ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4501 HHES FED. BLOCK GRANTS - HEALTH CARE MEETING (10-22-87) 73

STATE OF ALASKA
ENERGY ASSISTANCE PROGRAM

PURPOSE: The Energy Assistance Program (EAP) is administered in Alaska by the Department of Health and Social Services through the Division of Public Assistance. The purpose of the program is to provide assistance for low-income households to offset the high cost of home heating energy.

FUNDING: The program is 100% federally funded with a Low Income Home Energy Assistance Program (LIHEAP) block grant from the U.S. Department of Health and Human Services. Approximately 10 million dollars is allocated for Alaska. While the State receives almost 7 million dollars, 9 tribal organizations run their own block grant programs with the remainder of the federal allocation. Based on the federal allocation method, Alaska's native organizations would not be able to offer comparable services to the state program. Therefore, the State arranges for the Department of Health & Human Services to provide a larger share of the state's allocation to the tribal organizations.

ELIGIBILITY: Both home owners and renters (including those who pay for heating costs as an undesignated portion of their rent) may apply for energy assistance. Eligibility is based on the applicant's average gross monthly income for the last 90 days. Applicants with income at or below 60 percent of the 1986 median income for Alaska are eligible for energy assistance:

Household Size	Average Gross Monthly Income
1	$ 994
2	1,300
3	1,606
4	1,912
5	2,218
6	2,524

For each additional member add approximately $57

Households containing an individual receiving Aid to Families with Dependent Children (AFDC), food stamps, Supplemental Security Income (SSI), or certain income-tested VA benefits are automatically eligible for energy assistance benefits upon application.

Households eligible for or receiving benefits from a tribal organization administering a LIHEAP grant are not eligible for benefits under the State EAP, except where an agreement to the contrary exists between the State and the tribal organizations.

In determining eligibility the following income is included:

- All wages and salaries before taxes and deductions.
- Payments from Social Security, Unemployment Insurance, Workmen's compensation, VA benefits, child support, alimony, and pensions.

- Receipts from self-employment after operating expenses.
- Insurance or annuity payments, dividends, interest, rents or income from estates or trusts.
- All Public Assistance payments.

The following are not included as income in determining eligibility:

- All assets including checking and savings accounts.
- Resources such as house or car.
- Alaska Native Claims Settlement Act payments.
- Permanent Fund Dividend
- Alaska Longevity Bonus

BENEFITS: The benefits given to an eligible household are determined on the basis of that family's gross monthly income, home heating costs, and the geographic region in which it lives. Maximum grant amounts vary in different regions of the state, ranging from $200 to $1050. EAP grants are given once per program year per household. EAP makes payments to home heating energy suppliers on behalf of eligible households. Households do not have to have overdue bills to qualify. If the household's account are not overdue, credit will be established with its home heating energy supplier. Credit can be established for home heating payments made for fuel oil, natural gas, electricity, propane, wood, and other petroleum products used for home heating needs. When the grant is used up, the household's case is closed and all bills again become the household's responsibility.

APPLICATION PROCESS: Households seeking energy assistance must contain an Alaska resident, and submit an application. Only one application may be submitted per household. Applications are sent directly to all households receiving Public Assistance from the State. Applications are also available from Public Assistance district offices, village fee agents, many home energy suppliers, social service agencies, or by contacting the EAP office. Completed applications should be sent to this address.

Energy Assistance Program
P.O. Box H-07
Juneau, AK 99811-0641
Phone: 465-3058

Incomplete applications and those lacking adequate verification of income will be returned for the necessary information. Applicants receive notice of their eligibility decision within 30 days of receipt of the application in the Juneau office. Applications are accepted until June 30, 1987.

EMERGENCY SERVICES: EAP provides expedited service to eligible households facing termination of energy services required for heating the home. Emergency service is also extended to those eligible households who cannot obtain home heating service due to supply shortages or natural disasters. Households whose service has been terminated after depletion of their EAP grant may be eligible for additional

benefits. Households facing these situations should contact the EAP office in Juneau.

