with the environmentalists was preferable to being the target of bad press and green boycotts. These earlier fears were confirmed, however, when environmental groups within SRC -- led by the Environmental Defense Fund and the Natural Resources Defense Council -- demanded that the group endorse a goal of 50 percent reduction in consumer packaging over 5 years. When the debate reached a deadlock, CONEG officials changed the procedural rules which provided environmentalists veto-power over SRC recommendations. Miffed, the greens picked-up there marbles and went home. Although the governors represented by CONEG have sent letters to the environmentalists pleading for their return, analysts believe that CONEG's influence in the solid waste debate will decline dramatically.

Policy analysts believe that CONEG's absence won't be missed much. CONEG's toxics-in-packaging bill will have more political impact than environmental consequence, given the essentially trivial nature of the risks addressed. The real significance of CONEG was the belief invested in its potential by the business community, which lended credibility to the group's recommendations with many state legislators. The fact that American business would walk so far down this policy road and court such economic disaster is distressing in itself. Modern packaging is a significant contributor to our nation's standard of living, a benefit to consumers, and a key factor in reducing America's solid waste stream through the well-documented reduction in food waste, broken products in transit, and efficient product use. CONEG was built upon the false premise that packaging was a solid waste problem in need of state action. Thus, no economic or environmental good could possibly come from the organization.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

California Court Curbs Initiative Process by Overturning Proposition 105: Proposition 105, enacted by California voters in 1988, was overturned this month by a state appeals court which found that the initiative violated the state's constitutional requirement for single-subject ballot initiatives (*Chemical Specialties Manufacturers Association, Inc., et al. v. Deukmejian et al,.* Cal CTApp San Fransisco, No. A04089). Proposition 105, the "Public's Right to Know Act," required businesses advertising household products with toxic constituents to provide warnings that the product should not be disposed of in the trash, among other things. The law, in the opinion of Appeals Court Judge Robert Merrill, "Seeks to reduce toxic pollution, protect seniors from fraud and deceit in the issuance of insurance policies, raise the health and safety standards in nursing homes, preserve the integrity of the election process and fight

Apartheid," which might be "well-intentioned" but not reasonably related to one another.

Political analysts note the California leftists have become experts at grouping vague, warm-sounding policies together in an unbeatable combination of mom-and-apple-pie propositions linked only to the extent that a *Jeopardy* category is linked by the moniker "Things Beginning with the Letter R." This dishonest practice will undoubtedly be difficult to continue if the Appeals Court ruling stands.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

Federal Court Rules Municipalities Can Be Responsible Parties for Superfund Cleanup & Liability: A U.S District Court ruled last month that household waste is not automatically exempt from federal Superfund law and the municipalities can be held legally liable for trash sent to landfills requiring cleanup (*B.F. Goodrich Co. V. Murtha, DC Conn,* No. N-97-52-PCD, 1/8/91). A similar ruling last December (*Transportation Leasing Co. v. California,* No. CV-87-7368-WMB, DC, Calif, 12/4/90) leads policy experts to conclude that massive cleanup costs stemming from the federal Comprehensive Environmental Response, Compensation, And Liability Act (CERCLA) will soon threaten taxpayers who may be responsible for at least 22 percent of the disposal facilities on the Superfund National Priority List.

Perhaps the realization that what the government defines as hazardous waste -- requiring billions of dollars for cleanup -- includes items stored routinely, without hysteria, in most every household in America will lead municipal officials to the conclusion that Superfund cleanup mandates amount to environmental overkill, are economically ridiculous, and potentially ruinous to a multitude of parties -- including taxpayers. It's unfortunate that this realization may come only when public officials, as opposed to industry, are faced with its mandates.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

EDUCATION

Vouchers Achieving Popularity in School Choice Battles: The most far reaching form of choice in education is one that provides parents with a certificate or voucher which can be used at any public or private school in the state. The passage of a Wisconsin bill in 1990 that provides low income parents in Milwaukee a voucher with a value of $2500 redeemable at any non-assigned public or participating private school opened the floodgates for variations of voucher legislation in 1991.

Legislation in Tennessee would grant all parents a voucher equal to the annual per student cost of public education redeemable at any non-assigned public or participating private school. In Florida legislation, HB 385, has been introduced that would grant all parents a voucher with a value equal to 80% of the annual per student cost of public

education if redeemed at a non-assigned public school or 60% of the annual per student cost of public education if redeemed at a private school. A bill in Kansas, S 199, would provide all parents in the county encompassing Wichita a voucher with a value equal to the annual per student cost of public education. And, in Maryland, legislation, H 598, would grant low income parents with children in "academically bankrupt" elementary schools in Baltimore a voucher with a value equal to the annual per student cost of public education.

Similar public/private choice legislation is currently being drafted by ALEC members Representative Grusendorf in Texas, Senator Salvatore in Pennsylvania, and Representative Bugielski in Illinois. It is also likely that the Louisiana Association of Business and Industry will be pushing for the introduction of a public/private choice bill in Louisiana this year.

A less effective but more common form of choice is "open enrollment" which allows parents to send their children to any public school in the state. Open enrollment bills have been introduced this year in Michigan, H 4107, South Carolina, H 3087, and Oklahoma, S 40, and are expected to be introduced in Alabama, Massachusetts and North Carolina. Since 1987, some form of open enrollment has been enacted in Minnesota, Ohio, Utah, Idaho, Washington, Iowa, Nebraska, Colorado, and Arkansas.

For additional information, contact Timothy Beauchemin, Director of ALEC's Task Force on Education, at (202) 547-4646.

CRIMINAL JUSTICE

Electronic Home Monitoring Expanding as Sentencing Option: Legislation to expand the use of electronic home monitoring has been introduced in Massachusetts (H 1931 and S 622), Montana (H 148), Nevada (A 314), New York (A 1345 and S 2156), and Virginia (H 1380). The Virginia bill, which has passed the legislature and is awaiting the Governor's signature, would allow probation and parole officers in addition to sheriffs and jail administrators to assign offenders to electronic home monitoring.

Although judges or corrections officials in each of these states currently have authority to sentence some offenders to electronic home detention, such an alternative is rarely used. For example, according to a 1988 National Institute of Justice survey, less than 200 convicts in the states mentioned above combined were being electronically home monitored compared to over 1,000 in Florida and Michigan each.

For more information, please contact Timothy Beauchemin, the Director of ALEC's Task Force on Criminal Justice at (202) 547-4646.

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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.

MAY 3 1 1991

. . . FEDERAL UPDATE . . .

National Conference of State Legislatures **Vol. V, No. 5 05/24/91**

* **FISCAL YEAR 1992 BUDGET RESOLUTION**: With House and Senate Appropriations Committees anxiously awaiting the go-ahead to start moving the 13 regular appropriations bills, senior members of the House and Senate Budget Committees have begun final deliberations on the Fiscal Year 1992 budget resolution. The conference committee is expected to be fairly short because there are only a small number of differences between House and Senate spending priorities. The biggest disagreements are in the areas of education, transportation, administration of justice, science, space, and technology. Most of these disputes will be resolved by simply "splitting the difference" between House and Senate recommendations.

The most contentious issue between House and Senate budgeteers will be the so-called "Brown Amendment" that is attached to the Senate version of the budget resolution. Under the Brown proposal, any new or expanded entitlement spending can only be financed through spending cuts in other entitlement programs. Under last year's budget agreement, which instituted new "pay-as-you-go" budget rules, new entitlement spending could be off-set by either spending cuts or new tax increases.

Many Senate Democrats are strongly opposed to the Brown Amendment as they believe it will "hand-cuff" Congress in its ability to finance new domestic initiatives. It is expected that Sen. James Sasser (D-Tennessee), Chairman of the Senate Budget Committee, will work with House Democrat conferees to strike the Brown proposal from the final version of the budget.

NCSL continues to encourage budget conferees to increase transportation spending to the level supported by highway user fees and Highway Trust Fund balances, provide sufficient funding for Unemployment Insurance administration, and express support for the Bush Administration's new $15 billion block grant for the states.

NCSL STAFF CONTACT: SUSAN WOLFE

* **CHILD CARE**: Among key programs contesting for limited domestic discretionary funding is the Child Care and Development Block Grant. NCSL and many other groups labored hard in the 101st Congress to enact this state grant program that carries no federal mandates or standards. At issue in the FY92 appropriations process is whether to fund this new program at its fully authorized amount of $825 million. The President's proposed budget and House and Senate budget resolutions call for increases over the FY91 appropriation -- but not full funding.

> **ACTION**: Contact members of the House and Senate Appropriations Committees and urge them to support a $825 million FY92 appropriation for the Child Care and Development Block Grant. A secondary issue regards the disbursement date for these funds that the Administration has recommended as September, 1992 (or one month before the federal fiscal year ends). An earlier disbursement date of March 1, 1992 should be sought in communications with Congress.

NCSL STAFF CONTACT: SHERI STEISEL

* **FOSTER CARE**: NCSL, governors, and state welfare administrators are seeking appropriations language that would end the perennial effects of HHS' underestimating of states'

claims for Title IV-E foster care and adoption assistance administrative costs. With the exception of the FY91 appropriation that provided $536 million of 1989 and 1990 back claims, annual Title IV-E appropriations have failed to cover both current costs and prior year claims. Complicating matters are statutes prohibiting payment for prior year claims from current year appropriations.

> **ACTION**: State legislators should call House and Senate Appropriations Committee members and urge: (1) the addition of budget neutral language that would make "such sums as may be necessary" available for unanticipated Title IV-E costs -- making this program similar to AFDC and Medicaid; (2) full funding of Title IV-E; and (3) funding for prior year claims (only $118 million recommended by Administration and House/Senate budget resolutions when several hundred million is owed).
>
> *NCSL STAFF CONTACT: SHERI STEISEL*

* **BANKING REFORM**: The House Subcommittee on Financial Institutions has begun consideration of amendments to the Administration's proposal to reform the nation's banking system. Over the next couple weeks, the Subcommittee will be considering various proposals that would authorize, by federal law, nationwide interstate branching by banks; preempt state banking laws; and threaten the future of the nation's dual banking system. NCSL has been working aggressively to preserve the states' ability to control entry into banking markets and adapt banking policy to the needs and characteristics of local markets, businesses, and communities.

With the support of NCSL and other groups, the Subcommittee has already rejected the Administration's proposal to limit the number of insured accounts per person per institution. However, an NCSL-supported effort to permit well-capitalized state banks to participate in activity not permitted by a national bank failed to garner Subcommittee approval.

The key vote in Subcommittee will be on an amendment offered by Rep. Bruce Vento (D-Minnesota) that will preserve states' ability to permit interstate branching. NCSL strongly supports the Vento amendment and a close vote is expected.

> **ACTION**: Contact your House delegations, especially those members on the House Banking Committee, and urge support for the Vento Amendment. In addition, urge support for any legislative proposals that preserve state banking powers and the resulting positive impact such regulation has on community development and small business growth.
>
> *NCSL STAFF CONTACT: BILL WAREN*

* **HIGHWAY REAUTHORIZATION**: The Senate Environment and Public Works Committee has taken the lead on surface transportation reauthorization legislation, S. 965. This proposal, which is being sponsored by Sens. Daniel Moynihan (D-New York), Quentin Burdick (D-North Dakota), Frank Lautenberg (D-New Jersey), John Chafee (R-Rhode Island), and Steve Symms (R-Idaho), would spend $105 billion for highways and mass transit over the next five years.

The most controversial provisions are: 1) the consolidation of most categorical programs into an omnibus $45 billion grant to the states; 2) greater planning and programming responsibilities for metropolitan planning organizations (MPOs); and 3) guaranteeing each state an apportionment equal to the average of federal funds received during 1987-1991. The legislation continues funding for Interstate completion and maintenance, but stresses overall transportation efficiency and integration, by rewarding the improvement of existing facilities with a higher federal matching rate.

At press time, the Environment and Public Works Committee has scheduled a meeting for May 22 to consider amendments to S. 965. It is expected that a number of changes to the state apportionment and MPOs sections will be considered. At this point, there appears to be no interest by Senators to propose an increase in the federal excise tax on motor fuels.

The House Public Works and Transportation Committee has yet to introduce its highway reauthorization proposal, as there appears to be no consensus among committee members regarding the future of the federal highway-aid program. Legislation may be drafted by early June and a 5-10 cent increase in the federal gas tax may be assumed. House Democrat leadership has expressed support for an increase in the excise tax. Additional hearings are expected after the introduction of the House committee bill.

NCSL STAFF CONTACT: REBECCA BRADY

* **SOLID AND HAZARDOUS WASTE**: Legislation waiving federal sovereign immunity and permitting states to assess fines and penalties against federal facilities continues to move ahead. H.R. 2194 (Reps. Denn.. Eckart, D-Ohio and Dan Schaefer, R-Colorado) is headed for a full House Energy and Commerce Committee hearing on June 4, while its Senate companion, S. 596 (Sen. George Mitchell, D-Maine), was voted unanimously out of the Senate Environmental Protection Subcommittee. Despite bipartisan cosponsorship, Administration support is limited to support for the "objectives" of the legislation only.

Meanwhile, Sen. Max Baucus (D-Montana) unveiled the Senate's bipartisan legislation, S. 976, intended to reauthorize the Resource Conservation and Recovery Act. Hearings are scheduled to commence in June. House legislation will not emerge until September as the Hazardous Materials and Transportation Subcommittee continues preliminary hearings.

> **ACTION**: NCSL continues to encourage legislators to contact their delegations to urge cosponsorship of and support for S. 596 as drafted and cosponsorship for and support for H.R. 2194. NCSL opposes section 2(c) of H.R. 2194 which preempts state authority to use fine and penalty proceeds as states determine by earmarking such proceeds exclusively for environmental purposes.

NCSL STAFF CONTACT: JON FELDE

* **MEDICAID**: The Administration has launched a major offensive against states' use of provider taxes and voluntary contributions to enhance state Medicaid matching funds. Almost half the states have enacted or have under consideration one or both of these financing options to expand access, improve provider reimbursement, and to pay for recently enacted federally mandated program expansions. Last year, the Health Care Financing Administration (HCFA) published proposed regulations that would have restricted the use of both financing options, but Congress enacted a statutory prohibition on the promulgation of regulations on provider taxes and placed a moratorium on regulations on voluntary contributions that expires December 31, 1991.

Legislation (H.R. 1457, S. 833) to extend statutory protection similar to that enacted last year regarding provider taxes, has been introduced by Congressman Jim Cooper (D-Tennessee) and Senator Wyche Fowler (D-Georgia). HCFA is preparing new regulations that are likely to prohibit the use of voluntary contributions and may also restrict the use of provider taxes by redefining what constitutes a tax.

> **ACTION**: Write your Congressional delegation and urge cosponsorship of H.R. 1457 and S. 833 which provides statutory authority for states to produce up to 10 percent of their total state

Medicaid match through voluntary contributions. You should also consider writing President Bush, Department of Health and Human Services Secretary Louis Sullivan, and HCFA Administrator Gail Wilensky advising them of the importance of these financing options.

NCSL STAFF CONTACT: JOY JOHNSON WILSON

* **MEDICAL MALPRACTICE**: The initial component of the Bush Administration's health care reform strategy, a medical malpractice proposal, was unveiled on May 15th. States would be given three years to cap non-economic damage awards, eliminate joint and several liability, eliminate the collateral source rule, require periodic payments, promote alternative dispute resolution mechanisms, and implement procedures to enhance quality of care through enhanced effectiveness research and improved peer review. Beginning in 1995, states that enact a certain number of reforms would be eligible to share in an incentive pool.

A budget neutral pool would be created by (1) withholding 2 percent of the state Medicaid match for salaries and expenses, generating approximately $90 million in FY 1995; and (2) withholding a portion of the annual update for Medicare hospital DRG payments. States that enact reforms would receive enhanced Medicaid matching rates for program administration and their hospitals would receive supplemental payments. States that fail to enact reforms lose the Medicaid administrative matching funds.

NCSL STAFF CONTACT: JOY JOHNSON WILSON

* **BELLAS HESS**: On May 17, 1991, North Dakota's Supreme Court upheld the state's right to require out-of-state mail order companies to collect state sales taxes. The decision reached in *North Dakota v. Quill* favorably treated the state's expanded definition of a "retailer" for sales tax purposes. The Court concurred with the state's argument that there was sufficient contact or presence (nexus) in the state by direct marketers to require tax collection under the due process clause. The *Quill* decision followed two recent Tennessee trial court renderings that found that use of government services and modern technology, rather than, strict physical presence, satisfied Due Process arguments for requiring sales tax collections. The *Quill* case is expected to be appealed to the U.S. Supreme Court.

NCSL STAFF CONTACT: SUSAN WOLFE

***** All action requests are consistent with NCSL-approved policy. *****

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. . . *FEDERAL UPDATE* . . .

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS[1]

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
OVERVIEW OF PLAN													
Approach													
pluralistic	X	X	X	X		X	X	X	X	X			X
unitary					X[2]						X[3]	X	
Access Assured													
universal	X	X	X	X	X	X		X[4]			X	X	X
not universal							X[5]		X	X			
PRIVATE PROGRAM													
Individual Mandates	X	X	X										X
Employer Mandates	X	X	X	X								X	X
phase-in	X	X	X	X									X
small employers permanently exempt													
minimum % of premium paid for full-time employees	50	80	80										75
minimum % of premium paid for dependents	50	80	60										
premium participation for part-time	X	X	X										X
Subsidies/Tax Incentives	X	X	X	X			X	X	X	X			
employer	X	X	X	X			X	X	X	X			
individual	X	X	X	X			X	X	X				
Cap on Tax Deductible Premium				X[6]									

AHA = American Hospital Association
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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
Insurance Market Reform	X	X		X		X	X	X	X	X		X	
reinsurance mechs./pools	X	X		X			X	X	X				
elim. pre-existing condition clauses	X	X	X	X			X						
required community rating		X	X[7]										
PUBLIC PROGRAM(S)													
Organization													
single program	X										X	X	
separate for different populations		X	X	X	X	X	X	X	X	X			X
Eligibility/Basic													
everyone					X						X	X	
poor	X	X	X	X			X	X	X	X			X
elderly/disabled	X		X[8]	X			X[8]	X[8]	X[8]	X[8]			X[8]
others on buy-in	X	X	X				X	X		X			X
Eligibility/Catastrophic													
everyone	X												
public program enrollees only		X			X[9]								
Funding													
federal	X	X	X	X	X	X	X	X	X	X	X		X
state		X	X	X	X	X	X	X	X	X	X		X
premiums	X	X	X		X	X				X	X		X
individual income-related	X	X	X		X	X				X	X		X
service specific	X[10]												

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FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
employer	X	X			X								X
Administration													
federal	X	X			X							X	
federal/state		X[11]	X	X			X	X	X	X			X
private as TPA	X	X[11]		X	X		X	X	X	X			
private as underwriters				X									
BENEFITS													
Federal Definition Of Minimum Benefit	X	X	X	X	X	X[12]			X	X	X	X	X
applies to public plan	X	X[13]	X	X[13]	X	X			X	X	X	X	X
applies to private plans	X	X	X	X		X						X	X
Preemption or elim. of state mandates	X	X	X	X			X	X[14]	X[15]	X[16]			
Scope													
basic	X	X	X	X	X	X			X	X	X	X	X
catastrophic	X	X	X		X[17]								
preventive	X	X			X	X				X	X		X
long-term care	X	X[18]		X[19]	X	X							
Limits													
quantitative limits on services		X			X[17]					X			
dollar limits													
marginal services excluded	X												
medically necessary & reasonable	X	X	X		X						X		
high front-end deduct. and copays	X	X			X[20]								

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
IMPROVED AFFORDABILITY													
Federally-Administered Controls on Prices or Total Expenditures					X							X	
State-Administered Controls on Provider Prices or Total Expenditures						X							
Optional Use Of Public Program Rates By Private Insurers													X
Incentives Operating Among Purchasers, Providers, And Consumers With Negotiated Payment	X								X	X			
Required Management Of Care	X	X								X			
all care	X												
only selected services (e.g., long-term care) or selected populations		X			X					X			
Promotes Management of Care		X						X	X				
Disclosure Of Provider Cost And Quality Data	X	X						X	X	X		X	X
Guidelines On Technology And Special Services	X	X				X		X				X	
Use Of Medical Practice Parameters	X	X		X		X	X	X				X	X
Tort Reform	X	X		X		X	X	X	X	X	X	X	X
Anti-trust and Other Legal Reforms to Promote Cost Containment	X									X			
Promotion Of Living Wills And Advance Directives	X												

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Endnotes

1. Some of the proposals are at the "principles" stage and may change significantly. Please refer to the attached summaries for the source and status of the information reflected in this chart.
2. Rep. Stark's proposal calls for public program coverage of all Americans for basic coverage, but it also mandates that employers supplement basic coverage with private coverage if they currently provide more than MediPlan's benefit package. Consequently, this "maintenance of effort" provision takes on some of the character of a pluralistic system. MediPlan LTC is completely public.
3. ACP's position paper presents a national universal financing plan as its long-term goal, but concedes that the immediacy of current access problems may make it necessary to suppport incremental expansions in insurance coverage through Medicaid expansions and, perhaps, an employer mandate. The recommendations presented in their paper are limited to the long-term goal.
4. While BRT's principles call for universal access, the program elements reflected in the principles would not provide for universal access.
5. The USCC adopted a long-term goal of universal access through a pluralistic system, but its proposal is limited to an expanded Medicaid program and a series of provisions designed to improve access to affordable private insurance.
6. Also includes tax-exempt rebates to employees selecting insurance plans with premiums less than those of employer's other plans.
7. Community rating would be required only for the system of regional insurers who would provide insurance to small businesses.
8. Does not propose any alterations of the Medicare program.
9. Catastrophic protection provided only for low-income enrollees.
10. Premiums would be service specific only for expanded benefits to current Medicare beneficiaries whose premium and cost-sharing levels for current services would be grandfathered under the new public program.
11. Presented as one of several options.
12. NGA splits this responsibility between federal and state governments: the federal government would establish guidelines for minimum benefits, while state governments would be responsible for establishing a process to develop, determine, and define the specific benefit package.
13. Enriched package under public plan.
14. BRT would eliminate any federal or state mandated benefit laws.
15. Exemption from state mandated benefit laws would appear to apply only to small employers.
16. Provides exemption from state mandated benefit laws only for basic catastrophic plans.
17. Quantitative limits for hospital care benefits and cost-sharing are eliminated for low-income individuals, thereby providing for some catastrophic coverage for the poor.
18. Means-tested.
19. Asset protection plan.
20. High front-end deductibles and copayments would apply only to long-term care coverage.

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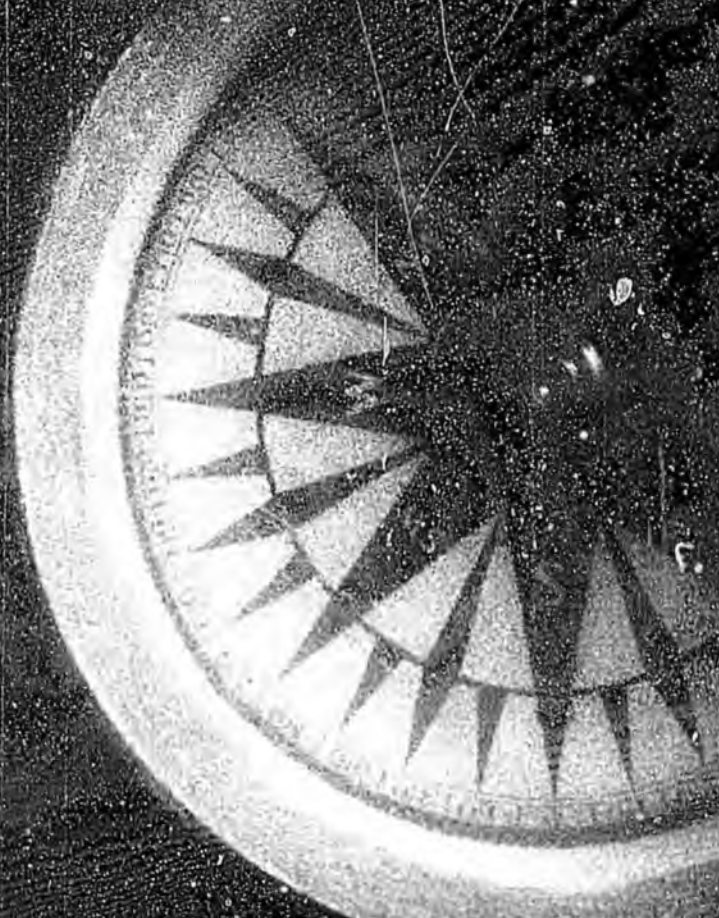
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* National Survey, Decision Research Corp., 1987.

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COVER PHOTO BY DAN GLASS

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EDITORIAL
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EDITOR'S NOTES

Is There Still Hope For Free Enterprise?

Whispers are starting in the corridors of Congress. Grumbles are growing louder in corporate suites. There is a sense of inevitability at some insurance companies.

It seems that politicians, doctors, consumers and even insurance executives are wearying of the fight to keep health-care costs down. After great sighs, they are beginning to murmur, "maybe a national government-run plan wouldn't be so bad."

It almost certainly would.

While the concept of government as Universal Nanny loses its intellectual force around the world, here in the home of capitalism there is a growing desire to cut private enterprise out of the health-care system as if that would somehow solve our health-care delivery problems.

It almost certainly would not.

True, health-care costs are difficult to restrain. Also true, the current system needs substantial change to cover the uninsured and guarantee cost-effective health care for all. But it's a long leap from that to a giant government bureaucracy doling out health care like food stamps.

Without the influence of market forces, health-care costs will rise even faster. Without competition among providers and between insurers, and without pressure from corporations to keep employee benefit costs down, the price spiral will get worse.

In Canada, Great Britain and other countries with socialized medical systems, government health care has lead inevitably to government rationing of health care and, after a brief pause, a renewed price spiral. History shows us that modified capitalism—a market economy to distribute goods combined with a safety net for those who cannot compete—is the fairest, most cost-effective and productive way to distribute goods and services. Insurance is the critical element in a free enterprise medical system, and the stresses and strains on the insurance business have been immense. Of course, in many ways the insurance industry is simply the bearer of bad tidings, being blamed for a message no one wants to hear.

We bring the message of over-utilization, cost shifting, waste and misapplication of resources.

Nonetheless, there is a real question whether or not the system will survive. Can those concerned, including our industry, creatively modify what doesn't work and keep what does? Can we as a nation manage to keep choice possible? Does the most technically advanced medical system in the world have any hope at all?

Those are the questions we thought deserved a special 13th issue of *Life Association News*. And after thousands of hours of research and hundreds of interviews, we can say with confidence that some tremendously intelligent and energetic people across the country, especially in the insurance industry, are working very hard to preserve the best parts of our system.

There is still hope, they told us, but time is running out for an industry solution, for a free-enterprise solution.

Ian Mackenzie

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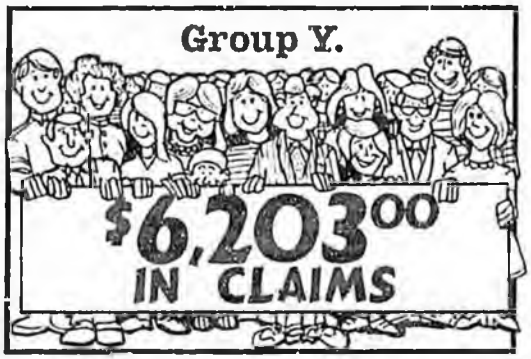
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VIEW POINT

High-Tech Ambulance Chasing

Back in the depression days of the 1930s, entertainment was delivered mostly by radio comedians who could articulate visual pictures in their routines. One such comic used to tell the story of a lady who slipped on a banana peel and before she hit the ground three lawyers were there asking to handle her lawsuit. This story, and others, popularized the term "ambulance chaser" as applied to lawyers specializing in personal injury lawsuits.

Today, such lawyers no longer wait for the accident to happen before pursuing their client. They now advertise aggressively to precondition the public to the notion that if anything out of the ordinary occurs, a lawsuit is the only solution.

Insurance companies, doctors and others offering professional services in this way are characterized as something just short of the devil himself. In contrast, the lawyer is portrayed as a modern-day St. George slaying the dragons of incompetence and oppression.

Ambulance chasing was not regarded as an honorable occupation during the depression—but rather a survival technique. In my view, the use of the electronic media and other high-tech communications has not changed that perception, despite the pious proclamations in their ads. Most lawyers I know are embarrassed by these activities and decry the damage being done to the image of an otherwise honorable profession. They privately admit, however, that it is not likely that the rest of the legal profession will be able to control this practice.

Unfortunately, the image of the legal profession is not the major problem created by this activity. Because we have thus become the most litigious society in the world, the price of almost all goods and services produced in our country carries a surcharge to cover the cost of this extravagance.

Nowhere is this more evident than in the cost of delivering health care. Admittedly there are many contributing factors to the high cost of health care, but litigation is probably the least essential.

One can understand the need for extra professional hands during surgery as well as standby machines and personnel in case of problems. But I don't think we need a standby lawyer eager to make a case.



By Jack E. Bobo, CLU, FLMI, NALU Executive Vice President

I cannot say with certainty how much the proliferation or threat of litigation increases the price of health care, although I have seen numbers that are frightening. It has been estimated that the overall cost of health care adds $700 to the cost of producing a car in the United States as compared to $300 in Germany and $200 in Japan. Malpractice litigation is virtually unknown in either Japan or Germany—so draw your own conclusion.

If excessive litigation cannot be curbed, what is the answer? In my report to the National Council last September, I suggested that the time had come to design around the problem. We do need to care for and indemnify casualties of the healthcare delivery system—but the tort system is outmoded and too expensive.

There are many contributing factors to the high cost of health care, but litigation is probably the least essential.

Others have reached similar conclusions. In 1988, Sarah Christianson, ASA, Ph.D., an actuary with the Principal Financial Group, wrote an essay as part of her actuarial studies that outlined a plan much along the lines of my September report.

Her proposal would establish a system giving patients free medical and rehabilitative care for anything related to error or negligence. In exchange, a patient's right to sue would be limited to four narrowly defined situations. Frivolous suits would be subject to a penalty of all trial costs. She further proposed that funding be a flat percentage (probably less than 5 percent) of all medical fees. The benefits and cost savings of the plan are too numerous to mention here.

My hope is that a full text of her proposal will be printed in a subsequent issue of *LAN* along with any additional insight she may have. I believe the concept is viable, but much thought and preparation must precede any effort at implementation. I would be very interested in hearing from anyone else who has pondered this question. Any proposal for health insurance reform that omits the tort question is, in my view, grossly inadequate. ■

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PRESIDENT'S
PAGE

The Baby Is Healthy

Just one year ago, the National Association of Life Underwriters (NALU) initiated the development of our health conference, the Association of Health Insurance Agents (AHIA). A lot has taken place in 12 months and we now have a strong and growing youngster.

During initial organization, discussion focused on what should be done, who would be affected and how to begin. By now you are seeing activities that respond to these questions. AHIA is off and running.

Still, some members continue to ask, "Why should I become involved in AHIA?"

Most of the members of our state and local associations sell or buy health insurance. Every member pays taxes that directly or indirectly support health insurance programs and policies at both national and state levels. In addition, every member has a personal opportunity and responsibility to vote for the people who pass the laws that affect and control so much of our health care, health delivery and health financing.

Health care and health insurance directly impact all of us. Those members who are heavily involved in health insurance work are familiar with the complexity of the problems, the elusiveness of solutions and the moving targets of legislation and regulation. Never in our industry has there been a more complex arena than health and never has there been greater need for better understanding of these subjects. Because health hits home to all of us, there is no one who isn't affected.

Most of us also recognize that no single person, organization or group has a monopoly on solutions to our health concerns. If it did, the problems we face would not exist. NALU has a direct responsibility to its membership to maintain high visibility and activity. Addressing the needs and concerns of 140,000 life and health underwriters gives us a strong presence where it is needed—in Congress, in state legislatures and in other industry organizations. Through our state and local associations, our positive, visible involvement gives legislators, companies, agents, consumers and other organizations an added dimension as they view the problem and search for realistic solutions. It is not a matter of which group; it is a need for all groups to work together.



By John N. Neighbors, CLU, LUTCF, NALU President

To date, hundreds of you have stepped forward to join and work for AHIA. You are creating a strong organization that will capitalize and focus on what NALU has been doing for many years. Similar to the birth of the General Agents and Managers Conference (GAMC) and the Association for Advanced Life Underwriting (AALU), we have brought together under the AHIA banner a team of leaders and specialists who provide the expertise, direction and motivation necessary to bring health insurance activities to the forefront.

Those who join AHIA will benefit directly from the programs and services of the health conference and all of NALU will gain, making the entire life and health insurance industry stronger as a result. The bottom line is better health care and more effective financing of health-care delivery for all Americans.

The bottom line is better health care and more effective financing of health-care delivery for all Americans.

There are always reasons, and people to dig up reasons, for not doing something. I've heard most of them relating to the health conference. They've ranged from excessive dues to potentially harmful impact on other industry groups. I'm glad these members spoke out, because along with the negatives came some very valuable ideas and suggestions about the conference. There is no monopoly on brains within NALU. The best ideas and the best input have always come from individual local members, both new and old, from locals large and small. With your input, we've created a better conference. From your criticism, we maintained sensitivity to all points of view. Keep those cards and letters coming, because putting a label on the door, creating another group, is not the objective, just the beginning.

If the health insurance industry is to be a major player in the solution of the nation's health care problems, and if agents are to be involved, all of us must come together. We must talk together and we must work together. ■

The Health-Care Crisis: Time Is Running Out For An Industry Solution

By Chuck Jones, *LAN* Associate Editor

Ask anyone. Health care in America is in trouble.

Ask doctors and hospitals; they'll tell you they're losing money. Ask the public; they'll tell you they can't afford to buy insurance, and the coverage they can afford has such high out-of-pocket expenses and strict underwriting exclusions that they aren't getting the care they need. Ask the insurance companies; they'll tell you outrageous medical inflation is driving premiums up and that critics are making them the scapegoats.

Whatever the cause, more than 30 million Americans have no health insurance and no secure access to health care. While the exact number of uninsured has often been the subject of heated debate, no one disputes that it is in the millions—and the U.S. Census Bureau counted 31.5 million uninsured during the last census.

Particularly worrying is that many of the uninsured are not poor or out of work. According to government studies, about two-thirds of the 31.5 million are "working poor"—people who are employed but whose employer does not offer a health-care plan and who can't afford to buy one on their own. Only the remaining third are unemployed or destitute.

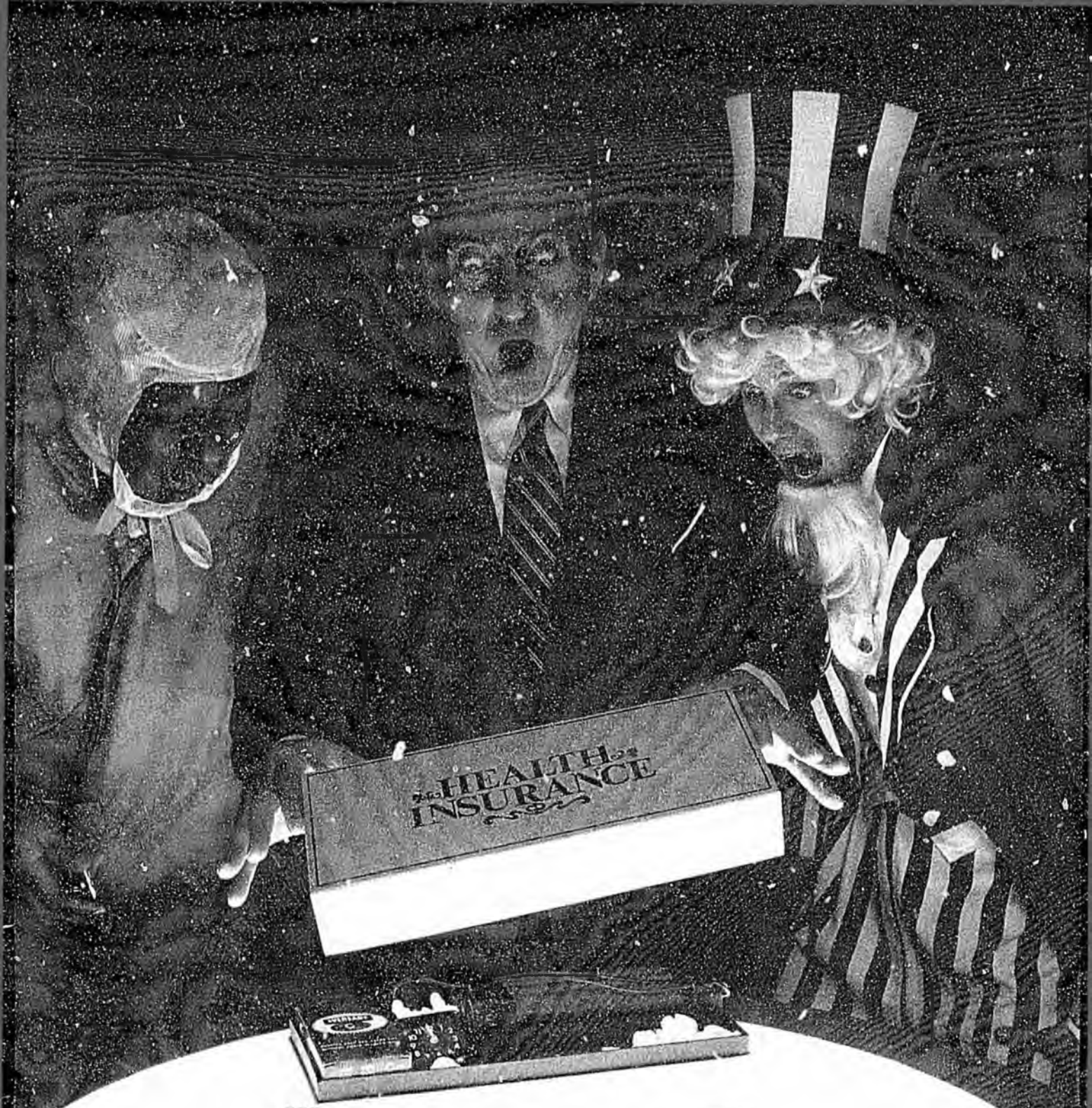
Although the United States spends more on health care, in absolute terms and as a percentage of gross national product, than any other country, many believe we are not getting our money's worth. Theodore Jay Gordon, chairman of the Futures Group, a respected research and trend analysis organization, believes that America is not getting good value even for those people who have access to health care.

The United States spends twice as much on health care as Japan, according to Gordon, yet infant mortality is twice as high. Similar comparisons can be made with most other industrialized nations.

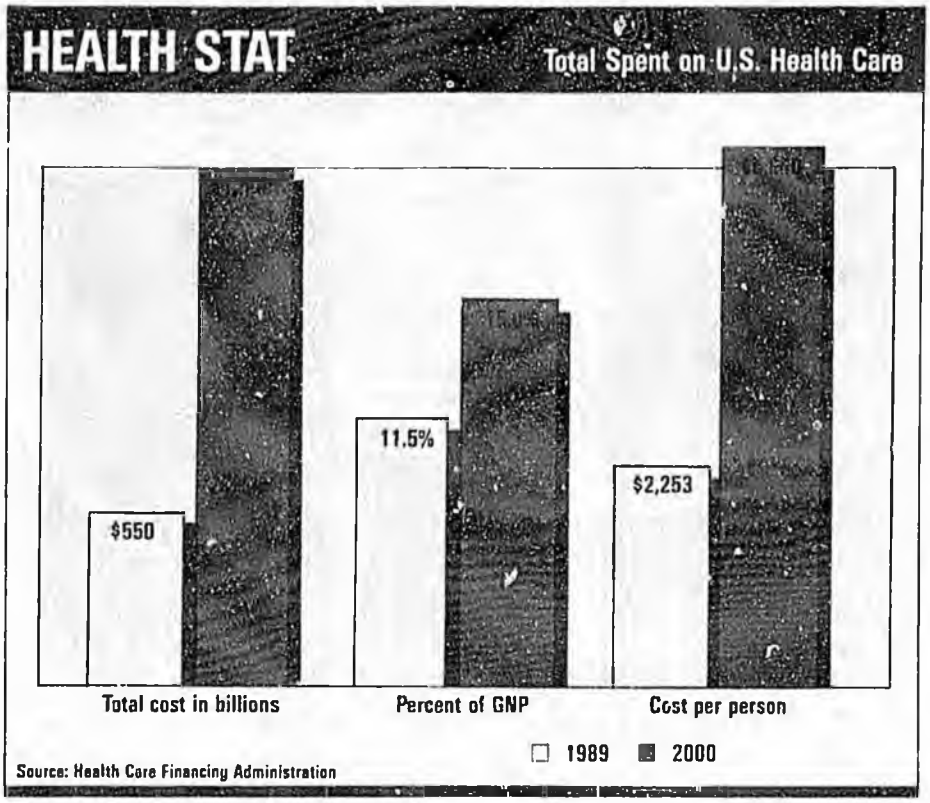
While the United States is the acknowledged leader in medical research and sophisticated medical technology, it is failing to deliver the fruits of its medical labor to the people who need it. The American system, Gordon says, simply allows too many to fall through the cracks.

The federal government and the insurance industry are beginning to take notice. The two most frequently proposed plans in Congress for cov-

PHOTO DAN GLASS



With over 30 million people without health-care coverage in the United States, a revolution of sorts is taking place. Just how are these people going to get health care — and who will pay for it?



ering the uninsured are a national health-care program, similar in structure to Canada's, or a requirement that employers provide health-care coverage to employees and their dependents. While these proposals are meant to broaden the public's access to health care, there are unanswered questions about both.

THE CANADIAN SYSTEM: FOR AND AGAINST

The Canadian system is itself beginning to experience many of the same cost-control problems as the American system, but with rationing added to the mix. However, federal legislators increasingly believe that any solution to our health-care woes must be national in scope and will likely have to come out of Washington.

The government's argument for creating a Canadian-style system is that not enough people are adequately covered. They can't afford medical coverage and insurance companies aren't eager to sell it to them anyway. In response to public outcry and to special-interest sob stories, Congress is looking cautiously to enact some sort of national health-care legislation.

The Pepper Commission, a bipartisan congressional group that conducted a two-year study on comprehensive health care, recommended that the United States adopt a national health-care program. In addition, many legislators, including Rep. Fred Grandy (R-Iowa), Rep. Dan Rostenkowski (D-Ill.) and Rep. Fortney Stark (D-Calif.) introduced universal access to health-care bills in the House during the last Congress.

None of them went anywhere, but Sen. John D. Rockefeller IV (D-W. Va.) will introduce another universal-access bill, based on Pepper Commission recommendations, in Congress this year. Although chances of passage seem slim, it is likely to get widespread coverage from the press and much public support.

If Congress does enact a national health-care system, the general public will take its lumps as the program eventually leads to health-care rationing. It seems almost inevitable. Other countries with national plans ration their health care.

While Rockefeller and others feel that a national health program similar to those in England and Canada would work in this country, Robert Murray MacMillan, M.D., executive director, Health Insurance Division of the Ontario Ministry of Health, disagrees.

According to MacMillan, a number of things would happen under a national plan: Waiting lists for surgery, restriction or refusal of elective treatment and surgery, and the government could simply cut off the care when their money runs out. It's happened in Canada, he says.

A Canadian-like health-care system probably would have initial public support because "Americans can't conceive of not getting health care if they can't afford it," MacMillan says. But such support would not last long because taxpayers would revolt at having to pay more taxes to fund the program while getting less coverage and having services rationed. "Canadians are far more tolerant of taxes," he says. "We have to be."

What's a government to do? If it doesn't ration, money will be sucked out of worthy existing social programs and the U.S. federal deficit will grow faster than it currently does, MacMillan says.

Think of how popular rationing will be with the American public. The federal government will be deciding who gets care and who doesn't; the elderly most probably will be shut off from expensive health care in favor of treating younger patients, and those with chronic and terminal diseases may be passed over for treatment because "wasting" money on them "would not be worth it." The government, in effect, would be deciding who would live and who would die.

Consider the following scenario:

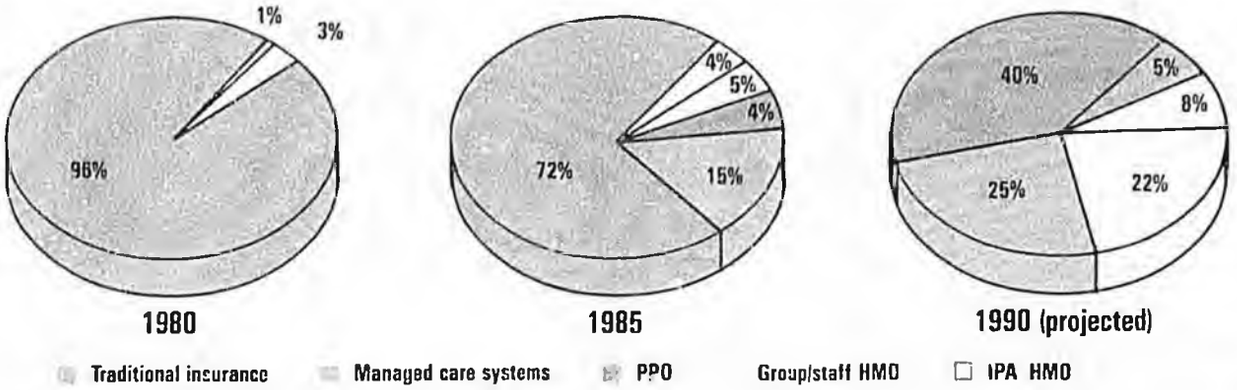
You're 61 years old with diabetes and your kidneys give out. Dialysis would prolong your life by maybe eight to 10 years, but dialysis costs $600 per session, and you need to go three times a week. Add to that the cost of therapy, transportation and medication and you're looking at well over $100,000 a year.

Over 10 years, the government will have spent more than $1 million on you: You, who are approaching retirement and will no longer be productive to society. You, who will only get progressively worse and will almost certainly need hospitalization several times over 10 years. You, who already have diabetes and will die relatively soon anyway.