STATUS REPORT: As of May 12, 1987 the EAP had processed over 9,500 grants, providing an average grant of $490 per household. Over 10,700 applications have been received to date. The EAP expects to receive up to 12,000 applications this year. The 9 tribal organizations will serve an additional 8,000 households in Alaska. The average household size served by EAP is 3.5 people. One fifth of these households contain an elderly member, 1/3 have a member on food stamps, and 1/4 have an AFDC recipient in them.

ISSUES: The program, begun in 1979, has been reauthorized by Congress for another 4 years. President Reagan has recommended a 35% budget reduction. The latest U.S. House of Representive's budget actually gives LIHEAP a small increase. At this time the Senate has not passed a budget and the proposals for LIHEAP funding vary. Last year we received an 8% reduction. The reductions are justified in part on the availability of Exxon overcharge dollars, however, it does not appear that the EAP will receive any of these funds in Alaska based on the proposed budget developed by Community and Regional Affairs.

Power Cost Equalization, while reducing electric bills in rural areas does not always generate a double subsidy for our clients. The grants are based on actual fuel costs to the clients by region. In addition, most of our rural grantees heat with wood or stove oil, rather than electricity, and EAP grants go to vendors providing those services.

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

THE HOUSE COMMITTEE ON
HEALTH, EDUCATION AND SOCIAL SERVICES

will conduct a

* * * STATEWIDE TELECONFERENCE * * *

Date: Friday, May 15, 1987

Time: 7:30 - 9:00 A.M. (AST)

Subject: FEDERAL BLOCK GRANTS FOR THE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

The Federal government requires, as a condition of receiving block grant funding, a statewide public hearing concerning the usage of federal funds received and expended by the State of Alaska.

The Department receives block grant funds in the following areas:

Preventive Health and Social Services
Maternal and Child Health
Alcohol, Drug Abuse and Mental Health
Low Income Energy Assistance

More detailed information on the amounts of money for each category received and specific program expenditures will be available at local Legislative Information Offices prior to the hearing.

Members of the committee are: Niilo Koponen, co-chair, (D) Fairbanks; Johnny Ellis, co-chair, (D) Anchorage; Dave Donley, (D) Anchorage; Max F. Gruenberg, Jr., (D) Anchorage; Alyce Hanley, (R) Anchorage; Bill Hudson (R) Juneau; Randy Phillips (R) Eagle River.

<u>THIS IS A PUBLIC HEARING. ALL TESTIMONY IS WELCOME.</u>

For more information, contact your local Legislative Information Office or call Lisa McClaren in Juneau at 465-3759

HEALTH:

Maternal & Infant Health Care

10-22-87

HOUSE HESS COMMITTEE MEETING MATERIALS

October 22, 1987

A. GENERAL HEALTH CARE MATERIALS

Separate

Alaska Comprehensive Health Care Financing Study: Description of Policy Options, Final Report, Volumes I and II (also known as the Batelle Study), March 1982

In the Packet

1. "Dukakis Plan puts Spotlight on the Uninsured", State Health Notes, October 1987, pages 1-4.

2. Washington Newsletter, "The Nation's Health", page 4, Sept. 1987, (articles: "Panels Vote Medicare/Medicaid Changes", "House Approves Catastrophic Insurance Plan", "House Backs $85 Billion HHS Budget")

3. "The Right Start: A Proposal to Provide Preventative Health Care for All Minnesota Children", Children's Defense Fund, 1986

4. 9/29/87 House Research Report (Sandi Depue), "Components of Health Care Costs in Alaska"

5. DRAFT: "A Comparison of State Indigent Care," Division of Planning, DHSS, April 1986

6. "The Analyst's Corner: Primary Care Case Management for Medicaid Clients: Michigan's Response", New England Journal of Human Services, Volume VII, Issue 2, page 33

7. Presentation Before the Council of State Governments, Western Legislative Conference Annual Meeting re: Mandated Benefits, Blue Cross and Blue Sheild, Sept. 22, 1987