So why not do it now? asks the gov-

HEALTH STAT

Enrollment in Private Health Insurance By Plan Types



Source: December 1989 *Business & Health*

ernment, who, after all, is controlling the money and care. Die now, avoid the suffering and (incidentally) save your fellow taxpayers the expense. By the way, do you know how many children—who have bright futures and long lives ahead of them—we can treat for the $1 million we would spend on you?

Pretty cold, isn't it? Your 10 years of life has just been converted into a $1 million savings to the government. It could happen.

MANDATED EMPLOYER COVERAGE: FOR AND AGAINST

The other popular notion on Capitol Hill—forcing employers to provide coverage to their full-time employees and their dependents—has received mixed reviews.

The Pepper Commission has recommended that the United States force employers to provide the coverage, but the business community is quick to point out that requiring employer-provided health care could cause massive small-business failures and make big business less competitive internationally.

"I don't know if it's going to put [small business] out of business, but it's certainly not going to help them," says J. Beryl Clifford, CLU, RHU, secretary of the Association of Health Insurance Agents (AHIA), a conference of the National Association of Life Underwriters (NALU). "If they can't afford to provide benefits now, how are they going to provide them if the government says they have to?"

When a company is forced to buy insurance, the agent's role is diminished, Clifford says. "They're going to say 'I have to buy this. I don't have to wait for an agent to come and sell it to me, so why do I need an agent?' "

Optimists say this approach may, on the other hand, create business for health insurance agents. If an employer must buy coverage, the thinking goes, then he'll seek out an agent. Pessimists say small businesses would wind up hiring only part-time workers and those who have no dependents.

Further, because an employer mandate would involve minimum federal standards, some industry observers believe that companies now offering excellent group health plans will be tempted to switch to cheaper plans that offer only the minimum.

Consider the following scenarios:

■ The Mom & Pop Shop employs 10 full-time people. Suddenly, they're forced by law to pay for a group health policy to cover all 10 and their dependents (and small-group rates are pretty expensive). They can't afford to do that because they measure their profit in pennies.

Regretfully, they reduce the number of hours they give each employee, change their status from full time to part time, and hire 10 more part-time workers to take up the slack. Not only is this a shock to the employees, many of whom will quit to find work elsewhere, but mom and pop now have a reorganizational nightmare to contend with and their business could quite possibly go under.

■ Super Shop, a small, but very profitable convenience store in a good location, employs 12 people. The owner can afford a high-quality small-group health plan for his employees—low deductible, low copayments and a lot of benefits.

Along comes the federal minimum standard for employee health coverage, and it's almost 50 percent cheaper than the current plan. The benefits are almost nothing compared to what the shop currently offers, but he switches to the less expensive plan anyway because it's cheaper. Why not? He's a businessman and he wants to maximize his profit. But that leaves his employees paying more money for less coverage.

ALTERNATIVES

Fortunately, the federal government isn't the only one that thinks it has answers. The insurance industry and other business sectors have ideas on how to better solve the problem of access to health care.

While many of these solutions are interesting, some would not be too effective: "IRAs for health insurance," proposes Theodore Gordon. He suggests the government allow Americans to set up private, tax-free bank accounts to pay for catastrophic health care later in life. Unfortunately, this idea would only work for the upper and middle classes—those with

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money to save. It won't work for those with low incomes—the very people who need health-care assistance most.

But it is very much in the interest of the health insurance industry to find alternatives to these radical proposals. Containing and managing cost is the only equitable solution from the insurance industry's point of view. Companies, for example, are looking into case-management and cost-containment programs to bring the astronomical costs of health care down and to keep them in check.

One insurance company organization that leads in this area is the Health Insurance Association of America. Its cost-containment and case-management programs are the model that several companies follow to try to keep costs—and hence premiums—down. (For more on what companies and agents are doing in the area of cost containment, see the article on page 28.)

Although some doctors and hospitals are making an effort to reduce the cost of health care, there is little they can do without losing money, according to Dr. James S. Todd, executive vice president of the American Medical Association. "One cannot really expect health-care costs to diminish under any system as long as the population continues to age. The older a person is, the more health care he utilizes."

Todd says that the only way providers can cut costs is to make harder decisions on who gets treatment and who doesn't. "We're going to have to make sure that we only give care that has a reasonable probability of being successful," he says.

While there are no specific bills currently in Congress that would prohibit the federal government from adopting

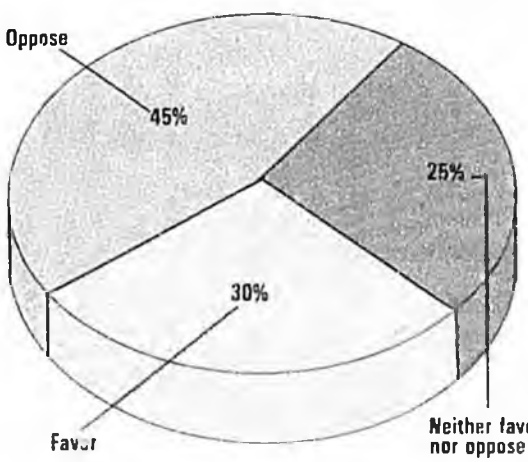


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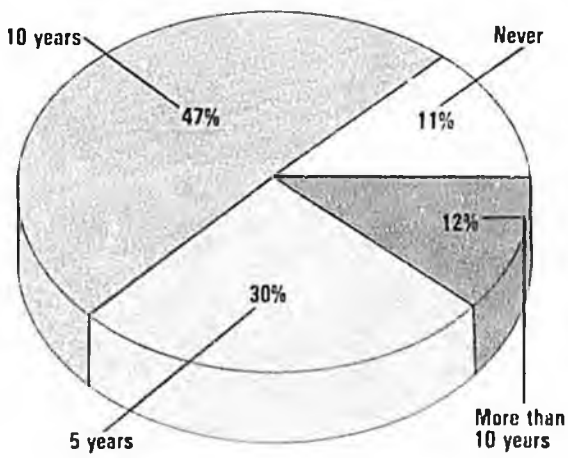
HEALTH STAT

What Executives Think About National Health Insurance

Who favors, who opposes NHI



When NHI will be instituted



Source: April 1990 *Business & Health*

"If they go to a plan like the Canadians have done, there'll be no place for an agent in the scheme of things. It would, in effect, put the health insurance business out of business."

—Beryl Clifford

a national health-care program, a private-sector solution is still possible, according to David E. Hebert, Counsel, NALU Government Affairs. There are several bills in Congress that would allow more liberal tax credits to those employers who provide coverage for their employees and to those who are self-insured, Hebert says.

The effect on the health insurance industry of a government-sponsored health program that gives everyone access to health care is obvious: Health insurance sales will plummet and those agents who make their living selling it may find themselves out of work.

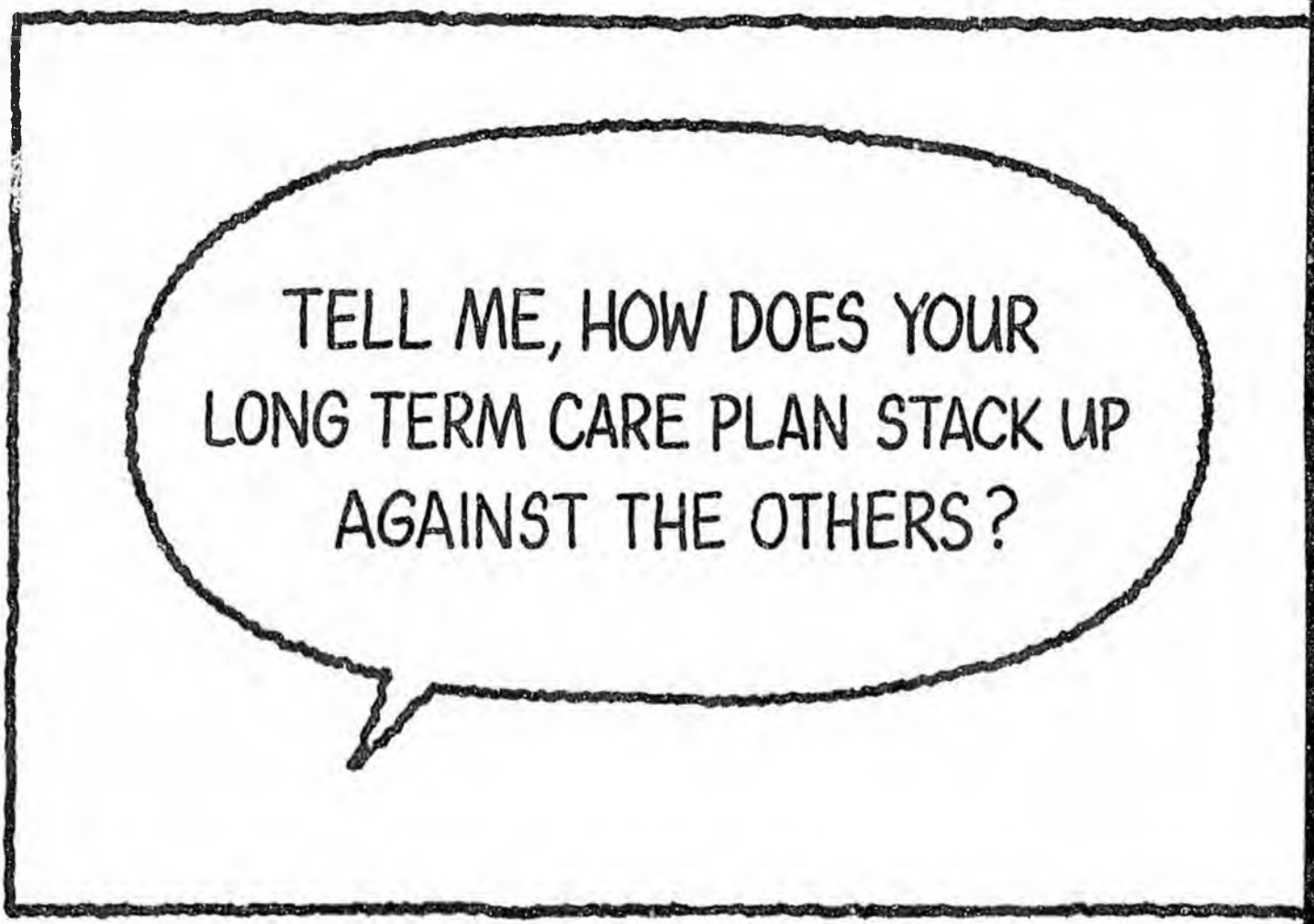
"If they go to a plan like the Canadians have done, there'll be no place for an agent in the scheme of things," Beryl Clifford says. "It would, in effect, put the health insurance business out of business."

Agents are crucial to getting health care to the public, Clifford says, because they educate consumers about what a good health plan should include and they guide them to the best coverage for their money. Without agents, the consumer would be spending his hard-earned money on plans he doesn't understand and which may not be right for him.

Another problem with a federal health-care program, according to Clifford, is that it takes regulatory authority out of the hands of the states and concentrates it at the federal level—a move that is sure to be opposed by businesses and many local governments.

"We have a better chance of solving the health insurance problem properly if several states work on it instead of just one body—the federal government," Clifford says. "One of the reasons for keeping regulation with the states is that you have 50 small laboratories to try out solutions." Also, a state government usually knows the individual needs of its citizens better than the federal government does. Being closer means being in a better position to track whether programs are working.

Whatever form a restructured health-care system takes, agents and



companies will need to adjust their roles to fit, says Clifford.

If they want to keep legislators at bay, insurers will have to either relax their underwriting practices to include more people or form risk pools for uninsurables that would spread the risk among many companies.

Agents, however, will play a new role in addition to that of salesman, Clifford says. They will become educators and planners, because no matter what the government provides, there will always be something better for the client who can afford it.

"We have a better chance of solving the health insurance problem properly if several states work on it instead of just one body — the federal government."

—Beryl Clifford

SO WHAT'S GOING TO HAPPEN?

With the government, industry and consumers all concerned about health care in America, what is likely to happen?

At worst, we end up with the federal government dictating who gets what care and in what quantity. Under this system, rationing is very likely, taxes will rise and the federal deficit will be passed on not only to our grandchildren but to our great-grandchildren.

At best, from an insurance industry point of view, things will stay pretty much the way they are. Companies will probably still look into ways to control costs, but agents will sell, the companies will underwrite, and the poor and uninsurable will be taken care of by the government through Medicare-like programs.

Most likely, however, according to industry and government thinkers, there will be a combination public/private system. The government will take care of the indigent and uninsurable and private insurers will step up efforts to sell affordable health coverage to individuals and groups.

America's health-care problem isn't quite the time bomb many people think it is. Just a little level-headed thinking on everyone's part should defuse the potentially explosive situation and keep everyone alive and healthy. ■

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LAN 2



Jack Hadley
Co-director, Center for Health Policy Studies, Georgetown University

National Health Care Unlikely In The Next Century

Health Talk

"Cost-containment programs that limit payment to providers can make coverage more affordable and should receive a high priority regardless of what happens with the fate of national health insur- .e."
—Ja idley

Jack Hadley, co-director of the Center for Health Policy Studies, Georgetown University, discusses some of the ways in which our current health-care system can be broadened to insure more people, and what it will mean to the insurance industry.

LAN *What kind of health-care system do you think will be in place at the turn of the century?*

Hadley: I think it will still be a pluralistic system. I doubt that it will be a single national health system as in other countries. But I think it's going to be a system with more constraints and limitations, particularly in the area of provider payments.

LAN *What would you recommend in order to get medical coverage to the estimated 31.5 million people who are uninsured?*

Hadley: Not all people are insured for the same reasons, so there are multiple things that need to be done short of having a mandated national system. I think the government can do a lot to expand access to government-subsidized insurance.

The idea would be to take something like the Medicaid or Medicare programs and make them a subscriber-available insurance program for people who cannot afford to buy private insurance. Depending on one's income level, people could buy into an expanded government insurance program with the cost of their premium decided according to their income.

Another thing that would probably help, particularly for people who are medically uninsurable, are private insurance risk pools. They could allocate people randomly or in some fair

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I think it's a consequence of the fragmentation of the insurance system in the sense that no insurance company has the clout in the marketplace to impose any kind of meaningful constraints on provider payment.

—Jack Hadley

way among different insurance companies so that people who want to buy insurance for pre-existing conditions [can buy it].

LAN *Would it be best to do this state by state?*

Hadley: That's certainly a logical way to do it—as long as all states have the same kind of pools so that there wouldn't be any disadvantages to people living in one area or another. Whether it's metropolitan areas or states or a collection of states is not a major issue, but given that regulation of private health insurance often occurs at the state level, the states seem to be the most logical organizational unit for doing that.

LAN *Would forcing employers to provide health insurance for their employees be a valid way to get more people insured?*

Hadley: It's one way. I don't know that it's necessarily the best way. It's a second-best solution because legislators are not willing to consider raising income taxes or making cuts in other programs to finance subsidies for health insurance. Mandating employers to do it is a way of imposing a tax without explicitly raising taxes.

I don't think it's the best way, but I think it is a way to extend insurance to a lot of people who currently do not have it. There would, however, clearly be some employment defects in the short run. Small employers, if hit with the additional cost [of paying for insurance], would have to cut back on employees or they would go out of business.

But I also think that over some period of time, wage rates in firms that are mandated to buy insurance will go up. And while there will be losses in some sectors of the economy, there will probably be job gains in the health sector. So the net effect over time will be minimal. But in the short run, there will be some sort of job loss.

LAN *How would a national health-care program affect the health insurance industry?*

Hadley: If it required community ratings, it would take insurance companies out of individual risk rating. Even so, there certainly would be a lot of activity for private insurance companies in terms of competing for subscribers at the community level, in claims processing, in benefits administration and in offering benefits that extend beyond the minimum mandated package.

LAN *Will the health insurance industry have to change the way it does business?*

Hadley: My guess is yes. I think the majority of what health insurance companies are offering has changed quite a bit already in the last 10 years with a lot more emphasis on managed-care programs and utilization-review programs.

If the government sets the way in determining rates of payment for providers and if private insurance companies buy into the government-established rates, one of the things I see happening then is that programs and products that emphasize special discounts for subscribers really won't have any market.

LAN *Do you think a Canadian-style health insurance system would work in the United States?*

Hadley: I think the odds of it happening are very small, but if it did happen, I suppose it's workable. Most of the rest of the world have national health programs so I don't see any reason why it wouldn't work here.

LAN *Would a national health-care program lead to waiting periods and rationing as it does in Canada?*

Hadley: With some things it inevitably would. But on the other hand, you have to ask "waiting periods and rationing relative to what?" Considering the 15 percent of Americans who don't have health insurance, I don't think it would be worse by any means.

LAN *What would you say is wrong with our current health system?*

Hadley: The cost of care is a big problem. I think it's a consequence of the fragmentation of the insurance system in the sense that no insurance company has the clout in the market place to impose any kind of meaningful constraints on provider payment. Either legislative action by the government or collective action by insurance companies would bring it about.

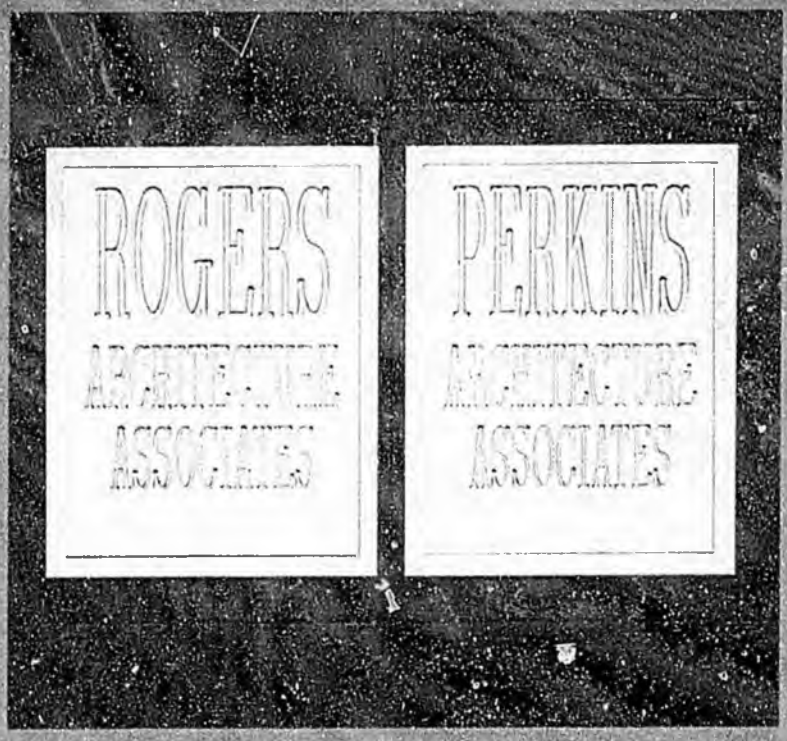
LAN *Would medical malpractice tort reform or cost-containment programs help bring down the cost of coverage?*

Hadley: First of all, I don't think medical malpractice is a major cause of high costs. It's a problem for some physicians and some specialists, but in terms of overall impact of health-care costs, it's minimal.

Among cost-containment programs, my feelings are that the ones that would have the biggest impact are programs that limit provider reimbursement. For example, if the Medicare Perspective Payment System for hospitals were adopted by private insurance, it would have a major impact.

Also, Medicare is about to implement a fee schedule for physician services. If private insurers adopted that fee schedule instead of paying physicians what they charge, it

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would have a major impact on costs.

Cost-containment programs that limit payment to providers can make coverage more affordable and should receive a high priority regardless of what happens with the fate of national health insurance.

LAN ***Is cost containment something that is being widely used now?***

Hadley: I think there are a lot of activities that are called cost containment, but most of them either reduce benefits to subscribers or increase coinsurance rates and deductibles. That shifts some of the costs back on the consumer.

Another type is managed care/utilization review/HMO-type programs, and they have a substantial effect on cost.

LAN ***What would you recommend to bring down the cost of health insurance?***

Hadley: The most promising approach is greater regulation of payment rates. I think a lot of the problems this country has experienced over the years are due to the lack of limits on what providers are reimbursed. This includes physicians, hospitals, labs, pharmaceuticals—the whole array of medical products.

LAN ***Do you think the government will throw out our current system and go to a totally government-administered program?***

Hadley: I think throwing out the current system is very unlikely, but the likelihood of insurance reform is certainly possible and has a greater probability of happening.

The reforms most likely to be considered are community rating methods rather than individual risk rating, pools for high risk individuals, and possibly some kind of collective action on the part of private insurance companies that would enable companies to negotiate rates or to adopt government rates. ■

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"Your Voice in America's Health Care Debate"

LAN

John McCain (R-Ariz.) is AHIA-sponsored. Invited as key speaker is Louis Sullivan, secretary of the Department of Health and Human Services.

Three Underwriter Updates, which are educational seminars, are scheduled for release in June. The seminars include: Errors and Omissions—Defensive Practices in Health Insurance; Alternative Funding Sources of Health Insurance; METs/MEWAs.

A discount for *Spencer's Research Reports on Employee Benefits* and *Spencer's Compliance Guide*, which are manuals put out for agents by Charles D. Spencer & Associates, Inc., is available to all AHIA members. The discount was promised at the NALU convention last September.

MEMBERSHIP PACKAGES

AHIA has two classes of membership; active and associate. Active members are those who currently sell health insurance or are in field management. Associate members include those who are not eligible for active membership but are affiliated in some capacity with health insurance; individuals who are in tangential professions that have a vested interest in health insurance issues are also eligible.

From the beginning, AHIA advocates also promised greater grass-roots involvement; part of the conference's purpose is to facilitate an enhanced NALU grass-roots political system by expanding the Life Underwriter Political Involvement Committee (LUPIC) to include more members knowledgeable about health issues.

Each AHIA committee member chose local associations in each state to focus their efforts on. Each vice chairman will now contact key people in the associations and encourage them to become involved by joining AHIA and coordinating health programs at their meetings.

"So far, AHIA is growing rapidly and is being accepted in the industry. Membership has already surpassed the five-month projections," says E. Dawn Lindsey, FLMI, executive director of AHIA. "We're excited about the progress we've made and all indicators point to a healthy future for the conference." ■

I/R Code: 1000.09 The National Association of Life Underwriters

and local health and employee benefits chairmen and state and federal law and legislative chairmen, will have an expanded capacity using AHIA as a new resource. AHIA intends to create a membership that is deeply involved in the health market, thus bringing continuity and identity to NALU's health-related policymaking process.

At the national level, AHIA has its own board of directors, including a president, an acting immediate past president, a president-elect, a secretary/treasurer and seven directors. AHIA has four committees—membership, communications/member services, legislation and meetings.

What is the association's focus?

AHIA primarily focuses on four areas crucial to the well-being of agents:

- Improving the legislative environment of the health insurance and employee benefits markets;
- Enhancing the communications process between local and state association members and national headquarters;
- Expanding health related educational opportunities for agents; and
- Informing consumers about health insurance and employee benefits. ■



KARL HANSEN, CLU
Western Life President's Club Member and President of the AHIA

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Karl Hansen has long been a leading producer of group business with our firm. We have enjoyed our relationship with Karl Hansen and appreciate his knowledge, competence and marked professionalism. We are confident that under Karl's leadership the important issues and objectives of the AHIA will be effectively addressed.

Western Life supports the AHIA's efforts on legislation, agent education, consumer awareness and professional communication. We wish the AHIA and Karl well, and urge all to support this vital organization.

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- Taxation
- ERISA exemption of state mandates
- Minimum standard benefit plans

In addition to the task forces, the committee decided that C. Gibbs Smith Jr., CLU, Nashville, Tenn., will serve as liaison with the NALU law department on federal issues. Task forces will be formed as they become necessary.

Finally, the legislative committee agreed that it will develop public policy position statements. They will deal strictly with health issues.

COMMUNICATIONS/MEMBER SERVICES IN ACTION

The Health Legislative Report is now an official AHIA publication. Only AHIA members, local and state health and employee benefits chairman, state presidents and state and federal law and legislation chairmen will receive them.

AHIA has also created a newsletter, *Health Matters*. It is now bound into *LAN* for three issues (see page 53 for premiere newletter); after three months, it will be sent monthly to AHIA members only.

One of the biggest events planned for this year is the Columbia Institute Seminars: The Arizona Forum on Health Care—A Focus on Our Needs and Goals; and the 1991 Colorado Conference on Health Care—Meeting the Needs of the 21st Century. The Arizona conference, chaired by Sen.

All You Ever Wanted To Know About AHIA

Why has NALU created an association dedicated to health and employee benefits agents?

America today is debating the future of the private health insurance industry. Therefore, it is vital that agents who participate in the health market be part of that discussion. Though NALU has been active in health insurance issues in the past, its board of trustees felt that the association should strengthen its current health-related structure so as to more effectively respond to the pace of today's historic dialogue.

NALU's mission statement pledges the association to "improving the business environment for those engaged in . . . underwriting." And over the past 100 years, it has done just that. By creating AHIA, with its specific focus on "health underwriting," NALU is fulfilling its intended mission and enhancing the positions of field underwriters nationwide.

By virtue of its name, AHIA gives its members immediate recognition as health insurance and employee benefits professionals. By combining that recognition with an expanded structure and NALU's resources, AHIA will enable agents to become better informed and more involved in today's industry reform movement.

What's the mission of AHIA?

The mission of the Association of Health Insurance Agents is to provide leadership in sustaining and improving the business environment for those engaged in health underwriting, enhance the professional skills of those providing health products and foster greater financial independence for the public.

What experience does NALU bring to the health insurance agent?

NALU has been involved in health issues as long as agents have been providing health products. A formal committee has been in place since 1952; the word "health" was incorporated into the NALU bylaws in 1965, and just last year the association spent over $2 million on health insurance and employee benefits issues. NALU has been the only agent voice in many congressional committee debates, including such key issues as the Internal Revenue Code Section 89 reform, small group underwriting and pricing, the Pepper Commission and, most recently, medigap reform. In other words, it has experience in health issues. By creating AHIA, NALU is acknowledging that it must do more if agents are to participate in today's health care debate.

Does NALU have any other conferences?

NALU already has two specialized conferences within its ranks—the General Agents and Managers Conference (GAMC) and the Association for Advanced Life Underwriting (AALU)—both of which have proven the benefits of the conference structure.

Since their inception in the 1950s and 1960s, AALU and GAMC have become respected organizations within the insurance community.

AALU began with a working committee of five, and now boasts a membership of 1,500, plus a waiting list. Its lobbying clout on advanced life insurance products is unmatched and its annual convention is described as one of the most informative in the industry.

GAMC, which like AHIA was a committee before becoming a conference, is now an indispensable tool to general agents and managers nationwide.

How is the association structured at the national, state and local levels?

AHIA is a national organization with direct membership. Though no local or state associations will be created, the health structure that currently exists in local life underwriters associations will be enhanced through AHIA. All state

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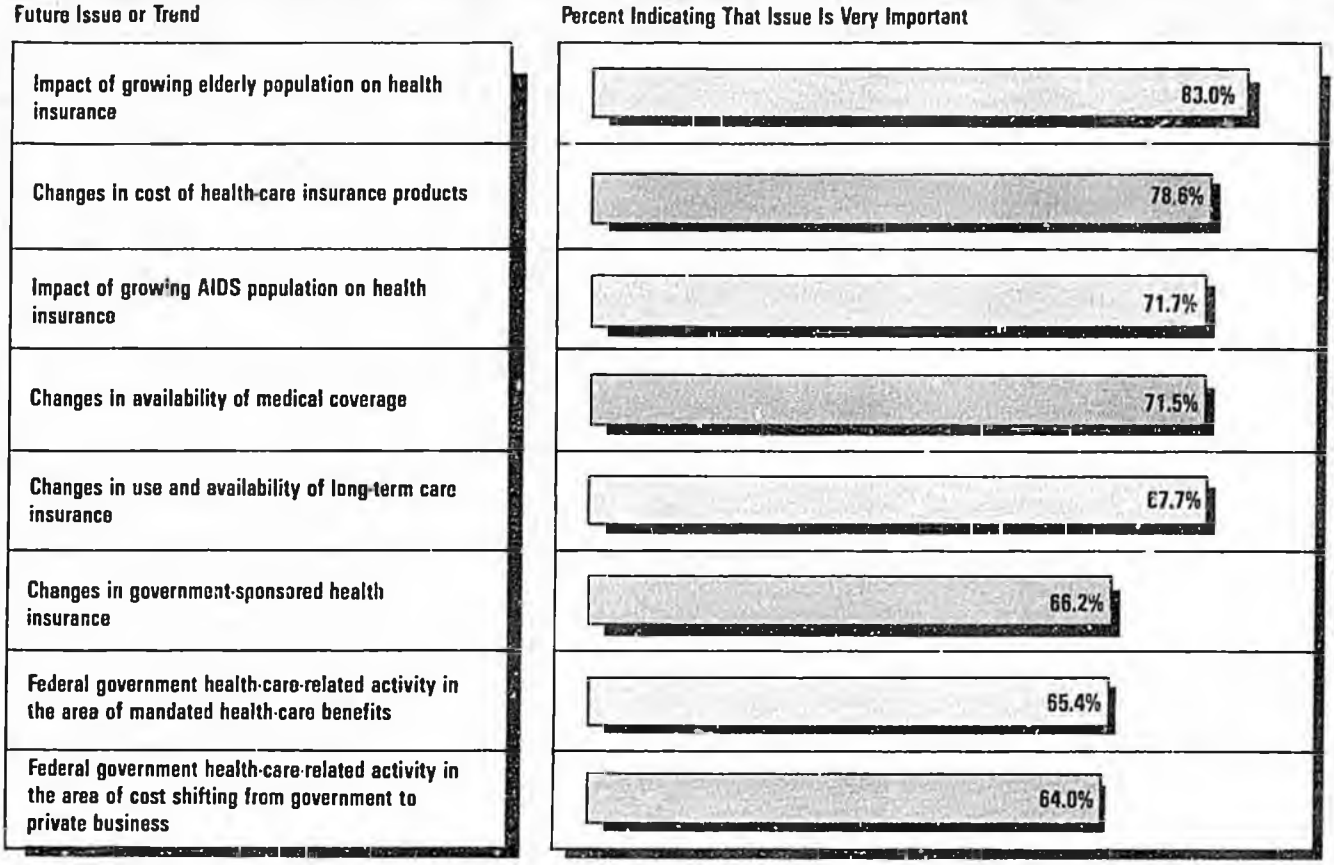
UNDERWRITTEN BY: Employers Reinsurance Corporation

ADMINISTERED BY: Rollins Burdick Hunter

SIUDIAA

HEALTH STAT

NALU Local Members' Eight Top Rated Future Health Insurance Issues and Trends



Source: October 1990 NALU Membership Survey Report

- Mandated coverage
- State and federal regulation
- Consumer education

Other areas of concern include: Mandated benefits, legislative education, retiree health care, cost containment, tort reform, regulated agent compensation, the Employee Retirement Income and Security Act (ERISA) pre-emption, AIDS, continuity of coverage, managed care, Canadian-style health care, federal minimum standards, multiple employer trusts and multiple employer welfare arrangements (METs/MEWAs), medical individual retirement accounts, flexible spending accounts, Medicaid expansion, medigap, indigent pools, accelerated death benefits, initiative legislation, §125, state licensing and continuing education.

Next on the agenda, three task forces were created. The first, Access to Health Care, is a task force whose objective is to create a questionnaire that can be used by key state association officers to review bills proposing to create state health plans or risk pools. The chairman of this committee is Carl W. Hill, CLU, board liaison to the legislative committee.

The second task force, Long-term Care, will address and respond to issues raised by David E. Hebert, counsel, NALU government affairs, regarding Congress and its treatment of long-term care. Co-chairmen of this committee are Richard F. Breen, JD, CLU, ChFC, of Plymouth Meeting, Pa., and Donald R. Bryson, CLU, of Sarasota, Fla. The following issues will be analyzed:

- Agent's commissions
- Agent abuses (stacking, replacement)
- Packaging versus endorsement
- Taxation of long-term care product benefits
- Disclosure of commissions
- Minimum policy standards

Small Group Plans, the third task force, will analyze the following issues as they pertain to groups with a maximum of 25 employees.

- Size of group
- Guaranteed renewability (National Association of Insurance Commissioners)
- Medical underwriting
- Affordability
- Pre-existing conditions
- Plans (METs, association, discretionary, Taft/Hartley, Health Maintenance Organizations, Blue Cross/Blue Shield, etc.)
- Disclosure of rating practices
- Mandating of coverage
- Continuity of coverage
- Mandating benefits



New NALU Health Conference Off To Strong Start

By Rivka Tadjer-Winkler, *LAN* Managing Editor

Just five months after its inauguration, the Association of Health Insurance Agents (AHIA) is 3,000 members strong and working to fulfill its campaign promises.

AHIA is the National Association of Life Underwriters' (NALU) newest conference, devoted entirely to health insurance matters. When the NALU National Council voted AHIA in at NALU's convention last September, proponents of the conference promised that benefits of membership would cover legislative issues, public relations/communications and member services.

NALU created the conference, according to Karl E. Hansen, CLU, ChFC, LUTCF, president of AHIA, to intensify its efforts to have the insurance industry's voice heard and reckoned with on health issues that affect not only the insurance industry, but the nation at large.

At NALU headquarters Dec. 3, 1990, AHIA's committees met with the AHIA board of directors to create action plans for each membership benefit area.

A LEGISLATIVE ACTION PLAN

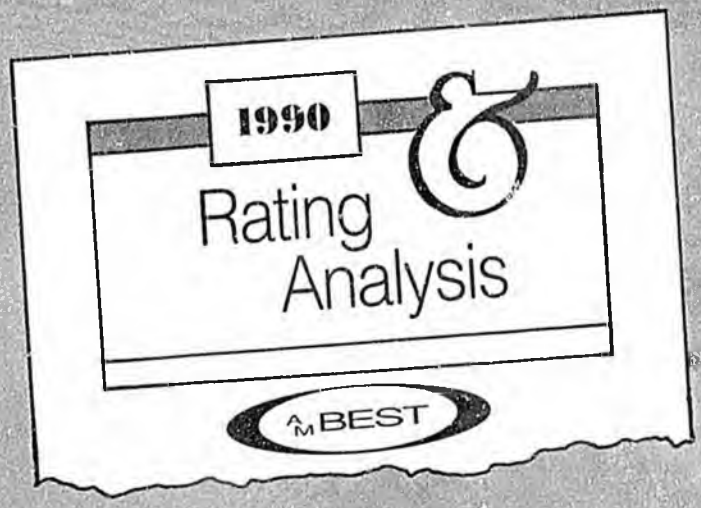
The legislative committee first ranked current legislative issues. The top 10 matters that AHIA will devote its resources to are:

- Small group underwriting and pricing
- Access to health care
- Long-term care
- The agent's role
- Taxation
- Uninsured pools
- The Consolidated Omnibus Budget Reconciliation Act (COBRA)

Focus On AHIA

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. . . I mean if private enterprise can't conduct itself in a fair and competitive manner for the benefit of all, then it seems like we have to ask the government to step in. And I'm sure you insurance guys would hate that."

You're right, I replied. I would hate that. But not because it would hurt my business. Rather, I have serious doubts that socialized medicine would serve us with the same high quality medicine we have come to take for granted.

Sure, it would offer the greatest access to the millions of uninsured but at a cost, according to reliable sources, of over $300 billion a year in new taxes.

And, if the facts learned from countries with socialized medicine can be trusted, we in this country will learn what the rationing of health service really means. I don't think this country will tolerate standing in line waiting for treatment, nor will it tolerate medical shortcuts to save money.

It won't hurt my business, because I'll sell extended health insurance benefits like they do in Canada, England . . . you know, countries with government-controlled medicine.

I'll be selling it to those people who can afford it and who want the best care when they need it. No waits.

"So what's the solution?" he finally asked.

Well, first, all of us must understand the whole complex problem and realize that there is no one solution or "quick-fix."

Second, all of us connected to health-care services have to find a level playing field. And that means we all have got to give a little.

Insurance companies have to give a little on premiums.

Hospitals need to share their resources with other lesser equipped hospitals and be willing to give up a little bonus and live with a little less profit. We don't need 28 hospitals in the Chicago area capable of performing open heart surgery.

Doctors need to learn how to operate with a little less income. Developers of high-tech medicine need to exercise greater cost control and give up a little on stock dividends. Lawyers need to get out of the way of tort reforms that would cap medical-liability awards and give a little on fees.

Third, the federal government needs to balance the budget so it can fund Medicare and Medicaid adequately. Expansion of these would allow many of the uninsured to be covered for basic services now denied.

Fourth, everybody involved in health care has got to get its administrative act together. Our collective inefficiency is costing us millions of dollars in waste. Millions that would go a long way in reducing the cost of health care along with opening up greater access for the uninsured.

Finally, all states should create "risk pools" for those denied health insurance due to pre-existing conditions. Such a pool should be funded by "special taxes" paid by insurance companies, employers and by users of cigarettes and alcohol.

"Why not put in a few bucks from state lotteries and other legalized gambling?" he interrupted.

Good idea, I said. Consumers need to become smarter health-care shoppers and think twice about lifestyle choices. Preventative medicine is cheaper than corrective medicine.

"That all sounds pretty naive to me. No matter how much sense it makes. By the way . . . "

Yes?

"Have a nice day on your boat."

Click! ■

Conrad Meier is president of Meier Insurance Services, Inc., a firm specializing in health care and pension plans for small employer groups in southeastern Wisconsin and northeastern Illinois. His address: 4343 Grand Ave., Gurnee, Ill. 60031.

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HEALTH STAT

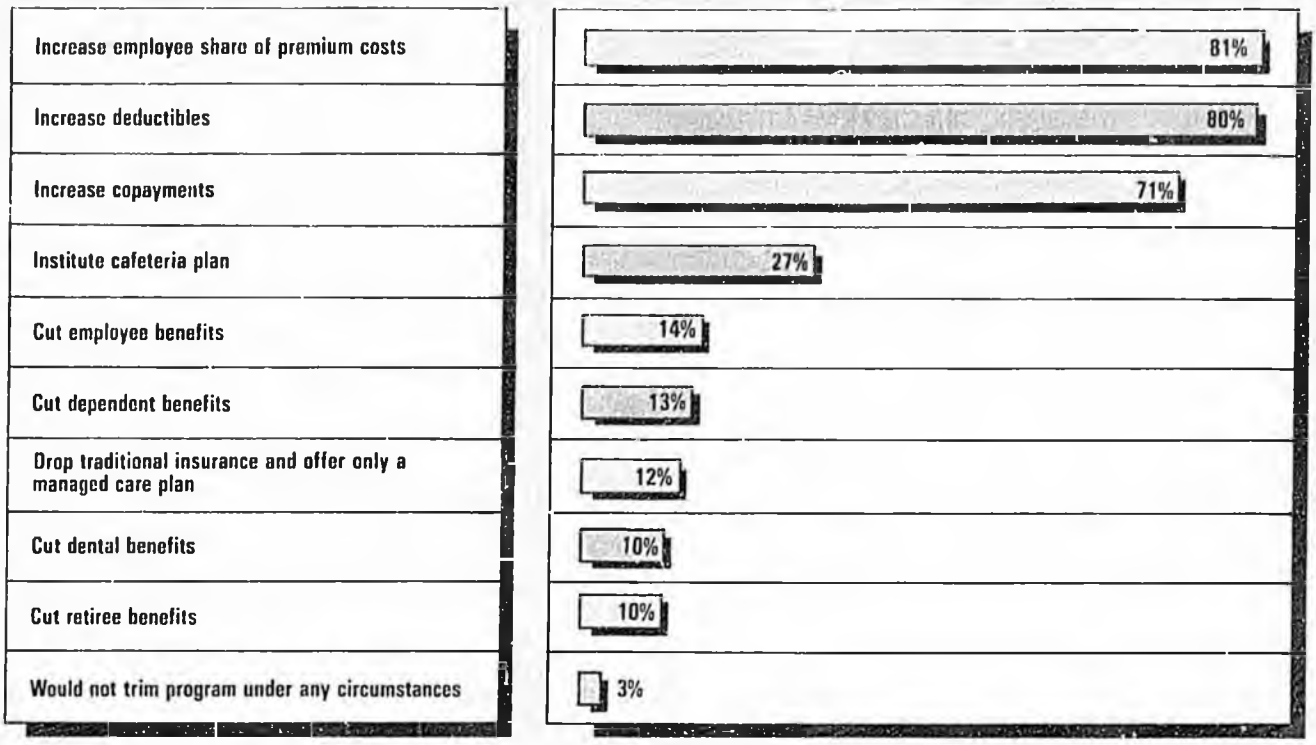
Extent of Executives' Concern About Health-care Issues

Issue	Very concerned
Rising health insurance premium costs	92%
Mandated benefits	69%
Paying for catastrophic illnesses such as AIDS	64%
Dependent coverage costs	60%
Workers' compensation costs	58%
Communicating benefits and costs to employees	54%
Quality of medical care services	53%
Drugs in the work place	49%
Quality of care provided	47%
Retiree health benefits costs	46%
Alcoholism in the work place	45%
Mental health costs	43%
Inability to determine value of health-care services purchased	42%
Prescription drug costs	31%
Disability and rehabilitation issues	30%
FASB retiree liability compliance	25%

Source: April 1990 *Business & Health*

HEALTH STAT

Ways Executives Will Cut Health Programs to Lower Costs



Source: April 1990 *Business & Health*

around for the best price on prescription drugs?

"Never. They all charge the same, don't they?"

Absolutely not, I said, one octave up. Reliable studies have shown that doctor's fees, hospital charges and prescription costs are not all created equal. They can vary substantially for exactly the same service.

Figuring I made a good point there, I added: I bet you spent more time shopping for your new car than you did for health-care services.

"Hey, Conrad. Who's got time to shop around for the best prices in health care? When I get sick I want the best care available, right away and whatever it costs. Besides, I don't pay the bill, the insurance company does."

Exactly my point, I countered. If the cost of claims came down as a result of everyone using the most cost effective services, your premium would reflect the savings. Problem is, most consumers don't shop.

There seems to be an unwritten law that says you're forbidden to ask how much it will cost to restore your health.

Before he could recover from that, I asked when the last time was he complained to his congressman about those expensive state-mandated benefits?

"Never. What's that got to do with anything?"

Because there are over 750 mandates to which insurance companies must comply. Every one is another layer of cost added to health care. Some mandates are reasonable I grant you, but you must admit forcing health insurance to cover the cost of a hairpiece leaves room for questions.

I was on a roll, so I asked if he understood how cost-shifting by doctors and hospitals forced his insurance premium up.

"No, I don't, but I bet you'll tell me."

Right. In the years 1980 to 1988, federal funding for Medicare and Medicaid has been consistently reduced. The budget proposal for 1991 requests a further reduction of $60 million. Look, it comes down to this: If the actual cost of health care used by patients on Medicare and Medicaid isn't more fairly reimbursed to the doctor or hospital, the cost will continue to be shifted to private-paying patients and will eventually be reflected in a higher premium for you.

I'll say this too: The health insurance industry is not altogether blameless in this scenario. Administrative and marketing costs consume about 20 cents of every premium dollar. I suspect at least half of that is used to uncover fraudulent charges and billing errors.

And, I think many insurance companies have lost sight of their purpose in life.

"Well, it sounds to me like I'm trapped in the middle of finger pointing by you insurance people, doctors, hospitals, lawyers, whoever . . . ."

Taking a breath, he continued with:

"I've never been in favor of socialized medicine, but it looks like a national health plan is the only answer



Explaining The Health Insurance Crisis In Three Octaves

By Conrad Meier

Focus On Clients

I expected his phone call. Actually, it was one of many that day.

Two octaves higher than usual, my client said: "I just got my new health insurance premium and I hope you're enjoying your new boat."

I took a deep breath and tried to explain that health insurance premiums are *reactive* to the costs being charged by doctors and hospitals and are a direct result of state mandates and cost shifting. Your premiums have nothing to do with me layering on another level of profit, I told him. In fact, the insurance company that just raised your cost 11 percent, lowered my commission 5 percent.

"So what the hell is going on?" he asked, still two octaves up.

I said I could respond if he'd let me ask a few questions first.

"OK," now down one octave.

Did you ask your doctor how much he was going to charge you?

"No. Nobody asks that."

Did you ask the hospital how much they charge?

"No. Nobody asks that, either."

When's the last time you checked a hospital or doctor bill for accuracy?

"I never check the bills. Besides being confusing, they say they are accurate 99 percent of the time."

That's interesting. Insurance claims experts report consumers don't realize that one out of two hospital bills have charges for services never rendered and that some charges are inflated due to cost-shifting. A few doctors alter their billing to include tests never done. Many charge for unneeded exams to shield from malpractice suits.

When's the last time you shopped

A crackling colloquy that will leave you perfectly tuned to soothe even the most savage client.