8. State Mandated Health Care Coverage Laws (enacted through June 1987, Office of Government Relations, State Services Dept., Blue Cross and Blue Sheild Association, August 1987

B. MATERNAL AND INFANT HEALTH CARE STATISTICS

Separate

The Health of America's Children: Maternal and Child Health Data Book - selected portions, Children's Defense Fund, 1987

"Intergovernmental Options for Reducing Infant Mortality" - selected portions, proceedings from a conference, Sept. 13-15

In File Folder

Selected data runs from birth/death certificates - draft analysis/comments by Marty Dilly, AK Dept. of Health and Social Services, October 1987

In the Packet

1. 9/18/87 Memo from Rita Schmidt re: "Prenatal Care and Statistics"
2. 10/12/87 House Research Memo (Mary Jennings) re: Location of Prenatal Care Providers in Alaska
3. 9/28/87 House Research Memo (Jay Livey) re: Maternal and Child Health Statistics for Alaska

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C. MATERNAL AND INFANT HEALTH CARE MATERIALS

1. "Medicaid Eligibility for Pregnant Women: Reforms Contained in the Sixth Omnibus Budget Reconciliation Act", prepared by Sara Rosenbaum, April 1987
2. 10/7/87 House Research Memo (Brad Pierce) re: Omnibus Budget Reconciliation Act Option for Pregnant Women with attachment
3. Alaska's Improved Pregnancy Outcome Project
4. Florida's Handicap Prevention Act of 1986
5. Washington state legislation for prenatal care
6. Letter from and to Governor Cowper re: establishment of National Commission to Prevent Infant Mortality, Sept. 1987
7. "Postneonatal Mortality", Barbara Starfield, Annual Review of Public Health, 1985

8. "The Need for Prenatal Care in the United States: Evidence from the 1980 National Natality Survey", Family Planning Perspectives, May/June 1985

10. "Background Paper on Universal Maternity Care," Journal of Public Health Policy, Spring 1986

11. "Cuts can mean high-risk babes," news article

HOUSE HESS - HEALTH MATERIALS ON FILE

1. Files containing information from each Canadian Province, and Territory, and from the Canadian federal government, regarding their health insurance programs

2. Report of the Task Force on Medical Liability and Malpractice, U.S. DHSS, Otis Bowen, August 1987

3. New Hampshire HB 393 - "An Act relative to health insurance for part-time employees" and back-up material

4. Connecticut - Comprehensive Health Care Plan (statutes)

5. Health Care Legislative Package (as adopted by the 1987 Washington State Legislature)

6. Washington Health Care Project Commission - Final Report, and List of Appendices, Dec. 1986

7. Wisconsin State - Health Care for the Uninsured information

8. Rhode Island - Catastrophic Health Insurance (statutes)

9. Comprehensive Health Insurance for High-Risk Individuals - A State-by-State Analysis, Aaron K. Trippler, August 1986

10. AETNA XTRA - A comprehensive Major Medical Insurance Plan

11. Blue Cross - Three health plans

12. A Manual on Providing Effective Prenatal Care Program for Teens, Children's Defense Fund, 1985

13. Opting: A Study of Medicaid Client Need, AK Legislative Affairs Agency, February 1977

14. A Decade of Progress, Office of Disease Prevention and Health Promotion, Dec. 1986

15. Major Changes in State Medicaid and Indigent Care Programs, IHPP, Dec. 1986

16. "A Corporate Rx for America: Managing Runaway Health Costs", Joseph A. Califanco, Issues in Science and Technology, Spring 1986

17. What Legislators Need to Know About Long-Term Care Insurance, NCSL, May 1987

18. State Efforts at Health Care Cost Containment: 1986 Update, NCSL, Dec. 1986

19. Medicaid Eligibility: New State Options, NCSL, Feb. 1987

20. What Legislators Need to Know About Health Data/Cost Information Program, NCSL, June 1986

Dukakis Plan Puts Spotlight on the Uninsured

The announcement by Governor Michael Dukakis in late August of a bold plan to provide health insurance for an estimated 600,000 uninsured MASSACHUSETTS residents has propelled the issue of providing health insurance for all Americans into the headlines. Is this development "just presidential politics," or does it signal renewed interest in closing some of the gaps in the nation's system of health coverage?