■

PHOTO DAN GLASS

February 1991

Revolutionary News

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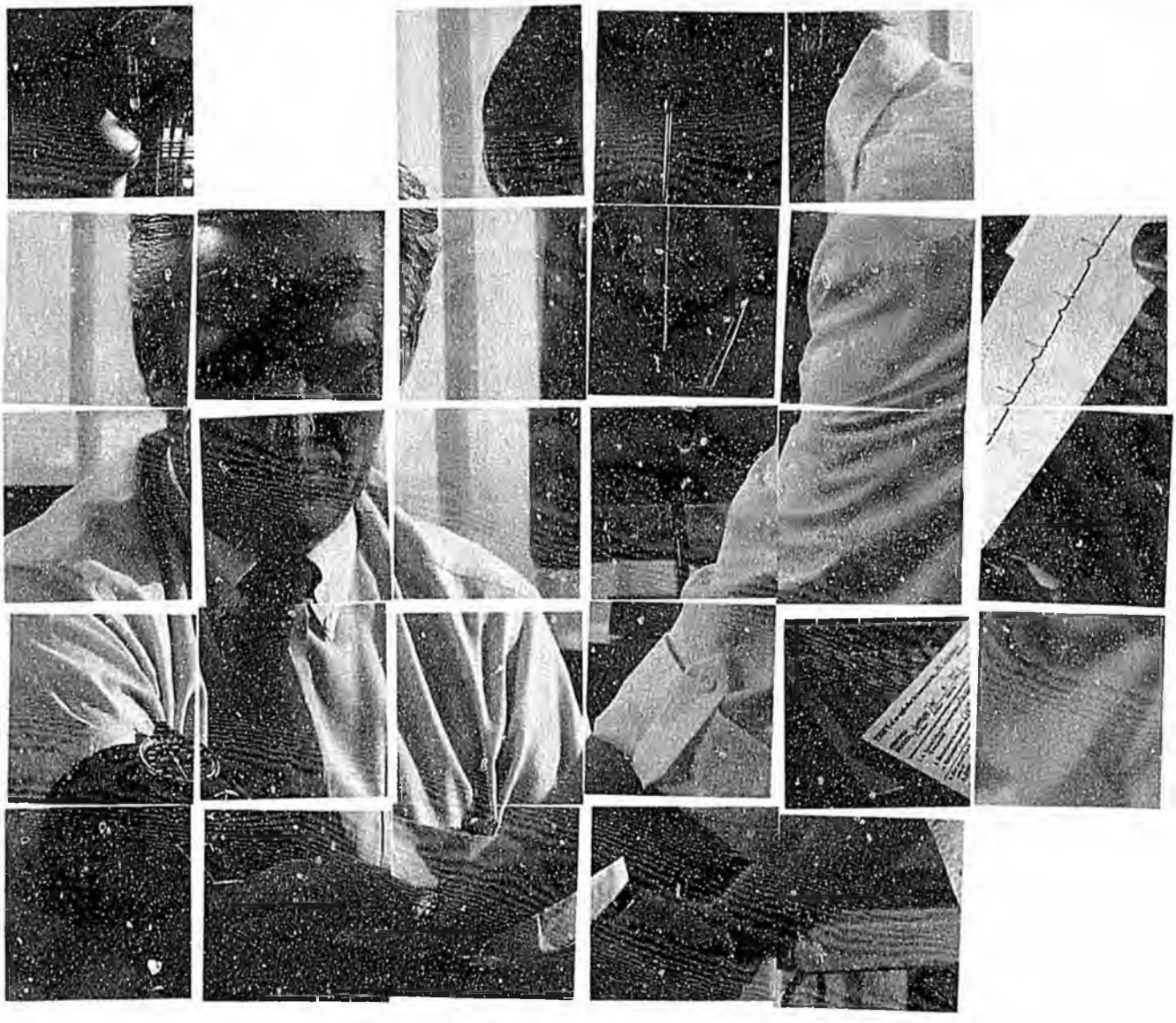
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There are a lot of things we can do in the public and private sector to make sure information is available and to make sure there are good incentives—better incentives—to have more cost-conscious behavior.

—Gail Wilensky, Health Care Financing Administration

vided. That's something we in the federal government can help and it's something the private sector can certainly help in terms of making sure they're more cost-conscious.

Employers can offer better incentives to their employees by paying a fixed amount, not a percentage of whatever plan an employee chooses, if there's a clear incentive to go to a more cost-conscious plan. Employers can make sure information is available about which providers are providing better services, and they can provide some incentives to go there.

There's an activity that Cleveland is starting up that has physicians and private insurance groups working together to get a better sense about what works and what doesn't work in medical care and making sure information is disseminated to the people who need to know.

There are a lot of things we can do in the public and private sector to make sure information is available and to make sure there are good incentives—better incentives—to have more cost-conscious behavior. We need to make sure we get better behavior on the part of physicians, hospitals and the insurance industry.

It would help a whole lot if we could have the participation of the American population, too. There's an awful lot of behavior we spend money on that can be changed [such as] smoking and alcoholism.

LAN ***So this should be a concerted effort among the medical profession, the insurance industry and the public?***

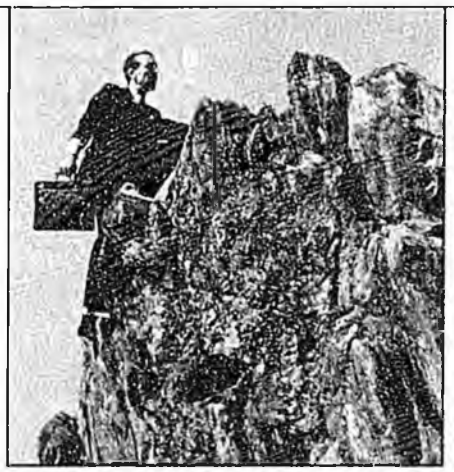
Wilensky: It's going to be real hard to have it happen unless we get all the different sectors moving together. You can have some impact if you only go after the provider community. You can have some impact if you go after the insurance community. But you're going to do a whole lot better if you have all these different sectors working together.

Whatever we end up with, it will be very much an American way of solving a problem. It will be pluralistic. I don't believe it's going to be a unitary government-financed, government-operated program. I don't think we like those. I don't think we trust them. We would be very unhappy with that.

I think we will retain our public/private mix of financing and a lot of diversity about how we go about doing business because we've set up a whole lot better incentives to make the providers of health care and the consumers of health care more cost-conscious about what they're consuming. ■

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Gail Wilensky
Administrator, Health Care Financing Administration

Health Talk

activities. One is an ever-growing frustration about the inability to contain health-care costs in the sense that we really have to be more active and more serious in trying to contain health-care costs.

I also see some serious discussion about how to try to improve and expand access to private insurance for the working population and about public insurance. I see some discussion about long-term care and its implications.

These discussions are going on all over the place. They're going on in the administration, in businesses, in the National Association of Manufacturers, the Business Round Table, the American Medical Association, the American Hospital Association [and at] Social Security. I think there is a consensus that we need to make some changes but there is no consensus about how to go about making these changes.

I also think there is wide agreement that unless and until we can do something to reduce the rate of spending, we are not going to go after the access problem. We're just not going to do it. I don't think there a sense that we have to solve the cost-containment problem before we go after access. But I believe there really is a wide spread agreement that we're not going to seriously expand or change access until we have some credible reason to believe we can control health-care costs.

LAN ***How can costs be contained?***

Wilensky: The Health Care Financing Administration is coming forward with our own package of specific proposals we would like to see enacted.

We need to instill better incentives in terms of how health care is pro-

"Reform needs to occur and sometime in the next couple of years is reasonable. The insurance industry may well have some phase-in period because it's somewhat hard to have change occur all at once."

—Gail Wilensky

Insurance Reform, Not Socialized Medicine, Is The Answer To Insuring Americans

Gail Wilensky, administrator, Health Care Financing Administration, discusses how the federal government might tinker with the U.S. health-care system—and how it might affect the insurance industry.

LAN *What is the probable future of the health-care industry?*

Wilensky: I believe we will continue to have a mixed public/private system of health insurance. There will continue to be the private health insurance industry.

It seems to me that there's a growing consensus [that] there needs to be some reforms in the insurance industry, particularly as it relates to small business. There is not quite yet consensus about what those reforms should be and how they should be achieved, but there is a growing recognition of the need for some changes.

That's healthy, and it is especially healthy that the insurance industry itself has been involved with some of those reform proposals. I think that makes it much clearer that change is likely to occur when the [insurance] industry participates in the discussion.

LAN *When do you think this will happen?*

Wilensky: Sooner rather than later. I think probably in the next couple of years is a reasonable time line.

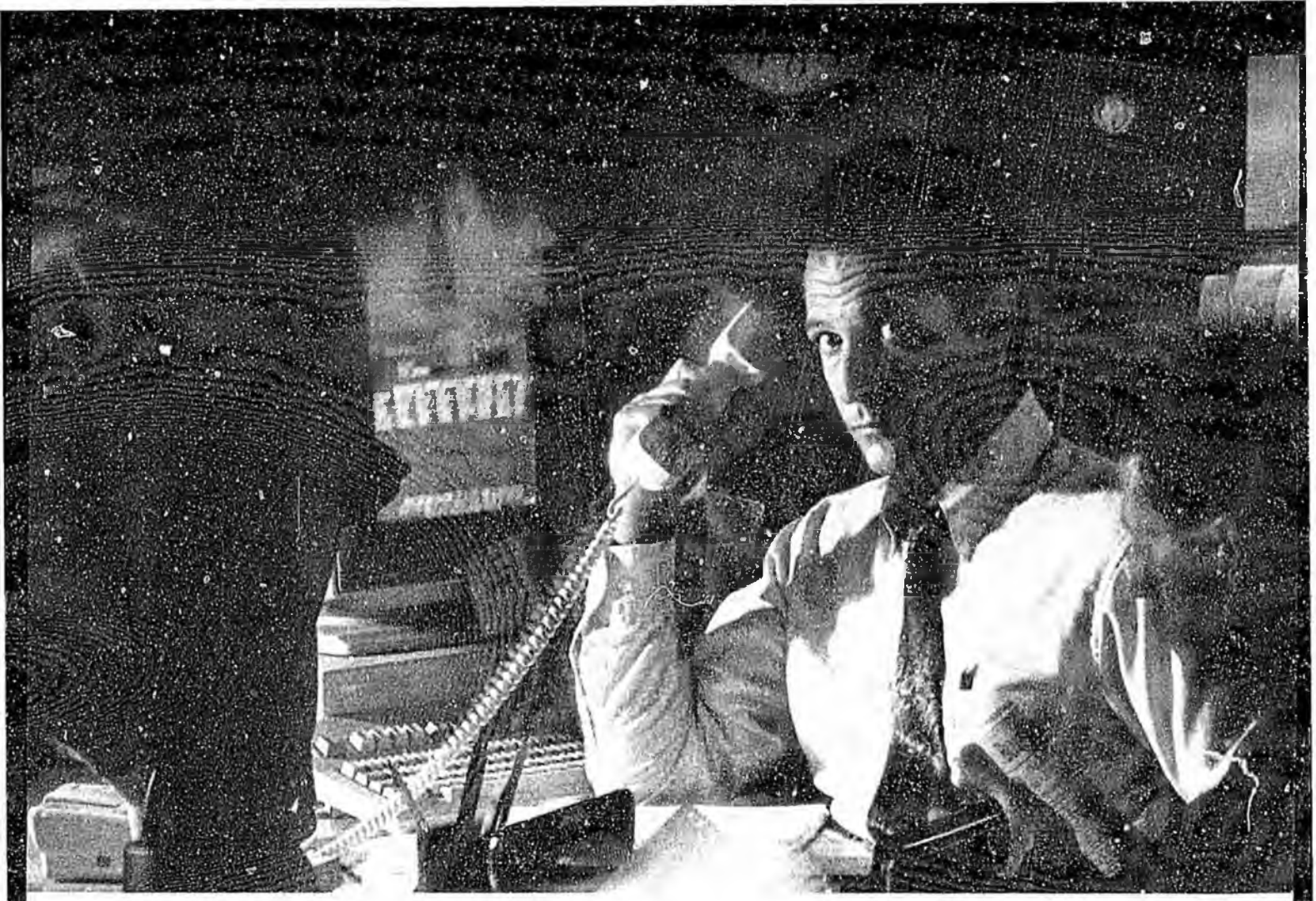
There's a lot of interest and there's been a lot of discussion going on within the industry and outside the industry. The Pepper Commission [and] a number of other groups have made recommendations that deal with some of the same issues.

It is an issue that there's widespread agreement. Reform needs to occur and sometime in the next couple of years is reasonable. The insurance industry may well have some phase-in period because it's somewhat hard to have change occur all at once. But there is much less need for a long phase-in for insurance market reforms than there is for changing how health care is financed and provided.

LAN *Do you think the United States will see a national health-care system soon?*

Wilensky: I don't think it's a possibility right now. At this point, we really haven't come to a consensus as to what we want to do. I think [universal access] will be regarded as one of the options of how to expand public and private insurance to the under-65. Some of the long-term proposals are less likely [to come about] than even the under-65 proposals.

What I see now are three different



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Two cost-cutting measures that may not be a wave of the future, at least not as big a wave as initially anticipated, are self-insurance and wellness programs.

nity to argue his position in person. In many cases, a different course of action can be negotiated. If there is no agreement, the attending physician has the right to appeal to another physician in the same kind of practice as his.

According to Janice Spillane, president of CoMed in Columbus, Ohio, these procedures have been able to save between 5 and 10 percent of hospital-related costs for its parent company.

Spillane says that the hundreds of managed care providers like hers have expanded their scope beyond the review of hospitalization expenses. Today, these companies evaluate the appropriateness of the facilities people are being admitted to, and recommend alternative treatment plans if necessary.

"I think managed care is definitely the wave of the future," says Spillane. "By the mid-1990s, virtually all health care will be delivered under some kind of managed care umbrella, whether it's an HMO, a PPO, a hospital precertification system or review of outpatient procedures."

Two cost-cutting measures that may not be a wave of the future, at least not as big a wave as initially anticipated, are self-insurance and wellness programs.

Writing in *Business & Health*, Maria R. Traska quotes several sources who say that the trend toward self-insurance, especially among large employers, is leveling off. One of those sources, Leonard Wood of Blue Cross/Blue Shield, Chicago, says that "self-funded employers had higher costs the same as the insurance companies did. But many of the employers hadn't had a 'down phase' until then. Employers are a whole lot more realistic now."

Wellness programs, regarded as a panacea in the mid-1980s, have not proved as effective at cutting health-care costs as proponents first thought. Such programs tend to cover a lot of ground, and therefore require a lot of overhead. They offer programs in anything from weight control and nutrition classes to fully-equipped exercise facilities, from smoking clinics to drug and alcohol abuse counseling.

Though companies that have instituted wellness programs have reported a measurably healthier workforce and lower absenteeism, the cost often offsets any savings in health-care expenses.

Peter Conrad, a sociologist at Brandeis University, says that companies should avoid thinking like accountants when it comes to their wellness programs.

"Health promotion may be an effective use of the benefit dollar," says Conrad, "not in terms of cost containment or improvement in health but in terms of productivity."

Finally, consumers and employees themselves are being asked to assume an ever larger share of the financial burden of health care. It's a request employees aren't always eager to comply with.

"It's not going to be easy to sell the idea of employees picking up more of the health-care tab themselves because of the traditional employer-employee relationship," says Carl Hill. He points to two of his Blue Cross/Blue Shield clients, Chrysler and General Motors, as cases in point.

"Their utilization is atrocious," says Hill. "One reason is the nature of the business—assembly lines tend to breed health problems with drugs and alcohol. Another is that they have Cadillac benefits, largely because they're union-negotiated and have been hard to come by over the years. Which means they'll be even harder to give up."

Employers of all sizes are opening their books to their employees, letting them know exactly how much they're paying for group insurance and other benefits. It's an eye-opening experience for many employees.

"Come the first of the year, employees in our own firm are going to have to start contributing to the cost of their health-care benefits," says Sally Nelson. "It will be the first time in the firm's 25 years in business they've ever been asked to do that."

Getting employees to go along willingly, or at least persuading them not to balk, is going to take a great deal of education and persuasion. This is something Richard Jones thinks agents are ideally positioned to do, even if it means stepping outside the traditional bounds of the agent's role.

"We've got show the employer different methods of cutting costs, even if it means acting as negotiators between employers and health-care providers," says Jones. "We have to be creative, act as the catalyst that gets things going, come up with solutions, initiate some action. That's why the Association of Health Insurance Agents (AHIA) is so important in putting out information that will help agents assume that role."

It's clear that great changes are needed and that managed care, in one form or another, is going to be a permanent fixture of the national health-care landscape. Though the bloom may be off the HMO rose, variations on the same theme are attempting to revive it, providing the flexibility of indemnity plans without the limitations of traditional HMOs. And the PPO alternative continues to grow in popularity.

The bottom line, however, may rest with consumers themselves. If the days of employers picking up the entire tab for health-care benefits are not yet completely over, they are most assuredly numbered.

"If we want private enterprise to continue providing health care," says Richard Jones, "we can't just sit back and let the government take control." ■

I/R Code: 100.00 Accident & Health Insurance

who shouldn't. Eighteen percent wanted consumers to make the decisions, and only 3 percent trusted elected officials with that power.

Nevertheless, the Oregon state legislature has embarked on the first stages of a Medicaid rationing plan that would emphasize primary care of children and pregnant women instead of costly, high-tech treatments.

"From Oregon's point of view, it was simply the recognition that we've got a limited amount of money we can allocate," says David Nelson, legislative representative for the Oregon Life Underwriters Association in Salem, Ore. "We had to determine what are the most important services to provide. The result was an antiselection against high tech services."

It's too early to tell the results of Oregon's experiment, however, since it hasn't even had a chance to get off the ground yet. The federal government must grant an exception for Oregon to implement its Medicaid rationing program, according to Nelson, and it has not yet done so.

UP TO PAUR

Another form of managed health care that came on the market four or five years ago is something New York Life calls Prior Authorization Utilization Review (PAUR), and everybody else calls *pre-certification* or *pre-authorization*. New York Life uses a subsidiary, CoMed Management, Inc., to monitor hospital expenses before claims are paid.

The idea is that a panel of trained staff nurses screen claims using preestablished criteria based on the severity of the patient's illness and the services they require. Cases that don't meet the guidelines are referred to physician consultants who make the final determination.

If there's a difference of opinion between the panel and the practitioner, the practitioner is given an opportu-

The Case of the Rolling Russians: Health Care Fraud Makes a Bad Situation Even Worse

In the minds of the public, the bad guys of the health care crisis are usually those greedy, heartless health insurance companies. Clearly, the public hasn't had the opportunity of meeting the brothers Smushkevich, and others like them.

Russian emigres, David and Michael Smushkevich had a sweet deal going in their adopted home of sunny Southern California. They operated a fleet of vans, packed with medical testing equipment, which they called "rolling labs." Their scam was to pull into the parking lots of health clubs, shopping malls, churches and nursing homes and offer free physical exams for anyone who wanted them.

Then the brothers billed three large national health insurers for over $100 million of unnecessary or unexecuted diagnostic and medical tests, with bills ranging between $10,000 and $18,000 per patient.

When the three insurers finally caught on, they brought suit, and won—to the tune of $18 million in damages. Metropolitan Life was awarded $7.7 million; Aetna Life & Casualty won $7 million; and Employers Health Insurance received $3.3 million.

Unfortunately, none of the companies is likely to see a single dime. Shortly after the suit was filed in 1986, the brothers Smushkevich rolled themselves and all their assets out of the country. One brother is reported to be in Mexico while the other is back home in Russia, presumably exploring the felonious possibilities of perestroika.

The three insurance companies involved in the case are all members of a relatively new organization, the National Health Care Anti-Fraud Association (NHCAA), formed in 1985 to deal with a problem that is not new at all, and more widespread than many people realize.

"Health care fraud touches all of us both directly and indirectly," says NHCAA board member James L. Garcia, of Aetna. "Estimated to be $50 billion a year and rising, health care fraud is a significant factor in the increase of health care costs."

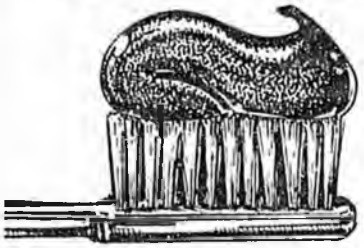
R. James Guzzi, chairman of NHCAA, estimates that between 5 percent and 25 percent of the $600 billion the nation spent on health care last year reflects outright fraud or abuse that flouts the letter of the law. The prime culprits, an estimated 75 percent of the time, are health care providers, while consumers themselves make up the difference.

The stated mission of the NHCAA is to improve the prevention, detection and civil and criminal prosecution of health care fraud. Toward that end, the antifraud organization acts a network for sharing information on insurance fraud schemes among its member companies, conducts regular seminars on fraud detection and prosecution, and helps identify and track trends in health care fraud cases.

"NHCAA is enhancing its abilities to share information on specific health care fraud offenders," says NHCAA Executive Director Richard H. Ekfelt. "As our data base increases we will become increasingly effective, through joint investigations, at stopping fraudulent practices and prosecuting health care fraud offenders."

—S.F. Sullivan

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pick a primary care physician from a list of doctors that CIGNA has contracted with after thoroughly evaluating their credentials and visiting their offices. The primary care physician acts as the member's health-care manager. He decides whether he can provide the necessary care himself, or he can refer a patient to a pre-authorized specialist within the network.

The open-ended HMO, however, allows members the option of going outside the network on their own. If they do, CIGNA's plan stops working like an HMO and begins working like a typical indemnity plan, with a 30/70 co-payment and a deductible.

"There are financial incentives to keep you in the network," says Amy DeMarco, spokesperson for CIGNA. "But you've got the flexibility to go to Sloan Kettering in New York if you feel you really have to, and still get some benefit."

One of CIGNA's earliest POS clients was Allied-Signal, Inc., an advanced technology company that instituted a POS plan it called the "Health Care Connection" in 1987. Allied-Signal was spending $355 million a year on health care and looking at projections of more than $600 million for 1990.

"Our corporate costs have been 23 percent lower for employees enrolled in the "Health Care Connection" than if these employees had remained in the fee-for-service indemnity plan," Edward L. Hennessy Jr., Allied-Signal's chairman and CEO, told the National Association of Manufacturers in March last year. "The savings to our company amount to about $750 per employee annually."

At 37,000 employees, that translates to a savings of around $28 million.

POS's haven't been around for very long, but more and more big companies are starting to market them and "they're taking off like wildfire," according to Health Insurance Association of America (HIAA) spokesman Donald White. "I call it employee-friendly managed care."

"The results [of managed care] have not been up to everyone's hopes," says Neil Waldron. "HMOs and PPOs have done a good job at reducing prices and shifting the setting of care from an in-patient to an out-patient basis . . . [but the] incremental impact has not been that great.'

TRIAGE

If all else fails, some suggest that the next step in cost containment might be triage. Also known as rationing, triage was originally a battlefield practice, a procedure for stretching overtaxed resources by treating only the most severely wounded first.

Translated into civilian life, this means deciding which patients, medical conditions and forms of treatment will be covered by health insurance and which won't.

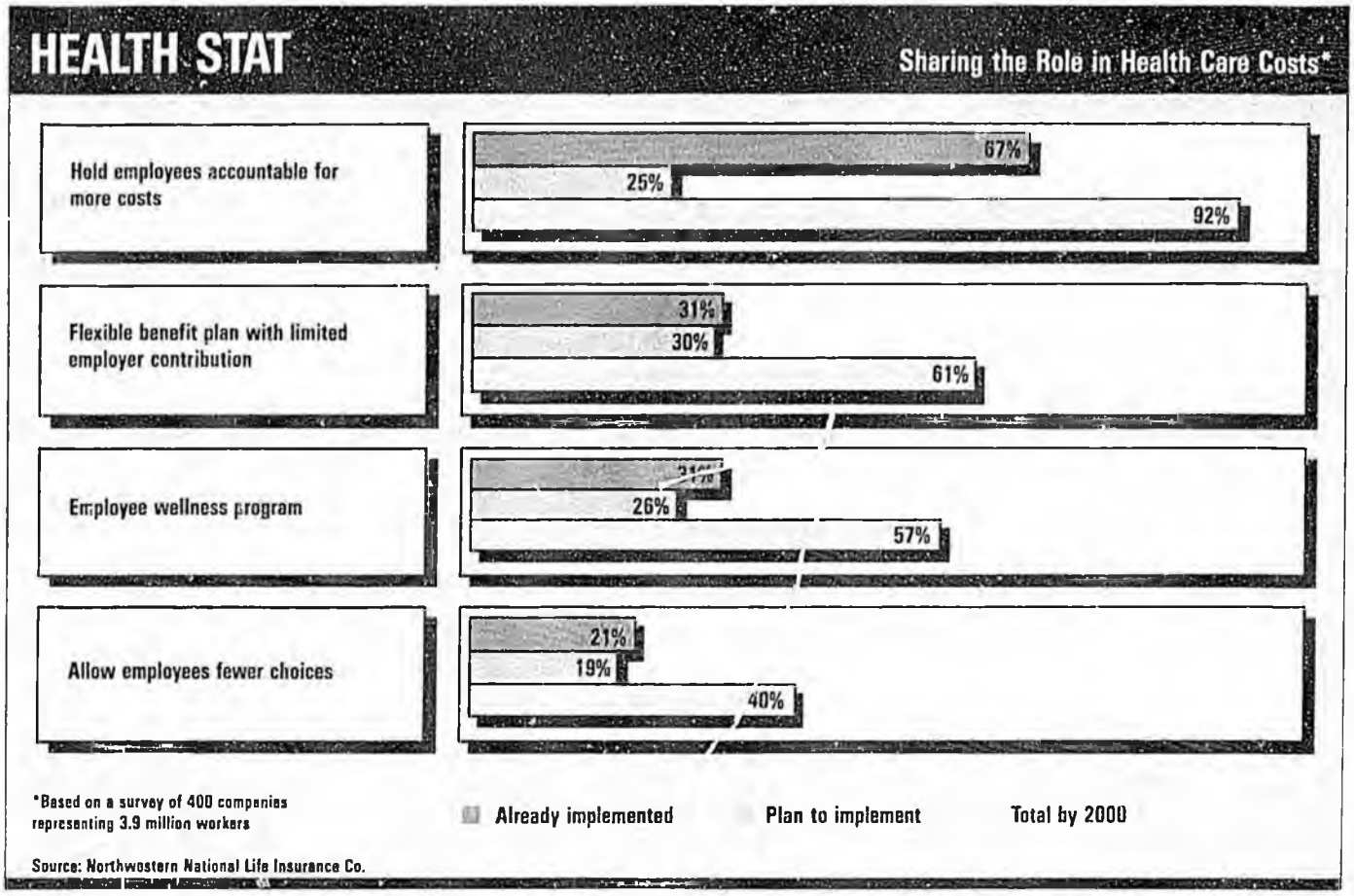
In a recent survey on health-care rationing, Northwestern National Life in Minneapolis defined rationing as denying health care services on the basis of predetermined criteria such as age of the patient or cost.

This would mean that, under a rationing system, an elderly patient who required expensive treatment might be denied coverage in favor of a younger person or an infant.

According to Northwestern National's survey, 85 percent of Americans believe that some form of rationing would work better at containing costs than the current health insurance system. Twenty-six percent believed that children should be given priority for health care services over the elderly.

"I don't know how Americans would really react if it came down to rationing," says Michael Conley, senior vice president of group insurance for Northwestern National. "I've got an 80-year-old father who had a quadruple bypass. I might be in favor of rationing as an abstract concept, but if you ask me to ration him out of the care he needs, I might have a different answer. And I'm not alone. Rationing opens up a whole lot of very difficult ethical and moral questions."

And who should be answering those questions? According to the survey, 50 percent of the respondents preferred a panel of medical professionals to determine who should get care and



sicians per patient and overall utilization. They also promote preventive health care.

With a PPO, groups of hospitals and providers contract with physicians, employers, insurers and other groups to provide services to plan members. The providers negotiate a discounted fee in return for patient volume.

Elliot K. Wicks, Ph.D., associate director of Policy Development and Research at the Health Insurance Association of America (HIAA), thinks more research needs to be done to find out how effective managed care plans are.

"It will be a couple of years before we can know how much savings we can expect," says Wicks.

Although the quality of care with PPOs hasn't really been criticized, HMOs are a mixed bag, according to Neil Waldron, vice president of product development for Massachusetts Mutual. Some do well and some don't.

"There is nothing inherent that says HMOs or PPOs will not provide good quality care," Waldron maintains, "but the question of care permeates the whole health-care system, not just HMOs."

HMOs are the original managed care arrangement and are used by over 14 percent of the U.S. population. They provide an agreed-upon amount of health-care services to enrollees, usually with no deductibles or with minimal copayments. HMOs can either employ health-care providers directly or contract with medical groups.

Despite their wide usage (enrollment in HMOs alone has increased tenfold in the past two decades, according to Dr. Arthur M. Southam, of CareAmerica Health Plans), the cost-cutting effectiveness of HMOs has come under heavy attack.

Some argue that HMOs are nothing more than assembly line operations, where doctors diagnose rows of faceless patients who sometimes pass too swiftly down the conveyer belt. Many employers claim they are not controlling health-care costs effectively.

Only one-third of U.S. employers feel that HMOs control health-care costs, and 60 percent feel PPOs control costs, according to A. Foster Higgins & Co., a national benefits consultant. Another survey, conducted by Confederation Life, found that HMOs are losing ground to utilization review and PPOs, which are gaining in popularity.

Employers also said that from 1988 to 1989, HMO premiums went up 16.5 percent, from $1,991 to $2,319 per employee.

Furthermore, according to American International Healthcare in Rockville, Md., the HMO industry has lost over $2 billion between 1986 to 1989, while the number of HMOs decreased from 607 to 575 between January 1989 and January 1990.

At the same time, HMO premiums increased 16.7 percent in 1989 (according to CareAmerica Health Plans) and are expected to increase another 12 percent by next year.

Some industry leaders say the cost increase of HMOs is at a higher rate than the overall rate increase of the health-care system.

A new wrinkle in the HMO fabric that could change the whole tapestry is something called an open-ended HMO or a point-of-service program (POS).

Under a POS, such as the one pioneered by CIGNA, members get to

cently, a Washington, D.C., consumer magazine rated over 300 dentists in the metropolitan area, right there alongside the microwaves, stereos and toaster ovens.

By conducting opinion polls among patients, the magazine rated the dentists on competence, chair-side manner, condition and quality of equipment, efficiency and, of course, price. The magazine plans to accord the same treatment to hospitals in a future issue.

Traditionally, however, the impetus for keeping health-care costs in check has come from the middlemen; the companies and institutions that, in one way or another, cover the cost of health insurance. Uncharacteristically, one of the earliest players to realize costs were getting out of hand and to take preventive action was the United States government.

In 1982, faced with rising costs and deficits, Congress directed Medicare to develop a structured payment system for reimbursing hospitals. The purpose of that system, known as diagnosis-related groups (DRGs), was to keep costs down by standardizing payments for specific treatments.

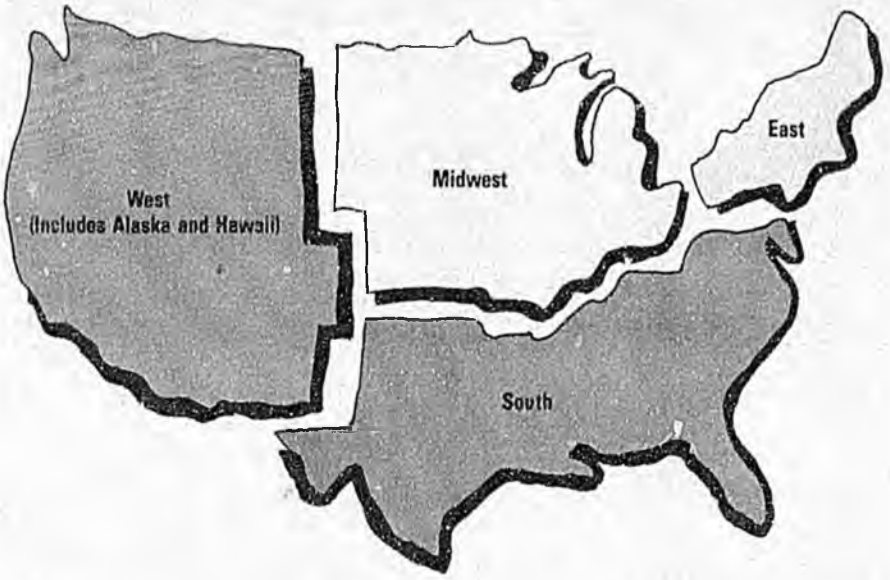
But that's not exactly how it worked. Since hospitals couldn't charge the government what they wanted to, they made up the difference by charging private insurance carriers more. While the use of DRGs succeeded in keeping Medicare's costs down, they merely shifted the cost from the government to the private sector.

Cost shifting is only expected to get worse. Last year, Congress reduced Medicare reimbursements by $34 billion over five years and introduced a new system of reimbursements to private physicians called resource-based relative value scale (RBRVS).

Based on a Harvard University Medical School study, RBRVS assigns a certain value reflecting the resources required for a procedure, compared with a specific baseline. Again, whatever Medicare saves through these procedures is sure to be passed along by the hospitals to private payers.

HEALTH STAT

Supplemental Benefits of Managed Care: Where in America Do You Find Them?



Regional Variations of Managed Care

Percentage

	West	Midwest	South	East
HMO	74	58	44	69
PPO	57	31	35	16
Managed mental health care	25	35	26	30
Case Management	47	37	38	34

Regional Variations of Supplemental Benefits

Percentage

	West	Midwest	South	East
Separate prescription drug program	31	37	27	43
Vision plan	48	29	27	34
Dental plan	94	79	77	79
Long-term care plan	25	18	19	23

Source: April 1990 *Business & Health*

MANAGED CARE

Probably the most common cost containment practice today is known as managed care; this is usually in the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

PPOs provide their members with health-care services by selected providers and help reduce health-care costs by limiting in-patient care, unnecessary surgery, the number of phy-



Focus On Cost Containment

"The Rand Corporation estimates that 25 to 33 percent of all health-care services are not medically necessary," said O'Brien at a meeting of the National Association of Independent Insurers. "This translates into at least $150 billion."

In any other marketplace, competition would be a strong incentive to keep costs down. But Americans don't seem to be comfortable with the idea of shopping for a doctor or a hospital.

"We Americans, when we need health care, want nothing but the very best and history has proven that price is secondary," says Carl W. Hill, CLU, Blue Cross/Blue Shield of Delaware in Wilmington. "We're hard business people when it comes to just about every other buying decision except health care."

Not long ago, the health-care industry started making moves that looked a lot like competition, according to Sally I. Nelson, of Nelson, Desmond and Payne Insurance in Falmouth, Maine. Doctors started competing with hospitals by opening up their own walk-in clinics, doing their own lab tests and investing in high tech equipment.

But appearances are deceiving.

"They're already taking business away from hospitals," says Nelson. "But they aren't charging any less. Many statistics say that costs are actually higher because of it, at least in our state. So it's really more cost shifting than competition."

There is also the prevalent perception that the more expensive a doctor is, the better he is. When it comes to health care, you get what you pay for.

"I've had doctors tell me that they charge more than 'usual and customary' because they're worth it," says J. Richard Jones, LUTCF, from Macon, Ga." And they mean it."

Still, there are signs of hope. Re-

Managed care is supposed to keep the supply-side costs of health care under control. If these measures don't work, the alternative may be even more unpleasant.

PHOTO CAN GLASS

Cost Containment: Is It Working?

By Steven Sullivan, *LAN* Features Editor

It doesn't cost anything to get sick in America. But it does cost a pretty penny to get well, and the cost seems to keep rising all the time—more than twice the pace of general inflation. It won't be long, many critics maintain, until only the wealthy can afford to be healthy.

There's no shortage of finger-pointing when it comes to allocating blame. Consumers point to employers for passing more of the cost of health care on to them. Employers point to insurers for raising insurance premiums. And insurers point to providers for charging too much.

They all have a point, but the fact remains that doctors, hospitals and other health-care providers charge a lot for their services. In 1979, the cost of health care per person was $349. By 1989, the cost had climbed to $2,748. By the year 2000, it's estimated that the cost of health care will reach a sobering $5,500 per person.

The growing cost and use of new medical technologies are major reasons, but surveys show that a whopping 25 percent of the rise is due to unnecessary treatments, while one-fifth is due to the amount that health-care costs have risen above the general inflation rate.

Another reason for escalating costs is that Americans just go to the doctor too often. According to Linda O'Brien, marketing director of Intracorp of Berwyn, Pa., Americans spend 31 percent more of their resources on health care than Canadians, 65 percent more than the Japanese and 79 percent more than the English.



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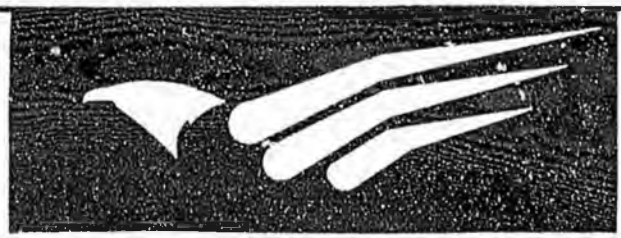
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The AIDS Epidemic: How The Insurance Industry Has Responded

By Steven Sullivan, *LAN* Features Editor

Focus On AIDS

When the cost of the acquired immune deficiency syndrome (AIDS) epidemic is reckoned, it is usually reckoned in lives. And the cost is staggering: over 95,000 deaths out of 152,000 reported cases as of October 1990, according to the United States Public Health Service. The Centers for Disease Control in Atlanta puts the number of Americans infected with the AIDS virus at somewhere around 1 million.

But the monetary cost of AIDS is staggering, too, and one segment of the community that seems to be bearing a large part of the burden is the life and health insurance industry. According to a survey conducted by the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA), the nation's life and health insurance industry paid an estimated $1 billion in 1989 AIDS-related claims.

This brings the industry's estimated cumulative total to $2.38 billion since 1986, when actuaries began collecting statistics on claims related to AIDS.

Not surprisingly, like the epidemic itself, these figures point to a rising trend. AIDS-related claims for individual life insurance were 1.7 percent of the industry's total claims paid in 1989, up from 1.1 percent the previous year. Group life claims, calculated at 1.6 percent in 1988, were up to 2.5 percent in 1989. Individual accident and health claims increased from 0.9 percent in 1988 to 1.3 percent the following year, while group accident and health claims rose to 1.4 percent in 1989 from 0.8 percent in 1988. (See tables, pp. 60-61.)

The average size of an ordinary life

The life and health insurance industry hasn't settled for simply protecting itself against the AIDS drain.

PHOTO IAN GLASS

Table 1
Estimated AIDS-Related Claims Paid
Industry Total for Four Major Lines
(Amount of claims shown in millions)

Line of Business	1986	1987	1988	1989
Individual Life	$93.3	$130.0	$135.5	$ 221.7
Group Life	79.4	132.5	155.5	253.0
Individual A & H	34.7	35.9	50.3	79.4
Group A & H	84.8	188.0	248.6	455.0
TOTAL	292.2	487.2	589.9	1,009.1

AIDS-related death claim in 1989 was $28,200, up sharply from 1988's $19,600, but slightly less than the $30,500 average in 1986. The average size of the group life AIDS-related claims was $34,200 in 1989.

"The survey results may significantly understate the number and amount of AIDS-related life and health insurance claims paid by the reporting companies," explains the report. Included among the reasons for this are death certificates that may not contain sufficient information about the cause of death, and health claim information that may not describe a patient's treatment as AIDS-related.

Although the number of reported cases is expected to increase, the impact it will have on the insurance industry is not as great as previously anticipated. One reason for this is that the industry seems to have won its fight to make testing for the HIV antibody part of the underwriting process.

Medical evidence strongly suggests that the presence of the HIV antibody almost guarantees that AIDS will follow. AIDS activists argued, however, that the cause-effect relationship is not necessarily axiomatic. AIDS testing by insurance companies, they maintain, is unfairly discriminatory and they were successful at making it illegal in many jurisdictions across the country.

Recently, however, the District of Columbia and such states as California and Massachusetts have heeded the medical evidence and reversed their testing bans, allowing insurance companies to make HIV testing part of the normal underwriting process.

"Obviously, we expect continued

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claims," says Gene Grabowski, a spokesman for ACLI, "although the claims will probably drop off. The vast majority (though not all) of insurance companies are screening with AIDS tests to protect against anti-selection. That means that fewer people with AIDS are going to be in the insured group and we do not expect to see levels like we had last year.

"At this time, the industry has not been damaged by the AIDS claims payouts," adds Grabowski. "We have prepared for it, made the necessary actuarial deductions and set aside enough money for it."

Stanley G. Karson, director of the Center for Corporate Public Involvement, a life and health insurance industry organization, is not quite so sanguine.

"Because of the 10-year incubation period, the number of AIDS cases will be getting much higher in the next several years," says Karson. "The number of infected people is much larger than the number of AIDS cases thus far."

But, he adds, nobody really knows the answer for sure.

THE RIGHT THING

Does that let the insurance industry off the hook as far as AIDS is concerned? Apparently not. There is another aspect of the financial burden of AIDS the insurance industry has assumed willingly, even aggressively—the support and funding of AIDS education, prevention and research programs.

By the end of 1991, according to figures provided by the Center for Corporate Public Involvement, insurance companies and affiliated trade associations will have contributed an estimated $34 million to education programs, research efforts and community groups serving people with AIDS.

This is not a new phenomenon. The life and health insurance industry took an early leadership role back in 1986 by providing $1.6 million for the first full-scale AIDS public education program. According to Stanley Karson, director of the center, the insurance industry has become the largest AIDS funder in corporate America.

Table 2
AIDS-Related Claims
As Percentage of Total Claims
Responding Companies

Line of Business	1986	1987	1988	1989
Individual Life	0.9%	1.2%	1.1%	1.7%
Group Life	0.9%	1.4%	1.6%	2.5%
Individual A & H	0.7%	0.7%	0.9%	1.3%
Group A & H	0.3%	0.6%	0.8%	1.4%

Source: American Council of Life Insurance/Health Insurance Association of America, 1989 AIDS-Related Claims Survey.

"Clearly, the industry's self-interest was heavily involved," says Karson, "but so what? For 25 years, we have avowed that self-interest is a basic rationale for corporate social responsibility."

In addition to the center, the Industrywide Network for Social, Urban and Rural Efforts (INSURE), a nonprofit foundation made up of several HIAA and ACLI companies, has pledged to provide $2 million in matching grants to community-based organizations, $900,000 of which has already been awarded.

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ban and rural areas all across the country, is the Community of Hope Health Services in Washington, D.C.

"The Community of Hope health clinic emphasizes direct care, education and prevention in treating AIDS and those infected with the HIV virus," says Lois Smith, the clinic's director. "In addition, we have a 12-week health advocate training program for people in the community that focuses on a variety of health issues, one of which is AIDS. The grant we received from INSURE has been used to employ one of these health advocates as an outreach person in the low-income community."

In addition to working through industry trade associations, many large life insurance companies sponsor their own AIDS relief programs in their local communities. The John Hancock in Boston, for instance, has sponsored numerous activities to raise money for its local AIDS Action Committee and has made its meeting facilities available to any AIDS-related organizations that want to use them.

John Hancock has also helped fund a 30-minute dramatic film called "Mother, Mother," designed to create compassion and understanding for people with AIDS. The film has had a national distribution and has been the focus of several fundraisers across the country.

"We believe the best way to combat AIDS is through education," says Pamela B. Kruh, spokeswoman for John Hancock. "Most of our support has been for educational programs, sponsorships and fundraisers designed to increase public awareness and understanding of the disease."

"The focal point of our anti-AIDS efforts," says Mark Lucius, a spokesman for Northwestern Mutual in Milwaukee, Wis., "is the education program we've done with the Red Cross here in Milwaukee over the last three years. So far, we've contributed about $130,000."

Northwestern has also given $18,000 to the Milwaukee AIDS Project for library resources and $135,000 over three years to the Milwaukee Blood Center for AIDS research, as well as smaller amounts to numerous other local organizations.

For the past two years, the National Association of Life Underwriters (NALU) itself has been marketing a two-hour AIDS education seminar to member associations across the country. "AIDS Strikes Home: You, Your Company, Your Career" is designed to help agents respond to clients' questions about AIDS, and also to let them know where to get the most accurate information.

In addition, according to Paul Meyer, NALU's director of education and member services, much of the AIDS material has also been incorporated in the recently revised four-hour seminar, "The Dynamics of Group Insurance." Both seminars are available from NALU's order department (202/331-6086).

"Private money has not necessarily been going to AIDS research, at least in our case, because that's where government money has been going," says Karson. "Money for research was not as needed and asked-for by the AIDS community as was money for education, prevention, and direct support for persons with AIDS. That's where our money is going."

By 1992, according to ACLI, the $34 million contributed by the aggregate of all insurer-sponsored programs to the fight against AIDS, is more than they've ever given for any other specific disease.

For Stanley Karson, a man Gene Grabowski describes as the "conscience of the industry," there's more than just self-interest at work here, no matter how enlightened that self-interest might be.

"Another reason for corporate public involvement," says Karson, "one seldom uttered as though it would embarrass or even taint the source, applies so well to the industry's commitment in the fight against AIDS.

"It was the right thing to do." ■

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Living Benefits Riders: Great Hype Or Great Hope?

By Joseph C. Razza Jr., CLU, *LAN* Senior Editor

When Ron D. Barbaro, then president of Prudential's Canadian operations, announced living benefits for terminally ill insureds, headlines blazed the news across Canada and the United States. For the first time in years, press coverage of the insurance industry was extensive and glowing.

Barbaro, who already had a reputation as a creative maverick in the industry, saw living benefits as a practical and humane way for the industry to help destitute and terminally ill patients keep their dignity by providing money for medicine, food and housing. The concept gained such rapid acceptance industry-wide that many believe it was at least partially responsible for Barbaro becoming President and CEO of parent company Prudential of America in the Fall of 1990.

Prudential of America brought the program to American policyholders in January 1990, offering a living benefits option to new and existing insureds as quickly as it could get state approval. By mid-December 1990, 44 states had approved the option and over three million policyholders were covered.

And in November 1990, the company extended the concept to insureds who are permanently confined to a nursing home. The option is currently available to new clients buying policies with face amounts of $50,000, and to clients with in-force policies of $25,000 or more.

James Longo, Prudential's public relations manager, Newark, N.J., said there is no separate charge to the policyowner for this option. However, when the client exercises the option, the company discounts the amount for the six months of interest it loses by paying the living benefit to the insured.

He offered this example: If a terminally ill client owns a $100,000 policy and exercises the option, Prudential will deduct the interest the company would have earned for six months had the policy remained in force. If the current interest rate is 8 percent a year, the company would keep 4 percent of the face amount and the client would get about $96,000.

"The terminally ill insured can collect about 95 percent of the face value of the policy," Longo said. "The remainder is the interest Prudential would have lost. And that is



Focus On Living Benefits

Living benefits help clients who are terminally ill to spend their last days with dignity. But despite massive publicity, a great idea hasn't yet translated into great sales for some companies.

the only cost involved."