Under the Governor's plan, all MASSACHUSETTS employers would be required to provide all of their employees who work a minimum number of hours a week with health insurance benefits. It parallels a measure (S 1265) introduced in Congress by Senator Edward M. Kennedy (D-MA) that would impose minimum health coverage requirements on employers throughout the country.

To implement the plan, the state will need an exemption from federal Employee Retirement Income Security Act (ERISA) rules, which prohibit states from mandating employer insurance coverage. If a waiver is not granted by January, 1989, the state will add a surcharge to the unemployment insurance tax (technically considered a "contribution"), to cover the cost of insuring workers without employer-provided coverage. Companies that voluntarily provide benefits will receive tax credits.

The plan is part of a comprehensive bill (H 6000) that addresses health care cost containment, excess hospital capacity, creation of a new agency -- the MASSACHUSETTS Health Partnership -- to manage and arrange for health coverage for the unemployed who are uninsured, and quality control.

While this approach to covering uninsured workers -- who make up at least two thirds of those without health insurance in the country -- is not new, it is a sufficiently difficult political objective that few other states have attempted it. Nonetheless, many states have created or are designing programs to achieve broader insurance coverage, through different avenues. And as the bills enacted this year demonstrate, there is widespread agreement on the part of state legislatures on the need to work towards the goal, even if all of the money needed is unavailable.

Forces Behind the MASSACHUSETTS Plan

That MASSACHUSETTS decided it could afford to take on the business groups and allocate state funds to cover other segments of the uninsured population arises from the convergence of a unique set of political developments. Last November, for example, MASSACHUSETTS voters weighed in by a 2-1 margin in favor of a referendum -- the first in the nation on this issue -- urging Congress to enact a national health program covering all citizens and providing a comprehensive set of services. The state is also fortunate to have a budget surplus and an unemployment rate that is about half the national average.

In addition, large businesses in MASSACHUSETTS currently contribute to care for the uninsured through increased premiums paid to health insurers, who must pay the surcharge on hospital bills. These funds support the state's uncompensated care/free care pool. The legislation authorizing the pool is due to expire October 1, 1987, however, creating pressure to devise a new system to deal with

the problems of inequitable financing (as perceived by business interests) and access (as perceived by consumer advocates).

Finally, the fact that Dukakis is running for President has helped marshall support within the state for his plan. All of these factors have fueled the current drive in the legislature to act quickly on the Governor's proposal. Some controversial hospital cost containment provisions of the proposal (capping increases in hospital charges, and certain changes in the certificate of need (CON) program are encountering opposition from hospitals. But according to legislative aides, that is not likely to threaten the part of the plan assuring universal health insurance.

Precedent: HAWAII's Plan

If MASSACHUSETTS succeeds in passing and implementing the Governor's proposal, it will not be the first to mandate universal employer coverage. In 1974, the HAWAII legislature enacted the Prepaid Health Care Act, which included a similar requirement that all employers provide health insurance, with some exceptions for those working part-time. The law was ruled invalid by the U.S. Supreme Court in 1981 as a violation of ERISA, but Congress quickly granted a waiver in 1982, allowing the law to stand.

Even with the law, however, HAWAII's medical indigency problem has not disappeared. In a preliminary report issued earlier this year (The Medically Indigent in HAWAII, January, 1987) the state's Health Department estimated that 5 percent of the population under age 65 remain uninsured. Those who are still without coverage include: 1) low-income self-employed workers and their dependents, 2) wage earners working less than 20 hours a week for more than one employer, seasonal workers, and others who fall into the excluded categories of the Prepaid Health Care Act or the Medicaid program; 3) non-working spouses or children of low-wage earners; 4) full-time students over age 21; and 5) immigrants who do not qualify for public assistance.

The MASSACHUSETTS proposal addresses the needs of these groups as well as the unemployed by subsidizing their insurance premiums or purchasing a plan for them. Funds for this would come from the state's free care/bad debt pool, which derives about $315 million annually from surcharges on hospital bills, and from general revenues.

Financing Dilemmas

While a few other states have expressed interest in obtaining an ERISA exemption, most have been reluctant to impose additional business costs upon employers within their borders.

Nonetheless, both WASHINGTON and WISCONSIN have developed state health insurance plans, providing the working uninsured and their families with income-based subsidies to enable them to purchase an affordable health plan. These strategies differ from that in MASSACHUSETTS by choosing to first experiment with demonstration programs that are more limited in scope and have smaller budgetary requirements.

Sources of financing for new health insurance programs vary widely among the states. WASHINGTON's Basic Health Plan, for example, will subsidize the premiums for up to 30,000 low-income enrollees out of approximately $19 million in general revenue funds over the next two years. (For details, see Notes. June 1987). In WISCONSIN, a $10 million appropriation for five pilot programs was vetoed by the Governor, who indicated that further study is needed in light of the considerable costs of implementing the programs on a statewide basis. Efforts are underway to restore at least some of the funds for the pilot projects, perhaps scaled down somewhat, before the legislature adjourns at the end of the year.

A Children's Health Plan recently enacted in MINNESOTA (HB 243, Section 63, Chapter 403 of 1987 Laws) uses an increase in the cigarette tax to pay for an expanded program of pregnancy-related and child health services for those making less than 185 percent of the poverty level. The state has estimated that when the program is fully implemented in FY 1991, the expected annual cost of the program will be $5.7 million. MINNESOTA has also developed a plan to provide state-subsidized health insurance for the uninsured called "HealthSpan." The plan is described in a report, The Challenge of Providing Financial Access to Health Care in MINNESOTA, Department of Health, February 1987.

In MAINE, lawmakers decided to repeal a catastrophic medical expense program and transfer any remaining funds (after providing financial assistance to eligible residents who applied before June 30, 1987) along with new state appropriations to a Managed Care Insur-

ance Plan Demonstration for uninsured individuals. The program will target low-income, non-Medicaid eligible individuals, both employed and unemployed, who cannot afford to purchase insurance. While the law does not specify the number of participants, it calls for development of further eligibility criteria to keep subsidies within the amount budgeted by the legislature -- approximately $550,000. Administrative expenses of program development are supported by a grant from the Robert Wood Johnson Foundation.

In other states where proposals to cover at least some portion of the uninsured through a subsidized premium are waiting in the wings, the financing issue looms as a tough hurdle. Many of these states are among the largest (e.g., **CALIFORNIA, NEW YORK** and **NEW JERSEY**), which means that the potential cost of covering care for all the uninsured is extremely high. In others (e.g., **FLORIDA**), the budget cannot meet existing obligations, much less any new ones.

Common Themes

Despite the differences in financing, the similarities between the **MASSACHUSETTS** proposal and those under development in other states are important because they indicate the beginning of a consensus by state governments on the basic elements and principles of a federal health plan guaranteeing coverage for all. Common themes include:

1) Concern for "mainstreaming" individuals into existing private insurance arrangements, rather than incorporating them into Medicaid. This departs from the proposal advanced in recent years to allow the working uninsured to "buy-into" Medicaid.

2) Creation of a fund to provide subsidies for low-income individuals to help cover the full premium costs of insurance coverage. Low-income is most often defined as those families earning below 150 percent to 200 percent of the federal poverty line. In all of the plans, enrollees are expected to contribute to the cost of premiums on an ability-to-pay, sliding scale basis and in many cases, cost-sharing is required for certain services.

3) Preference for steering people into managed prepaid health care systems, such as HMOs, PPOs or other health arrangements that provide more efficient delivery of health services and emphasize ambulatory care over inpatient hospital care. The concept of risk assumption is also of importance to states concerned with constraining their own budgets. The choice to favor prepaid plans is not surprising in states like **WASHINGTON, WISCONSIN,** and **MINNESOTA**, which already have significant HMO market penetration.