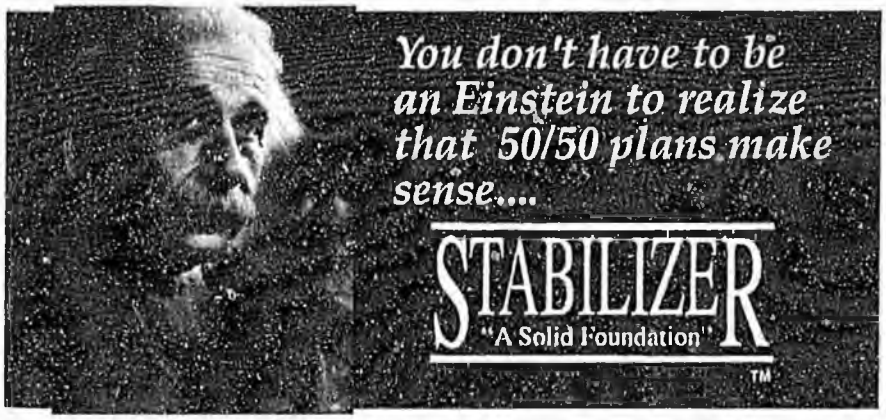
The tax implications of receiving living benefits are unclear at the moment. It is possible that the Internal Revenue Service (IRS) will tax the benefits as ordinary income. The IRS has yet to make a determination on this point.

Many other insurance companies in the United States have followed Prudential's lead and are developing living benefits options, riders and policies (for more detail see our survey of living benefit products on page 68). In some companies, they are called accelerated benefits, and in others convalescent care riders or policies. Because these products are so new, companies do not know how the public or their agents will accept and use them. In some cases, however, new product results have been disappointing.

Robert B. Daney, CLU, ChFC, FLMI, Lincoln National's second vice president of individual products marketing in Ft. Wayne, Ind., said his company offers a convalescent care benefit rider, but the product is not particularly popular with agents and brokers. He estimated that only 10 percent of Lincoln National's policyholders bought the convalescent benefits care rider through the agent/broker distribution system.

On the other hand, a sister company, First Pacific Penn, is writing a lot of this coverage through financial institutions. He estimates this company is putting the rider on about 35 percent of all policies.

In describing these transactions, Daney said that financial institutions



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sell the rider primarily as a substitute for certificates of deposit (CD). If a person with a $100,000 CD in one bank decides to move the money to another bank, the first bank refers the lead to its insurance department. In contacting the customer, the agent says, "We're sorry to lose your business in the CD. Perhaps, we have something better than taking it down the street to one of our competitors.

"Could we talk to you about a single premium life insurance policy? This policy will provide comparable crediting rates but also provide additional benefits that a CD at a competing bank couldn't provide, such as death benefit protection and long-term care protection."

Banks do not widely advertise these products because they don't want to have disintermediation between their own CDs and their insurance company. However, once the bank determines that it will lose the CD, then it will pursue the insurance sale and emphasize the accelerated benefits rider.

"We don't think that would be a particularly popular rider," Daney said. "Living benefits are getting a lot of attention in the media. It is something that we want to have. However, I think we will have a similar experience to Prudential and other companies where there is a lot of hype, but not a lot of action."

However, William J. Castle, assistant vice president and associate actuary of Security-Connecticut, Avon, Conn., expects interest in the living benefits option will be high. He predicts that once the IRS clears up the tax questions about these benefits, public interest in these products will be great.

His company will charge a $150 administration fee when the option is used and discount the payout by the amount of interest the company will lose by providing the living benefit to the client. To qualify for Security-Connecticut's option program, a client must have a minimum of $100,000 of insurance with the company.

The living benefit is limited to 25 percent of the face amount, with a maximum of $250,000. Clients may exercise the option for any diagnosed terminal illness, whether or not the policyowner is at home, in a hospital or in a nursing home facility.

Castle said the company used the option rather than either a policy loan or a lien because the policyowner could be severely hurt if the diagnosis was incorrect. He said a lien is similar to a policy loan. The difference is that the amount of money paid to the client as a living benefit may exceed the cash value of the policy. If the diagnosis is wrong and the policyowner survives, the loan interest could equal the death benefit, leaving no money for the beneficiaries when the policyowner dies.

Prudential's Longo said that since January 1990, the company has had about 75 claims, chiefly from clients who were over 50 and suffering with cancer or AIDS.

Fred N. Bush, LUTCF, a Prudential sales manager in North Versailles, Pa., praised the living benefits option, introduced in his area in September 1990.

"We have been contacting all our clients who received the letters to explain the benefit to them. They all want to add the rider," he said. "That leads to the agent reviewing the client's total insurance portfolio. The result is that we are writing a lot of new business. The client reasons that if he needs to use the living needs benefit, he still wants to have some death benefits for the family."

Bush said, "As of mid-December, my staff has increased its production of life insurance by at least 50 percent. A lot of that increase is attributable to the living benefits. That's the approach that we use. We cover the living benefit in the interview, and it lets us get into a whole needs presentation with the client." ■

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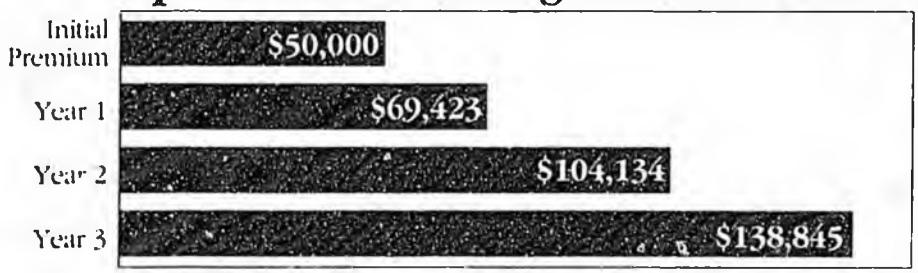
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LAN's Survey of Living Benefits Insurance Riders

	Company Name Policy Name or Number	Policies It Can Be Attached To	Age Limit on Purchase	Premium Type	Waiver of Premium	Smoker/ Non-smoker Rates	Events Triggering Early Payout
1.	**Aegon USA Life Investors** Accelerated Death Benefit Rider	Universal Life	50	Level	No	Yes	Heart Attack, Stroke, Life-threatening Cancer, Bypass, Major Organ Transplant
2.	**Bankers Life & Casualty** Accelerated Death Benefit Rider	Fixed & Flexible Premium Universal Life	75	No Charge	N/A	N/A	Terminal Illness or Permanent Confinement in a Nursing Home
3.	**Best Meridian Insurance** Accelerated Benefit Rider	Whole Life	65	No Charge	N/A	N/A	Heart Disease, Terminal Cancer
4.	**Continental General** L4600F (Uni-Flex)	Universal Life	75	Increases	Yes, to Age 60	Yes	Heart Attack, Cancer, Renal Failure, Coronary Artery Surgery, Stroke, Major Organ Transplant
5.	**Continental Western Life** Long-term Care Rider #01359	Universal Life	25-70	Increases	Yes, During Benefit Period	No	Confinement in an LTC Facility
6.	**Equitable Life of Iowa** Silver Plan	Universal Life	20-65	Level	Yes, for Length of Disability	No	Unable to Perform 3 Activities of Daily Living (ADLs) as Defined
	Gold Plan	Universal Life	20-65	Level	Yes	No	Unable to Perform 3 ADLs
7.	**Guarantee Mutual Life** Living Benefit Rider	Universal Life	75	Increases	No	Yes	Heart Attack, Stroke, Coronary Artery Surgery, Life-threatening Cancer, Renal Failure, Major Organ Transplant, Paraplegia, Blindness
	Long-term Care Rider	Universal Life	75	Increases	Yes, During Period of Care	No	Confinement to a Nursing Facility or Need for Home Convalescent Care
	Long-term Care Plus	Universal Life	75	Increases	Yes, During Period of Care	Yes	Heart Attack, Stroke, Coronary Artery Surgery, Life-threatening Cancer, Renal Failure, Major Organ Transplant, Paraplegia, Blindness and Confinement in a Nursing Facility or Need for Home Convalescent Care
8.	**Gulf Life** Death Benefit Advance Rider	Any Policy	30-60	Level	Yes	Yes	6-month Life Expectancy
9.	**ITT Life** Long-term Care Rider	Universal & Whole Life	20-75	Level	Yes, 90 Days Beyond Benefit Period	Yes	Unable to Perform 2 ADLs
10.	**Jackson National** Lifeline Ultimate	See Footnote[1]	80	Level	Yes[4]	Yes	Heart Attack, Stroke, Cancer, Renal Failure, Bypass
	Lifeline Level Term Rider	Lifeline Ultimate & Interest-sensitive Whole Life	70	Increases	Yes[4]	Yes	Heart Attack, Stroke, Cancer, Renal Failure, Bypass
11.	**John Hancock Mutual Life** Living Care Benefit Rider	Whole Life	20-75	Level	Yes	No	Confinement in a Nursing Home or Receiving Home Health Care
12.	**Leaders Life** Lifestyle	See Footnote[2]	70	Level	Yes[5]	No	Heart Attack, Heart Surgery, Cancer or Stroke
	Term to 100 with Accelerated Benefits	See Footnote[3]	70 for 30% benefit, 55 for 60%	Level	Yes[5]	Yes	Heart Attack, Heart Surgery, Cancer or Stroke

Percent of Face Amount Paid	Maximum Payout	When Benefit Is Paid	Covers Medical Care Costs Only	Pre-Existing Conditions	Benefit Can Be Collected	States Where Policy Is Sold
Up to 50%	$100,000	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK, AZ, AR, CO, DE, ID, IN, IA, KY, LA, MD, MS, MO, MT, NE, NM, ND, OH, OR, RI, SD, TN, WV, WI, WY
Up to 100%	None	Upon Diagnosis Over Time	No	None	Whenever Qualified	State Approvals Pending
25%	$25,000	Upon Diagnosis Over Time	No	None	Once	FL
50%	$50,000	Upon Diagnosis in a Lump Sum	No	2 Months After	Once	AL, AK, AZ, AR, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, MD, MS, MO, MT, NE, NV, NM, NC, ND, OH, OK, OR, SD, TN, TX, UT, WA, WV, WI, WY
See Footnote[1]	N/A	Upon Confinement	No	60 Months After	More Than Once	AL, AK, AZ, CO, DE, HI, ID, IL, IA, LA, MS, MO, MT, NE, OH, OK, OR, SD, WI, WY
50%	None	As Expenses are Incurred	Yes	6 Months Before & 6 Months After	More Than Once	AL, AK, AZ, AR, CO, DE, ID, IN, IA, KY, LA, MD, MO, MT, NE, NV, NM, ND, OH, OK, SD, TN, WA, WV, WY
100%	None	As Expenses Are Incurred	Yes	6 Months Before & 6 Months After	More Than Once[2]	AL, AK, AZ, CO, DE, ID, IN, IA, KY, LA, MD, MO, MT, NE, NV, NM, ND, OH, OK, SD, TN, WA, WV, WY
25%	$250,000	Upon Diagnosis in a Lump Sum	No	2 Months After	Once	AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY
50%	$250,000	After Elimination Period, Over Time	No	6 Months Before & 6 Months After	More Than Once	AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY
75% to Age 70, 50% Thereafter	$125,000 ($250,000 for Long-term Care)[3]	Upon Diagnosis in a Lump Sum, or Over Time for LTC	No	6 Months Before & 6 Months After for LTC; 2 Months After for Illness	Once for Illness; More Than Once for LTC	AK, AZ, HI, ID, IN, IA, MO, NE, NV, NM, SD, WA, WY
50%	$100,000	Upon Diagnosis in a Lump Sum or Over Time	No	6 Months Before	More Than Once	AL, FL, GA, KY, LA, MS, NC, SC, TN, VA
48%	$7,250 per Month	Monthly	No	6 Months After	More Than Once	AL, AK, AZ, AR, CA, CO, DE, FL, HI, IL, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PR, RI, TN, TX, VI, VT, VA, WI, WY
25%	None	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, WA, WV, WI, WY
25%	None	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, WV, WI, WY
50%	$5,000 per Month for Nursing Home Care[4]	After 90 Days	No	6 Months After	More Than Once	AK, AZ, AR, CO, DE, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, TX, VA, WA, WV, WY
30%	$29,070	Upon Diagnosis in a Lump Sum	No	90 Days	Once	OK
30% or 60%	$250,000	Upon Diagnosis in a Lump Sum	No	90 Days After	Once	OK

FOOTNOTES

[1] Pays out that portion of the policy equal to the risk at the end of the elimination period

[2] Until face amount is depleted

[3] Individual policy

[4] For life, if disabled

[5] For one year

[6] $100,000 for coronary bypass

[7] After 90 days

[8] Immediately, if shown on the application

[9] 16-75 for smokers

	Company Name Policy Name or Number	Policies It Can Be Attached To	Age Limit on Purchase	Premium Type	Waiver of Premium	Smoker/ Non-smoker Rates	Events Triggering Early Payout
13.	**Life of Georgia** Accelerated Benefit Care	Universal Life	15-65	Level	Yes	Yes	Cancer, Renal Failure, Severe Injury
14.	**Lincoln National** Convalescent Care Benefit Rider	Universal Life	18-70	Increases	Yes	No	Confinement in a Nursing Facility and Unable to Perform 3 ADLs
15.	**Midland National** Accelerated Benefit Rider	Universal Life	80	Increases	No	Yes	Heart Attack, Stroke, Coronary Artery Surgery, Major Organ Transplant, Renal Failure, Life-threatening Cancer
16.	**Mutual of Omaha** Living Benefits	Employer-sponsored Group Term	N/A	Level	No	No	Terminal Illness with 9-month Life Expectancy
17.	**Nationwide** Long-term Care Rider	Universal Life	21-70	Increases	Yes, for Length of Disability	Yes	Confinement to an LTC Facility
18.	**Old American** Golden 50	See Footnote[1]	80	Level	No	No	Terminal Illness
	Benefit Pre-Payment Plan	Whole Life	80	Level	No	No	Terminal Illness
19.	**Principal Mutual Life** Benefit Advance	Whole Life	None	No Charge	N/A	N/A	12-month Life Expectancy
20.	**Provident Life & Accident** Living Benefit Option Rider	Employer-sponsored Group Universal Life	N/A	N/A	No	Yes	Terminal Illness
	Accelerated Benefit Life	See Footnote[3]	20-70	Level	Yes	Yes	Life-threatening Cancer, Heart Attack, Heart Transplant, Bypass, Stroke
21.	**Saleco** L-9570	Permanent & Term	None	No Charge	N/A	N/A	6-month Life Expectancy
22.	**Security-Connecticut** Living Benefits Rider	All Policies	None	No Charge	N/A	N/A	6-month Life Expectancy
23.	**State Life** VitalCare Plus	Universal Life	20-75	Increases	Yes, During Payout and 90 Days After	No	Nursing Home Confinement
24.	**Time Insurance** Long-term Care Rider	Universal Life	20-75	Level	Yes	Yes	Confinement to an LTC Facility
	Accelerated Death Benefit Rider	Universal Life	75	Level	No	Yes	Heart Attack, Stroke, Bypass, Life-threatening Cancer, Confinement in an LTC Facility
25.	**Transamerica Occidental Life** Living Benefit Rider	Universal & Interest-sensitive Whole Life	75[9]	Level	Yes	Yes	Alzheimer's Disease, Heart Attack, Coronary Artery Disease, Stroke, Life-threatening Cancer, Renal Failure

Percent of Face Amount Paid	Maximum Payout	When Benefit Is Paid	Covers Medical Care Costs Only	Pre-Existing Conditions	Benefit Can Be Collected	States Where Policy Is Sold
25%	$250,000[6]	Upon Diagnosis in a Lump Sum or Over Time	No	90 Days After	Once	AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA
2% per Month	Varies	Upon Diagnosis Over Time[7]	No	6 Months After[8]	More Than Once	AL, AK, AZ, AR, CA, CO, DE, DC, FL, HI, ID, IL, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, TX, UT, VA, WA, WV, WY
25%	$125,000	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK AZ, AR, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, VT, WA, WV, WI, WY
25%	$50,000	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK, AZ, AR, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, SC, SD, TN, UT, VA, WA, WV, WI, WY
50%	$3,000 per Month	3 Months After Confinement	Yes	6 Months After	More Than Once	AL, AK, AZ, CA, CO, DE, GA, ID, IL, IN, KY, LA, ME, MD, MS, MO, NE, NV, NH, NC, ND, OH, OK, OR, PA, RI, SD, TN, UT, VA, VI, WV, WY
50%	$25,000	Upon Diagnosis in a Lump Sum or Over Time	No	N/A	More Than Once	AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, LA, MD, MI, MN, MS, MO, MT, NE, NV, NM, NC, ND, OH, OR, SC, SD, TN, TX, UT, VA, WV, WI, WY
50%	$25,000	Upon Diagnosis in a Lump Sum or Over Time	No	N/A	More Than Once	AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, LA, MD, MI, MN, MS, MO, MT, NE, NV, NM, NC, ND, OH, OR, SC, SD, TN, TX, UT, VA, WV, WI, WY
75%	$250,000	Upon Diagnosis in a Lump Sum or Over Time	No	N/A	More Than Once	AL, AK, AZ, AR, CO, DE, FL, GA, HI, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, NC, OK, OR, RI, SD, TN, UT, VA, WV, WI, WY
25%	$25,000	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AZ, AR, CA, CO, DE, FL, GA, IA, KY, LA, MS, MO, MT, NE, NV, NH, ND, OH, OK, TN, UT, VA, WA, WY
30%	$300,000	Upon Diagnosis in a Lump Sum	No	None	Once	AL, AK, AZ, AK, CA, CO, DE, DC, FL, ID, IN, IA, KY, LA, ME, MD, MI, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WV, WI, WY
75%	None	Upon Diagnosis in a Lump Sum	No	None	Once	AK, GA, HI, LA, MA, MI, MS
25%	$250,000	Upon Diagnosis in a Lump Sum	No	None	Once	State Approvals Pending
100%	$1 million	Upon Diagnosis Over Time	No	Covers All	More Than Once	AL, AK, AZ, AR, CA, CO, DE, DC, HI, ID, IN, KY, LA, MD, MI, MS, MO, MT, NE, NV, NH, NM, NY, ND, OH, OR, SD, TN, VT, WV, WI, WY
50% or 100%	$500,000	After 90 Days, Over Time	Yes	None	More Than Once	AL, AZ, AR, CA, CO, DE, GA, ID, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, OH, OK, RI, SD, TN, TX, WA, WV, WI, WY
10% or 25%	$250,000	Upon Diagnosis in a Lump Sum	No	2 Months After	Once	AL, AZ, AR, CA, CO, DE, DC, FL, GA, ID, IN, IA, KY, LA, ME, MD, MN, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, RI, SC, SD, TN, TX, UT, VA, WA, WV, WI, WY
Up to 25%	$250,000	Varies	No	None	Once	AL, AK, AZ, AR, CA, CO, DE, DC, FL, GA, HI, ID, IN, IA, KY, LA, ME, MD, MS, MO, MT, NE, NV, NH, NM, NC, ND, OH, OK, OR, RI, SD, TN, UT, WA, WV, WI, WY

FOOTNOTES

[1]Pays out that portion of the policy equal to the risk at the end of the elimination period

[2]Until face amount is depleted

[3]Individual policy

[4]For life, if disabled

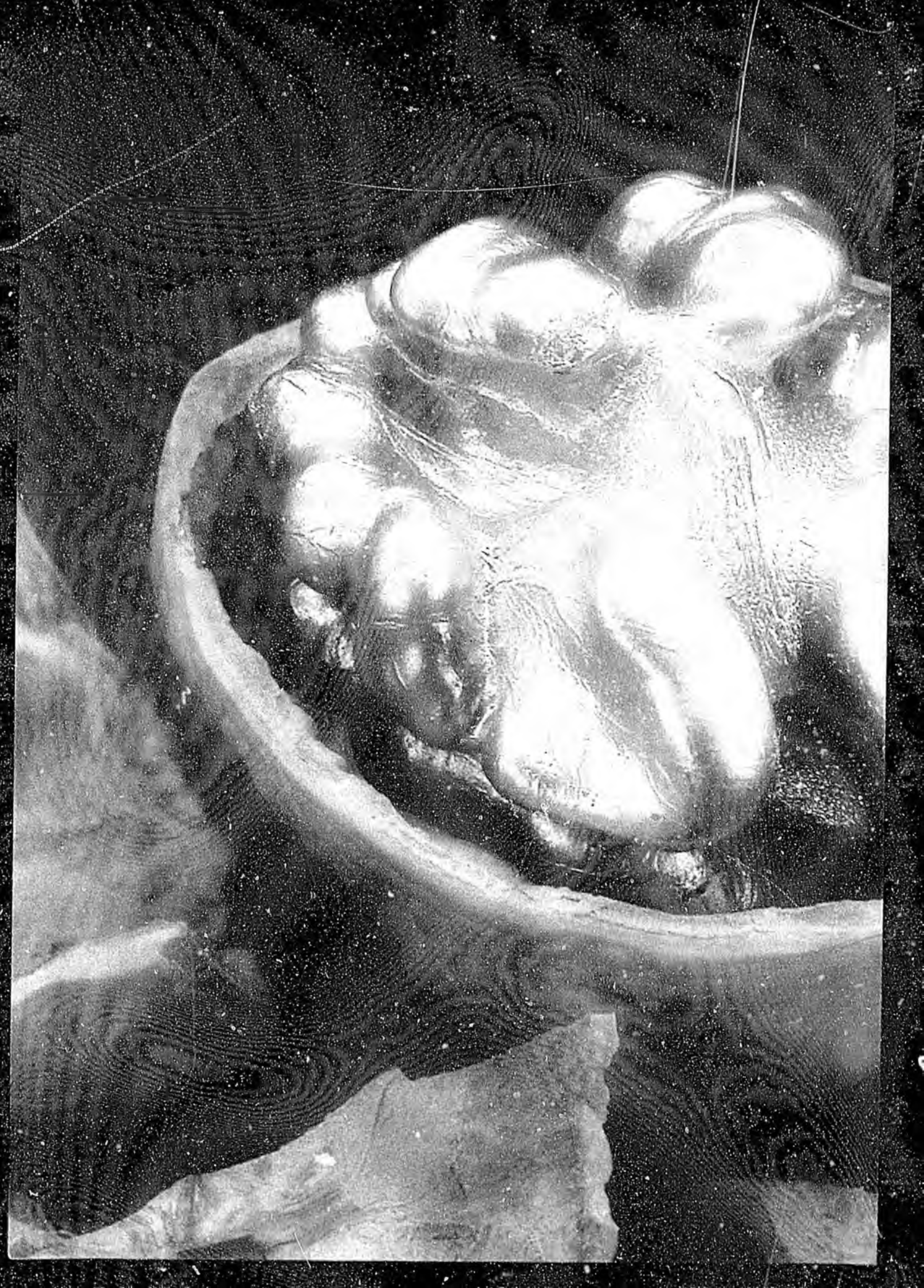
[5]For one year

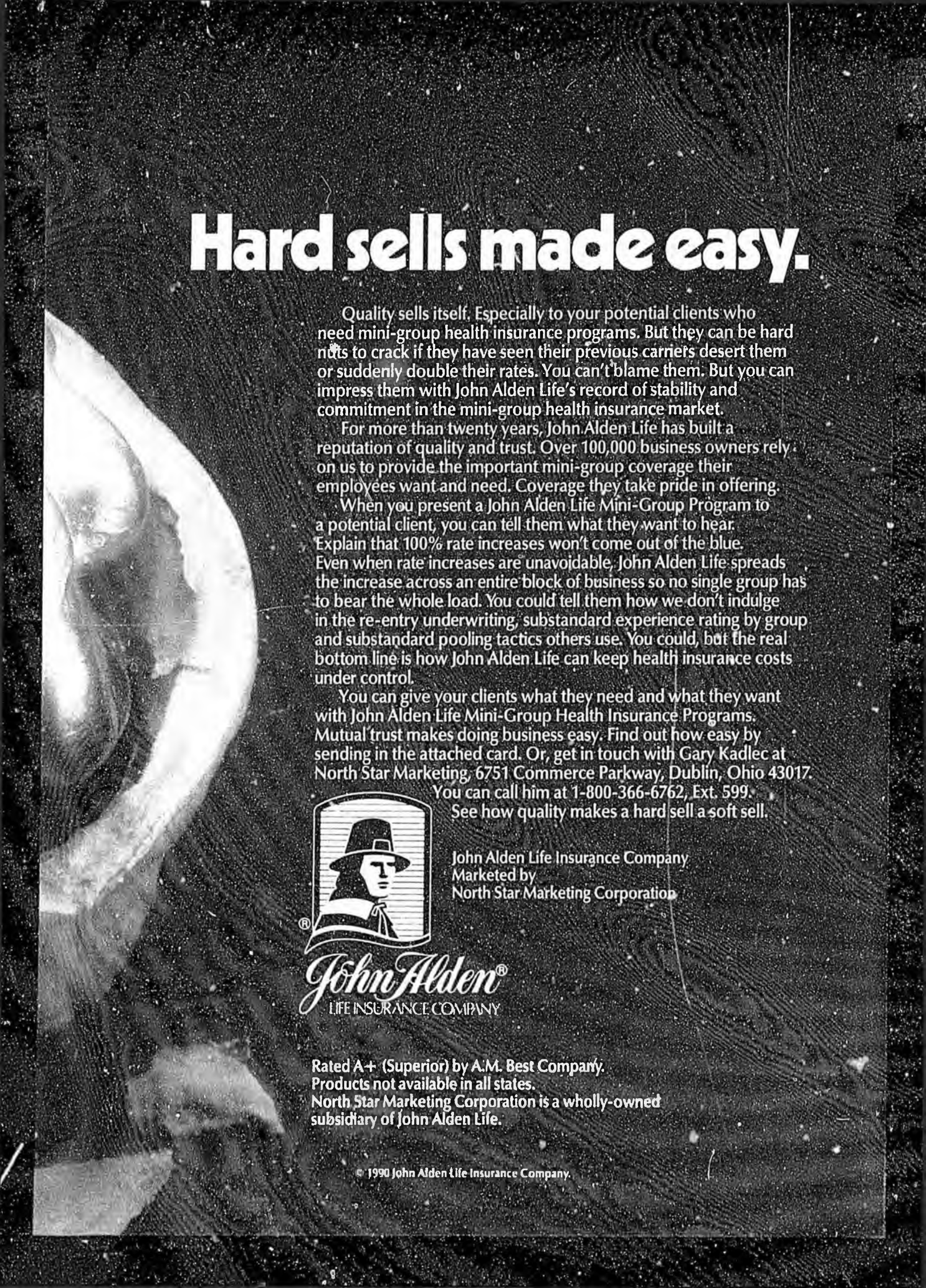
[6]$100,000 for coronary bypass

[7]After 90 days

[8]Immediately, if shown on the application

[9]16-75 for smokers




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Don't Forget The Disability Sale

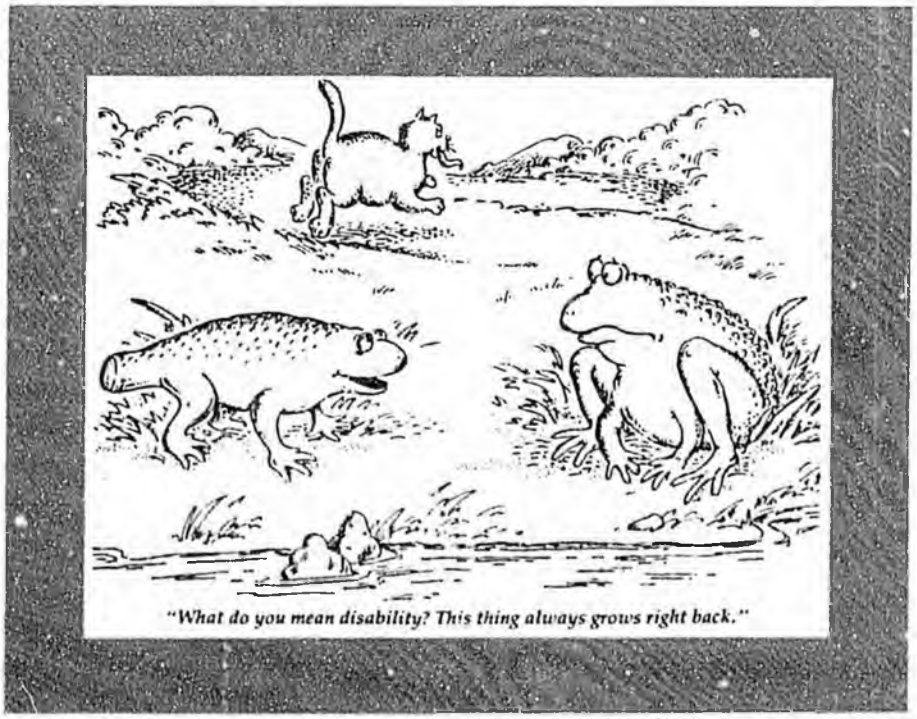
By Steven Sullivan, *LAN* Features Editor

It isn't often that the business press is actually on the side of insurance agents. Yet there it was, printed in the business section of the April 29 *New York Times:* "Many employees . . . assume they have adequate coverage through their employee benefit plans and that they don't need to buy their own policy. But even if your company offers disability plans, buy your own anyway."

Sounds like an invitation, doesn't it? So what are you waiting for?

Joel Garfield, CM Alliance, Detroit, Mich., believes that disability income insurance (DI) is sold, not bought. That means that if most people aren't buying it, there must be a lot of agents out there who aren't selling it. To Garfield, this makes no sense. He points to what he calls "Garfield's Analogy."

"When an individual goes on claim for life insurance," he says, cheek bulging with tongue, "he's usually dead. A person only dies once. And when that person dies, my commissions cease. However, when a person becomes disabled, I can get involved with him. I become a very important man in that family. I am the one bringing the checks when the employer doesn't. And it's usually for a long period of time. While they're collecting, their premiums are waived. But my commissions are still coming. You



"What do you mean disability? This thing always grows right back."

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Focus On Disability

Five life underwriters share their ideas about disability income insurance and why it should be a part of every agent's presentation.

PHOTO DAN GLASS

make more money as an agent by selling disability than by selling life."

Wait a minute. More money with DI? Absolutely, says Garfield.

"The persistency on disability is better than on life. More people are reluctant to drop it and it's not uncommon to see renewals of 15 to 25 percent. You may be dealing with smaller amounts but it's a steady stream of income."

Garfield's sales approach depends on statistics and analogies. He begins by asking prospects about their medical insurance—have their rates been going down or up?

They usually laugh at that one. Up, of course. Garfield explains that part of the reason is usage. More and more people are using their health insurance, which means that more and more people are in hospitals and medical facilities.

If a person is in the hospital, using his medical coverage, then he's not earning a living. And that's why a person needs disability, to make sure that when he can't earn a living, Garfield's company will pay him.

If that doesn't work, Garfield has another approach. He mentions a particular funeral home familiar to most of his clients. How many stories high is it?

One, they answer.

And what about the local hospital? How many stories high is that?

You know, he tells them, they don't make them that high for nothing. Obviously there are more people using the hospital at any given time than there are using the funeral home.

"I still use the same presentation I used 20 years ago," says Garfield. "It's canned but I change it around, adapt it to the situation. You have to have a track to run on in selling disability. There's no question about it—

"It's just filling in gaps, so to speak. Most people don't have DI coverage. They buy life and health, but you've got to talk to them about the reasons for owning DI. I don't really prospect for it directly."

—Bruce (Doc) Holliday, CLU, RHU

whether it be in securing the appointment, making the presentation, or making the delivery."

And, adds Garfield: "When you ask a question in any sales situation, shut your mouth and wait for an answer."

For **Bruce (Doc) Holliday, CLU, RHU, New York Life, Pensacola, Fla.,** disability is just a normal part of his needs selling presentation. As such, it constitutes about 25 percent of his business.

"The best thing that's worked for me over the years is going through life insurance sales to get to the disability products," says Holliday. "It's just filling in gaps, so to speak. Most people don't have DI coverage. They buy life and health, but you've got to talk to them about the reasons for owning DI. I don't really prospect for it directly."

Most of Holliday's disability work is done as group insurance for small businesses.

"They've got a business to protect as well as their own incomes. I go in and talk about overhead expense insurance, which is a form of DI to protect the business in the event the key person can't come in and operate. The business will lose money but the expenses keep coming in. The fact that the business overhead policy is tax deductible usually catches their attention.

"Disability insurance is a harder sell than life," says Holliday. "People know they're going to die but they don't think they're going to get disabled. You have to bring that out and show them they have a reason to protect something. When I was younger, I didn't buy DI because I thought I was invincible. That's the attitude of most people."

Not everyone agrees. **Don Garms, Mass Mutual, Dallas, Texas,** is an agency staff supervisor specializing in DI. Because he's management, he doesn't sell unless he wants to. When he does, DI is his product of choice.

"It's easy to sell because it's a value that people readily realize," Garms believes. "They don't want to lose their credit rating or their standard of living. They see they've got all their other material assets insured; doesn't it make sense that they would want to insure their ability to earn a living? It almost sounds too simple, doesn't it?"

Garms draws his prospects a simple picture of two parallel horizontal lines. The top line represents their normal income. The bottom line is their normal level of expenses. Once disability strikes, Garms explains, their income either stops immediately or tapers off. The top line takes a 45 degree dive into the bottom line and beyond. The expenses, meanwhile, either increase or stay the same.

"Either way, the two lines cross," says Garms. "Where those two lines cross is where debt begins. If they had been saving 10 percent of their income for the last 10 years, I explain to them, one year of disability could wipe out that 10 years worth of savings. Just like that. It's usually a fact that's hard for them to ignore."

Marlene Hurst, The New England, Albuquerque, N.M., sells disability income insurance because she believes in it. Her reason for believing in it has turned out to be her most potent sales tool. But it's one she hopes her fellow sales professionals never have to use.

"I broke my ankle five years ago," says Hurst. "It was a very simple fall, one step, not dramatic, not sports, simply walking. It could happen to anybody but I did a real job on it. I broke all the bones, tore the ligaments and tendons, and had extensive nerve damage. It never got any better; it simply got worse. I still have to wear a brace."

It was her own DI policy that paid her bills while she couldn't work. And the brace is eloquent testimony to what a disability can do to someone's life.

Hurst prospects mainly in the professional market—concentrating on doctors and real estate offices. She sells DI not only to the business owners but as an employee benefit as well.

"With professional firms, we try to get the personal in force first, then go back and get the group for everyone," says Hurst. "The most recent one we did like that was a doctor's office. The staff was just ecstatic at getting DI. The doctors saw they could really do their staff—as well as their practice—a big service by providing this as an employee benefit."

Hurst is able to view her own disability with a wry sense of humor. She's offered to rent herself out to other salespeople in her office to help with their disability cases. But the real pain and heartbreak is always there, beneath the surface.

"When I tell my prospects the story of why you need disability insurance, they know it's the absolute truth," says Hurst. "With every policy I deliver, I say that I hope they never have to use it. And that comes from the heart, too."

Another true believer in DI is **Joe Houlihan, Paul Revere, Nassau County, N.Y.** He believes that any life agent who doesn't at least try to cover a client's DI needs is doing a professional disservice. He, too, has arrived at that opinion through personal experience.

"It's difficult for me to listen to peo-

ple tell me they're never going to be disabled," says Houlihan. "With a mother in a wheelchair for over 20 years due to an accidental blow to her spinal column that precipitated spinal deterioration, I can't hear when people tell me they don't need it."

One prospect once told Houlihan that he'd never been sick a day in his life, so he didn't need disability insurance.

"So?" said Houlihan, "You've never been dead, either, but you have life insurance."

Statistically, Houlihan tells his prospects, the probability is that they're going to become disabled prior to death. In his opinion, the slow, figurative death of continuing to consume without producing is almost worse than a real death.

"It's not just the usual debilitating illnesses like heart attack or MS [multiple sclerosis] that are s[illegible]ing people today," says Houlihan. "They're burning out with stress-related disabilities. They're coming down with depressive neurosis, anxiety attacks, inability to perform and function on a daily basis, and it's construed as disability. DI has become a key element in a person's well-being and financial peace of mind."

Don't accept a prospect's assurance that he's already adequately covered, urges Houlihan. A simple review will often reveal that a person thinks he has far more than he really does. Uncovering that gap can make a skeptical prospect into a grateful client.

And finally, disability insurance can be a great boon to the agent's own bottom line.

"One of the biggest misconceptions is that DI is not lucrative to the agent," asserts Houlihan. "If compensation is keeping you away from it, you're in for a pleasant awakening. Anybody who starts to market this product virtually becomes a true believer in it. It's the most financially rewarding product in the marketplace." ■

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Payroll Deduction Disability — An Emerging Opportunity

By Allan Checkoway, RHU

Focus On Disability

Our ability to respond to change often dictates success. The 1990s offer some new directions in employee benefit planning that can create significant opportunities for those of us who are ready to respond.

With the changing demographics of the work force, where the high divorce rate has created multitudes of one-parent families, we no longer have "average" families with two children per household. Marriage commonly occurs at older ages, frequently with professional couples choosing not to have children. Sixty percent of the households in America are financially dependent upon the incomes of both spouses, and it's expected to increase to 75 percent by the end of this decade.

At the same time, employees, eager to sustain quality life-styles and conscious of rising health care costs, are re-examining their employee benefits programs. As needs have changed, flexible (Flex) employee benefit plans have evolved to allow employees more control over their benefits. The substantial cost of medical insurance, which averages from at least $300 to $500 per family each year, demands regular scrutiny of corporate medical benefits. The use of higher deductibles, coinsurance and sharing costs with employees is commonplace.

And what about disability income? Employers are struggling with benefit programs that cost 30 to 35 percent over and above salary expense. Although the largest share of that expenditure is medical insurance, the total price tag gives employers cause for concern and seriously affects the

When employers decide not to provide long-term disability benefits for all their employees, the need is still there.

■

PHOTO DAN GLASS

One out of five employees faces the unfortunate reality of a serious, disabling and lingering illness. When the principals in the firm purchase individual disability insurance on themselves, employees are being left to fend for themselves.

future selection of benefits for employees.

In recent years we have witnessed a moderate growth in the number of companies buying group long-term disability coverage for all employees. Ninety percent of the businesses in this country have less than 20 employees. When the decision is made not to buy group long-term coverage for everyone, the need for adequate disability insurance still exists. One out of five employees faces the unfortunate reality of a serious, disabling and lingering illness. When the principals in the firm purchase individual disability insurance on themselves, employees are being left to fend for themselves.

In focus group studies, when employees are asked how they would survive financially when disabled, too often they indicate "The company will take care of me." Regrettably, their sick leave benefits stop after a few weeks, and they're left with no income and frequently no job to return to, should they recover from their disability.

There is also considerable danger with "pick and choose" plans. If sick leave programs are verbal, or not communicated to everyone eligible for benefits, there's the question of tax deductibility of salary paid while disabled. Discrimination, favoring one employee over another, is clearly an issue as well. An "informal" sick leave program can create an enormous potential liability for the corporation.

What is the corporation's responsibility to a long-term valued employee? How can a company be fair to all its employees in a way that is affordable? These questions lead us to the word **opportunity.** We can offer employers the opportunity to solve the disability problem for all personnel with a multitude of options.

Most employers recognize the risk of disability. They understand that the chance of one employee becoming disabled out of a group of 10 approaches 90 percent. They simply make the decision to help solve the employee's problem and we do the rest.

As part of a company-endorsed program, each employee is given the opportunity to participate in the employer-sponsored plan. The corporation decides up front which approach it plans to take. The cost to the company can be nothing. The firm simply urges employees to consider participating in the payroll deduction plan. It agrees to deduct the premium from each paycheck, to remit to the insurance carrier.

Another option has the company pay some portion of the premium, either a fixed dollar amount or a certain percent of the premium. For example, the company can contribute $200 per participant. With a plan like this, employees will be much more likely to enroll.

Let's look at an example of a $1,000 annual premium. With a 10 percent list billed discount, the total cost will be $900. With the $200 employer's contribution, the employee's cost will be only $700. Therefore, he is receiving a $1,000 value for only $700.

In our role, it's important to understand that the traditional approach is becoming less and less feasible. Benefits used to be employer-paid and consistent for everyone. Modern demographics and the rapidly rising costs of company benefits plans have changed that. Companies are not inclined to buy disability insurance on everyone. Nor do they have to. All they need to do, and should do, is recognize the problem and agree they want to help solve it.

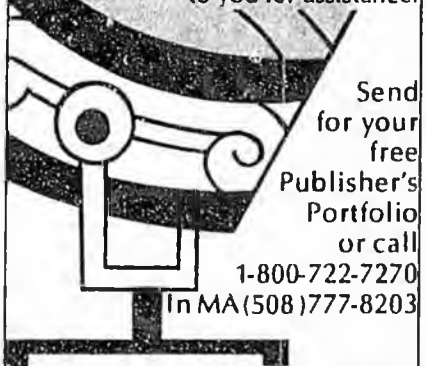
The solution of voluntary payroll deduction programs is a wave of the future. When you propose a workable plan with this as the key element, you can nearly always gain their interest. And you're offering an option for them that spells opportunity for you. ■

Author of Disability Income: A How-to Guide to Sales, *Allan Checkoway, RHU, has 28 years of life and health insurance experience. He served as regional vice president of the National Association of Health Underwriters and is past president of the Disability Insurance Training Council. Checkoway is vice president of American Specialty Underwriters, Inc., and specializes in the placement of high limit special risk disability insurance. His address: 600 Unicorn Park Dr., Woburn, Mass. 01801.*

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Group Insurance Planning For Small And Midsized Companies

By Barry Carton, CLU

Medical care inflation has historically exceeded the rate of inflation in other segments of the economy. As a nation, we spend approximately 11 percent of our gross national product on medical care—$189 billion in 1978, $591 billion in 1989. Per capita, we spent $822 in 1978, $2311 in 1989. Research and development costs, the lack of consumer pressure, as well as increased utilization, cost shifting, malpractice claims and increased fraud are fueling this phenomenon.

As a result, both the insurance industry itself and consumers have demanded and begun instituting changes in the health insurance marketplace that address these issues and seek to correct some of these problems.

These changes have occurred in three main areas: Plan design, new funding methods and more flexible benefit options. Not all insurers offer all available options, but with guidance and careful consideration, various combinations can be found among large and reputable companies.

PLAN DESIGN

The newest product now on the market is a program that combines conventional insurance and health maintenance organizations (HMOs).

By conventional insurance, I mean a plan in which participants have complete choice of doctors and facilities. An HMO, on the other hand, offers participants increased benefits such as wellness care, vision care, etc., while limiting their choice of doctors and facilities.

Under conventional plans, participants must satisfy annual deductibles and coinsurance payments. HMO participants generally do not.

Until recently, the HMO/conventional insurance choice was an either/or proposition, offered only once a year. Today, there are dual option plans in which participants can choose either a conventional plan or an HMO approach at point of service, not just once a year.

Companies such as Prudential, Metropolitan, CIGNA, and New York Life already offer these programs. Others, such as Travelers, U.S. Healthcare and Aetna will be bringing them to market in the near future.

MANAGED CARE

This trend is important because it brings to the conventional insurance programs the elements of managed care found in HMOs.



Table 1
Claim Lag Illustration For Self Insured & Minimum Premium Plans

Assumed effective date - 1/1/91
Assumed monthly claims - $25,000

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Total Claims Incurred	25K	25K	25K	25K	25K	25K	25K	25K	25K	25K	25K	25K
Claims Paid by Ins. Co.	25K	25K	25K	0	0	0	0	0	0	0	0	0
Claims Paid by Corp.	0	0	0	25K	25K	25K	25K	25K	25K	25K	25K	25K

Annual claims 12 × $25,000 = $300,000

Claims Paid by Corp. 1/1/91 - 12/31/91 9 × $25,000 = $225,000

*Claims incurred prior to 1/1/91 are the responsibility of your current insurer. Typical claim lag is three months.

Managed care consists of negotiated doctor fees, reduced hospital and supply costs, wellness programs, individual case management and hospital pre-authorization. The claim savings generated by effective claims management can be substantial. Incorporating cost containment/managed care features into all programs positions the industry not only for the short term, but for longer term savings.

FUNDING METHODS

Where mid-sized companies formerly had no choice but to pay a premium for a fully insured plan, today there are other options—namely self-insured and minimum premium plans. These options exist primarily in conventional plans (not HMOs) but more and more HMOs and dual option plans will be offering them soon.

In a self-insured plan, a company decides to pay its own claims. It can limit its risk in two ways: First, a specific stop loss agreement insures each individual claim that exceeds a certain dollar amount. This protects the client from the devastating effects of a single large claim.

Second, an aggregate stop loss agreement insures total claims that exceed a certain dollar amount.

In addition to stop loss premiums, the client will typically pay an insurance company or a third-party administrator (TPA) for administrative services (determination of benefits, payment of claims and claims analysis). In a self-insured plan, these administrative services will generally cost less than in conventional plans. Self-insured plans also cost less because the employer is not subject to state premium taxes.

Focus On Group

Mid-sized companies formerly had no choice but to pay a premium for a fully insured plan, but today there are other options: self-insured and minimum premium plans.



Cash flow is improved in two ways:

1. Claims incurred prior to the effective date of the plan were paid by the old carrier. This creates a payment lag where new claims are not paid under the new plan for approximately three months. (See Table 1, p. 87.)
2. In a self-insured plan, claims are paid as they are incurred, not in advance as in a fully insured plan.

Typically, a company with less than 200 employees will not self-insure because it's difficult to protect itself from catastrophic claims. Minimum premium plans, however, offer some of the best features of self-insurance while still providing a ceiling on cost.

In a minimum premium plan, the client pays monthly administrative costs. These charges include claims administration, pooling charges and commissions/consulting fees. Claims, which the client pays as they are incurred, are limited by an insurance company cap. This arrangement allows the client the use of its own reserves and the ability to pay claims as incurred, instead of in advance. The net effect is an increase in cash flow and a reduction in cost, compared to interest earned on these funds.

Another advantage of a minimum premium plan is that premium taxes are reduced. No premium taxes are due on the self-insured portion of the plan. Depending on the state, this could result in a savings of 1 percent to 3 percent.

Minimum premium plans also offer an opportunity for reduced administrative expenses. And if claims are lower than anticipated, the client will see reduced costs immediately.

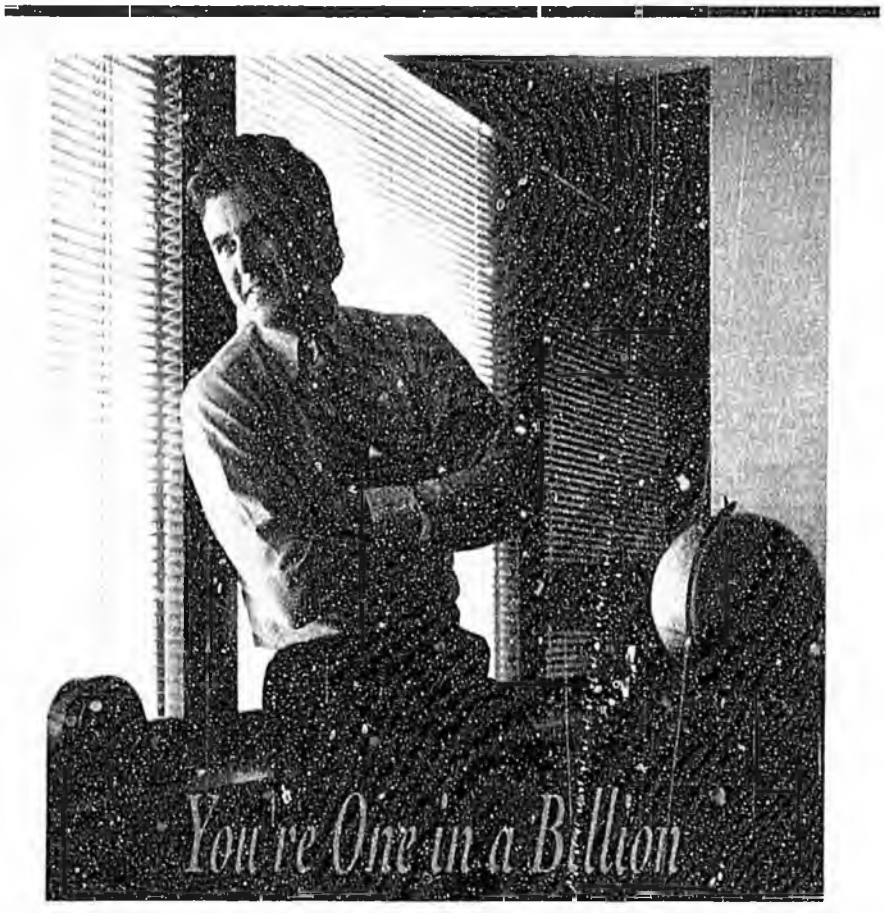
Basically, a minimum premium plan is truly a fully insured plan with certain funding options not generally available in a conventional plan. These funding options have been designed to create cost savings.

BENEFIT OPTIONS

Any reduction in benefits should be viewed as cost shifting—transferring the cost from employer to employee.

In order to reduce costs today, companies have the option of asking for direct employee contributions, increased deductibles and coinsurance, or additional benefit restrictions such as an in-hospital deductible. All of these will reduce employer cost.

Asking all employees to contribute to the cost of the plan spreads the cost throughout the company. In-



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creasing deductibles or reducing benefits increases the cost for the plan users. Many companies use a combination of these options to create the necessary impact on costs. (See Table 2.)

Increasing the deductible from $100-$200 or $200-$300 will result in an average savings of 4 percent-5 percent. Increasing the employee share of covered expenses will also produce a savings.

For example, changing from a plan that pays 80 percent of the first $2,000 to a plan paying 80 percent of the first $5,000 will result in average savings of 3 percent to 4 percent. Some insurers are now offering plans that pay 50 percent instead of 80 percent. These plans are often priced 20 percent to 40 percent below the 80 percent plans. Many companies have also begun adding separate in-hospital deductibles (typically $100-$250), which can reduce premiums by as much as 3 percent to 5 percent.

Pre-authorization for hospital stays and surgery is a method of making plan participants more responsible for their care. These provisions impose penalties if certain prenotification procedures are not followed. These pre-authorization programs make it possible for administrators to uncover potentially large claims early, enabling them to offer alternative care options where appropriate.

Table 2

Benefit Options

	Change	*Average Cost Reductions
Deductible	$100 - $200 $200 - $300	5% 4%
Coinsurance	80% of $2,000 to 80% of $5,000	3 to 4%
In Hospital Deductible	$100 $250	3% 5%

*The stated cost reductions are averages arrived at by polling various insurers. These reductions could be higher or lower depending on which insurance carrier and what type of program is used.

SECTION 125—PRE-TAX PREMIUM PLAN

Section 125 is a provision of the Internal Revenue Code that allows employees to pay their share of the cost of their group insurance benefits with pretax dollars. Under this provision, employees' paychecks are reduced by the amount they contribute toward the cost of their health-care benefits. That money is removed from the company's salary structure before federal income, Social Security, and in most cases, state income taxes are calculated.

For employees, this results in lower taxable income and higher take-home pay. And because payroll-based taxes are reduced, the company enjoys tax savings.

Assuming employee contributions are required, Section 125 is the way to offer tax relief to the employees while providing some payroll tax relief to the corporation. The administration and set-up of a Section 125 plan is very straight-forward and should be a priority. When it comes to choosing insurers/administrators, those that have shown a commitment to managed care, claims management and cost containment will have the edge.

We are also going to have to face the reality that employees are going to have to be responsible for a larger piece of the benefit pie. If the employees do not share the cost, they will have no incentive to keep costs down.

The current health insurance marketplace offers some important alternatives to conventional insurance plans for medium-sized companies. Careful selection of plans that incorporate some or all of these options is necessary if we are going to control costs in both the short and long term. ■

Barry Carron, CLU, is owner of Carronco, a firm specializing in employee benefit plans, business insurance and estate planning. His address: Carronco, 2 Madison Ave., Suite 207, Larchmont, N.Y. 10538.

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Health Care In The Year 2000: Same Problems, Same Complaints

Dr. Gerard Anderson, director of the Johns Hopkins Center for Hospital Finance and Management, Baltimore, discusses what he sees as the major concerns affecting America's health-care future and what the insurance industry can do to help shape it.

LAN *There's a flurry of debate surrounding health-care delivery and finance in the United States. What kind of health-care system do you think will be in place at the turn of the century?*

Anderson: I think we'll basically have more of the same type of thing. I don't think the American public is willing to confront the difficult choices that need to be made in order to fundamentally reform the states' health-care systems.

LAN *So you don't see anything too different from what we have now?*

Anderson: By the year 2000, we're going to have the same level of complaints about people not receiving health insurance coverage. I think we're going to have the same concerns about life and health.

LAN *Do you see the federal government installing a national health-care program in the near future?*

Anderson: I don't think they will put a national health-care system in place. I think that the major issue health insurers are going to have to [confront] in the 1990s [is] providing low-cost health insurance to the small-business men and women.

Second, [insurers will have] to devise a way to provide coverage for those people with chronic illnesses. It can be AIDS, it can be Parkinson's disease, it can be a whole variety of different illnesses, but excluding those people from coverage and not giving them access to any private health insurance is what's going to be the issue for private health insurance in the '90s.

LAN *What can the insurance industry do to get the estimated 31.5 million people without health-care coverage insured?*

Anderson: We've got two-thirds of those people employed. So only one-third of them are unemployed. The question is "How can we get them covered through their employer?"

Employers, especially small firms, say that the cost of getting any type of private health insurance is so astronomical that they can't afford to do it. So what the government is exploring are alternatives that will force small businesses to purchase it and insurance companies to make it available at a low cost.

LAN *How can insurers do this?*

Anderson: What we may have to do is enfranchise one insurer in each community or state or some geographic region, give them a franchise to all the small firms and affect some kind of community rate.

LAN *Similar to a risk pool?*

Anderson: Not a risk-pool type of arrangement but a franchise for that geographic area. In other words, the government will have to, in effect, give [the insurer] a monopoly.

LAN *You mentioned that two-thirds of the uninsured are currently working and could probably get insurance through their employer. How would you propose covering the one-third who are not employed?*



Dr. Gerard Anderson

Director, Center for Hospital Finance and Management, Johns Hopkins University

Health Talk

"What we may have to do is enfranchise one insurer in each community or state, give them a franchise to all the small firms and affect some kind of community rate."

—Dr. Gerard Anderson

Anderson: That's a government responsibility. The government's clearly got to provide the funding to do that. The mechanism for doing that can be through Medicaid buy-in, basically allowing them Medicaid coverage. Or it can be through the private sector if they are able to make premiums [available] at a low-cost.

LAN *If the government were to enact a health-care system based on the Pepper Commission's recommendations, how would that change the industry?*

Anderson: It effectively mandates community rating, and that goes against what has happened in insurance for the past 20 or 30 years. It's by legislative fiat, forcing everybody to turn against economic interests, and it will probably mean that insurers will drop out of the market in greater numbers than they are currently.

LAN *If a national health-care program is put in place, do you think people will still buy private insurance?*

Anderson: I think most people will, in fact, want to spend the extra money. All you have to do is look at medigap coverage to see that is true. Medicare provides the minimum coverage and many people choose coverage beyond that. I think 70 to 80 percent of Medicare beneficiaries choose some kind of medigap coverage.

LAN *A lot of people are denied coverage because of preexisting conditions. How do you recommend this be altered?*

Anderson: Create this franchise in each community and you have to allow everybody to receive care.

LAN *And the healthy people would make up for the people who have major medical problems?*

Anderson: Correct.

LAN *How should the insurance industry adapt to changes in the health-care system?*

Anderson: Private insurance companies are going to have to concern themselves with finding some way to take care of small business and the medically uninsurable. That can be through the franchise I've talked about, or it can be through some other mechanism. But if it doesn't solve those two problems sometime after the turn of the century, the patience of the American public will evaporate. But I don't think it's going to evaporate in the next 10 years.

Maybe by pooling industries [they can] create not one single firm but a whole series of firms which in aggregate would be a large enough firm that they can insure.

LAN *Do you think a national health-care system is likely for the United States?*

Anderson: It really comes down to how can we cover the uninsured and how can we take care of the medically uninsurable. If [the insurance industry] is able, through the private sector, to cover both problems, I don't think it's likely. If the insurance industry does not take up the challenge, then I think it is increasingly likely.

LAN *Do you think the industry will take up the challenge?*

Anderson: I think they are trying to develop alternatives. Whether or not collectively they will take up the challenge, I can't predict.

LAN *Is health care a big concern with the American public?*

Anderson: We have very high expectations from our health-care system, probably unwarrentedly high expectations that they can cure everything and we don't seem to be willing to pay. We're unwilling to pay the price for that level of care. We've got to start a period of education. We can't afford to do everything for every single patient. ■

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LEGISLATIVE FRONT

Long-Term Care Insurance

At its winter national meeting, the National Association of Insurance Commissioners (NAIC) adopted the following consumer safeguards as part of its Model Long-Term Care Insurance Regulation:

- If a group long-term care policy is replaced by another group policy, the replacing insurer must offer coverage to all persons covered under the previous policy.
- Agents must list on the application form for individual long-term care policies any other health insurance policies they have sold to the applicant that are either still in force or were sold within the past five years and are no longer in force.
- In situations involving replacement of a long-term care policy, the replacing insurer must notify the existing insurer of the proposed replacement.
- Insurers are required to maintain and report to state insurance departments information pertaining to replacement sales and lapses of long-term care policies, with amounts expressed as a percentage of total annual sales. Insurers must report this information on a company-wide basis and for the 10 percent of its agents with the greatest percentages of lapses and replacements. The regulation expressly states that reported replacement and lapse rates do not, in and of themselves, constitute a violation of any insurance law or imply any wrongdoing.
- If a state in which a policy is to be delivered or issued has a Senior Citizens Health Insurance Counseling (SCHIC) program, the insurer must provide written notice to the applicant of the name, address and telephone number of any such program.
- Any insurer or agent who is found to have violated any state requirement pertaining to long-term care insurance or the marketing of such insurance is subject to a fine of up to three times the amount of any commissions paid for the policy, or, up to $10,000.

The initial exposure draft of the consumer protection amendments issued by the NAIC last August had included a provision restricting agent commissions. This provision was identical to the one adopted by the NAIC in December 1989 as part of the NAIC Model Medicare Supplement Insurance Regulation. This proposal was not adopted. Instead, the NAIC took a more moderate position, addressing the commission issue by means of an "optional provision" and an accompanying drafting note to be inserted at the end of the model regulation.



By H. James Douds, NALU Senior Vice President and General Counsel

The drafting note states that the NAIC recognizes that the long-term care market is still in its developmental stages, and that further market development is necessary in order for the product to be responsive to consumer needs. This note advises states to recognize that not all replacements are improper, and advises state insurance departments that if there is evidence of abuse in the long-term care market in the state, the commissioner may wish to consider adopting the agent compensation language set forth in the optional provision.

This language is identical to Section 12 of the NAIC Model Medigap Regulation which, among other things, limits first year commissions on initial policy sales to 200 percent of the renewal commission. The optional provision and drafting note are intended to provide guidance to commissioners who find evidence of long-term care insurance marketing abuse in their states and wish to take additional action in response to such evidence.

The National Association of Life Underwriters (NALU) remains opposed to unnecessary commission regulation. Insurance is sold, not bought, and if the salesperson is denied adequate compensation, the conclusion is inescapable that people simply will not have vitally necessary coverage when they need it.

The compromise adopted by the NAIC seems to hold the promise of meeting regulatory problems while avoiding unnecessary infringement on the opportunities for agents to receive adequate compensation for their services. In other words, under the optional provision in the model regulation, commission restrictions will not be visited upon the marketplace by draconian fiat, but will only be called upon in a given state after the marketplace has been given reasonable opportunity to demonstrate the absence of widespread abuse.

Even then, commission restrictions will be imposed only where the evidence shows that a state's regulatory problems cannot be solved without resorting to commission regulation. It is the hope and belief of NALU that experience will show that agents will serve the long-term health insurance market so as to leave no question that they are well worthy of their hire. ■

LEGAL SIDE

Medigap Changes Focus on Consumer Protection

By David E. Hebert, NALU Counsel, Government Affairs, and Gary A. Sanders, NALU Counsel

Influential health policymakers on Capitol Hill decided that 1990 would be the year for medigap reform and one such target of reform would include health insurance agents.

At its Winter National Meeting held in December 1989, the National Association of Insurance Commissioners (NAIC) adopted significant amendments to its Medicare Supplement Insurance Minimum Standards Model Act and Regulation. These revisions, referred to as the consumer protection amendments, were adopted partially in response to a desire to further regulate marketing and claims practices pertaining to so-called medigap policies.

Of particular concern to agents was an amendment to the model regulation requiring that first year commissions on initial sales of medigap policies be no more than 200 percent of the renewal commission paid on the policy, and that the renewal commission must be paid for a "reasonable" number of years.

When replacing an existing policy, first year compensation cannot exceed the amount of renewal compensation paid by the replacing insurer on renewal policies unless the benefits under the new policy are "clearly and substantially greater" than the benefits under the policy being replaced.

In addition to the commission provision discussed above, the NAIC also adopted several other amendments to the model regulation that were designed to enhance policyholder protection. These revisions included the following:

- Agents must make reasonable efforts to determine whether a proposed policy is appropriate for the consumer;
- Marketers of medigap policies must establish marketing procedures to assure a fair and accurate comparison of policies and to prevent the sale of excessive insurance;
- The first page of the policy must prominently notify consumers that the policy may not cover all expenses incurred;
- Agents must make reasonable efforts to determine whether the applicant already has health or disability insurance, and if so, the types and amounts;
- Applications for medigap policies must include a series of questions regarding coverage under Medicaid and whether the applicant already owns a medigap policy;
- A prohibition on making misleading presentations and incomplete or fraudulent comparisons of policies;
- A prohibition on high-pressure sales tactics and cold lead advertising.

To date, over 30 states have adopted the NAIC's consumer protection amendments, including the provision on agent commissions. Several of these states have adopted commission restrictions that are more stringent than those contained in the NAIC model, including the following:

- Delaware and Minnesota—level commissions must be paid during the first four years of all Medigap policies.
- Michigan—Commissions paid in the first policy year can be no more than commissions paid in each of the two subsequent consecutive annual renewal periods.
- Washington State—commissions paid may not exceed an insurer's renewal commission on existing policies in cases where an existing policy is replaced by another policy issued by another insurer and the benefits under the new policy are substantially similar to the benefits under the policy being replaced.
- Wisconsin—requirements are similar to those contained in the NAIC model, except that first year commissions can be no more than 150 percent of renewal commissions.

As the states continue to move toward nationwide adoption of the NAIC's 1989 consumer protection amendments, the NAIC has begun the process of drafting further revisions to the NAIC Medicare Supplement Insurance Model Act and Regulation. New medigap standards contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA) now require the nationwide standardization of medigap policies.

The NAIC has until August 1991 to design the standard benefit packages meeting the requirements of the federal legislation. If the NAIC fails to act

by this deadline, the Secretary of Health and Human Services (HHS) is required to design the standardized benefit packages.

In light of the strict time deadline, the NAIC's Medicare Supplement and Other Limited Benefit Plans Task Force is working on an accelerated schedule to meet the OBRA requirements. The Task Force expects to have an exposure draft of the standardization requirements prepared in time for discussion at the NAIC's April 1991 spring meeting; a final version of the standardization amendments is expected to be ready for adoption by the NAIC at the June 1991 NAIC Summer National Meeting. The states will then have one year from the date of adoption by the NAIC to make the necessary changes to their own regulatory programs.

CONGRESSIONAL ACTION

On March 9, 1987, then Secretary of Health and Human Services Otis Bowen sent a report to Congress entitled "Study of Health Insurance Designed to Supplement Medicare and Other Limited Benefit Health Insurance Sold to Medicare Beneficiaries." The study was conducted pursuant to a congressional mandate in order to determine the extent of abuses in the sale of Medicare supplemental insurance and the possible need for mandatory federal minimum standards.

In a letter to then Speaker of the House Jim Wright, Dr. Bowen remarked that "a review of State insurance regulations relating to Medicare supplements and other types of health insurance sold to Medicare beneficiaries was done to determine how



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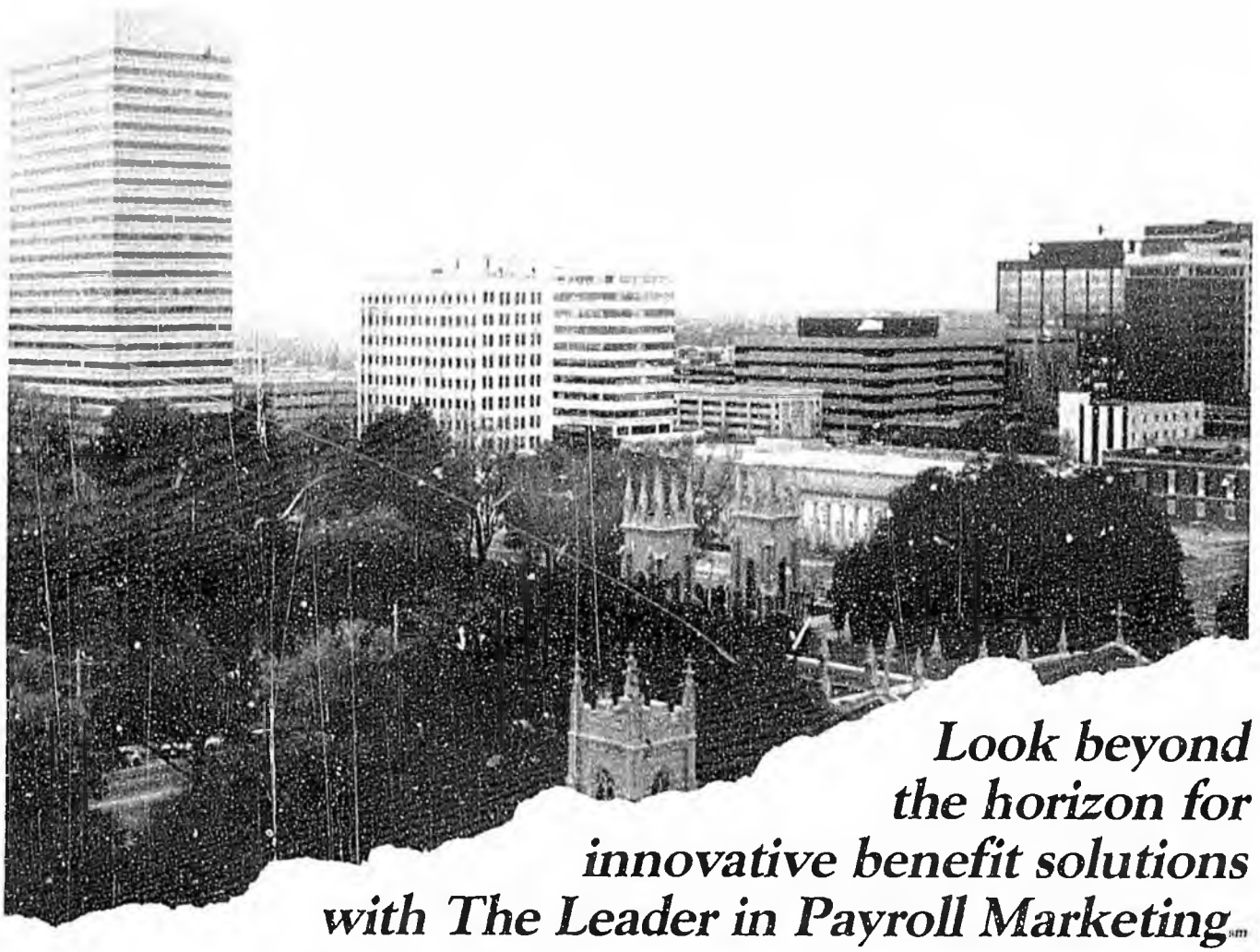
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many states have adopted the regulations found to be effective in dealing with the problems. Based on this review and other findings in this report, we concluded that there is no need for a federal mandatory program for Medicare supplement policies because all but four states meet or exceed the standards in P.L. 96-265" (Federal Voluntary Certification Program).

Bowen concluded by noting that "in summary, the Department believes that the states have dealt adequately with many of the past problems with Medicare supplement policies and encourage all states to consider some changes for other types of health insurance sold to Medicare beneficiaries."

Needless to say, Congress was singularly unimpressed with the Bowen/HHS Study. Dictated by either political expediency or genuine disagreement about the Reagan administration's findings, many influential health policymakers on Capitol Hill decided that 1990 would be the year for medigap reform and one such target of reform would include health insurance agents.

Stung by harsh criticism of its handling of the Medicare Catastrophic issue—an unpopular senior citizen program that was ultimately repealed—Congress seemed eager to placate an angry senior citizen constituency. A series of congressional hearings brought forth numerous elderly witnesses who claimed that zealous agents pressured them into purchasing several duplicative Medigap policies. Senior citizen organizations, flanked by self-styled consumer groups, joined in the chorus for reform.

Notwithstanding the lack of empirical evidence to document the allegation of abusive practices, members of Congress on both sides of the aisle introduced a plethora of bills in an attempt to respond to a growing public outcry.

Although the insurance community was unconvinced that widespread abuses had in fact occurred, NALU and other insurance groups



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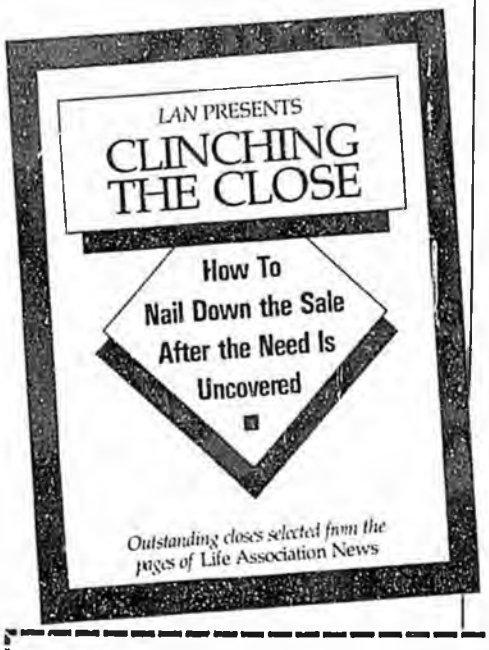
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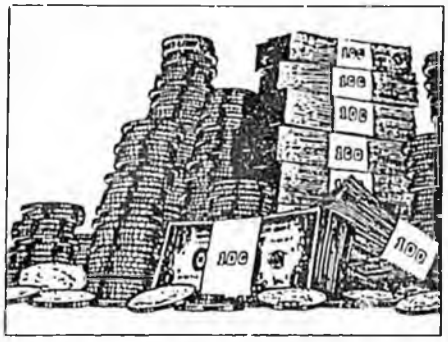
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worked with Congress to draft legislation in the hope that the final product would not unduly restrict either the ability or desirability of the industry to market and sell medigap policies. Congress focused on five main issues of concern: curbing agent abuse through commission restrictions, standardization or simplification of products, increasing individual and group loss ratios so that more premium dollars would be returned to the consumer, prohibiting the sale of duplicate coverage and agent/company liability for non-compliance.

■ *Agent Commissions.* Despite initial concerns that Congress would move to level commissions, the battle turned quickly to an initiative to adopt a more restrictive standard than that imposed by the NAIC Model, proposed by Sen. Tom Daschle (D-S.D.) and Rep. Ron Wyden (D-Ore.).

Under this proposal (S. 2640/H.R. 4840), first-year commissions could be no greater than 150 percent of renewals. Ultimately, Congress chose to remain silent on the issue. However, by making the voluntary Baucus federal certification standards mandatory Congress avoided direct regulation, but in effect mandated that states adhere to the NAIC standard on commissions or face the requirement that medigap policies be individually submitted to HHS for approval.

■ *Standardization/Simplification.* NALU supported Rep. Pete Stark's (D-Calif.) bill (H.R. 5626), which would have restricted the number of medigap policies companies could offer. Believing that if senior citizens are having difficulty sifting through the myriad of policies, NALU felt that perhaps imposing some limitations might ultimately assist seniors. While Congress found it difficult to agree on exactly how many different products should be available from any one company, the conferees agreed that companies may offer a core benefit package and up to nine alternatives.

■ *Loss Ratios.* Much to the chagrin of the industry, Congress quickly became enamored with the idea of raising loss



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ratios for both individual and group medigap policies. For insurance companies, an increase meant a diminished ability to sell the product. For insurance agents, a hike in ratios translated to a likely decline in commissions as companies searched for methods with which to cut costs in order to return more premium dollars to the consumer. In the final analysis, Congress increased only individual ratios from 60 percent to 65 percent and left group ratios at 75 percent.

■ *Duplicate coverage.* NALU strongly supported efforts to stop the sale of duplicative policies. According to the new law, insurance agents and companies will be required to obtain a written statement from the client that indicates they do not have another medigap policy and they are not entitled to Medicaid. Insurance agents would not be liable for non-compliance if the statement is signed, answered completely, reflects non-duplication and indicates that state counseling may be available.

■ *Penalties for non-compliance.* NALU believed that while appropriate penalties would be worthwhile to discourage those who might take advantage of senior citizens, severe penalties that result from strict liability might have a chilling effect that could dissuade agents from selling the product. House and Senate conferees settled on $15,000 fines for agents and $25,000 fines for companies that fail to obtain the appropriate written statement or otherwise sell a policy to individuals who acknowledge that they have other policies.

Clearly, agents will be in the spotlight again in 1991 as Congress focuses on efforts to inhibit so-called abuses in the long-term care market. Once again, agents face a major battle with legislators who want to appear responsive to their constituents. Agents must handle the monumental task of convincing Congress that imposing ceilings on commissions will not only dissuade agents from selling time-intensive policies, but also that such restrictions will ultimately diminish the availability of a still evolving product in an increasingly older society. ■

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February 15, 1991

HEALTH MATTERS

PRESIDENT'S MESSAGE

AHIA working toward solutions in health care crisis

By Karl E. Hansen, CLU, ChFC, LUTCF

In a recent NALU local association member survey, there was strong support for the need to focus on health care, health insurance and the interests of the individual health underwriter. A whopping 91 percent of you said there is a health care crisis in the United States. Almost 87 percent of you said that NALU should become a more active player in helping to shape today's health care issues. In short, over 80 percent of you sent us the same message: "Get involved." That's why AHIA was formed--to develop solutions to the crisis and to preserve the role of the health and employee benefits agent.

To those of you who have become charter

Continued on Page 2

STAT OF THE MONTH

	Life Underwriters Responding Yes
NALU should increase its efforts to influence federal and state government health care decisions	86%
NALU should serve the interests of its members by having a stronger voice on health insurance issues	85%
The individual health insurance underwriter needs a stronger voice on health care issues	78%

Source: National Association of Life Underwriters 1990 Local Association Membership Survey

THE WATCH LIST

What's hot in the statehouse

FEDERAL

Congress is expected to consider regulating agent commissions on the sale of long-term care (LTC) policies in 1991. Congress may wish to level commissions or impose restrictions similar to those adopted by the NAIC on medigap. This is in addition to LTC action taken by the NAIC at its winter convention.

VIRGINIA

Enacted legislation that allows insurers to issue basic, limited benefit policies that are exempt from existing state-mandated benefits. The policies may be offered to certain individuals, families or groups of less than 50 members.

KANSAS AND HAWAII

Among the states enacting legislation requiring that an assessment be made of the social and financial effects of any proposed mandated benefit **prior to** the adoption of any bill mandating a new health insurance coverage.

COLORADO, WYOMING, LOUISIANA, UTAH AND SOUTH CAROLINA

Recently enacted legislation establishing state health insurance high-risk pools.

CONNECTICUT

Adopted comprehensive legislation which, among other measures, includes small group market reforms designed to increase affordability and accessibility of insurance through the use of reinsurance pools and limits on premiums and pre-existing conditions.

The material in this special section was developed by the staff of the Association of Health Insurance Agents. For more information about AHIA, call (202) 331-2161.

Written by the Association of Health Insurance Agents AHIA

PRESIDENT'S MESSAGE

Continued from Page 1

members, I welcome you. To those of you who haven't, I ask you to consider it.

The past investment in the health arena by the NALU volunteers and staff members has been second to none. In recent years, we have represented the 138,000 NALU local association members in numerous key health issues. In fact, Congress has called on us to testify in such important areas as:

- IRC Section 89 Reform;
- Small Group Underwriting and Pricing Reforms;
- The Pepper Commission; and
- Medigap Reform.

NALU and its locals have also had a dramatic effect within the NAIC and during critical state regulatory campaigns.

Obviously, the tasks before us are imposing and may even seem insurmountable to some.

That's why the NALU Board of Trustees and National Council, responding to a call from its members for intensified involvement, voted in September to establish a new national health conference: the Association of Health Insurance Agents (AHIA). Since then, membership in this new and vital association has grown to more than 3,000 charter members.

The past investment in the health arena by the NALU volunteers and staff members has been second to none.

The members of the AHIA Board of Directors and standing committees have dedicated themselves to better identifying, enhancing and expanding the health-related benefits currently being offered to members by NALU. AHIA will provide members with an expanded variety of benefits, from public relations tools to consumer information brochures; from this monthly newsletter to regional seminars and annual meetings. A partial list of these benefits appears on page 3.



Karl Hansen

Obviously, your greatest benefit in AHIA will be the opportunity to expand your knowledge and enhance your capacity to serve your clientele. The $50 annual dues brings you all of this **and** creates the opportunity for dedicated professionals to have a voice in Washington and in state capitals across the nation.

If you are a professional involved in the sale and service of group or individual medical insurance, disability income protection, medigap coverage or long-term care plans, we at AHIA need your supporting membership. Your investment in this health conference will raise our flag higher and better guarantee the association's forward path as we prepare ourselves to battle the health insurance storms that lie ahead and to protect the vital role of the health insurance agent within the delivery system.

QUICK HITS

Selling disability income protection

By Robert J. Heller, FICF, LUTCF

Robert J. Heller, FICF, LUTCF, has been a district representative with Lutheran Brotherhood Financial Services in Dale City, Virginia for the past eight years. He has qualified for the NQA seven times, the NSAA seven times, the HIQA four times, and his company's prestigious President's Club for the past six years.

The sale of disability income (DI) protection is not as difficult as you might think. The main key to selling disability is to "talk about it." I have made it a rule for myself to mention the word "disability" in my presentation at least three times. While most people realize that they are going to die and need life insurance, you have to make clients appreciate the need for DI. They need to know that a person's most valuable asset is their ability to get up in the morning, get dressed and go to work to provide an income for their family's everyday expenses. So, even though it's difficult for prospects to visualize themselves as disabled, you must keep going back to it to make them realize the high chance of disability (see page 4) and the devastating effects of it. Here are my suggestions:



- Mention disability at least three times during the interview and continue to go back to the need and importance of DI protection.
- Don't be afraid to mention and sell disability protection because it seems confusing. Use the health marketing specialists in your home office to help you understand the provisions and make you more comfortable with the product.
- Keep in mind that you are putting your client's welfare in jeopardy if you don't propose DI protection.
- When you make a proposal for the need for life insurance, automatically include a proposal for the disability protection also. Sell it as a package.

By following these few simple steps, I think you'll find selling disability income protection isn't as difficult as you thought.

ASSOCIATION NEWS

AHIA's four standing committees met at AHIA headquarters in Washington, D.C. recently and continued to develop programs for health and employee benefits agents. Here's a breakdown of committee activities.

MEETINGS COMMITTEE

The Meetings Committee is charged with the task of "providing informative, educational and sales-oriented programs for those engaged in the health insurance industry." One of the major benefits of being an AHIA member is the opportunity to attend and participate in a variety of seminars, luncheons, meetings and workshops to enhance one's knowledge and professionalism, often while earning continuing education credits.

The first scheduled AHIA regional seminar will be in Phoenix on February 25th. AHIA is co-sponsoring the seminar with the highly-respected Columbia Institute. The seminar, which will be chaired by Arizona Senator John McCain, will feature Health and Human Services Secretary Louis W. Sullivan as the keynote speaker. Titled "The Arizona Forum on Health Care: A Focus on Our Needs and Goals," the meeting will last from 8:30 a.m. to 2:00 p.m. The only cost to AHIA members is the price of the luncheon. More information will be mailed to AHIA members.



Senator John McCain

LEGISLATION COMMITTEE

Task forces were created by the Legislation Committee to address issues of particular importance. The task forces address the following issues:

- Access to health care;
- Long-term care (LTC); and
- Small group reform.

The task force on access to health care will analyze current studies done by other organizations and develop working solutions to the access crisis.

The Long-Term Care Task Force will analyze congressional treatment of long-term care policies and review such issues as agent commissions, taxation of LTC product benefits and minimum policy standards.

The Small Group Plans Task Force will examine issues surrounding groups with 25 or fewer employees. How these groups are affected by issues such as medical underwriting, pre-existing conditions, mandated benefits and taxation will be evaluated.

Public policy position statements outlining AHIA's stand on health issues are also being revised and developed.

COMMUNICATIONS/ MEMBER SERVICES

This committee is in charge of creating and developing the vast resources and benefits available to the member-agent. As AHIA works to establish itself, the Communications/Member Services Committee is racing to develop these resources:

- Health Legislative Reports;
- Three "Underwriter's Update" education programs;
- A monthly newsletter;
- Local program modules;
- Consumer brochures;
- Speeches; and
- Increased access to information.

MEMBERSHIP

The Membership Committee is responsible for attracting new members and is building AHIA into a large, powerful agents group.

GET INVOLVED

Progress to date by all four committees has been extensive, but much is to be done. As an association of agents, AHIA is always interested in hearing from members who would like to become involved. To inform AHIA of your interest, simply drop a note to: AHIA Involvement, 1922 F Street N.W., Washington, DC 20006-4387, or call (202) 331-2161.

COLUMBIA INSTITUTE

AHIA

Editor
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Health Matters *is written by the staff of the Association of Health Insurance Agents (AHIA). For questions or more information, please write, AHIA, 1922 F Street, N.W., Washington, DC 20006-4387 or call (202) 331-2161.*

TROUBLE SELLING DISABILITY INCOME INSURANCE?

- See the Disability Income (DI) sales piece on page 4. Photocopy and use with clients any way you wish.
- Read Dr. Bruning's article on page 4 and order his video where he talks directly to clients about DI insurance. He demonstrates the need, you make the sale.

AHIA members only can get this video at a special discount, just $64.50 (N.C. residents add 5%). One agent reports that in his first four months of using the video, he increased DI sales by 60 percent for the whole year!

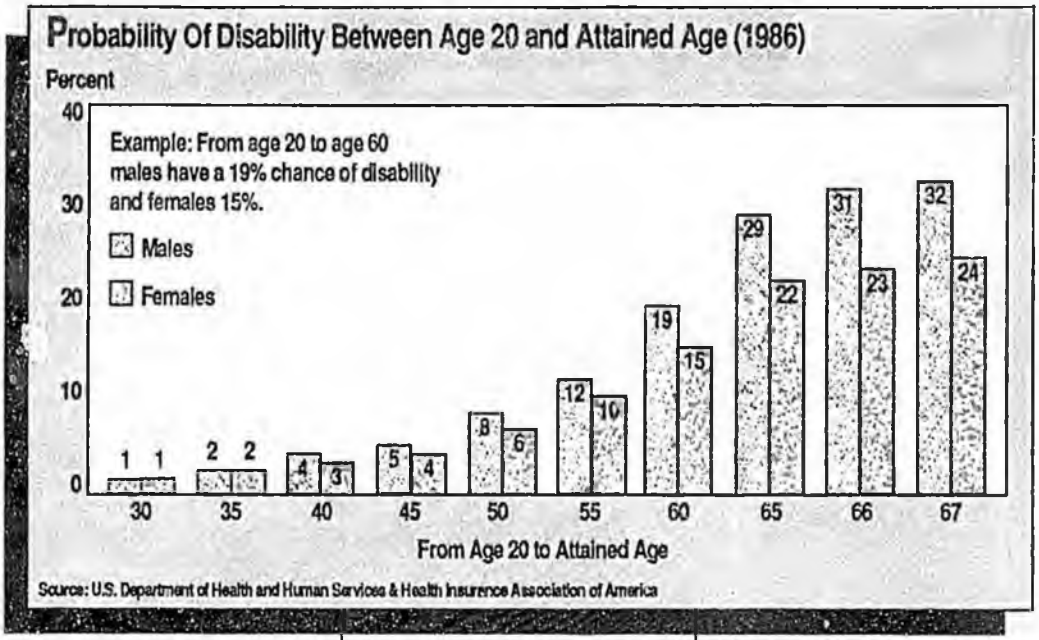
AHIA members, mail your check, made payable to Mary M. Bruning, to AHIA, 1922 F Street, N.W., Washington, D.C. 20006-4387, for verification of your membership. Non-AHIA members may get the video by mailing $69.50 (N.C. residents add 5%) directly to Mary M. Bruning, 642 N. Race St., Statesville, N.C. 28677.

WHAT YOU SHOULD KNOW ABOUT DISABILITY INCOME INSURANCE

If someone told you that you had a one in five chance of winning the lottery, you'd play, wouldn't you? Well, those are the odds of you becoming temporarily or permanently disabled between the ages of 20 and 60 (64 for women). And that number shoots even higher as you get older (see chart). In fact, you are up to six times more likely to be disabled than die at any age up to age 65.

What if suddenly, tomorrow, you couldn't work? What would happen to your house, your college fund, you? How long could you maintain your current lifestyle without an income? Especially if, while your income stopped, hospital bills began. According to a recent survey, 48 percent of all home foreclosures in the United States are the result of a disability in the family, while only 3 percent are caused by a death.

Disability income insurance can protect your income and investments. If you don't have it, you're playing a lottery with very good odds, but it's one you don't want to win.



DISABILITY INCOME INSURANCE: THE BENEFITS SPEAK FOR THEMSELVES

Dr. James Bruning, now 42, was a young dentist in his second year of practice in Statesville, N.C., in 1979 when he suffered a crippling injury in a diving accident. Dr. Bruning had purchased a disability income (DI) insurance policy shortly before his accident and now discusses what that policy means to him and his family.

"I had been swimming and diving in that same lake since 1963. I was a certified water safety instructor and I didn't even think I was doing anything dangerous. Then a few things went wrong and I took a 30-foot dive into four feet of water. I was left a quadriplegic and I couldn't continue my dental practice. I had no source of income in sight.

"A NIGHTMARE"

The first few years were a nightmare, as the whole family's life changed. Family life revolved around my physical needs. But through it all, when we thought we were going to go insane, one thing didn't change: the financial picture. It was the rock we knew we could count on.

Now, 11 years later, my disability income (DI) insurance keeps us in the business of life. It allows me personally to do those things that I want to do, like provide for my family. My kid's college is paid, my mortgage is taken care of and we can get out and do things. It does wonders for my self-esteem.

"THE OTHER GUY"

"When my agent approached me about getting DI insurance, I gave him all the textbook reasons why I didn't need it. Even after I bought it, I really thought it could only happen to the other guy. Then suddenly, I was the other guy. I've never sold insurance to anybody, but I'm hard-pressed to think of a more satisfying feeling than being able to walk into the hospital room of one of your clients, someone who's been paralyzed, who thinks his world is crumbling, and say, 'I've got it covered. Your business is taken care of, your house is taken care of and your kids can go to college. The cavalry is here.'

"A LIFESAVER"

"And now, when my kid grows up, he'll have the same memories as other kids. He'll say, I hope, that 'Dad might have been in a wheelchair, but he did all right for us anyway.'

"My DI policy has been, quite simply, a lifesaver."

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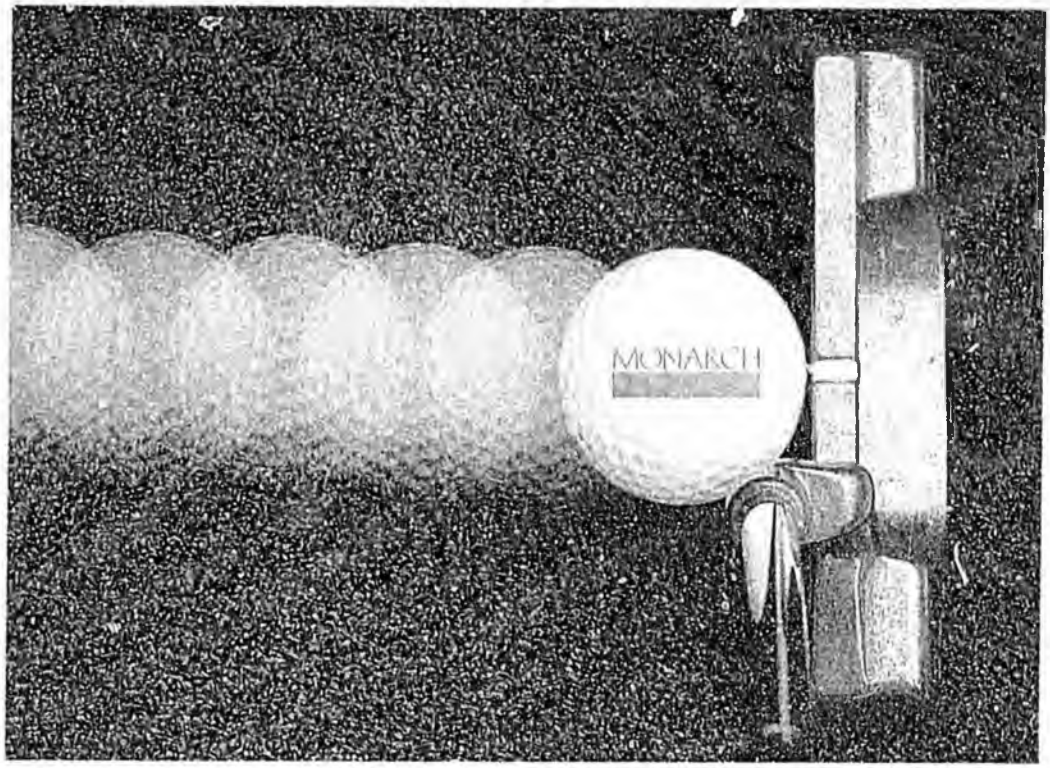
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Toward Solving America's Health Cost Crisis

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

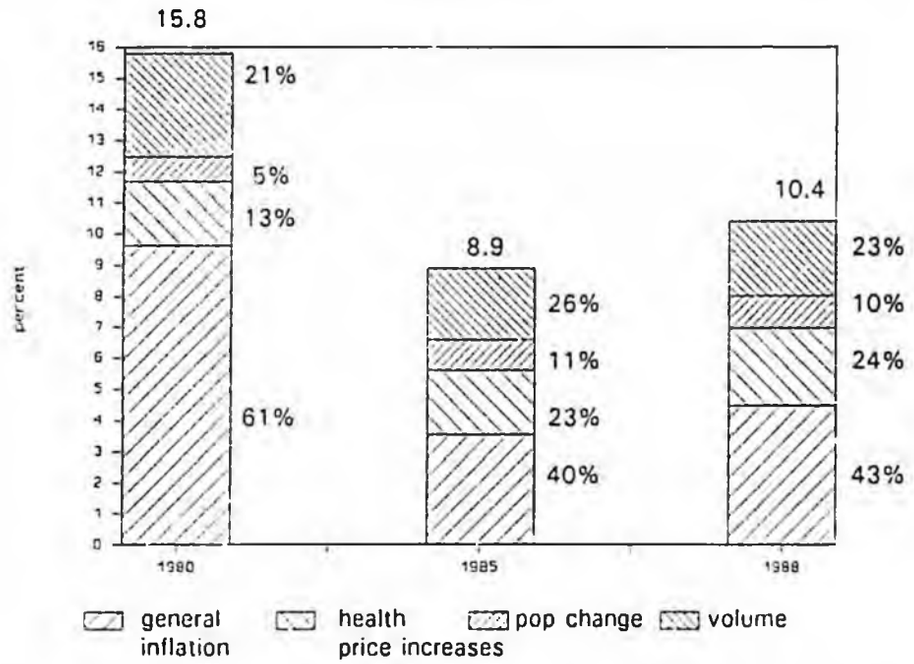
Health care spending has increased at more than twice the rate of general inflation during the last decade and, absent reform, this trend is expected to continue during the 1990s. An analysis of the components of health care inflation reveals areas that can be controlled without affecting quality.