4) Incorporation of health promotion and preventive services into plan operations. This is especially evident in programs that include a full range of prenatal care services for pregnant women, including psychosocial and nutritional counseling, health education, and related support services.

5) Recognition of the need to prevent employers from dropping existing coverage for their workers. This could be achieved by imposing taxes on employers who cancel their health plans -- an approach that states so far have failed to adopt. Instead, the new plans generally require that new enrollees provide evidence that they have not been covered by any plan in the previous six months. These requirements do not address the need to encourage employers to provide coverage, however.

Voluntary Employer Health Plans

While efforts to mandate employer coverage of workers' health insurance premiums have been stymied by ERISA, several states are supporting private-sector efforts to encourage businesses to provide health insurance on a voluntary basis. One such plan was authorized by the **OREGON** legislature this year. The new law (HB 2594, Chapter 691) establishes an Insurance Pool Governing Board to oversee a voluntary program for employers who 1) have 25 or fewer employees; 2) have not contributed to the cost of health insurance premiums in the previous two years for workers to be enrolled in the new program; and 3) are willing to make a minimum contribution to the premium cost.

The state will contract with a health benefit plan to cover the costs of previously uninsured workers and their families, limited to 10,000 individuals. The program was kept small because of uncertainty about the cost to the state of tax credits to employers for premiums paid during the first five years of their participation in the program. It remains to be seen if the tax credit will provide enough incentive for small employers to participate in the program. A non-profit organization, HealthChoice, in Portland had been operating a similar program (without the benefit of a

tax credit) that was not successful -- largely because small businesses find it difficult to add new fixed costs when they have cash flow uncertainties.

Meanwhile, the **FLORIDA** legislature provided statutory authority this year for the Small Business Health Access Corporation, which will pool groups of individuals employed by small businesses into larger groups to facilitate a program of affordable group insurance. To participate, employers cannot have provided or offered health insurance in the 6 months prior to July 1, 1987. Initially the program will operate in one urban county and in a multi-county rural site. The state is supporting the effort by allowing the corporation to reinsure using funds from the Public Medical Assistance Trust Fund. The program was developed by the state Health and Rehabilitative Services Department with a grant from the Robert Wood Johnson Foundation.

Momentum or "Wait and See"?

Other states will continue to experiment with health insurance plans on a demonstration basis but for now, the spotlight will remain on the Dukakis plan.

It remains to be seen, however, whether the plan is a "forerunner to a national health insurance plan" as Dukakis has asserted. There is a chance that the MASSACHUSETTS plan will remain just that -- another option among the plurality of state approaches to a complex problem.

At the least, it has focused attention on the critical role that states play in financing care for the uninsured. And as the debate over a national health insurance plan proceeds, the states' collective experiences in providing coverage for the uninsured will no doubt be carefully examined. -- Debra J. Lipson

Washington Newsletter

Published since 1959

by Richard Sorian

Panels Vote Medicare/Medicaid Changes

Medicare payments to primary care and rural physicians would rise sharply while those to all other doctors would be curtailed under legislation approved by a pair of Congressional committees. The legislation, which is part of Congress's annual budget reconciliation process, also would limit Medicare hospital payments and broaden Medicaid coverage of children and pregnant women.

The House Commerce Committee has proposed a 6 percent increase in fees for primary care services. That is nearly double the 3.2 percent increase in fees scheduled for January 1. Doctors serving in rural areas with a shortage of physicians would get another 5 percent bonus. All other doctors would get only a 2 percent fee increase in 1988. In 1989, Commerce would limit the increase in physician fees to the rise in the Medicare Economic Index minus 2 percentage points. The savings from that move would be used to allow rural doctors to bring their prevailing fees up to 55 percent of the national average over a three-year period.

The Commerce Committee plan is in conflict with another measure approved earlier by the House Ways and Means Committee. Rather than providing incentives for primary care doctors, Ways and Means is trying to attract more doctors to Medicare's participating physician program. Participating physicians agree to accept Medicare assignment for all cases in the coming year. Ways and Means proposes a 2 percent fee increase for those doctors and a 1 percent hike for all others.