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.

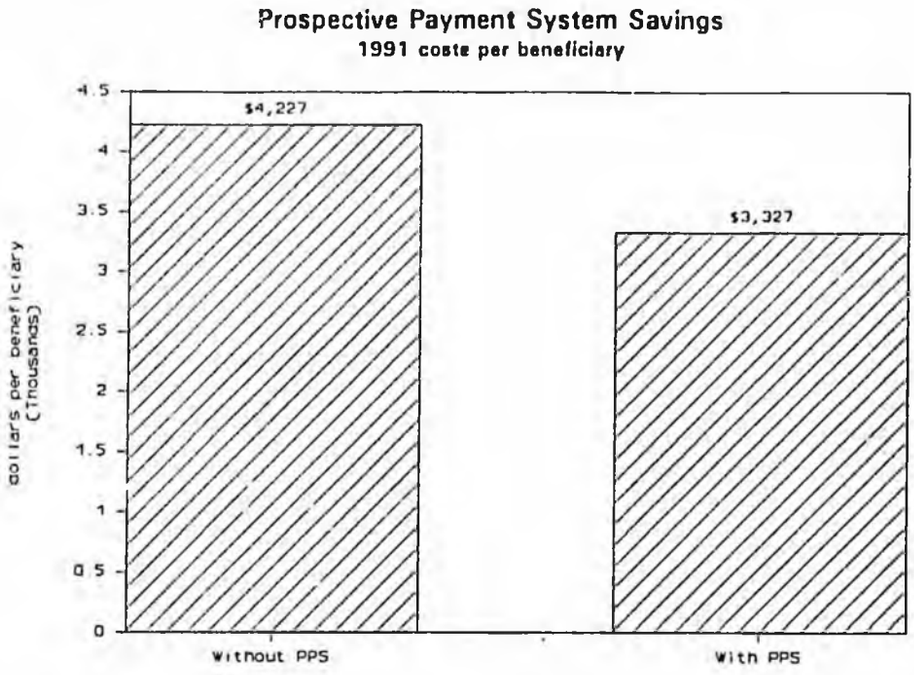
Although both public and private health care plans have initiated a variety of cost containment efforts in the last decade, these piecemeal approaches have failed to control costs system-wide. The fragmented nature of our multiple-payer approach has been a major barrier to effective cost containment. 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.

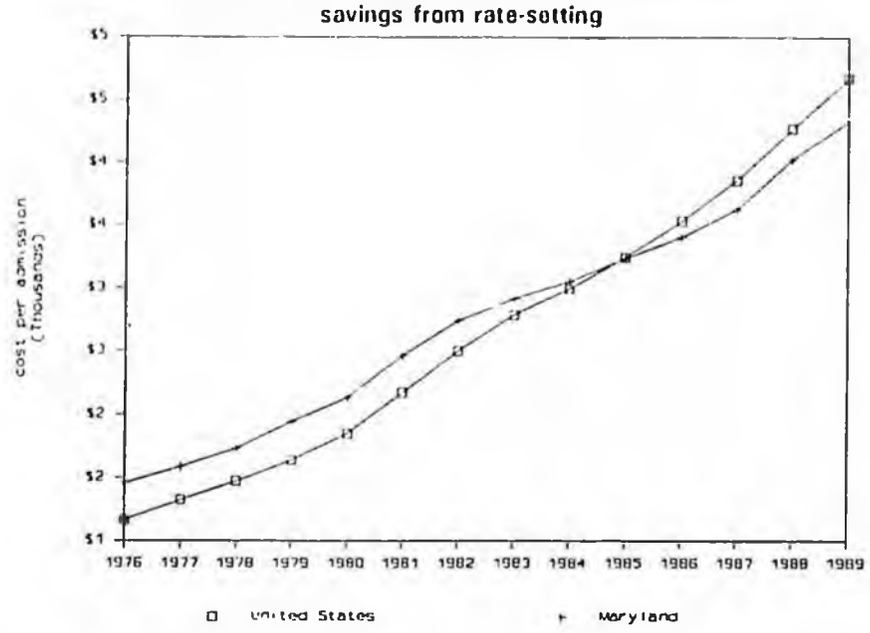


Source: Committee on Ways & Means, *1990 Green Book*, p. 238

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]

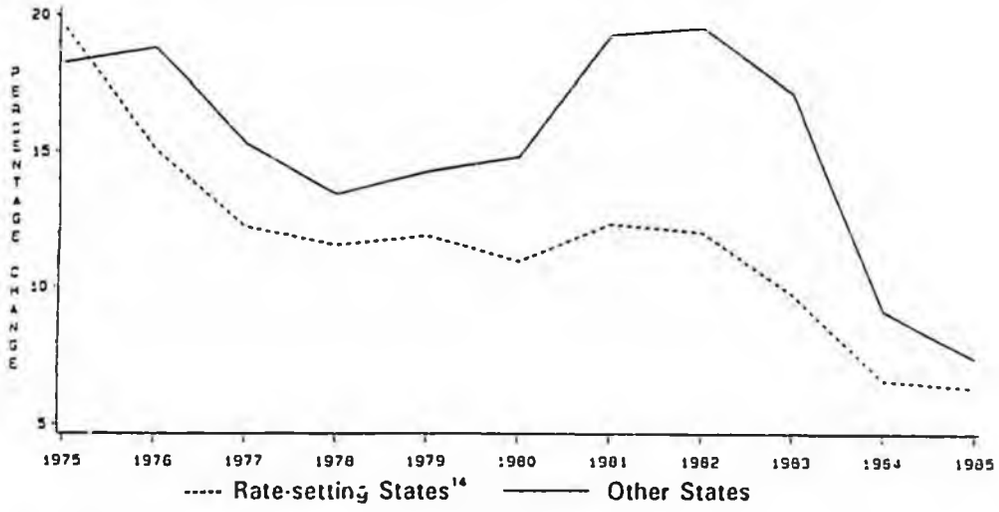
Several states have controlled hospital costs by establishing rates for all payers, public and private, large and small. The rate of increase in individual hospital expenses was reduced 4% in these states. Hospital charges per admission were 3.8% lower in the experimental states compared to other states.[12] 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]

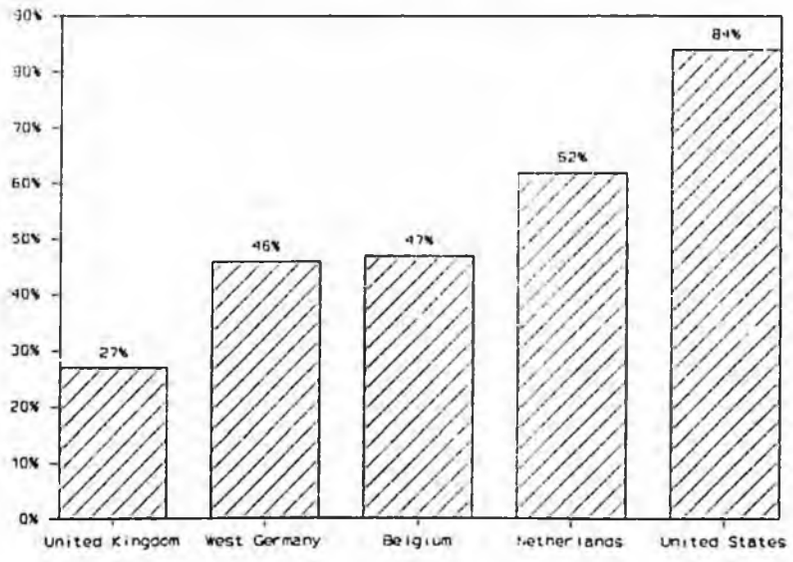
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes. 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



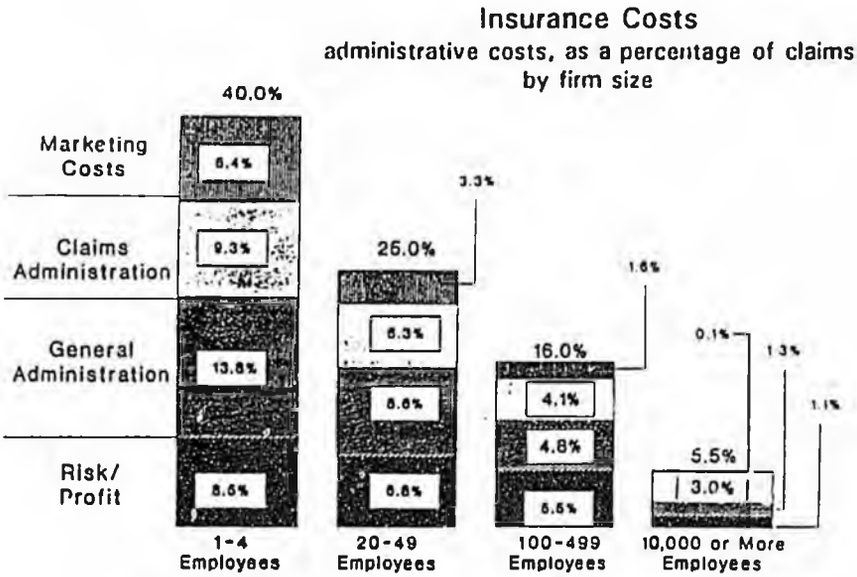
Source: *Journal of the American Medical Association*

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

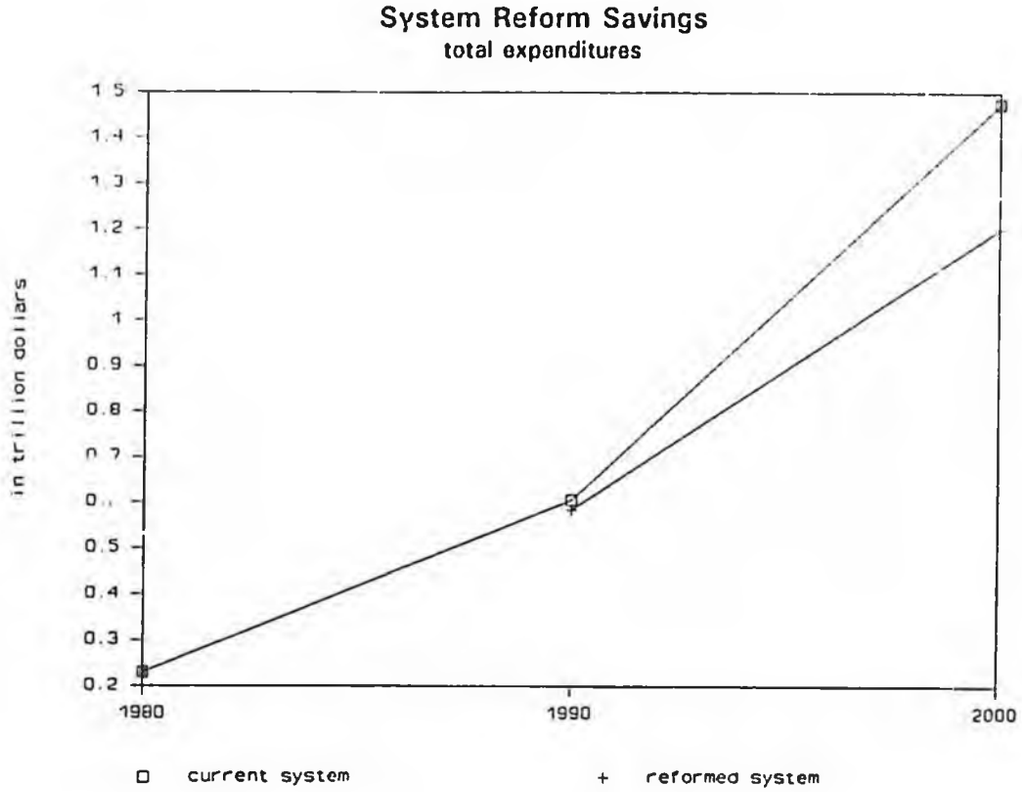
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

- 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.

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

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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)	(124,503)	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	354,138	(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)	(1,087,148)	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)	(980,695)	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)	6,061,352	(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	1,634,546	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)	(267,894)	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	(152,020)	(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)	(376,230)	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)	1,593,908	(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)	(33,603)	791,062	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(21,376,038)	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%
OHIO	1,039	2,493	140.0%	26	5,667	445.6%
OKLAHOMA	906	2,139	136.2%	37	4,867	437.3%
OREGON	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	440.3%
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	5,567	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	3,226,864	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	3,566,669	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	2,740,188	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	3,838,548	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	821,658	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	7,266	6,155	13,720	13,720	17,773	101,013	370,062	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	300,778	325,184	1,929,340	844
CALIFORNIA	6,111,415	7,201,598	710,178	370,271	1,401,953	1,401,953	4,164,002	6,839,211	28,080,581	1,186
COLORADO	695,272	933,532	74,685	43,390	87,470	99,272	302,454	642,638	2,878,913	996
CONNECTICUT	1,026,949	1,220,813	238,910	43,829	179,702	179,702	611,034	57,729	3,566,669	1,148
DELAWARE	168,160	130,750	28,466	5,707	23,279	23,279	87,529	98,949	570,197	960
DISTRICT OF COLUMBIA	168,707	123,705	28,275	6,661	86,588	86,588	148,816	142,410	791,551	1,241
FLORIDA	2,814,989	1,770,637	478,802	98,866	165,422	237,450	2,153,010	1,851,597	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	668,050	708
ILLINOIS	3,400,815	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	411,838	97,491	155,513	208,516	754,790	115,419	5,047,369	919
IOWA	817,145	979,140	230,551	51,428	102,750	133,838	486,426	85,621	2,894,898	993
KANSAS	674,088	790,112	204,462	42,979	86,399	111,000	443,405	130,491	2,498,938	1,057
KENTUCKY	945,732	738,292	181,140	31,508	97,004	208,798	397,702	373,522	2,951,700	809
LOUISIANA	1,198,552	880,118	196,340	40,451	133,052	293,670	470,671	741,550	3,954,402	940
MAINE	284,843	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	667,136	4,388,016	1,041
MASSACHUSETTS	1,961,518	2,207,911	437,646	88,910	500,501	536,007	1,529,777	104,800	7,367,870	1,284
MICHIGAN	2,648,828	3,441,020	710,157	159,462	550,719	550,719	1,771,076	317,690	10,158,071	1,097
MINNESOTA	1,243,181	1,498,322	381,198	83,258	269,169	337,814	704,635	27,881	4,525,259	1,110
MISSISSIPPI	619,332	410,589	0	23,326	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	19,060	9,501	22,871	41,158	73,442	168,847	676,015	859
NEBRASKA	469,733	532,375	134,404	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	9,908	28,738	45,157	107,879	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,168	450,150	85,935	388,438	388,438	1,146,073	92,675	6,848,103	930
NEW MEXICO	228,563	248,079	25,501	14,411	22,378	49,875	91,184	247,833	925,932	711
NEW YORK	5,502,085	8,045,460	1,304,202	248,347	2,334,327	2,334,327	4,012,129	285,980	22,066,936	1,257
NORTH CAROLINA	1,443,006	1,108,169	227,200	52,418	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	120,845	29,759	696,115	1,066
OHIO	3,218,536	4,009,817	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	291,136	358,994	72,062	12,411	69,551	95,300	204,278	17,604	1,121,337	1,184
SOUTH CAROLINA	663,690	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	1,036,809	228,360	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	1,878,289	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	26,122	55,687	79,516	268,814	1,082,735	741
VERMONT	119,592	133,426	29,474	5,360	19,259	41,687	63,594	4,002	416,395	815
VIRGINIA	1,402,784	1,123,908	234,835	46,655	160,351	208,611	593,161	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	$63,149,984	$65,626,952	$12,946,686	$3,123,818	$10,687,198	$13,147,309	$37,248,701	$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: Lewin/ICF 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	1,932,643	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	240,860	137,174	222,669	367,852	1,367,192	1,418,278	8,105,810	2,211
ARKANSAS	1,449,372	892,449	198,921	57,525	103,787	292,830	990,607	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	14,853,732	12,926,177	84,754,469	2,894
COLORADO	2,097,807	2,670,571	263,730	139,260	304,439	304,439	969,276	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	66,058	66,058	291,705	218,999	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,188	50,262	11,191	182,516	182,516	344,880	228,617	1,559,131	2,586
FLORIDA	9,375,203	6,218,476	1,396,790	322,360	878,583	1,125,484	6,083,607	4,010,599	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,638	124,588	489,424	852,179	2,224,539	2,301,976	13,669,245	2,072
HAWAII	697,628	966,101	96,984	48,022	102,084	108,251	295,352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,186	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	532,708	1,231,633	1,231,633	6,719,023	519,434	30,597,883	2,819
INDIANA	3,382,637	3,988,394	818,531	228,316	481,451	813,468	2,204,733	447,133	12,362,682	2,201
IOWA	1,834,062	2,218,841	448,618	115,314	247,922	355,295	1,345,939	49,288	6,815,478	2,351
KANSAS	1,772,719	2,218,335	415,790	100,640	220,378	220,379	1,287,848	190,689	6,426,779	2,548
KENTUCKY	1,947,743	1,418,857	270,882	67,343	254,108	599,458	1,233,765	1,229,672	7,021,825	1,675
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	128,835	284,450	460,731	62,124	2,687,928	2,175
MARYLAND	3,169,204	2,674,955	484,581	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	185,223	1,239,474	1,239,474	3,827,313	280,008	17,947,477	3,031
MICHIGAN	6,085,418	7,977,876	1,391,031	372,097	1,001,088	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	1,318,923	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	383,463	438,546	46,226	25,273	57,205	112,948	241,279	336,263	1,641,223	2,059
NEBRASKA	1,132,690	1,381,739	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	58,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,660	107,811	33,381	87,829	118,839	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	82,220	49,698	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,861	14,346,785	2,020,835	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	587,966	130,692	378,718	850,088	1,957,921	1,712,411	12,250,381	1 833
NORTH DAKOTA	442,809	540,478	111,059	26,699	66,967	108,809	350,419	85,946	1,751,185	2,661
OHIO	6,966,974	8,754,357	1,645,871	420,028	1,244,280	1,739,605	5,655,987	557,522	27,193,403	2,493
OKLAHOMA	2,026,546	1,379,606	288,712	76,027	294,947	400,683	1,278,650	1,081,298	6,824,669	2,139
OREGON	1,657,140	2,007,536	207,895	110,855	171,645	274,649	988,819	1,106,958	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	385,577	1,248,011	1,835,583	7,748,007	375,838	30,541,650	2,536
RHODE ISLAND	704,349	853,513	135,007	30,385	173,508	223,809	531,629	48,987	2,701,187	2,707
SOUTH CAROLINA	1,809,718	1,401,609	269,561	63,523	160,028	428,154	889,168	991,426	6,011,188	1,689
SOUTH DAKOTA	469,323	532,487	106,789	30,642	51,119	107,733	320,442	43,718	1,662,251	2,322
TENNESSEE	3,284,049	2,385,982	493,952	110,504	341,451	804,357	2,185,968	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	777,209	1,095,590	80,021	51,752	85,019	172,448	318,184	525,181	3,085,385	1,784
VERMONT	323,043	381,043	64,236	13,292	47,488	96,673	172,612	18,629	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,548	469,473	532,390	2,061,301	2,160,846	12,931,845	2,076
WASHINGTON	2,613,628	3,346,969	321,777	188,957	587,419	588,783	1,558,885	1,518,178	11,084,596	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	260,771	720,922	743,573	3,846,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	166,623	528,448	713,420	2,258,899	379,584	11,980,357	2,449
WYOMING	206,156	269,576	26,328	13,994	18,865	19,865	107,370	158,705	821,858	1,758
TOTAL	$161,818,653	$174,125,101	$27,063,851	$8,308,703	$27,397,885	$34,256,738	$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 STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	6,587,653	4,706,531	976,883	267,898	387,825	960,063	5,375,234	3,424,054	22,667,039	5,201
ALASKA	865,699	1,121,008	78,581	71,054	152,806	152,806	250,751	536,159	3,228,864	5,390
ARIZONA	5,610,602	6,764,390	606,598	438,907	610,878	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	66,844,841	6,086,483	4,304,439	8,982,840	8,982,840	45,912,860	29,714,318	223,595,772	6,364
COLORADO	4,891,263	6,222,417	616,198	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	1,148,656	1,148,656	4,340,630	203,993	20,998,403	6,136
DELAWARE	1,195,017	959,780	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	904,558	445,965	3,500,076	5,882
FLORIDA	26,031,662	17,254,594	3,886,487	1,008,793	2,351,978	3,012,935	28,673,673	9,842,004	90,060,126	5,520
GEORGIA	10,852,590	8,320,811	1,565,419	383,620	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	6,619
IDAHO	993,703	1,184,244	120,221	71,028	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	8,940,606	1,835,468	570,081	1,041,239	1,759,200	5,877,353	888,461	28,504,460	5,004
IOWA	3,643,891	4,405,316	893,561	257,698	474,894	680,588	3,177,648	86,542	13,620,316	5,343
KANSAS	3,916,623	4,897,775	920,558	250,103	469,432	469,432	3,381,372	372,350	14,677,643	5,792
KENTUCKY	4,324,250	3,147,873	602,648	168,169	543,908	1,283,120	3,255,128	2,412,801	15,737,895	4,288
LOUISIANA	5,456,366	3,899,393	757,556	231,930	712,733	1,256,887	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	31,074,829	5,541
MASSACHUSETTS	10,176,490	14,127,420	1,718,518	502,668	2,736,599	2,736,599	9,871,559	566,719	42,436,773	6,890
MICHIGAN	13,452,128	17,623,526	3,081,357	925,199	2,135,251	2,806,316	13,553,224	1,114,322	54,691,321	5 840
MINNESOTA	7,051,420	9,305,818	1,568,223	470,911	1,478,930	1,695,420	3,891,005	298,049	25 755,773	5,641
MISSISSIPPI	3,116,442	2,003,742	418,860	135,852	254,033	926,041	2,320,679	1,868,319	11,044,767	3,984
MISSOURI	8,368,592	10,095,144	1,945,872	580,906	787,968	1,212,968	8,340,413	814,402	31,946,084	5,837
MONTANA	813,087	929,192	98,216	80,273	116,938	230,888	607,947	630,119	3,486,657	4,686
NEBRASKA	2,403,868	2,887,461	607,149	187,138	282,930	350,103	1,886,381	215,683	8,580,707	5,578
NEVADA	2,264,610	2,895,540	277,016	179,199	193,513	193,513	1,627,012	1,206,717	8,837,119	6,272
NEW HAMPSHIRE	1,867,766	2,188,757	295,910	102,842	257,810	314,084	1,207,467	117,078	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	592,868	42,383,428	5,056
NEW MEXICO	1,814,472	1,871,107	211,785	144,264	216,600	480,760	1,053,827	1,283,268	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	1,018,092	115,121,894	6,408
NORTH CAROLINA	9,878,128	7,405,600	1,477,120	361,519	947,618	2,127,070	8,038,653	3,927,803	32,163,511	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	19,232,288	3,625,387	1,080,689	2,637,287	3,087,115	15,298,854	1,063,233	61,941,308	5,887
OKLAHOMA	4,165,518	2,833,788	590,559	175,778	584,502	794,040	3,123,838	1,984,314	14,232,334	4,867
OREGON	3,848,838	4,657,015	483,608	289,452	384,153	814,885	2,722,592	2,271,062	15,269,405	5,260
PENNSYLVANIA	17,430,559	20,877,036	3,490,750	898,713	2,823,883	3,438,893	20,073,868	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,360	499,858	1,462,951	100,253	6,448,859	6,153
SOUTH CAROLINA	4,553,474	3,524,182	679,663	179,781	388,200	1,033,778	2,858,719	2,204,679	15,222,478	3,842
SOUTH DAKOTA	1,032,399	1,170,535	235,401	75,818	108,414	226,484	837,887	84,893	3,773,731	5,278
TENNESSEE	7,962,737	5,732,759	1,200,168	301,378	788,187	1,800,317	6,298,723	3,734,459	27,908,735	5,145
TEXAS	28,125,731	19,869,305	3,656,095	1,227,572	2,589,258	2,888,233	10,351,490	12,106,189	86,910,873	4,887
UTAH	1,889,913	2,682,266	194,991	141,549	152,431	404,292	919,416	1,128,869	7,493,528	4,082
VERMONT	777,694	916,691	154,965	35,992	110,215	224,378	493,630	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	380,799	1,192,047	1,351,801	8,451,550	5,029,566	34,364,026	4,724
WASHINGTON	6,406,052	8,197,810	700,326	520,941	1,340,650	1,344,072	4,540,641	4,155,168	27,295,859	5,258
WEST VIRGINIA	2,215,108	1,441,469	344,513	78,170	201,945	507,382	1,728,984	1,326,244	7,844,814	4,752
WISCONSIN	6,803,891	8,886,593	1,653,258	409,690	1,109,502	1,503,550	5,868,345	733,039	26,967,967	5,587
WYOMING	409,029	534,489	52,348	31,230	37,999	37,999	253,181	278,293	1,634,548	3,998
TOTAL	$385,931,868	$412,389,109	$63,755,912	$22,248,107	$62,147,543	$77,766,846	$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	5.8%	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, wa 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 1980 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	31.6 %	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	1.0	0.0	0.0	14.3	25.4	100.0
ARKANSAS	30.2	19.1	4.5	1.2	3.4	8.1	15.6	18.9	100.0
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.8	23.8	100.0
COLORADO	24.2	32.4	2.0	1.5	3.0	3.4	10.5	22.3	100.0
CONNECTICUT	28.0	34.5	0.7	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	3.0	0.8	10.9	10.8	18.6	18.0	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	8.6	24.5	100.0
IDAHO	23.6	28.6	2.6	1.4	2.7	5.3	9.8	25.6	100.0
ILLINOIS	27.2	33.6	7.3	1.8	4.9	4.9	16.7	1.6	100.0
INDIANA	29.7	35.6	8.2	1.0	3.1	4.1	15.0	2.3	100.0
IOWA	28.2	33.6	8.2	1.6	3.5	4.6	16.6	3.0	100.0
KANSAS	27.0	31.9	8.2	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	26.2	4.8	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	20.8	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	8.0	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	28.2	32.5	6.6	1.9	2.4	3.6	18.6	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	18.3	3.5	100.0
NEVADA	22.6	29.4	2.6	1.4	2.6	2.6	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	0.6	26.6	100.0
NEW YORK	24.9	27.4	5.9	1.1	10.6	10.6	18.2	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	26.6	32.2	6.6	2.0	2.7	4.3	17.4	4.3	100.0
OHIO	26.7	35.6	6.5	1.7	3.3	4.1	16.2	1.7	100.0
OKLAHOMA	30.7	21.2	5.1	1.0	3.6	6.3	15.6	16.2	100.0
OREGON	22.6	28.5	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	4.9	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	24.8	100.0
VERMONT	28.7	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	7.9	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 %	5.6 %	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 STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	29.6 %	21.1 %	4.4 %	1.1 %	1.7 %	4.5 %	20.3 %	17.4 %	100.0%
ALASKA	26.5	34.4	2.4	1.9	4.0	4.9	6.5	18.6	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	16.9	17.5	100.0
ARKANSAS	30.8	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	3.8	3.8	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	18.6	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	29.6	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	3.3	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
KENYUCKY	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	24.0	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	1.3	3.5	6.9	14.7	20.5	100.0
NEBRASKA	26.6	34.6	7.3	1.5	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	4.0	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	30.6	6.3	1.5	5.0	6.1	20.0	4.6	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	26.2	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	26.9	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	15.9	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	18.7	18.3	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	28.7 %	28.7 %	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 employer 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 %	20.6 %	4.3 %	1.2 %	1.8 %	4.2 %	23.7 %	15.1 %	100.0%
ALASKA	20.8	34.7	2.4	2.2	4.7	4.7	7.8	16.6	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	26.0	33.1	3.3	1.0	3.6	3.6	14.3	14.2	100.0
CONNECTICUT	25.1	30.4	4.8	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	20.9	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	28.8	19.2	4.3	1.1	2.8	3.3	29.6	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	8.0	10.1	15.4	100.0
ILLINOIS	25.8	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	20.6	31.4	6.4	2.0	3.7	6.2	20.6	3.1	100.0
IOWA	26.6	32.3	6.0	1.8	3.5	5.0	23.3	0.6	100.0
KANSAS	26.7	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	8.2	20.7	15.3	100.0
LOUISIANA	26.5	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	20.9	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	26.2	31.6	6.1	1.8	2.5	3.8	26.1	1.9	100.0
MONTANA	23.3	26.0	2.8	1.7	3.4	6.6	17.4	18.1	100.0
NEBRASKA	26.0	33.7	7.1	1.9	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	5.8	5.8	23.2	1.4	100.0
NEW MEXICO	25.6	26.4	3.0	2.0	3.1	6.8	14.9	18.1	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	24.8	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	5.6	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	30.8	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	6.8	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	8.1	17.9	1.3	100.0
VIRGINIA	29.8	23.9	4.4	1.1	3.5	3.9	18.8	14.6	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	26.1 %	27.9 %	4.3 %	1.5 %	4.2 %	5.3 %	22.2 %	8.4 %	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 Lindberg → 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 th·gh 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

September 21, 1990

While the benefits of effective health treatment are often viewed from the point of view of the patient and his or her family, it should not be forgotten that there is much to be gained for the patient's employer as well.

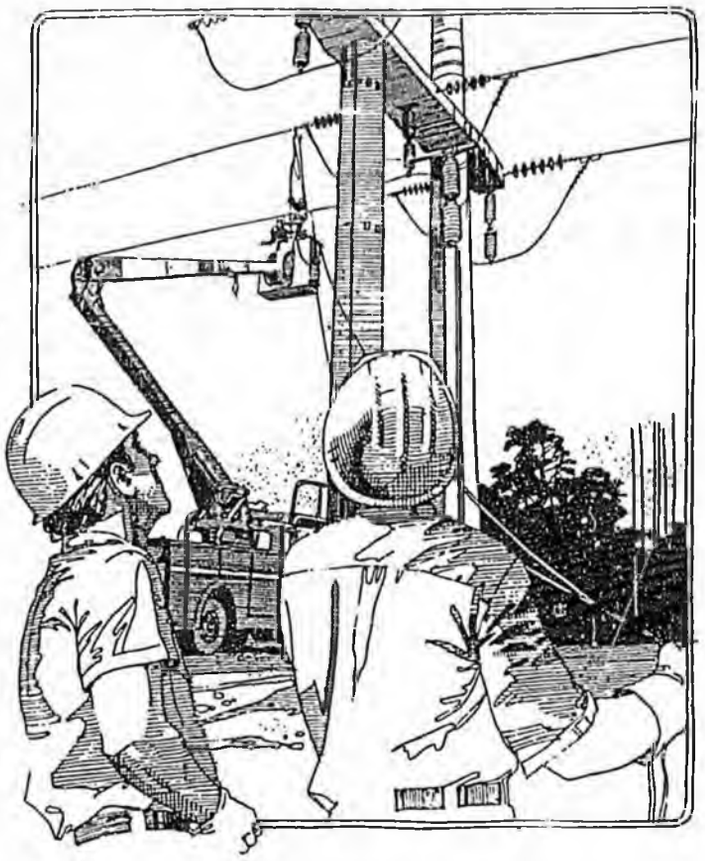
If the employee can be kept healthy, the employee can be kept productive. If timeoff for sickness and injury can be reduced, Workers' Compensation and insurance costs can be saved.

Numerous time loss studies of industrial back injury show conclusively that under chiropractic care, work days lost and total treatment cost is significantly less than with medical treatment. The facts attest the advantages of including chiropractic in any health plan designed for industry.

Comparative Cost Studies of Industrial Back Injuries

The studies cited here are presented to demonstrate to Industrial and Union health planners, HMO directors, federal officials, Congressional staffs, third-party payors, and other health care professionals the direct cost-effectiveness abilities of chiropractic treatment. However, the studies show chiropractic to be not only cost-effective, but quite efficacious as well. Measures of time loss at work, employee disability, and duration of treatment all point to the advantages of chiropractic care in the treatment of certain major categories of back and neck injuries. The fact that back injuries are a major cause of work-time loss and various degrees of disability, are two of the main reasons that chiropractic care is growing in usage and is an important part of the health care system.

Although these studies focus upon Workers' Compensation expenses, there is some indication that chiropractic treatment reduces overall costs in several hard to quantify areas. It is difficult to measure the overall savings to society in getting working people back to their job as promptly as possible. Also, chiropractic care does not rely upon the use of any pharmaceuticals or in the hospitalization of patients, which enables additional savings.



References

[1]California Work Injuries, 1970, State of California Department of Industrial Relations, Division of Labor Statistics and Research, 455 Golden Gate Avenue, San Francisco, California.

[2]American Chiropractic Association, "Comparison of Chiropractic and Medical Treatments of Non-Operative Back and Neck Injuries in Montana 1975-1978", Statistical information from the Montana Industrial Commission, tabulated by the Department of Research and Statistics, ACA. (Des Moines, Iowa). 1978.

[3]Patrinos, Dan, "Study Backs Chiropractors", Wisconsin Chiropractic Association Journal. March, 1979, p. 15.

[4]The First Research Corporation, "A Survey and Analysis of the Treatment of Sprain and Strain Injuries in Industrial Cases", Florida Chiropractic Association. (Orlando, Florida), 1960.

[5]American Chiropractic Association, Chiropractic State of the Art, ACA. (Des Moines, Iowa), 1979, pp. 31-33.

[6]Martin, R. A., M.D., "A Study of Time-Loss Back Claims: Workmen's Compensation Board, Medical Directors Report, State of Oregon", Archives of the California Chiropractic Association. Vol. 4, No. 1, 1975, pp. 91-95.

[7]Cichoke, Anthony, D.C., and West, Henry, D.C., "A Comparative Study of Time-Loss Back Claims", The ACA Journal of Chiropractic. December, 1978, pp. 17-18.

[8]American Chiropractic Association, "Comparison of Chiropractic and Medical Treatments of Non-Operative Back and Neck Injuries in Iowa 1976-1978", Statistical information from the Iowa Industrial Commission, tabulated by the Department of Research and Statistics, ACA. (Des Moines, Iowa), 1978.

CALIFORNIA STUDY

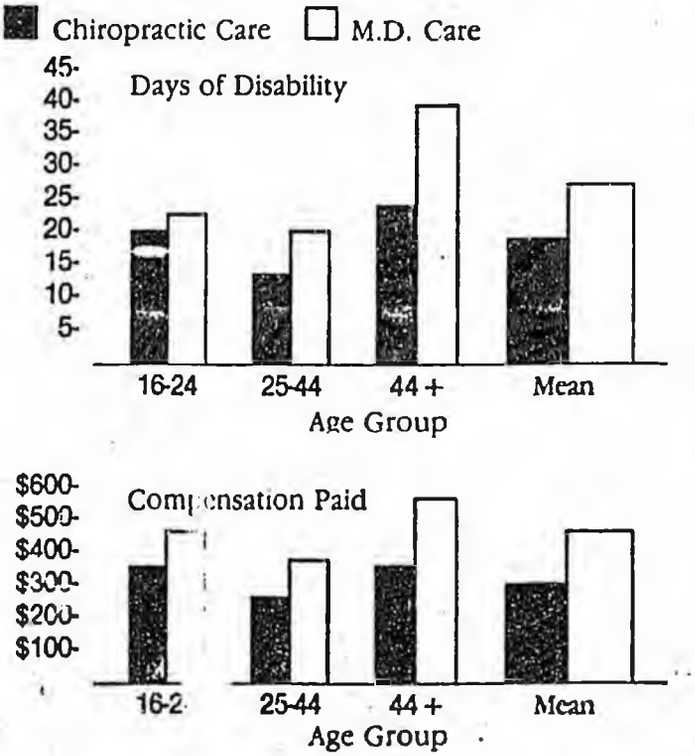
This study was conducted by C. Richard Wolfe, M.D., utilizing records provided by the California Division of Labor Statistics and Research, in 1972. Dr. Wolfe's independent study was designed to compare cases of time loss due to industrial back injury when treated by a medical doctor and when treated by a doctor of chiropractic. The study was structured to report on the next arriving 500 cases of back injuries treated by M.D.'s and the next 500 cases under chiropractic care. Each of the patients was contacted by mail and asked three questions regarding the treatment they had received. 1,000 patients were queried, and 629 replied. Following are the results of the study.[1]

	Aver. No. Work Days Lost	% Reporting Complete Recovery	% Reporting No Lost Work Time	% Losing Over 60 Work Days
Chiropractor	15.6	51	47.9	6.7
Medical Doctor	32	34.8	21	13.2

MONTANA STUDY

An American Chiropractic Association sponsored study of Montana's workers' compensation claims from 1975-1978[2] demonstrated substantial savings to patients using chiropractic services versus M.D. services. Of special note is that the period of disability resulting from an industrial back injury and the treatment costs were considerably less when a doctor of chiropractic was utilized.

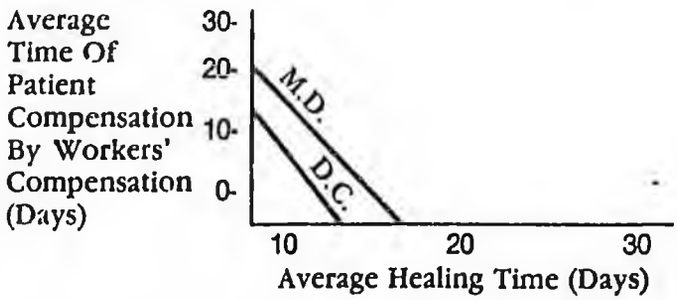
The bar graph below clearly highlights the above statement concerning costs and the length of disability.



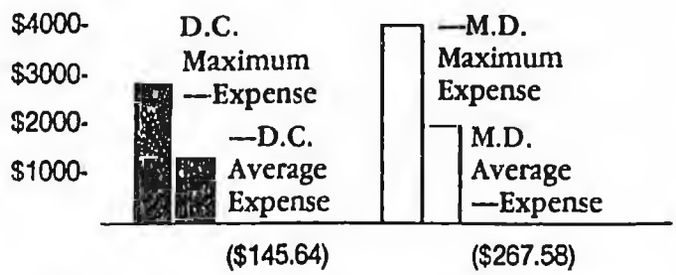
WISCONSIN STUDY

In March, 1979, the Wisconsin Chiropractic Association commissioned researchers at The University of Wisconsin to perform a study of persons having strained or sprained backs.[3] The study excluded back fractures, and cases that resulted in permanent total disability. The research revealed that those patients treated by chiropractic recovered faster, returned to their workplaces more promptly and had lower overall health care costs.

The study was based upon documented cases filed with the State Department of Industry, Labor and Human Relations during 1977. Also, the cases were covered by the State's Workers' Compensation Laws. The two charts presented next show the quicker healing time and lower cost of chiropractic care.



Expense Range For M.D. And D.C. Care Per Back Injury



OREGON STUDY

In 1971, a detailed back injury study[6] was performed using the records of the Workers' Compensation Board of the State of Oregon. This study revealed that all of claimants under chiropractic care, 82% returned to work after one week of time lost. This compares to 41% who resumed work after one week under the care of M.D.'s.

A separate study using the Oregon records[5] compared the costs of rendering care for strains and sprains. The results of this study are briefly outlined below. Note that chiropractic care costs were less than 25% of the M.D. costs.

	Strains and Sprains Treated By M.D.'s	Strains and Sprains Treated By D.C.'s
Average Total Cost of Care	$298.52	$72.92

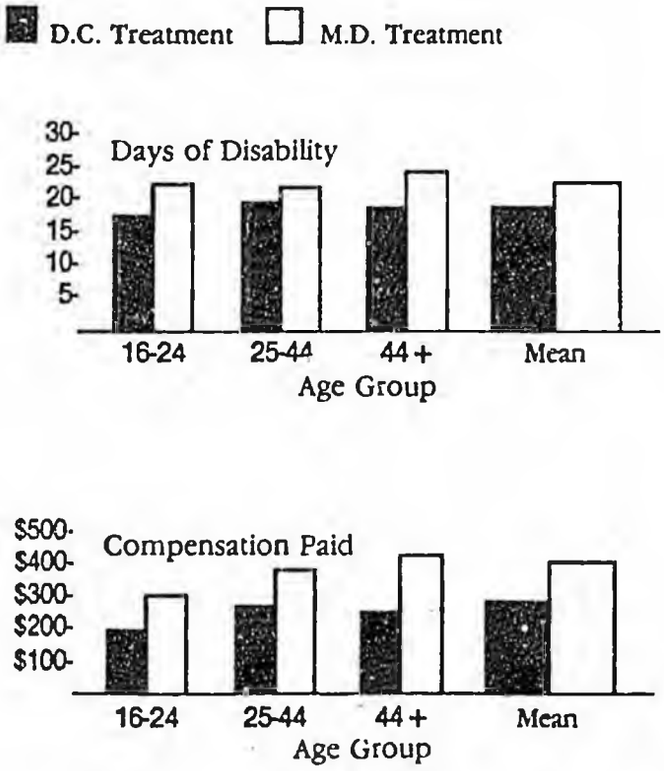
A follow-up study, completed in 1975[7], again using the workers' compensation data, further reinforced the efficacy of chiropractic care in Oregon. This study revealed that twice as many patients treated by medical physicians received temporary disability awards than those treated by chiropractic physicians. Additionally, 13% of the M.D. treated patients were awarded permanent disability awards while only 6% of the D.C. treated patients received permanent disability awards.

IOWA STUDIES

Two studies utilizing Iowa back injury data have been undertaken. The original study used cases for the years 1966 and 1969.[5] The statistical information was provided by the Iowa Workers' Compensation Authority.

	Back Injuries Treated By M.D.'s	Back Injuries Treated By D.C.'s
Cost Per Case 1966	$118.74	$68.25
Cost Per Case 1969	$210.06	$79.28

In 1978, an analysis of nonoperative back and neck injuries claims processed by the Iowa Office of the Industrial Commission[8] revealed a number of interesting conclusions. Both the average period of disability and the average amount of compensation awarded were lower for chiropractic patients than for non-chiropractic patients.



FLORIDA STUDY

Based on Florida statistics, a 1960 study by the First Research Corporation[4] also demonstrated the cost-effectiveness of chiropractic treatment. The comparison between chiropractic and other types of professional treatment for similar nonoperable injuries is shown in the chart below. Note the difference in both cost and average work days lost per employee.

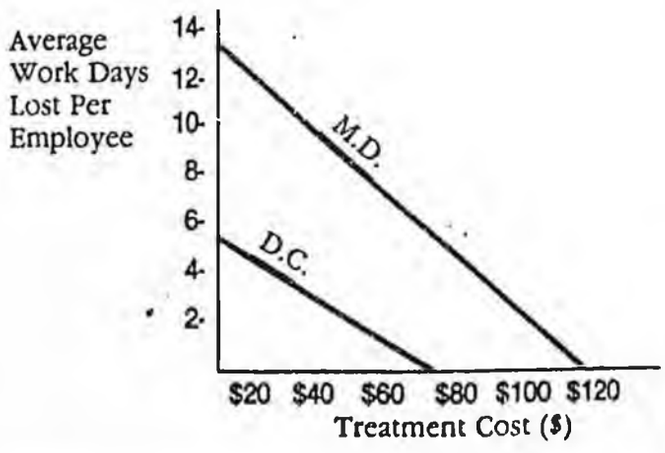
	Cases Treated By M.D.'s	Cases Treated By D.C.'s
Average Work Days Lost Per Employee	9 Days	3 Days
Average Total Treatment Cost	$102.00	$60.00
Average Number Of Visits	6	9

A similar comparison was made on nonoperable injury cases treated by M.D. specialists, such as orthopedists, and neurologists.

	Cases Treated By M.D. Specialists	Cases Treated By D.C.'s
Average Work Days Lost Per Employee	30 Days	2.5 Days
Average Total Treatment Cost	$299.00	$30.00
Average Number Of Visits	18.1	8.6

KANSAS STUDY

A study of 1972, Kansas Workers' Compensation[5] records concerning the comparison between chiropractic and medical treatment for nonoperable injuries, is graphically presented below. Please observe that the average D.C. treatment cost was $68.43 as compared to $117.61 for the M.D. This is approximately 40% less than the M.D. cost. D.C. treatment also resulted in an average workday loss per employee of 5.8 versus 13.1 days for non-D.C. physician treatment.



DRAFT

State-Specific Estimates of the Size and Characteristics of the Uninsured Population

Submitted to:

The American Association for Retired Persons

Prepared by:

Lawrence Bartlett
and
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Health Systems Research, Inc.
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August, 1990

CHAPTER ONE:
Background and Purpose of this Document

In recent years, increased public attention has focused on the problems this nation's uninsured population often face in obtaining access to needed health care services. At the federal level, this increased recognition of the problem has heightened the debate about the need for a national solution. However, it is at the state government level that many of the most significant public policy measures have been taken to address the problems of the uninsured.

One of the factors that has prompted state policymakers to act is the sheer size of the problem. Indeed, until recently, the estimate that 37 million Americans, or about 15% of the population, are without health insurance has been cited as evidence of the access problems that exist within our health care financing/delivery system.

This estimate of the number of uninsured persons was based upon data from the Current Population Survey (CPS), a national survey conducted each year by the U.S. Bureau of the Census. Data from the CPS had shown an increase in the number of uninsured nationwide from 1979 to 1984, with that number remaining fairly constant at approximately 37 million from 1984 to 1986. However, a recently published analysis of preliminary data from the 1988 CPS showed a significant drop in the estimated number of uninsured persons, from 37.4 million to 31.1 million, a decline of nearly 17%.

As will be discussed later in this document, a significant portion of this recent decline is likely to be due to changes in the way the CPS asked about health care coverage and in the manner in which the survey data are analyzed. For example, in addition to revisions of both the content and the sequence of questions used in earlier

surveys, several new coverage-related questions have been added to the new version of the CPS.

Such technical issues may explain much of the difference between the estimates of 37 million and 31 million uninsured nationwide. However, until these and other reasons for such differences are more widely understood, in many states the net effect of the new national CPS estimates will be, at best, to create considerable confusion and, at worst, to result in complete paralysis of access-related policy development. Such responses are likely to occur because many states that have developed proposals to expand coverage of the uninsured have based their analyses on state-specific estimates of the number of uninsured derived from pre-1988 CPS survey results.

This report seeks to reduce the confusion that may exist within many states and therefore enable policymakers to move forward in developing appropriate programs and policies that address the access problems that exist within their states. More specifically, the purposes of this study are the following:

- To reduce the confusion caused by the release of significantly different national estimates of the size and characteristics of the uninsured by explaining in easy-to-understand terms the possible reasons for such variations.

- To educate the target audience about the statistical reliability of estimates derived from surveys such as the CPS so that they will be better able to understand both current and future state-specific estimates of the uninsured that are derived from the CPS or similar survey.

- To provide persons at the state level--including state legislators and executive branch officials, AARP volunteers, and other concerned parties

with information on the size and characteristics of each state's uninsured population.

- To enable concerned parties from individual states to compare the size and characteristics of their uninsured populations with those of other states.

The material presented in this document can be divided into two major categories. In Chapter Two, the reader will find information about the general nature of the Current Population Survey, the questions in the survey that deal with health care coverage, and statistical issues concerning the accuracy and reliability of estimates derived from the CPS. While we have attempted to present this information in as simple a manner as possible, it is nonetheless somewhat technical in nature. Readers not immediately interested in this level of detail may wish to skip much of this material, although they should review the section dealing with the accuracy and reliability of estimates so that they will be aware of the limitations of certain state-specific estimates and understand the rationale behind certain of our analytic methods (e.g. combining two years of survey data for smaller states).

Chapter Three provides a narrative overview that discusses the national estimates of the size and characteristics of the uninsured population based upon data from the 1989 and 1988 CPS and highlights the extent of the variation that exists across states with respect to their uninsured populations. Information that should be of significant use to readers interested in learning more about the uninsured in their own state is contained in a series of tables that provide detailed information on the estimated number of uninsured people in each state and the age, poverty status, and employment characteristics of these persons. The tables are structured to allow easy comparisons both between national and state data and across states.

While it is beyond the scope of this document to provide a detailed state-by-state analysis of the demographic, economic, and public policy factors that result in a state having a relatively large or small uninsured population, what will become clear from the information presented in this report is the relationships that exist between age, poverty, and employment and being uninsured. The figures presented in this document may differ from figures that some states are now using to measure the size of their uninsured populations. Our hope is that such differences will prompt interested groups to assess the relative strengths and weaknesses of these estimates--including the methods used to collect the information and the time period to which the information applies--and to determine which set of figures best measures the situation in their state. Indeed, the overriding goal of this study is to generate greater interest among state policymakers and other individual parties in understanding the specific factors affecting the size of their state's uninsured population. It is hoped that the result of this enhanced understanding will be the development of more effective and appropriate strategies to address the access problem.

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
U.S. TOTAL	214,660	134,072	15,984	16,958	10,619	34,112	15.9
ALABAMA	3,478	2,069	202	311	134 *	695	20.0
ALASKA	453	212	27	63	58	90	19.7
ARIZONA	3,053	1,837	191	142	179	662	21.7
ARKANSAS	2,146	1,160	148	204	120	484	22.5
CALIFORNIA	24,907	13,740	1,780	2,615	1,399	5,080	20.4
COLORADO	2,802	1,731	231	183	202	428	15.3
CONNECTICUT	2,794	2,109	211	89	58 *	294	10.5
DELAWARE	589	409	29	42	40	64	10.9
DIST. OF COL.	507	294	36	47	18	101	20.0
FLORIDA	10,420	5,674	904	574	782	2,336	22.4
GEORGIA	5,564	3,286	395	421	316	1,049	18.9
HAWAII	920	549	60	47	145	111	12.1
IDAHO	879	511	114	47	39	159	18.1
ILLINOIS	10,094	6,838	695	891	313	1,219	12.1
INDIANA	4,849	3,404	373	190	211	617	12.7
IOWA	2,416	1,603	412	117	52	219	9.1
KANSAS	2,072	1,419	217	77	102	232	11.2
KENTUCKY	3,116	1,894	173	255	174	573	18.4
LOUISIANA	3,847	1,839	256	482	204	1,012	26.3
MAINE	1,038	669	82	100	50	121	11.6
MARYLAND	4,152	2,657	193	276	338	440	10.6
MASSACHUSETTS	5,164	3,651	377	388	178	510	9.9
MICHIGAN	8,205	5,532	553	948	316	719	8.8
MINNESOTA	3,908	2,498	523	349	66 *	451	11.5
MISSISSIPPI	2,282	1,126	186	273	138	516	22.6

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
MISSOURI	4,518	2,926	421	340	159	617	13.6
MONTANA	706	373	97	59	48	122	17.2
NEBRASKA	1,375	817	187	77	104	174	12.7
NEVADA	983	591	51	28	78	230	23.4
NEW HAMPSHIRE	968	716	63	17	38	126	13.0
NEW JERSEY	6,633	4,885	480	336	132	725	10.9
NEW MEXICO	1,331	588	111	134	123	361	27.2
NEW YORK	15,367	9,844	966	1,893	417	1,948	12.7
NORTH CAROLINA	5,576	3,594	406	266	350	843	15.1
NORTH DAKOTA	573	321	119	22	44	63	11.0
OHIO	9,717	6,777	590	884	313	995	10.2
OKLAHOMA	2,744	1,442	229	182	214	644	23.5
OREGON	2,427	1,601	142	152	87	425	17.5
PENNSYLVANIA	10,405	7,466	690	727	309	1,023	9.8
RHODE ISLAND	877	609	72	71	39	75	8.6
SOUTH CAROLINA	2,970	1,918	159	201	194	449	15.1
SOUTH DAKOTA	620	326	114	34	41	100	16.1
TENNESSEE	4,303	2,481	376	468	212	678	15.8
TEXAS	15,221	8,188	1,043	876	919	4,067	26.7
UTAH	1,519	1,058	117	79	54	203	13.3
VERMONT	480	318	48	31	18	60	12.6
VIRGINIA	5,312	3,309	348	283	552	737	13.9
WASHINGTON	4,193	2,709	311	262	356	522	12.4
WEST VIRGINIA	1,631	1,007	91	187	48	264	16.2
WISCONSIN	4,140	3,033	345	202	109	414	10.0
WYOMING	417	263	40	18	29	65	15.7

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

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 49 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.

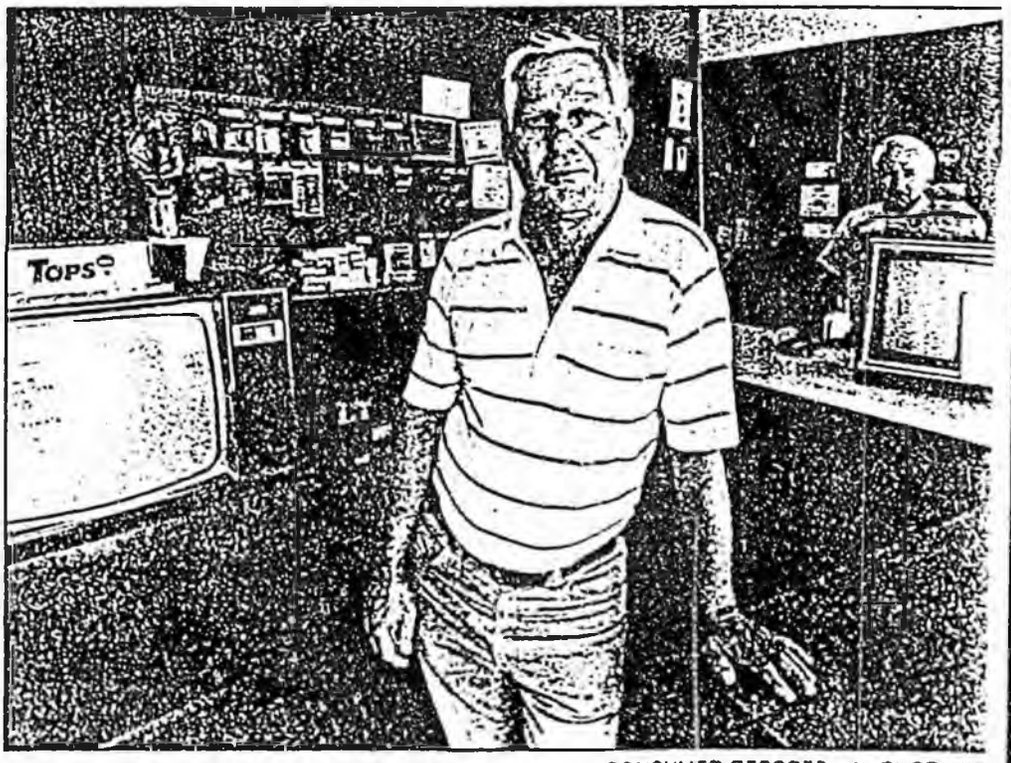
Crisis: Unaffordable premiums

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 h.. ı 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 $642.

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 health-care 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 "lowball" 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

THE CRISIS IN HEALTH INSURANCE

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.

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.

THE CRISIS IN HEALTH INSURANCE

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 Fennsylvania 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.

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

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 544

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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.

CONTINUING COVERAGE

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

Policy	Comments	1 Annual premiums: Men	Women	Family	Maternity rider
Major-medical					
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	$1493 [1][2]	$1962 [1][2]	$5100 [1][2]	Included
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 [3]	1815 [3]	3923 [2]	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]	2225 [2]	Included
American Republic	UltraComp	1632 [2]	1953 [2]	4333 [2]	536
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.	1032 [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]	1300 [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	3858	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 [12]	1294 [12]	2580 [12]	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]	1860

● ◓ ○ ◒ ● Better ← → Worse

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	4 Catastrophic claims	5 Lifetime maximum	6 Maternity coverage	7 Renewability	8 Rate history	Waiting period, mo.	Look-back period, mo.	10 Available to anyone	11 Exclusion riders	12 Higher rates	13 Other coverage	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	82	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	800-777-9000
	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

		Annual premiums			
	Policy	Men	Women	Family	
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 928	$ 987	$2108	$1164
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	Incluc
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Incluc
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]	None
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]	None
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] [17]	2640
Washington National	Classic Choice (AM2836)	1764 [2]	2205 [2]	3249 [2]	900
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]	Incl
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 [16]	1162 [16]	2846 [16]	Non
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]	Incl
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]	Incl
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]	No
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 [2]	1043 [2]	2137 [2]	No
Union Bankers	Major Hospital Surgical (HS-89)	806 [2]	1043 [2]	2137 [2]	No
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 [4]	853 [4]	2177 [4]	No
Certified Life	Hospital Surgical Protection (CER-G020)	806 [2]	1043 [2]	2137 [2]	No
Pyramid Life	G95	1016 [3] [16]	1250 [2] [16]	2472 [2] [16]	64
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 [16]	839 [16]	1886 [16]	In

[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.*
[10] *$500 deductible on nonhospital only.*
[11] *$400 deductible.*
[12] *$750 deductible.*
[13] *$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.*
[18] *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.

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
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	Quality index	Payout: Single	Payout: Family	Payout: Catastrophic claims	Payout: Lifetime maximum	Maternity coverage	Renewability	Preexisting illness: Rate [illegible]	Preexisting illness: Waiting period, mo.	Preexisting illness: Look-back period, mo.	Preexisting illness: Available to anyone	Preexisting illness: Exclusion riders	Preexisting illness: Higher rates	Other coverage	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	207-775-3536
	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-20 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 $2664 for every man, woman, and child. Health-care spending now consumes 11½ 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.)

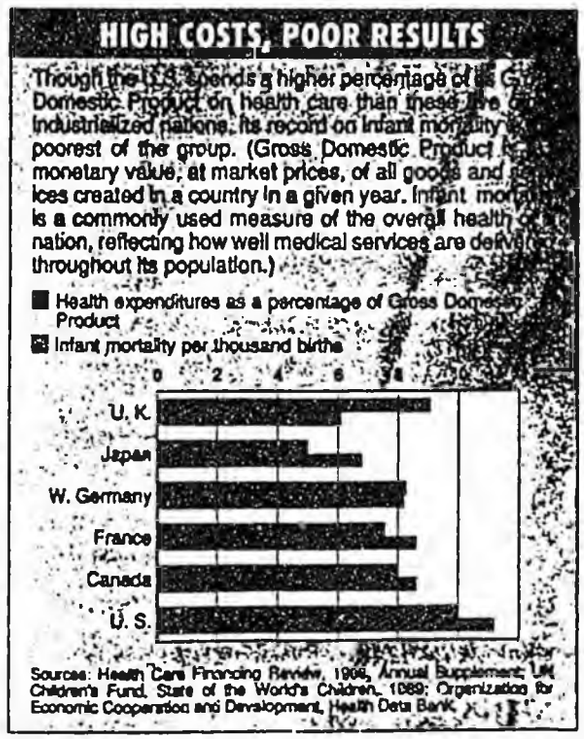
The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some $4.1-million on behalf of political candidates.

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



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.

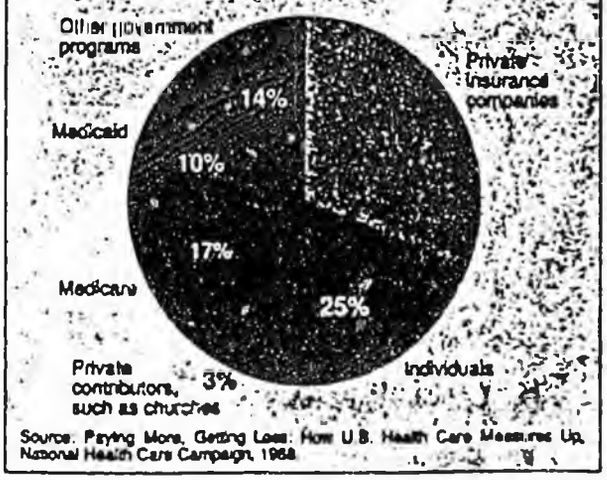
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

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, 1988



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 adjusts 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.

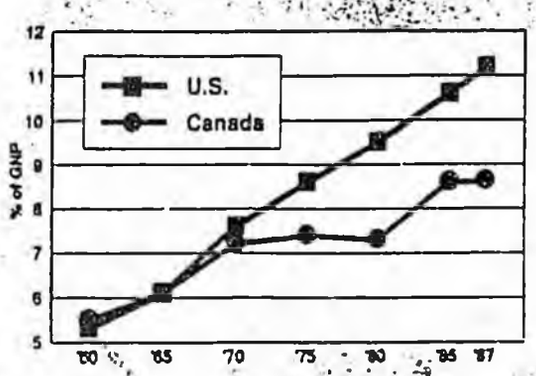
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

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 Daoleish 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.

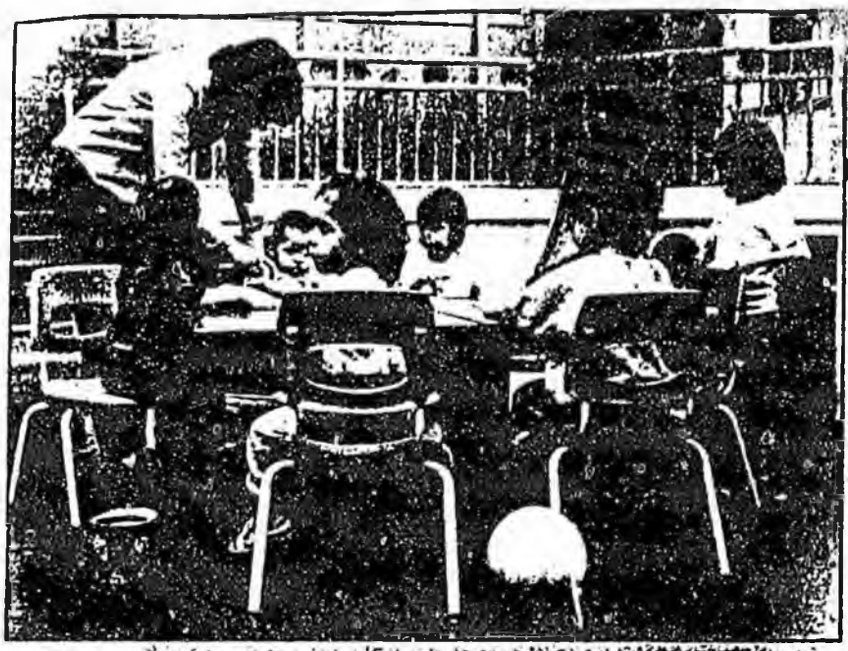
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two 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." ■

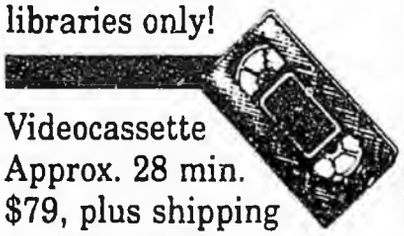
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JAMES GANNON



Sick state of health-care costs

THE RISING cost of health care in the United States is enough to make a healthy person sick.

Americans are spending staggering amounts on health care and finding that the more they spend, the faster costs rise. Between 1970 and 1989, health care spending climbed from $950 a person annually to $2,354 — after adjusting for inflation.

Per-person spending on health care in the United States is about double that of Japan and Germany and nearly three times the average in Britain.

Health care spending is a monster gobbling up an alarming share of the federal budget and the nation's total income. National health spending totaled $675 billion in 1990 — more than double U.S. spending on national defense.

For what we spend on health care, we could fight 10 Persian Gulf Wars each year and have enough left over to gold-plate the Pentagon.

If all that spending assured quality health care to everyone who needs it, there would be little complaint. But the nation's health care system leaves a massive number of Americans shut out.

About 33 million Americans have no health insurance. And contrary to popular belief, these are not the poor (who are covered by Medicaid) but largely the working class; more than three-fourths of the uninsured are employed men and women and their dependents.

"The health care crisis is no longer a matter of the poor — it is a middle class issue, a family issue, a small business issue, and a federal government issue," said Sen. John D. Rockefeller, D-W.Va., one of the Senate's leading experts on health care. "The system is imploding — collapsing in on itself."

THE CRISIS Rockefeller senses is changing the political dynamics of the issue and forcing Congress to get serious about major reform. It is uniting old adversaries — organized labor, huge corporations, small business interests — into powerful coalitions demanding federal action to control costs and expand access to health care.

"Now, for the first time, we find ourselves in broad alliance with many of our traditional opponents on this issue," AFL-CIO President Lane Kirkland told a Senate hearing on health care reform last week.

"The health care tragedy is no longer confining itself to the fringes of our society; it is striking at millions of solid, working, taxpaying families."

Kirkland and others testified at a hearing called by Chairman Lloyd Bentsen, D-Texas, of the Senate Finance Committee, who cited polls showing that more voters are worried about the rising cost of health care than about "taxes or interest rates or even about losing their jobs."

Bentsen, the Democrats' 1988 vice presidential nominee and a prospective opponent to President Bush in 1992, has begun a series of hearings he hopes will focus attention on the issue and point toward some solutions.

There is a growing sense in Democratic circles that the long-simmering problem is reaching the kind of critical mass that could make it an important 1992 presidential campaign issue.

But the Democrats are no more certain than Bush is on the question of what to do. Piecemeal remedies — such as cost controls applied to Medicare and Medicaid and promotion of health maintenance organizations — have had limited effect, and radical surgery on the system is politically scary and extremely costly.

Some Democrats propose to replace the current private-insurance system with one big government-run national health plan.

There's virtually no chance any major legislation will reach a vote this year. But, with the heat rising, look for the lid to blow in the campaign of 1992.

James P. Gannon is Washington bureau chief for the Detroit News.

Falling through the net

90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON
Daily News reporter

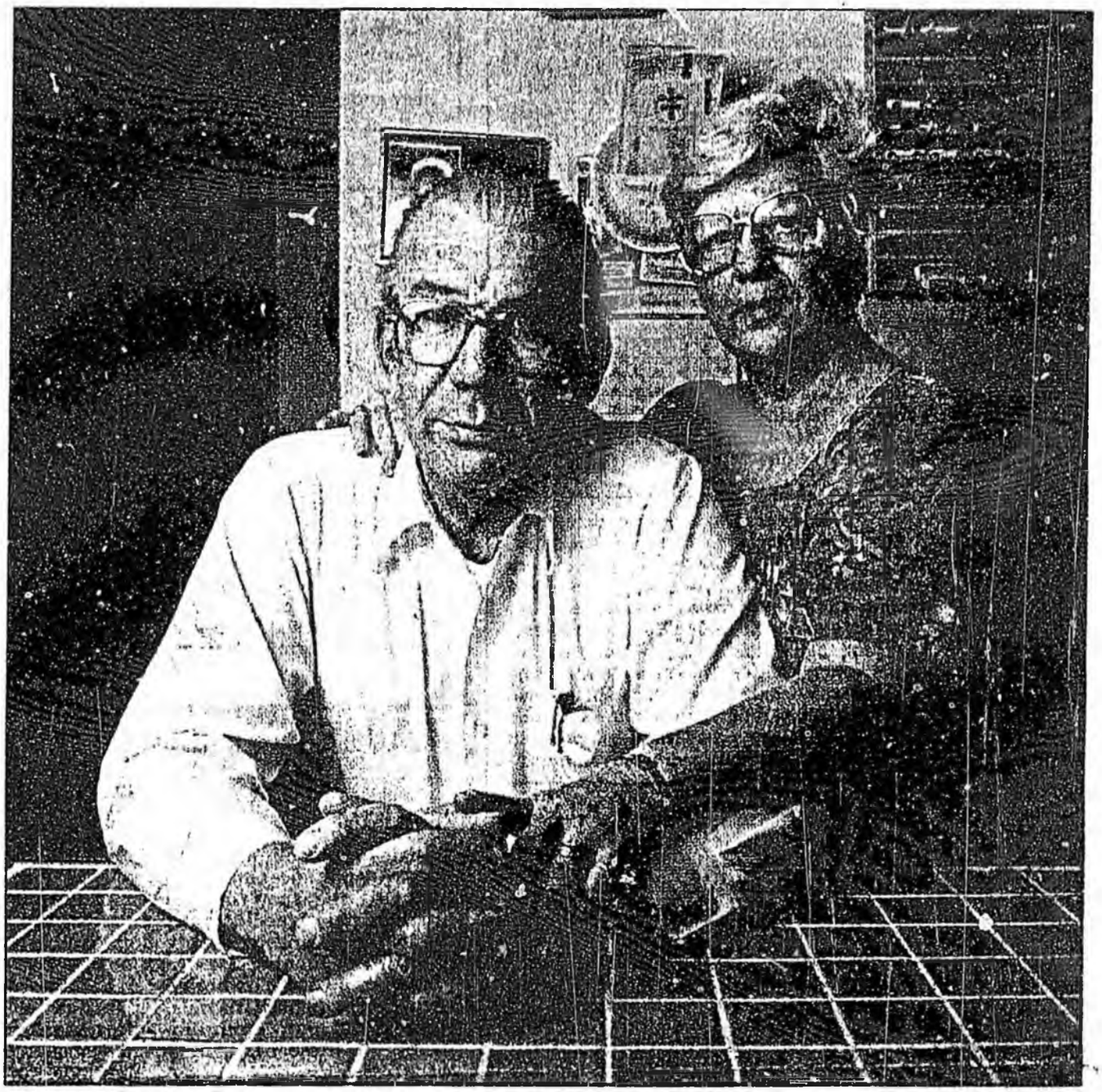
Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with 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 d.dn'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 trailer, 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 SOUDERS /

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.

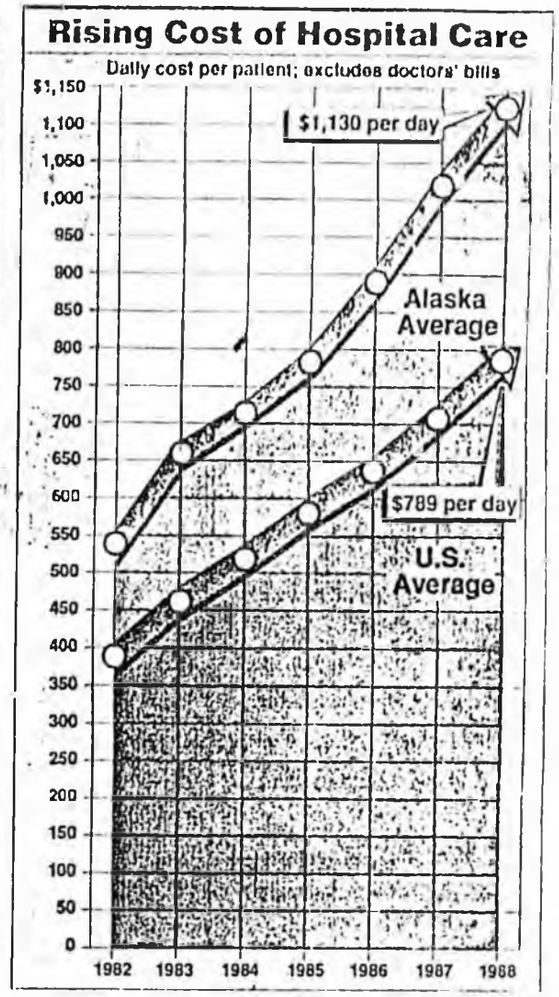
Anchorage doctors' incomes have risen at roughly the same 6 percent annual rate noted in a national survey by the American Medical Association, according to Ray Schalow, executive director of the Alaska State Medical Association.

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, has offered one of 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.

Rolinda Standridge, for example, has a

"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



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 2 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-6 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 reforms 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.


IT COULD BE WORSE!!! WE COULD BE BACK HOME, SERIOUSLY ILL, IN NEED OF HOSPITALIZATION, BUT POOR AND WITH NO INSURANCE!!!!
The Miami Herald

always said that the lands act is about preserving our culture and our land," said John Shively, vice president at NANA Regional Corp. of Kotzebue. "We didn't set out saying, 'Give me my corporations.' "

money is an item that contradicts the very essence of cultural survival for Native people, which is the concept of sharing," said Ross Schaeffer, president of NANA.

"The challenge I see is

Native values."

THE BOTTOM LINE

Other corporations have been willing — at times eager — to trade Native land

Cook Inlet Region Inc., an Anchorage corporation representing a polyglot mix of 6,553 Indian, Aleut and Eskimo shareholders, had traded away 600,000 acres for the bidding rights on developed federal

Kodiak has sought to trade 112,000 acres locked within a wildlife refuge for a sliver of potentially oil-rich land in the Arctic National

Please see Page E-2, ANCSA

groups.

But while conditions are better today, Inupiat leaders have reason to be

Please see Page E-8, BRADNER

Layoffs, corporate maneuvers strip millions of health insurance

By DONALD L. BARTLETT and JAMES B. STEELE
Knight-Ridder Newspapers

Bobby Jean McLaughlin of Charleston, W.Va., mother of six and grandmother of six, is a multiple statistic in America's new economic order.

McLaughlin lost it all.

She lost her job, her health insurance, her pension, her savings and, in the end, her husband.

She lost her job as a $6.20-an-hour department store manager, after 18 years, as a result of the prevailing corporate financial craze.

With it, she lost the health insurance that had paid the family medical bills.

And she lost her pension when she took the lump sum payment set aside for her retirement and was obliged to use it instead to pay hospital and doctor bills.

She had little choice. Her husband of more than 35 years, Joseph, worked in a small bakery in Charleston that did not provide health insurance for its employees.

He was suffering from emphysema, his condition deteriorating with each passing day. When he no longer could breathe without the aid of a ventilating machine, he was forced to quit.

Recalled McLaughlin:

"It just wiped out my savings. I couldn't tell you the amount of money we put out. He was using those tanks (of oxygen). And it was just breaking us up, 'cause they were $38.50 every time they came with one.

"I tried to get help with the medical bill, but they look at you like you are dirt under their feet. We were always kind of independent. He worked at the bakery 30 years. He worked even after the doctor told him his lungs were bad enough he could get disability."

Last December, Joseph McLaughlin died.

No one, not in the federal government, not in private industry, keeps an accurate count of the Bobby Jean McLaughlins.

But their numbers already are in the millions. They are the anonymous middle-class health-care casualties of high-stakes corporate finance in America, the victims of a government rule book that looks after the demands of deal-makers and ignores the needs of ordinary citizens.

They are not poor enough to qualify for state or federal health-assistance programs.

They are not affluent enough to be able to afford the cost of private medical insurance.

And so they go without — joining the ranks of an estimated 40 million Americans who have no medical insurance. That does not take into account more millions who are underinsured.

Those numbers are bound to grow — unless the U.S. government reverses policies.

Consider:

• U.S. Labor Department surveys of large and medium-sized companies that offer health insur-

Please see Page E-7, INSURANCE

The **DEATH** *of the* **MIDDLE CLASS**



SERIES AT A GLANCE

☐ **NOV. 24:** Two decades of economic rule changes by a succession of Congresses and presidents are causing the dismantling of America's middle class and the further enriching of the rich.

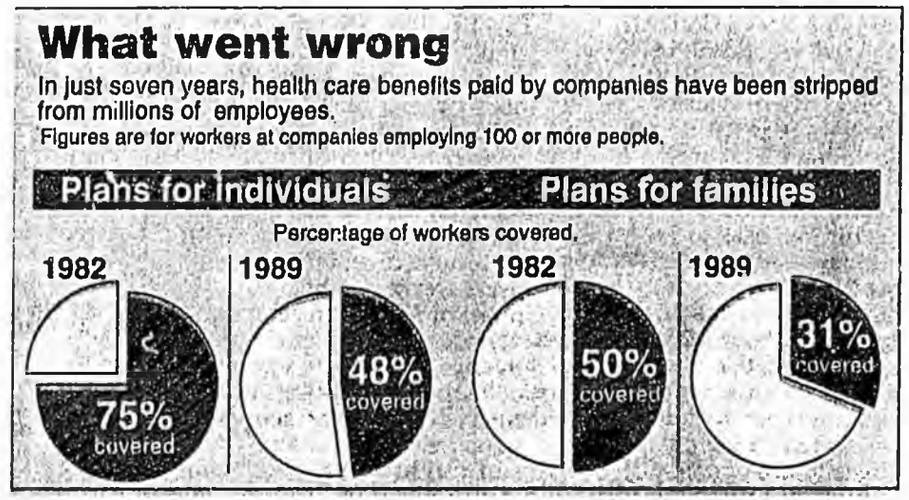
☐ **NOV. 24:** Through a variety of corporate tax breaks, Congress has systematically shifted the federal income tax burden from businesses to individuals.

■ **DEC. 1:** Foreign-owned companies in the U.S. can eliminate fringe benefits, such as health insurance, and pay lower U.S. taxes. And foreign ownership of American business is growing.

☐ **DEC. 8:** Deregulation of the airline, trucking and S&L industries has eliminated middle-income jobs and will end up costing workers hundreds of billions dollars in taxes and lost wages.

☐ **TODAY:** As more companies are bought, sold, merged, restructured or go bankrupt, a growing number of middle-class workers are being forced to go without health insurance protection.

☐ **DEC. 22:** Come retirement, millions of Americans will discover to their dismay that the pension they thought was there isn't.



INSURANCE: Corporate maneuvers cheat millions of benefits

Continued from Page E-1

ance for 31 million employees show that the percentage of those employees with fully paid coverage for themselves alone fell from 75 percent in 1982 to 48 percent in 1989, the latest period studied. (Large and medium-size companies employ 100 or more people.)

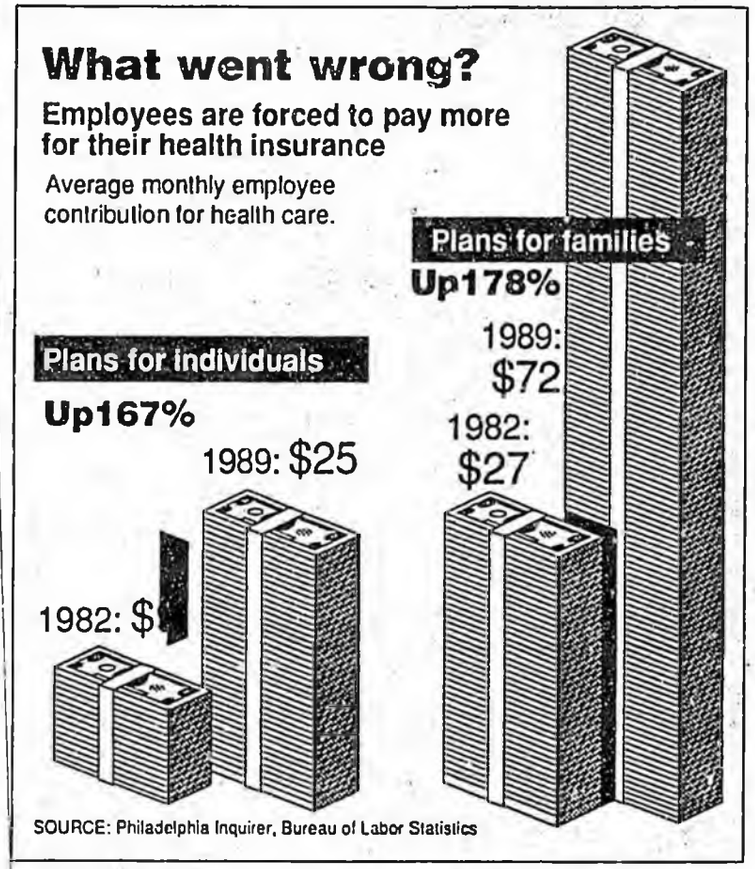
• At those same companies, the percentage of employees with fully paid coverage for themselves and members of their families fell from 50 percent in 1982 to 31 percent in 1989.

• The average monthly employee contribution for individual health-care protection rose from $9 in 1982 to $25 in 1989, an increase of 178 percent. During that same period, the average weekly paycheck went up 25 percent.

• The average monthly employee contribution for combined individual and family health-care protection rose from $27 in 1982 to $72 in 1989, an increase of 167 percent.

• Because part-time workers seldom receive fully paid fringe benefits such as health insurance and pensions, their numbers are growing exponentially. Companies like this arrangement because it reduces costs. At Wal-Mart, now the nation's largest retailer, 40 percent of the workforce is part-time. At K mart Corp., it is 47 percent. At Sears, Roebuck & Co., it is 55 percent.

• As a result of the largest increase in corporate bank-



losing their health-care protection grows daily as one company after another dismisses employees to trim expenses, eliminates jobs while seeking to reorganize in Bankruptcy Court, or goes out of business.

For a lucky few workers across the country in that situation, the government rule book — as crafted by a succession of lawmakers and presidents, Democrats and Republicans — offers some relief.

Call it the hospital legal lottery.

ble for all those medical bills.

If you are among the lucky few, you will win and recover, if not your health, at least the money you lost.

But the process can be expensive and time-consuming.

Ask Roy Mahon Jr.

In 1984, Mahon went to work as a salesman in Garden City, Kan., for Massey-Ferguson Ltd., the Canadian company that was one of the world's largest manufacturers of agricultural tractors, combine harvesters and other farm equipment.

A year later, Massey-Ferguson executives followed a course charted by so many U.S. corporations. They reorganized the business, as they put it at the time, to "achieve profitable growth through acquisition."

First, in May 1986 they created a new company called Massey Combines Corp., which took over the money-losing combine operations, including the dealership that employed Mahon in Kansas.

The rest of the business operations stayed with the old Massey-Ferguson, which gave itself a new name, Varity Corp., and sold stock. The proceeds were earmarked for the acquisition of businesses.

The new Massey Combines got more than just the depressed combine business. It got:

About $200 million in debt; about 1,500 employees, including Roy Mahon, and the financial obligation to pay the medical claims and other benefits of retirees and the widows of retirees of the original Massey-Ferguson.

On March 4, 1988, Massey Combines Corp. went into receivership in Canada, the equivalent of Bankruptcy Court. The company fired all its employees and notified retirees that their health and other benefits were being terminated.

Roy Mahon remembers that time well.

Earlier in the year, he said, "I was working on a new parts counter on our building. I stood up and I thought I had sprained something real bad. Turned out I had an aneurysm and it gave way.

"That night I was in the hospital. Two days later I had my leg taken off. Consequently, they found out I had an aneurysm in each groin and my aorta was about to blow. ...

"So basically the operations were the amputation of the left leg, then aorta surgery, and they went in and rebuilt the area on the right leg. ... (The surgeon) spent 7½ hours on that leg."

Soon after Mahon returned home to recuperate, he discovered something amiss at Massey Combines.

"I was wondering what was happening because one of my claims went to the administrator and they sent it back not paid," he said.

"The next thing I knew I got a telephone call from my former boss who said the company went belly up. They were bankrupt and everything was gone. ...

"That was it. I was left hanging with about $65,000 to $75,000 in hospital bills."

Eventually, Mahon said, Kansas Medicaid paid all but $18,000 to $20,000 of the bills. He had to pay the rest.

"I had to cash in my IRA account to survive," he said. "I sold one of my cars. In August 1988, I sold my house to get what I could get out of it because I had to have funds to live on. I had to get these bills down.

"But consequently I have absolutely no credit whatsoever. ... Financially, I'm now at the bottom."

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growing exponentially. Companies like this arrangement because it reduces costs. At Wal-Mart, now the nation's largest retailer, 40 percent of the workforce is part-time. At K mart Corp., it is 47 percent. At Sears, Roebuck & Co., it is 55 percent.

• As a result of the largest increase in corporate bankruptcies since the Great Depression, millions have lost their health insurance protection. The bankruptcy surge is continuing unabated.

• Faced with steadily rising expenditures for the health-care costs of retirees, companies are curtailing or eliminating a benefit once promised for life. Millions of future retirees will see their coverage disappear. The government's General Accounting Office estimates that companies paid $9 billion in retiree medical costs last year, but should have set aside $32 billion for future payments. They did not.

The number of workers goes out of business.

For a lucky few workers across the country in that situation, the government rule book — as crafted by a succession of lawmakers and presidents, Democrats and Republicans — offers some relief.

Call it the hospital legal lottery.

If you win, your medical bills are paid.

If you lose, you pay your own medical bills.

But very few win.

Here is how it works:

Let's say the company where you have been employed so many years decides to restructure itself to cut its costs. As a part of the realignment, your job is terminated.

Suddenly, you lose the health insurance that has been paying your medical bills.

You hire a lawyer and sue the company.

If you are like most workers, you will lose, which means you will be responsi-

But the process can be expensive and time-consuming.

employees, including Roy Mahon, and the financial obligation to pay the medical claims and

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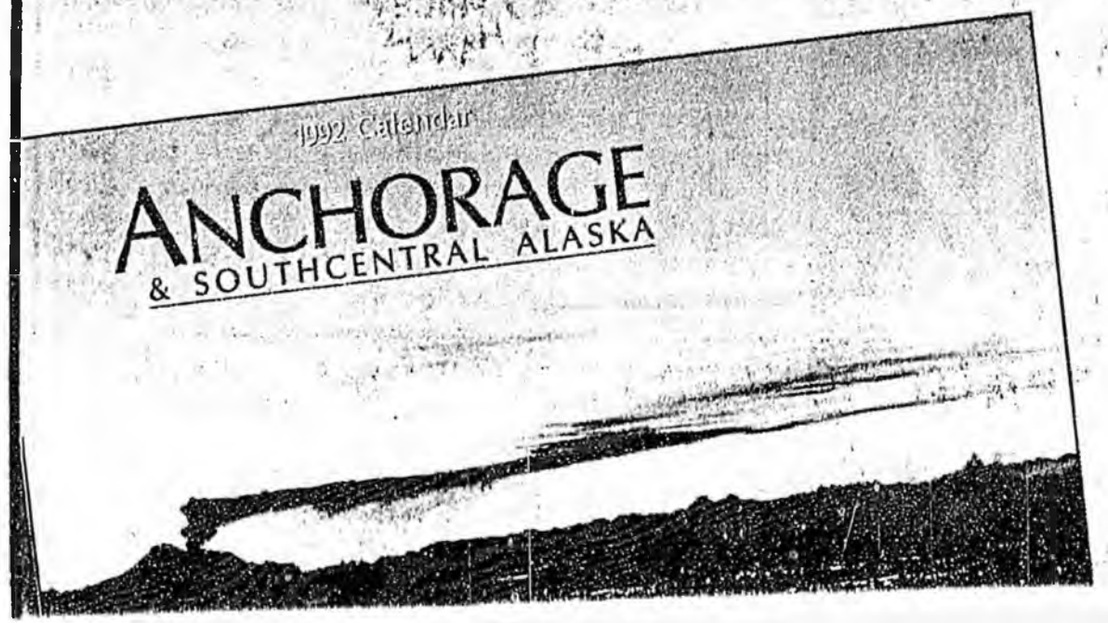


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TAKING A STAND Times 12/12/91

Alaska health care ideas workable, in line with national proposals



Jim Duncan

Attempting to get The Anchorage Times to understand my health care reform proposal, Senate Bill 83, is much like my trying to teach a pig to sing. It annoys the pig and it wastes my time.

The Times editorial of Dec. 12 shows a complete lack of understanding of SB83 as did its previous editorial on this issue earlier in 1991. This despite the voluminous information I provided The Times as well as a personal visit with its editorial board.

The Times continues to insist that my approach in SB83 is designed "... to help the state's estimated 135,000 government employees to have cheaper coverage." Well, it does that, but if The Times editorial writers would read on they would find that it also will provide cheaper coverage for the private sector employers and employees who presently have insurance, as well as providing improved access for the estimated 90,000 Alaskans who are either uninsured or underinsured.

The key to successful health care reform is a comprehensive approach. That means you not only provide universal coverage but also enact a tough, no-loophole strategy to bring health care costs, system wide, under control. Without cost containment measures, the inflationary spiral of nearly 20 percent annually in health care costs will continue and any reform proposal will be doomed to failure. SB83 proposes this comprehensive approach.

The cost containment steps in SB83 of rate setting and utilization standards are controversial and I guess for that reason The Times believes the proposal is only trying to focus blame. To the contrary, SB83 recognizes that all parties: consumers, health care providers and the insurance industry have to participate if health care reform is to work. SB83 does not place blame. It proposes a cure.

It is interesting to note that many national proposals embrace rate setting as a necessary cost control strategy, as does SB83.

- The National Leadership Coalition for Health Care Reform endorses rate setting. The coalition is comprised of unions, associations of health care professionals, consumers and businesses including AT&T, Bethlehem Steel, Chrysler, Ford, Eastman Kodak, General Electric, Lockheed, 3M, Westinghouse and Xerox. Former presidents Gerald Ford and Jimmy Carter have endorsed the coalition plan.

- The National Planning Association, in a report titled, "Curing U.S. Health Care Ills," endorses a global spending limitation and fee schedules for provider reimbursement.

- The national AFL-CIO recently endorsed health care reform that includes a national cost containment program with a cap on health care spending and uniform reimbursement rates for all providers.

- The National Governors Association staff in a briefing paper, "Strategies for Controlling Health Care Costs," favors a single public agency to negotiate health care payments with health care providers.

- Congress is considering legislation that proposes a federal agency to set spending targets and negotiate rates between providers and consumers.

It is clear that major health care reform will happen and it will include universal coverage and cost containment. However, as SB83 proposes, I believe it is preferable to have Alaskans solving Alaska's problem than to turn it over to a federal authority.

The Times editorial concludes by stating, "It is time to stop the hand-wringing and turf protecting and to focus on a cure." I agree. I stopped wringing my hands by introducing SB83. It's not turf protection, and it proposes a cure.

The Anchorage Times, like the pig, can be annoyed at learning how to sing, but I am sure many other Alaskans will continue to sing the tune for comprehensive health care reform like SB83.

Jim Duncan represents Juneau in the state Senate. Opinions expressed in Taking a Stand do not necessarily reflect the editorial position of The Anchorage Times.

MONDAY
January 6, 1992
TIMES

State working to heal health insurance woes

ASSOCIATED PRESS

JUNEAU — Alaska lawmakers are trying to find a cure for the rising cost of health insurance, but any treatment is bound to be costly.

There are more than a dozen bills regarding health insurance pending from the 1991 session, and more are expected to be introduced in the final session of the 17th Legislature, which begins Jan. 13.

A legislative report says Alaskans pay as much as $2 billion annually to doctors, hospitals, clinics, pharmacies and other health-care suppliers — an increase of 300 percent over the past decade.

Many people are finding they cannot afford health insurance and are foregoing basic medical treatment.

An estimated 90,000 Alaskans — 16 percent of the state's population — are without health insurance but make too much money to qualify for welfare.

If costs increase at the current pace, which is more than double the inflation rate, Alaskans could be faced with a $10 billion-a-year bill for health care by next decade. And the number of uninsured Alaskans could total one-quarter of the state's population, experts estimate.

The cost of the Medicaid program also is on the rise. Lawmakers last year appropriated about $102 million toward Medicaid. The program pays for medical care of poor, aged, blind or disabled people, and for nursing-home care. The cost is split between the state and federal governments.

This year the Legislature and Gov. Walter J. Hickel approved $108 million for the state's share of Medicaid. But based on current costs, that will not be enough, said Janet Clarke, director of administrative services for the state Department of Health and Social Services.

The state also pays out tens of millions of dollars a year to insure its employees. The $385-a-month premium pays for medical, dental and vision coverage for the employee, his or her spouse and children. Unlike most private-sector health plans, the employees contribute nothing toward the premium.

Lawmakers are considering several bills to solve or at least ease the health-care cost dilemma. A legislative task force also is looking for solutions.