The two panels also are in conflict over reductions in payments for overpriced surgical procedures. Ways and Means voted a 15 percent chop in payments for nine common surgical procedures including cataracts, heart bypass, and prostate surgery. Commerce voted a 5 percent cut for cataract surgeons and a 10 percent reduction for others.

Other provisions in the reconciliation package would:

- Provide Medicare coverage of flu shots, special shoes for diabetics, and drugs taken by organ transplant patients.
- Allow states to cover pregnant women and young children in families with incomes up to 185 percent of the national poverty line. States would have to cover children in families below a state poverty line.
- Require nursing homes to have 24-hour nursing beginning October 1, 1990. A registered nurse would be on duty eight hours a day in small homes and 16 hours in large homes; and licensed practical nurses would be on duty for longer time periods.
- Set up federal rules for home health agencies to follow and require state inspections of agencies and random homes to check for quality of care. Errant agencies would be fined and could be suspended or expelled from Medicare and Medicaid.
- Increase the penalty on hospitals that dump patients without insurance on the nearest public hospital. Dumpers would be liable for a 30-day suspension from Medicare and fines of as much as $50,000 per patient.
- Require states to establish insurance risk pools for the medically uninsurable. Employers in states with such plans would cover the costs or would be taxed 5 percent of their employee benefits.

House Approves Catastrophic Insurance Plan

Medicare beneficiaries would be protected from certain catastrophic medical costs under legislation approved in late July by the House of Representatives. The legislation, which passed with strong bipartisan support, has been labeled veto material by the White House. It includes new coverage of prescription drugs and expanded coverage of nursing home, home health, and mental health services.

Under the terms of the House bill, no beneficiary would pay more than $1,800 in 1989 for covered Medicare services. In 1988, the elderly would pay only one hospital deductible, now estimated at $544. In 1989, spending for physician and other Part B services would be held to about $1,100. Also in 1989, retirees with drug bills about $500 would get federal help to pay 80 percent of the cost of all other prescriptions. The elderly would be entitled to 150 days of skilled nursing care (up from 100), 35 consecutive days of home health care (up from 21), and $1,000 worth of outpatient mental health care (up from $250).

To pay for the new and expanded coverage, the elderly would be charged a monthly premium of $2.65 in 1989. The rest of the cost would be borne by taxpaying retirees — an estimated 40 percent of the Medicare population. They would pay an annual "supplemental premium" ranging from $10 per person to $560 in 1988.

While the House legislation is loosely based on a proposal sent to Capitol Hill by President Reagan in February, the changes made to the bill have prompted criticism from the President. In a July 25 radio speech to the nation, Reagan accused the House of turning his "responsible" plan into a "massive program that will impose a new tax on the elderly and soon threaten to bankrupt the Medicare trust fund." Reagan labeled the House's supplemental premium idea a "surtax on beneficiaries' income" that would raise the tax rate on most elderly from 15 percent to 22 percent. The House, Reagan noted, would begin collecting that tax a year before the benefits are completely available.

The Senate is scheduled to take up its own version of the catastrophic insurance bill after recess in September.

The Senate bill is similar in many ways to the House plan but does not yet contain a drug benefit. Five Senators, led by George Mitchell of Maine, will propose a limited drug benefit when the Senate takes up its bill. The plan would only cover chemotherapy drugs, intravenous drugs, and immunosuppressive drugs for organ transplant patients in 1989. Coverage of other drugs would begin in 1990 but would be limited to costs of about $600 a year with a 20 percent coinsurance charge.

House Backs $85 Billion HHS Budget

Federal funding for AIDS research and education and general biomedical research would rise sharply under a budget approved August 4 by the House of Representatives. AIDS spending would rise to $945 million in fiscal 1988, nearly double the fiscal 1987 total. More than half the total would go to research but money for public education and risk reduction would rise substantially.