The most comprehensive and controversial proposal has been offered by Sen. Jim Duncan, D-Juneau. It would create a state authority to set guidelines for the cost of medical services throughout Alaska.

Rep. Mark Boyer, D-Fairbanks, has introduced a simi-

See Health, page B3

Health

Continued from page B1

lar measure in the House.

The legislation also would pool Alaska employers, possibly including the state, to create a larger policyholder group with more leverage to negotiate lower insurance premiums.

Duncan's plan is opposed by some doctors, hospitals and other health-care suppliers. "They have this fear this will lead to a state insurance company," Duncan said.

One version of the plan would allow the authority to serve as a self-insurer, bypassing the insurance industry.

Duncan said his legislation would try to control the escalating cost of medical care, create a larger pool of employees and employers to help bring down premiums, and educate consumers on choices in medical care.

"We don't think you control costs by merely controlling hospital charges," said Harlan Knudson of the Alaska State Hospital and Nursing Home Association. "You can't just set arbitrary fee schedules, which he would do in his bill."

The association supports creating a state health authority. But Knudson said detailed information on health-care costs and who pays the bill should be collected before legislators lock the state into a comprehensive health-care law. Such an exhaustive research project could take between two to six years, he said.

Meanwhile, Sen. Virginia Collins, R-Anchorage, has two bills pending that she says will tide the state over until a comprehensive health-care law can be approved.

She has proposed creating a non-profit corporation comprised of Alaska insurers to pool small businesses' insurance needs and spread the risk among many employers.

"People who are uninsured are working, but have no insurance through their employers," Collins said.

If a small firm employs someone with a high risk of needing medical care, finding insurance often can be impossible. The idea behind pooling is to spread the risk out among a large group of smaller businesses.

Another Collins bill would create a non-profit corporation charged with offering low-cost health insurance to schoolchildren. Her proposal would set premiums based on parents' income.

Sen. Jay Kerttula, D-Palmer, is sponsoring a bill that would set up a new state authority to determine basic health-care services, and then offer state-subsidized insurance plans to small businesses and uninsured Alaskans.

Another Kerttula bill would require insurers and hospitals to join an association charged with providing insurance to people with high medical risks and those who cannot afford standard insurance.

There also is talk of reviving the state catastrophic illness fund which helped pay for high medical costs incurred by patients without insurance or adequate coverage.

It used to serve about 200 people a year to the tune of about $3 million, but the fund has received no money from lawmakers since 1987.

The fund was mostly used to pay the high cost of premature births and infants with severe medical problems, said Rep. Niilo Koponen, D-Fairbanks. People had to pay some of their own money toward their medical bills before they could qualify for the state aid.

Whether lawmakers can agree on major changes governing health care and insurance before they adjourn next May is doubtful. Collins, a member of the state task force studying the problem, said she does not expect lawmakers to have the time to pass a comprehensive bill this session.

Some say the state should wait and see if Congress can come up with a national solution to the health-insurance problem. But Duncan and Koponen say that may take too long.

"We can make a beginning here and assist people in Alaska, which is what we tried to do with the catastrophic illness fund," Koponen said.

Duncan said the states must show initiative and creative thinking in facing the problem. "The states are going to have to be the laboratories."

States mull bills tinkering with health care

By HAL SPENCER 1/2/92
ASSOCIATED PRESS

Weighing experiments that could lead to national health care reforms, at least 18 state legislatures will consider bills this year that range from expanding services to the poor to providing insurance for all.

The Washington and Minnesota legislatures are among several that will consider multimillion-dollar proposals financed by new taxes and fees to replace private medical insurance with state-operated insurance programs much like Canada's national health insurance system.

■ Descriptions of health legislation facing state lawmakers in '92. A8

Alaska will look at ways to pool health insurance for small businesses so they can afford to provide basic coverage to workers. Kentucky legislators will decide whether to broaden Medicaid coverage for the poor, and Michigan will continue debate on a Senate-passed plan to provide subsidized insurance to the working poor.

The growing involvement of the states in health care is another measure of the "desperate need" to reform the nation's health care system, said Washington state Rep. Dennis Braddock.

"It's too bad it has to come from the states and not the Congress, but it looks like that's what will happen," said Braddock. He is the sponsor of a measure that would collect taxes and fees from employers and individuals and use the money to administer health care and pay providers.

Congress is expected to take up health care reform this year. Nearly 35 million Americans are uninsured and the number is rising along with health care costs. Those costs, increasing at twice the inflation rate, are expected to reach $738 billion this year, the Advisory Council on Social Security said recently.

"It is likely, however, that some state or states will show the way" to a national health care system, said Sidney Wolfe, a physician and director

See Health, back page

Health

Continued from page A1

of the liberal Public Citizen Health Research Group in Washington, D.C.

Robert Moffit of the conservative Heritage Foundation agreed.

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At least another nine states, with varying enthusiasm, are pursuing major health care reform that one way or another would give virtually every citizen access to basic medical care.

The proposals are taking two basic forms. One, the "pay or play" approach, would preserve the private insurance industry. Employers would be given the option of providing affordable health insurance to workers or paying into a state fund from which health care for the uninsured would be financed.

The other, a "single-payer" system modeled after Canada's system, would eliminate the industry in favor of one big state insurance program. Business and individuals, through taxes and fees, would pay into a state fund from which health insurance for all would be administered and financed.

In some states, including California and Washington, both proposals are in the hopper.

Some versions of these plans include various cost control mechanisms. Washington's pay-or-play measure, proposed by Democratic Gov. Booth Gardner, would set up a regulatory commission with the power to control medical costs.

Any real reform must include the ability to control Medicaid costs as well, state officials said. Several states will seek federal permission, or waivers, to bypass federal rules controlling Medicaid in order to reduce the cost and increase service.

Health legislation facing some state legislatures in 1992

ASSOCIATED PRESS

Alaska: Several measures, ranging from state-run health insurance for all through a Canadian-style "single-payer" system to pooling small businesses so they can afford to provide insurance.

California: Several proposals, including "pay or play" and Canadian-style single-payer plans under which business and government would finance health care insurance for all.

Florida: Governor's commission preparing recommendations for more health care access. Legislation includes a state-run, Canadian-style insurance system.

Hawaii: Measures to improve the state's unique system under which 98 percent of residents already have some form of health care coverage.

Idaho: A health care access study committee expected to make recommendations for possible legislative action. A Canadian-style system could be on the table.

Kansas: Measure for business pay or play insurance coverage for all to be financed through new taxes.

Kentucky: Proposals to broaden Medicaid coverage for the poor through cost controls and other steps.

Michigan: State Senate-passed measure to provide subsidized insurance to the working poor facing House action. Businesses and individuals could get tax credits for buying the insurance.

Minnesota: Legislative proposal, vetoed by governor last year but still being negotiated, to raise the cigarette tax to help finance health care for an increasing number of people. Eventually, the legislation would create and fund in some form a state-subsidized health care system for all.

Nebraska: Modest proposals to cover more poor people and control medical costs for all.

New Jersey: Preparing regulations to enact 1991 law providing "bare bones insurance policy" to 1 million uninsured residents. Legislature will consider fund sources including a payroll tax.

New York: Several proposals, including a pay or play proposal requiring employers either to provide basic insurance or pay a tax which would pay basic health care costs of the uninsured.

Ohio: Proposals include a Canadian-style "universal care" plan, and more modest bills seeking to improve current system through cost containments and other steps.

Utah: Modest proposals to broaden Medicaid coverage, and to make it easier for some citizens, such as young people, to get or keep private insurance.

Vermont: A single-payer health care plan similar to Canada's.

Virginia: Proposal to provide state-funded health insurance to poor children not covered by Medicaid.

Washington: Proposals for Canadian-style system and a pay or play approach with a payroll tax on businesses. Also would expand a state subsidized health insurance program now serving 21,000 working poor.

Wisconsin: Several proposals including a Canadian-style plan.

18 states consider health-care reform

By HAL SPENCER
THE ASSOCIATED PRESS

Weighing experiments that could lead to national health-care reforms, at least 18 state legislatures will consider bills this year that range from expanding services to the poor to providing insurance for all.

The Washington and Minnesota legislatures are among several that will consider multimillion-dollar proposals financed by new taxes and fees to replace private medical insurance with state-operated insurance programs, much like Canada's national health-insurance system.

Alaska will look at ways to pool health insurance for small businesses so they can afford to provide basic coverage to workers. The bill, submitted by Juneau's Sen. Jim Duncan, might also include the state in the pool, to create a larger policyholder group with more leverage to negotiate lower rates.

Duncan's legislation also would create a state authority to set guidelines for the cost of medical services throughout Alaska.

Kentucky legislators will decide whether to broaden Medicaid coverage for the poor, and Michigan will continue debate on a Senate-passed plan to provide subsidized insurance for the working poor.

The growing involvement of the states in health care is another measure of the "desperate need" to reform the nation's health care system, said Washington state Rep. Dennis Braddock.

"It's too bad it has to come from the states and not the Congress, but it looks like that's what will happen," said Braddock. He is the sponsor of a measure that would collect taxes and fees from employers and individuals and use the money to administer health care and pay providers.

Congress is expected to take up health-care reform this year. Nearly 35 million Americans are uninsured and the number is rising along with health-care costs. Those costs, increasing at twice the inflation rate, are expected to reach $738 billion this year, the Advisory Council on Social Security said recently.

"It is likely, however, that some state or states will show the way" to a national health-care system, said Sidney Wolfe, a physician and director of the liberal Public Citizen Health Research Group in Washington, D.C.

Robert Moffit of the conservative Heritage Foundation agreed.

"There is a real deep sense of desperation. The states are excellent laboratories of social experimentation. Some are going in the wrong direction on this issue, but that's all right, too, because we can learn from their mistakes," said Moffit, deputy director of the foundation's Domestic Policy Studies in Washington.

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Please turn to States, Page 8

Don't look for help from Washington

By WALTER R. MEARS
THE ASSOCIATED PRESS

AP NEWS ANALYSIS

WASHINGTON – While the issue won't wait in 1992, the answer to the problem probably will because there's little chance the government will be able to write a new national health-insurance policy in an election year.

But with costs and concern rising, the health-care crisis and rival ideas to deal with it are going to be fixtures in every campaign – from the White House to Congress to state house.

By President Bush's count, there already are 31 varying proposals before Congress. He'll be adding his own in the State of the Union message on Jan. 28.

"I do think the time has come for the administration to come forward with a comprehensive program," he said. "We will capitalize on and learn from some of those programs that are floating around up there."

Until Bush made that commitment, almost offhandedly, answering questions at the Kiwanis and Rotary Clubs in Ontario, Calif., on Dec. 6, the White House had seemed willing to let the issue ride with a limited, holding-action proposal.

But the numbers are getting worse, the soaring cost of medical care is a drag on the faltering economy, and the question has climbed the roster of voter concerns.

National health insurance was one of the issues Sen. Harris Wofford pushed in Pennsylvania in winning his Democratic upset in November.

The Commerce Department reports an 11 percent increase in U.S. spending on health care during 1991, to a total of $738 billion in 1991, and forecasts annual increases of 12 percent to 13 percent for the next five years.

That report says health spending will reach 14 percent of the

Please turn to Congress, Page 8

States...

Continued from Page 1

of one big state insurance program. Business and individuals, through taxes and fees, would pay into a state fund from which health insurance for all would be administered and financed.

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Some versions of these plans include various cost control mechanisms. Washington's pay-or-play measure, proposed by Democratic Gov. Booth Gardner, would set up a regulatory commission with the power to control medical costs.

Any real reform must include the ability to control Medicaid costs as well, state officials said. Several states will seek federal permission, or waivers, to bypass federal rules controlling Medicaid in order to reduce the cost and increase service.

Medicaid costs are shared about 50-50 between the federal treasury and the states.

Oregon is still awaiting federal approval of a controversial plan to make Medicaid available to more poor people by putting limits on access to certain expensive medical services, such as organ transplants.

Wolfe said the time is ripe for change.

"The time has come when the middle class is medically indigent," he said. "People are hurting."

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USA TODAY

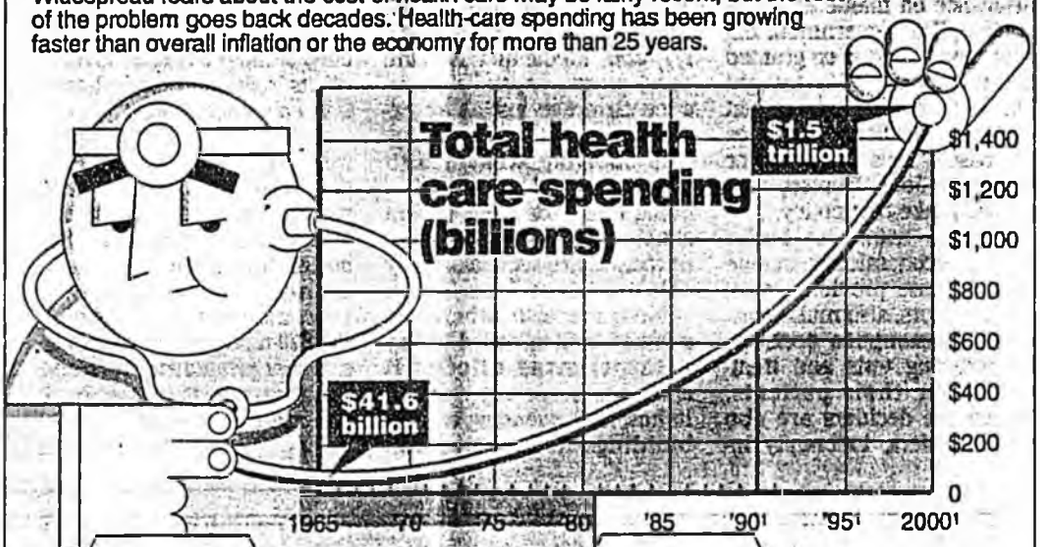
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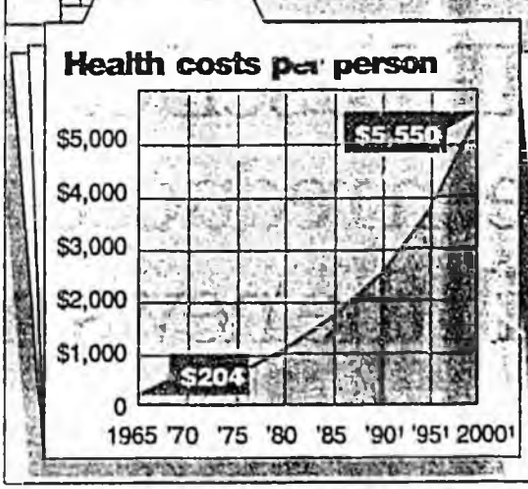
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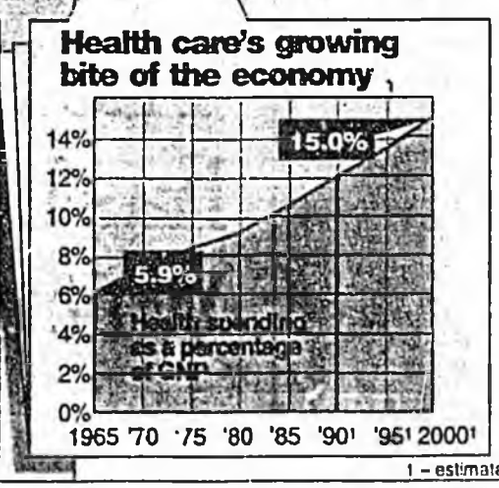
SPECIAL REPORT

Health-care ills

Widespread fears about the cost of health care may be fairly recent, but the root of the problem goes back decades. Health-care spending has been growing faster than overall inflation or the economy for more than 25 years.







1 – estimate

Source: Health Care Financing Administration

By Marty Baumann, USA TODAY

HEALTH & MONEY

A continuing series



No other part of the U.S. economy seems less understood than health care. Few realize why health-care costs are so stubbornly high ($2,700 per American this year) or why health care seems to defy free-market economics — why, for example, increases in the supply of hospitals and doctors only increase prices.

What a growing number people are coming to know is dissatisfaction with a health-care system that absorbs ever-soaring sums of money while letting more and more people fall through the cracks.

Health & Money, a continuing series beginning today, will explore how the health-care system works, why it sometimes fails and what's being done to change it.

COVER STORY

Health care costs more, serves fewer

On 3B:
▶ **Technology vs. cost**
▶ **Reform plans**

By Kevin Anderson
USA TODAY

The U.S. health-care system made a dream come true for Priscilla Brewer's family in 1976. Doctors at Norton Children's Hospital in Louisville, Ky., knocked her daughter's leukemia into remission. Between the hospital's leukemia research grant and Brewer's insurance, the family paid nothing.

Today, however, both the grant and the insurance coverage are gone, and Brewer's dream is tarnished. The textile worker says that her employer "changed insurers a number of times, and our rates went up with each change." Her truck-driver husband's employer provides no insurance coverage. By last year, her share of the premium for family coverage was eating up 44% of her take-home pay. A search for a cheaper alternative was fruitless: Although her daughter's leukemia has been dormant for 15 years, no insurance company would touch them because of it. "Finally, I had no choice but to drop coverage," Brewer says. "We couldn't afford it."

Mark Carlson has no such problem. As a middle manager at Du Pont, the Newark, Del., man has no worries that his health insurance will protect his family's finances in cases of catastrophic illness. But Carlson's insurance covers less of the routine care his family needs. When the Carlsons' first child was born in 1983, out-of-pocket costs came to $25. Those costs were $650 for the second baby in 1986, $1,200 for the third in 1988 and $2,700 for the fourth last year.

Of all the cold showers of reality falling on the USA as the '90s dawn, none is as chilling as this: The health-care system in this country is in deep, deep trouble.

To those it serves best, it offers the most sophisticated, innovative and effective medical care in the world. But it is an expensive welter of inefficiency that excludes more and more people even as it consumes an ever growing chunk of

Please see COVER STORY next page ▶



USA TODAY

COVER STORY

Health-care malady

Continued from 1B

our national resources. There is growing agreement that unless there is fundamental change, the US will be in danger of sacrificing other important national priorities — education, environment, competitiveness — for health care.

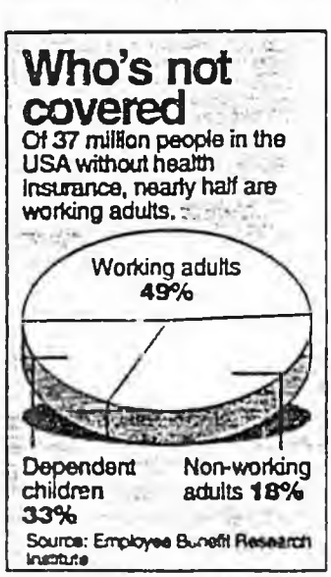
Forces are building for such change. CEOs of corporations, reeling from 20%-plus annual increases in health insurance costs, proclaimed health care the No. 1 challenge facing American business in the '30s. Labor, noting that worker-paid insurance costs have risen 70% in two years — and that 80% of recent strikes are over health benefits — has embraced health care as its No. 1 issue. So have congressional Democrats.

We'll spend an estimated $700 billion this year on health care, nearly 8% more than last year, 144% more than 10 years ago. We'll spend as much on health care this year as on cars and trucks, plus gasoline and parts — plus our entire military. Health care accounts for 12% of our total economy, vs. 9.1% of gross national product in 1980.

At the current rate, the nation's health-care bill will top $1.5 trillion and 15% of GNP by the year 2000, and few see current cost-control efforts changing that forecast.

Yet gaps are widening. There are an estimated 37 million Americans with no health insurance. That's 15% of the population, or more than one person in seven who must rely on a shrinking charity-care establishment. An additional 30 million to 50 million are believed to lack adequate coverage.

The crisis atmosphere may be new, but the problems are not. Real health-care costs (with general inflation factored out) have been growing at a steady 4% to 5% a year since the 1960s. The ranks of the uninsured have been growing since 1980, when they numbered about 25 million.



USA TODAY

What is pushing the health-care mess to the forefront of middle-class consciousness may have less to do with tragic cases like the Brewers' and more with nagging situations like Carlson's. Since 1988, one employer in six has cut or limited health benefits. Carlson doesn't blame Du Pont. "The company is paying a hell of a lot more for health," he says.

And though shrinking benefits don't have Carlson worried about handling a major medical problem financially, they do have millions worried. In a recent poll by Northwestern Mutual Life, 60% said they had no confidence their insurance would cover a major illness a few years from now.

Money is now the biggest health-care worry. In a separate poll by the Gallup Organization last August, 19% named out-of-pocket costs their No. 1 worry when it comes to their health; 30% named fear of losing their insurance.

Those fears are well-founded, if a projection by Harvard University's School of Public Health is right. It foresees 28% of all workers losing health coverage by 1993 because they change jobs or their employer changes insurers.

Access to health insurance — with its dramatic stories of suffering and its blatant inequities — is a hot political issue. But it is merely a symptom of rampant health-care inflation. "I don't know who's to blame for this situation in our country," Brewer says. "What happened to make it so expensive?"

The glib answer: everything. "We never tried to put together a systematic arrangement on health care in this country, unlike probably every other country you can think of," says John Dunlop, former U.S. Secretary of Labor. "What we have today is the result of a series of pragmatic decisions made over time to meet narrow questions." *(See story, above right.)*

The good intentions behind those decisions paved the road to inflation — a built-in inflation that defies efforts to bring it down across the board. Government efforts to curb the growth of Medicare and Medicaid spending succeeded — for those programs. For the health-care system as a whole, the effect was that of squeezing an inner tube in one place only to have it balloon in another.

What has ballooned, as hospitals shifted costs, is private health-insurance rates. For larger employers, rates have doubled since 1986. For those small employers who provided insurance in the first place, rates are rising even faster, sometimes doubling or tripling in a single year.

Small employers have often responded by eliminating coverage for employees or for dependents. Roughly two-thirds of the uninsured are small-business employees and their families. Larger employers have responded by cutting benefits, raising employee premiums and shared payments, and shifting to alternatives: prepaid group care; utilization review (UR), in which nurses and doctors hired by the insurer screen hospitalization requests; and preferred provider organizations (PPOs), which limit employees to certain doctors and hospitals with whom the insurer has negotiated discount fees.

These approaches are controlling some cost growth, but not in any way that holds much promise for systemwide change. Southern California Edison's PPO cut its health-care cost growth in half, from 25% a year to 12%, still far above general inflation. "There are limitations to having discount medicine be the only way to save money," says Wally Maher, Chrysler Corp.'s former benefits chief and current health policy leader.

Roadblocks to reform abound. Some hope to cut the 15% to 30% of all medical tests and procedures believed to be of little or no medical benefit. But medicine is art as well as science, and doctors note that what looks unnecessary on statistical charts seems necessary when considering specific patients. That aside, there's a dearth of comprehensive national data on medical outcomes, without which tackling unnecessary care "is like taking a step in a dark room full of trap doors," says William Cutler of the Employee Benefit Research Institute.

Insurance administration costs, which eat up about 15% of health spending vs. 5% in Canada, are another promising target. But ironically, administrative overhead is rocketing as private cost-cutting efforts mount. And while the aging of the population has accounted for only about 10% of excess health-care inflation, demographics indicate higher costs in 20 years or so, when the baby boomers start to retire.

Despite the clamor for change, there's no agreement on what change to pursue. "A huge segment of the business community has a vested interest in the status quo. Consensus is fractured, despite the problems," Maher says. "But inaction is tantamount to deciding as a nation that we'll keep spending more and more of our GNP for health care, leaving less and less for the education and investment we need to compete in the 21st century."

How the cost spiral started

Indemnity plans 'doomed to fail'

Health insurance in the USA traces its history to 1798, when Congress established the Marine Hospital Service for merchant sailors, a prepaid care system funded by wage deductions.

We might be better off today had we stuck with prepaid care as our main form of coverage. But indemnity health insurance — reimbursement for unexpected costs — began to supplant it in the late 1800s. It exploded into widespread use during World War II, when employers were in stiff competition for workers, yet couldn't raise wages because of wartime controls. So they began offering health insurance en masse as an incentive. The government encouraged it, and even granted tax incentives. "We thought health-care increases might not be as inflationary as wage increases," says former labor secretary John Dunlop, who helped make that policy.

But the nature of health care is economically unique in that those providing most care, doctors, also make most of the consumption decisions by ordering tests and treatments for their patients. "Since the deciders are also the providers, indemnity insurance was doomed to fail" because it shields the deciders from having to weigh a procedure's benefits against its cost, says Dr. Arnold Relman, former editor of the *New England Journal of Medicine*.

Bad economics such as that made for good medicine, however. Freed from having to be gatekeepers of resources, American physicians trained themselves to be advocates for their patients. The USA led the world in medical science. "You can get the best health care in the world here, but it depends on circumstances," says Dr. Glen Aukerman, president of the American Academy of Family Physicians. "We don't have a system. We have a lot of random moving parts."

Those moving parts didn't meld into an inflation machine until the mid-1960s, when Medicare (for the elderly) and Medicaid (for the poor) greatly expanded insurance coverage just as an explosion in medical technology was boosting what health economists call "intensity" — doing more for each patient simply because physicians-as-advocates are technologically able to do more to help them.

Medicare also ushered in another well-intended policy with perverse effects: It agreed to cover any shortfall in hospitals' spending on new buildings and equipment. "Hospital capital spending took off," says Carl Schramm, president of the Health Insurance Association of America, fueling health-care inflation.

After numerous failed efforts to slow health-care inflation in the '70s, drastic change came in 1985, when Medicare changed from an indemnity basis to the Prospective Payment System — paying hospitals a flat fee based on a patient's diagnosis. If the patient's care costs more than the fee, the hospital eats the difference, but keeps the surplus if the care costs less.

Real growth in Medicare spending fell from nearly 7% a year in the '70s (vs. 5% for overall health spending) to 3% since 1985 (vs. 4% for overall spending). Average hospital occupancy dropped from about 80% in 1983 to 60% by 1988. Meanwhile cuts in Medicaid eligibility pushed 60% of those living in poverty off its rolls, adding to hospitals' charity-care load.

Since those changes put hospitals in a financial squeeze, hospitals have passed the burden on to privately insured patients. That cost-shifting is what has hospital room rates rising 12% a year, has aspirin tablets costing $20 on some hospital bills, and has private insurers and employers passing the buck one more time — to you.

— Kevin Anderson

A SPECIAL MONDAY REPORT ON YOU AND YOUR MONEY

Why health-care costs are tough to cure

ABOUT THIS REPORT

HEALTH MONEY
A continuing series



The stories on this page and page 1B launch Health & Money, a continuing series of special reports on the USA's health-care system: how it's paid for, where it succeeds and fails and what forces are building within it for sweeping change. In coming months, Health & Money will take you inside hospitals, doctors' offices, medical schools and companies for a look at how finance and economics shape decisions that affect your health care.

By Kevin Anderson
USA TODAY

For the roots to the reasons why U.S. health-care costs have stubbornly outpaced general inflation for three decades, look in the mirror.

Our crazy-quilt health-care system has been shaped not by a master blueprint, but by countless isolated decisions — each made in keeping with American attitudes and values.

To be sure, we got some unintended consequences, such as the growing legions of uninsured. But by and large, we built high inflation into our health-care system by molding it to our national character. Ours is a system that leans heavily toward technology. It is biased toward action. Most important, it is a system that someone else seems to pay for.

Dr. Elizabeth Korte sees our expensive attitudes in action every week. "Patients will walk in and say, 'I think I should have an MRI scan,'" or some other fancy test or treatment gleaned from a news story or heard from a neighbor. Before ordering an $850 trip to a magnetic resonance imaging scanner, Korte uses the diagnostic skills honed in 32 years of practice in Carthage, Ill.

But in the end, "whether I think an MRI will show us anything or not, if the patient insists on one, I go along." Part of the reason, she allows, is that she exposes herself to legal risk if she doesn't. But Korte urges her patients to be equal partners in caring for their health, and she hesitates to say no, even when her "partner" forgets which of them holds the M.D. "I think overall, it's nice that people are informed about medical technology and treatments. But they need to be informed about when they're indicated and when they're not."

Our love of technology and faith in science has played an especially strong role in building high inflation into the health-care system.

"We are to medical-care technologies what the French are to wines," says Robert Blendon, chairman of Harvard's department of health policy. Like our military, our health-care establishment is dominated by sophisticated technology — dazzlingly effective in given situations, but very costly. *(See chart, left.)*

But techno-lust wouldn't be such a powerful engine of health inflation were it not that we pay for health care in ways that shield consumers from costs. Our reimbursement insurance system has developed into a blank-check approach to health-care financing.

Health-care consumption decisions — 75% to 80% of which are made by doctors on their patients' behalf — traditionally haven't been made with an eye toward weighing cost and benefit. That's why Korte can order that MRI scan for her insistent patient. Without cost-shielding, health-care inflation wouldn't be such a problem. With it, a host of other native values and attitudes play into inflation's hand:

▶ We value the individual over society, and we cherish miracles and heroic efforts against daunting odds. Countless thousands are alive here that might not be in other countries. In Sweden, doctors seldom try to save preemies weighing as little as 18 ounces; they succeed one time in four — generally for a hospital bill well into six figures. Britain's national health system bars transplant surgery, hemodialysis and other costly treatments beyond certain ages and health conditions. Roughly a third of the average American's lifetime health expenditures will be spent in the last year of life, half of that in the final two months. Health-policy people call this the "$100,000 funeral" problem.

▶ We hate to wait or to travel long distances for necessities. That has meant an insatiable market for closer hospitals, more surgeons and operating rooms, more machines, more costly treatments to allay smaller and smaller discomforts. All consideration to convenience, little to costly duplication of facilities and services.

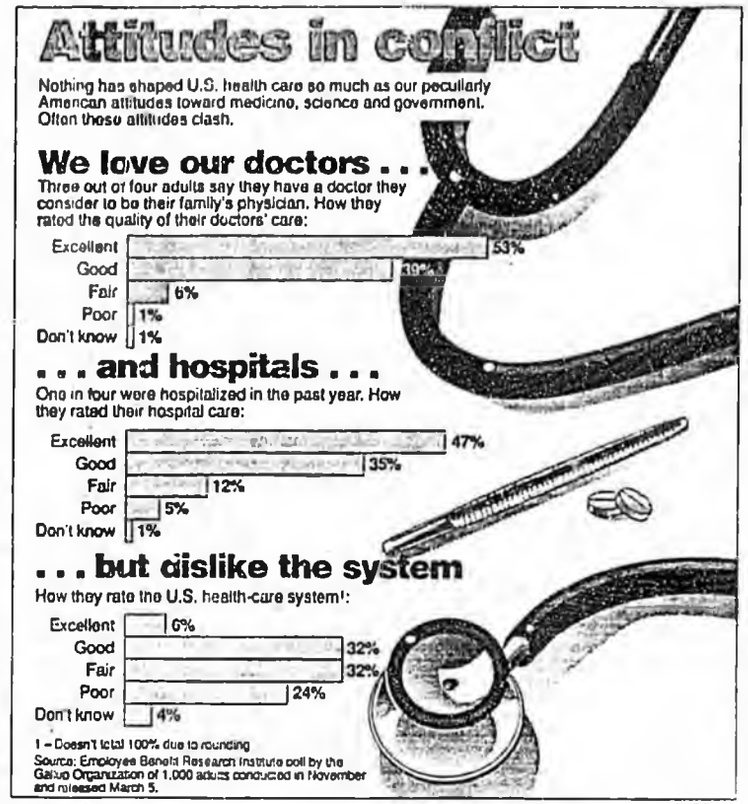
▶ We are quick to sue. The malpractice-suit explosion since the early '70s permeates every treatment decision and hospital policy. That leads to so-called defensive medicine — excess testing to document a lawsuit defense. "These days, we have to prove what's *not* wrong with a patient," says Dr. Ed Langston of Indianapolis.

▶ We favor action over patience. The don't-just-sit-there-do-something mind-set is present in a fair number of health-care decisions in the USA. Doctors in the USA are biased toward trying a test or treatment — just in case, just to be safe — although it's not clearly indicated. Patients are biased toward demanding it and letting insurance pay.

▶ We are optimists. The dark side of that attitude is a penchant for self-denial. Much is made of the costly overuse of health care. But underuse is an expensive problem, too: Not seeking care when you should can let a problem get more serious and thus more expensive to treat. And it's not just the uninsured who underuse the system. A 1987 study in *Health Affairs* noted this among people who had insurance and did see a doctor for some reason in the past year: A startling 41% said although they had experienced one of seven serious symptoms that always require attention (unexplained bleeding, chest pain during exercise, etc.), they did not see a doctor for it.

"Cost-shielding has led to a culture of entitlement — of high expectations and little idea of costs," says Dallas Salisbury, president of Employee Benefits Research Institute. EBRI polls show that 34% of adults with health insurance had no idea what the total bill was for their last hospitalization; 78% had no idea what their employer pays for their insurance.

Yet for all its expense, waste and inefficiency, the U.S. health-care system works very well for a large majority — which poses a public-attitude hurdle for reformers. "We are very dissatisfied with the health-care system," says Blendon, "but we like our own doctors and hospitals. So reforms can't really dramatically change those relationships."



USA TODAY

Reform plans focus on access, cost of care

The widening debate over how to fix the USA's health-care system doesn't suffer from a lack of reform proposals. The count is around three dozen and climbing.

Two types of plans predominate: those that focus on access — providing health insurance for the 37 million who lack it; and those, mostly national health plans, that address soaring costs. A sampling:

Labor: Last year, the AFL-CIO adopted 10 principles to guide the drafting of any blueprint for health reform — concepts such as universality, accountability and portability. And it kicked off a massive grass-roots campaign to build support for reform.

But instead of unveiling a blueprint three weeks ago as some expected, the AFL-CIO chose to be a power broker, agreeing to back any idea that moves health care in the direction it wants. Insiders say it's a pragmatic way to get first-step legislation this year.

Insurers: Three years ago, before the access problem became a national issue, the Health Insurance Association of America began moving to preempt the assaults it saw coming. Final details of its proposal came just two weeks ago. An access plan, the HIAA would institute small market reforms — including tax incentives, looser coverage requirements, risk pools, reinsurance funds, and prohibitions against dropping or excluding high-risk individuals from coverage — to enable its members to offer affordable coverage to small business. The plan doesn't address costs, opposes mandates and is meant to be adopted by state legislatures with some variations. Connecticut begins operating under the first version in May. The HIAA plan stands out in that it gores its own ox: It makes health insurance a less profitable business. But it wouldn't be abolished, as many plans advocate.

Picking up the health-care tab

For decades, people have long paid lip service to the idea of a national health program, but support erodes when a specific price tag is mentioned.

Good idea . . .

Percent favoring government-financed national health program



. . . but no big tax hike

Percent favoring

1990 poll question

Would you support a comprehensive national health-insurance program if it cost more than $200 a year per person in added taxes? — **22%**

Source: *New England Journal of Medicine*, July 1990

USA TODAY

Business: The National Leadership Commission on Health Care, which includes businesses and unions, advocates a national pay-or-play system in which the "pay" goes to a Universal Access Program that would supplant Medicare. The National Association of Manufacturers is pushing HIAA-style reforms, including risk pools and tax incentives, to expand voluntary insurance coverage. It opposes mandates.

Doctors: The American Medical Association's Health Access America plan would expand Medicaid, federally mandate employer coverage and risk pools, limit tax deductions for employers and drastically reform the malpractice system. The 2,000-member Physicians for a National Health Program calls for a Canadian-style free care system: 100% tax funded, basing levies on what's now paid for health care; and state run, with pre-set hospital budgets and salaries or fixed fees for doctors.

Others: The Heritage Foundation, a conservative think tank, would mandate coverage but would put the mandate on the individual, not the employer. Employees would get what employers now pay for health as added wages and would be taxed on it but would get tax credits on what they spend for coverage. Health economists Alain Enthoven and Richard Kronick of Stanford University devised Consumer Health Choice. It requires government and employers to offer many coverage choices and "manage the competition" among them for cost-effectiveness.

Congress: Most plans require changes that would have to be passed by Congress, which has already embraced elements of several plans in its own thinking. From some members' rhetoric, you'd think sweeping reform was about to burst forth from Capitol Hill in a matter of weeks. Senior staff experts on health policy counsel, however, say this will be another year of debate; a few bills might see floor votes, but real reform is three to five years away. Among proposals:

▶ **In the Senate,** the focus is on access plans. Sen. Jay Rockefeller (D-W.Va.) chaired Congress' biggest effort on health care, the joint, bipartisan Pepper Commission, which developed the pay-or-play concept. Legislation based on the Pepper Commission's March 1990 final report is expected this month.

Sen. Ted Kennedy (D-Mass.), chairman of Labor and Human Resources, remains Capitol Hill's leading figure on health care. His current proposal was co-sponsored in each of the past two Congresses with Rep. Henry Waxman (D-Calif.), health subcommittee chairman of the House Energy and Commerce Committee. Also an access bill, it relies on national mandates rather than pay-or-play, making health coverage a right of employment like the minimum wage. Expect Kennedy-Waxman to be reintroduced this spring.

▶ **In the House,** national health programs predominate — so far. In January, Rep. Pete Stark (D-Calif.), chairman of the Ways and Means subcommittee, introduced MediPlan, a universal national program that would supplant private insurance and Medicaid, adopt Medicare's payment methods for doctors and hospitals, and cost everyone except the poor $1,000 a year in premiums plus limited out-of-pocket expenses. Last week, Stark's fellow subcommittee member, Rep. Marty Russo (D-Ill.), introduced a Canadian-style national health plan.

Some bills from the last Congress drew widespread attention and may be reintroduced. Rep. Mary Rose Oakar (D-Ohio) called for a government-run national system that would pay employer, public and group insurance plans, on a capitation basis, enough to cover 80% of all care costs, with caps on individual out-of-pocket spending. Rep. David Obey's (D-Wis.) plan was unique in requiring each state to design its own reform plan, then going with those that work best.

GLOSSARY

Terms you should know in the continuing health-care debate:

Capitation: Paying doctors and hospitals a fixed amount in advance per person covered to provide all needed health care.

Mandates: Requiring employers by law to provide basic health-insurance coverage to employees.

Pay-or-play: Giving employers the choice of either "playing" by providing a required level of insurance coverage or paying into a state program that will provide it.

Risk pools: Statewide entities funded by taxes, employers and insurers to provide coverage for otherwise uninsurable people.

Small-market reforms: Changing the rules governing health insurance to make it more affordable for small employers, small groups and individuals.

Technology fuels health-care inflation

Every aspect of our health-care system seems designed to lock in high inflation. But what are the main engines driving costs? Which features contribute most to keeping health-care inflation a consistent 4 to 5 percentage points above general inflation? USA TODAY asked a number of health economists and policy experts. Their consensus:

Technology: There's widespread agreement that technology is the largest engine of health-care inflation. We spend vastly more on health care simply because we have vastly more things to spend it on. Treatments and procedures developed just since 1975 — total body scanners, transplants, implants, less-invasive surgery, artificial enzymes, genetically engineered drugs — now account for more than a third of the estimated $275 billion we'll spend on hospital care this year and most of the $8 billion we'll spend on prescription medicines.



Developing and perfecting technology is hugely expensive. It's an expense the USA shoulders for much of the planet by supporting more than half the world's total medical research. And medical technology, by its very nature, expands the overall health market — and thus overall health spending — even while making things easier, cheaper and safer for each patient. Pinpointing a problem by a magnetic resonance imaging scanner rather than exploratory surgery is fast, painless, safe, more accurate and costs less per patient. But because of this, hundreds more MRI scans are done than were exploratory operations.

The technologies of the future — gene therapy, fetal surgery, tissue cloning — promise to eclipse the boom of the past 15 years, both in miracle power and cost. The dilemma: We still lack a way to measure the benefits of medical technology against the overall cost. "Not knowing exactly what we're getting for what we spend is the conundrum that has frozen health policy," says William Cutler, research chief for the Employee Benefit Research Institute.

Workforce: Health care is hugely labor intensive. The payroll makes up more than 70% of the average hospital's budget. Hospitals must raise wages to compete with wages in non-health-care jobs. "But non-health wages are being driven by productivity gains that hospitals, by their very nature, have trouble matching," says Henry J. Aaron, a senior Brookings Institution economist. Machines can't give nursing care.



Also, the machines hospitals do buy have a perverse effect on labor, compared with other economic sectors: An expensive new machine going into a factory will reduce labor needs; an expensive machine going into a hospital increases labor needs. The more sophisticated the machine, the more schooling, skill — and pay — its operators need.

Another workforce-related engine of health-cost inflation is the makeup of the medical profession. Two-thirds of the USA's 585,000 physicians practice a medical subspecialty, twice the proportion of most Western countries. Technological dominance accounts for part of that. But the health-insurance system rewards doctors far more for doing the procedures of specialty medicine than for the counseling, listening and preventive services of primary-care medicine. There's a bitter chicken-or-egg dispute over whether the payment bias evolved in response to the prestige and clout specialists wield or whether the profession grew lopsided because of a biased reward system. But both factors long ago knitted into a vicious cycle. Result: Average U.S. physician income, a record $137,000 last year, is 65% higher than in the second-best paying country, Canada.

— Kevin Anderson

Demanding Mercedes care for VW prices

Robert J. Blendon has amassed the largest storehouse of data on how Americans feel about health care — the results of nearly every poll question on the subject asked since the 1940s. Blendon, professor and chairman of the department of health policy and management at Harvard University's School of Public Health, discussed some of what he's learned in a recent interview:

Q. Are our values and attitudes also shaping health-care reform efforts?

A. One of the major ways we're trying to rein in costs is outcomes research, which has a lot to do with our attraction toward scientific answers to difficult questions. In this country, we don't want to set a budgetary limit on health spending. We still want to say that everybody who could benefit by anything should get it. So all the people who'll be doing outcomes research over the next few years are trying to scientifically search out those tests and treatments of little or no benefit to patients by amassing huge computer databases.

The idea is we'll just be able to take kind of a Patriot missile to knock out unneeded procedures, surgically striking with no collateral damage, no one having to give up anything. To believe in that, you have to have a unique faith in science. Other countries don't. They have a unique faith in budgets.



By Tim Dillon, USA TODAY

BLENDON: People don't trust budgets.

Q. Meaning?

A. Meaning they don't go trying to figure out a computer program that says this patient should get that help under these circumstances. Instead, they give doctors and hospitals the money they got last year, plus a little, and ask them to do the best they can. A lot of discretion is left to the physician, but there are pressures on the resources available to him. Americans are very uncomfortable with that. People don't trust anyone to set budgets. The U.S. is unique in its general distrust of government.

Q. Then why do polls consistently show that most Americans favor a national health program?

A. Roughly two-thirds of Americans, every time you poll them, say they want a national health plan, but they really have two different things in mind. To about half of Americans, a national health plan essentially requires government coming in with the National Guard or something to make your employer provide you with private insurance, with the government taking care of the unemployed and the poor. In the other half of American minds, it means Medicare for everybody.

Q. What reforms can we realistically make given the constraints of our attitudes and values?

A. We can make sure that nobody is without basic insurance. Secondly, we can put in some restraints on procedures and facilities to eliminate waste and duplication where there's a lot of consensus things aren't necessary. That's not going to sound very good to people who think we need to adopt really tough rationing choices if we are to save big dollars. They're correct — if we want to save big dollars. I don't believe we're going to do that. We'll go after administrative waste, put some budgetary pressures in for doctors and hospitals and maybe slow growth 10% or 15%. But the underlying pressures from our value system will always keep health care very expensive. No one in America really wants a Volkswagen health-care system — basic cheap care for all. They say they want it in the abstract. But they don't want it in practice.

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SENT: 02/27/91 TIME: 15:50
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SUBJECT LINE TO READ: TC NO.; PL FS;SHORT SUBJECT;DATE

T/C NO: 91-02-107
DATE: 02-27-91
SPONSOR: S LABOR & COMMERCE
SUBJECT: SB 82, SB 83
MODERATOR: JUDY
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4. CHARLES NORTHRUP/APBC			HB 82
5.			

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1. MATT HOLMES KFSK
2. DAN CALLAWAY KRSA

IS IT POSSIBLE FOR US TO LEARN WHEN SB 83 IS GOING TO BE DISCUSSED??

DOROTHY

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SUBJECT LINE TO READ: TC NO.; PL FS;SHORT SUBJECT;DATE

T/C NO: 91-02-038
DATE: 2/13
SPONSOR: S LABOR AND COMMERCE
SUBJECT: SB 83 HEALTH CARE COST CONTAINMENT
MODERATOR: JUDY
SITE: ANCHORAGE

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1. LISA WOLF/PROVIDENCE HOSPITAL			
2. JANET OATES/PROVIDENCE HOSPITAL			
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T/C NO: 91-03-081
DATE: 3-22-91
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T/C NO: 91-03-081
DATE: MARCH 22, 1991
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	3100 TONGASS AVE, KETCHIKAN 99901	225-5171	
2. DAVID JOHNSON, AK STATE MEDICAL ASSN.			SB 83
	3612 TONGASS AVE, KETCHIKAN 99901	225-5145	

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3.	DAVE HENNIGAN/PROVIDENCE HOSP.		261-3002	SB 83
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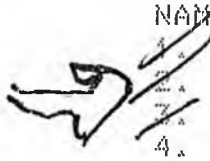
T/C NO: 91-03-081
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3.	DAVE HENNIGAN/PROVIDENCE HOSP.		261-3002	SB 83
4.	DAVID FRAZIER	1600 A ST	258-1169	SB 83
5.	MITCH GRAVO	2550 DENALI	272-6474	SB 83
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3.	SHARON ANDERSON/HUMANA HOSPITAL		264-1713	SB 83
4.	CHARLES STOKES/HUMANA HOSPITAL		264-1703	SB 83
5.	NONI BALDWIN	2525 BLUEBERRY#107	276-4849	SB 83
6.	JEFF DUZENBERY	1079 POTLATCH CIR		
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8.	TOM TURNER	1400 W BENSON STE 350	257-5216	

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LABOR AND COMMERCE

DATE: 3/22/91

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Subject of meeting:
SB 83

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Mary Van Nimwegen

Senate Labor and Commerce 3-22-91 3:30 pm