The appropriations measure includes $85.4 billion for the Department of Health and Human Services, nearly $6 billion more than was requested earlier this year by President Reagan. The House has ignored Reagan's request for a cut in medical research and health professions training money. Instead, it voted a $7 billion budget for the National Institutes of Health and $209 million for manpower training and assistance. Many public health programs were left unattended in the bill because Congress has not yet approved legislation extending their authority. Funding is expected to be approved at a later date for such programs as family planning, health block grants, and prevention of sexually transmitted diseases.

The House bill would provide $30 million for health care for the homeless, $1.2 billion for Medicare contractors to process claims, $60.5 million for state nursing home inspections, and $30 million to pay for start-up costs for Medicare catastrophic insurance protection.

Richard Sorian is editor of McGraw-Hill's "Medicine and Health" newsletter, a part of the McGraw-Hill Health newsletter group in Washington, DC.

Register for the APHA Annual Meeting in New Orleans, October 18 - 22. Forms in this issue.

The Right Start

A Proposal to Provide Preventive Health Care for All Minnesota Children

by Luanne Nyberg, Monica Herrera, and Dana Hughes

Children's Defense Fund — Minnesota Project

The Children's Defense Fund

The Children's Defense Fund was founded in 1969 to provide an effective voice for the children of America who cannot vote, lobby, or speak for themselves. CDF pays special attention to the needs of poor, minority, and handicapped children. Our goal is the healthy growth and development of all children, recognizing that early investment in health and education prevents serious costly illnesses, learning-related problems, and delinquency.

CDF is a unique organization. CDF focuses on programs and policies that affect large numbers of children, rather than helping families on a case-by-case basis. Our staff includes specialists in health, education, child welfare, mental health, and child development. We monitor the development and implementation of federal policies. We provide information, technical assistance, and support to a network of state and local child advocates. We pursue an annual legislative agenda in the United States Congress and litigate selected cases of major importance. CDF also educates thousands of citizens annually about children's needs and responsible policy options for meeting those needs.

CDF is a national organization with roots in communities across America. Although our main office is in Washington, D.C., we reach out to towns and cities across the country to monitor the effects of changes in national and state policies and to help people and organizations who are concerned with what happens to children. CDF maintains state offices in Mississippi and Ohio and state projects in Minnesota, Texas, and Virginia. CDF has developed cooperative projects with groups in many states. Child Watch, a national effort of the Association of Junior Leagues, CDF, and other national organizations to assess the impact of federal and state budget decisions on children, is an example of this collaborative effort.

CDF is a private organization supported by foundations, corporate grants, and individual donations.

The Minnesota Project of the Children's Defense Fund began in January, 1985. Support for CDF's work in Minnesota has come from the Blandin Foundation, Dayton Hudson Foundation, General Mills Foundation, The Minneapolis Foundation, The St. Paul Foundation, Northwest Area Foundation, and generous individuals. General support for CDF publications is provided by the Charles Revson Foundation.

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Luanne Nyberg
Director
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St. Paul, Minnesota

The Right Start

A Proposal to Provide Preventive Health Care for All Minnesota Children

by Luanne Nyberg, Monica Herrera, and Dana Hughes

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Contents

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Luanne Nyberg
May 1, 1986

Executive Summary

Minnesota's traditions — a commitment to the best quality of life for all citizens, and a standard of health care which is heralded nationwide — are being seriously undermined. While we still enjoy the reputation our previous good planning and policy-making have afforded us, we have neglected to meet the needs of all of Minnesota's people. The problems are serious:

- Not all Minnesotans have access to our health care system — many babies are being born to women who have had no prenatal care early in pregnancy.
- Not all of us are in good health — infant mortality rates in 34 Minnesota counties exceed the national average.
- Insurance programs don't cover people who are too poor to afford them — about 340,000 Minnesotans have no health coverage.
- Public health programs are being cut back and those that exist are already falling far short of the need.
- The cost to Minnesotans of caring for those who have not received adequate preventive care is far beyond what it would cost to provide that care.

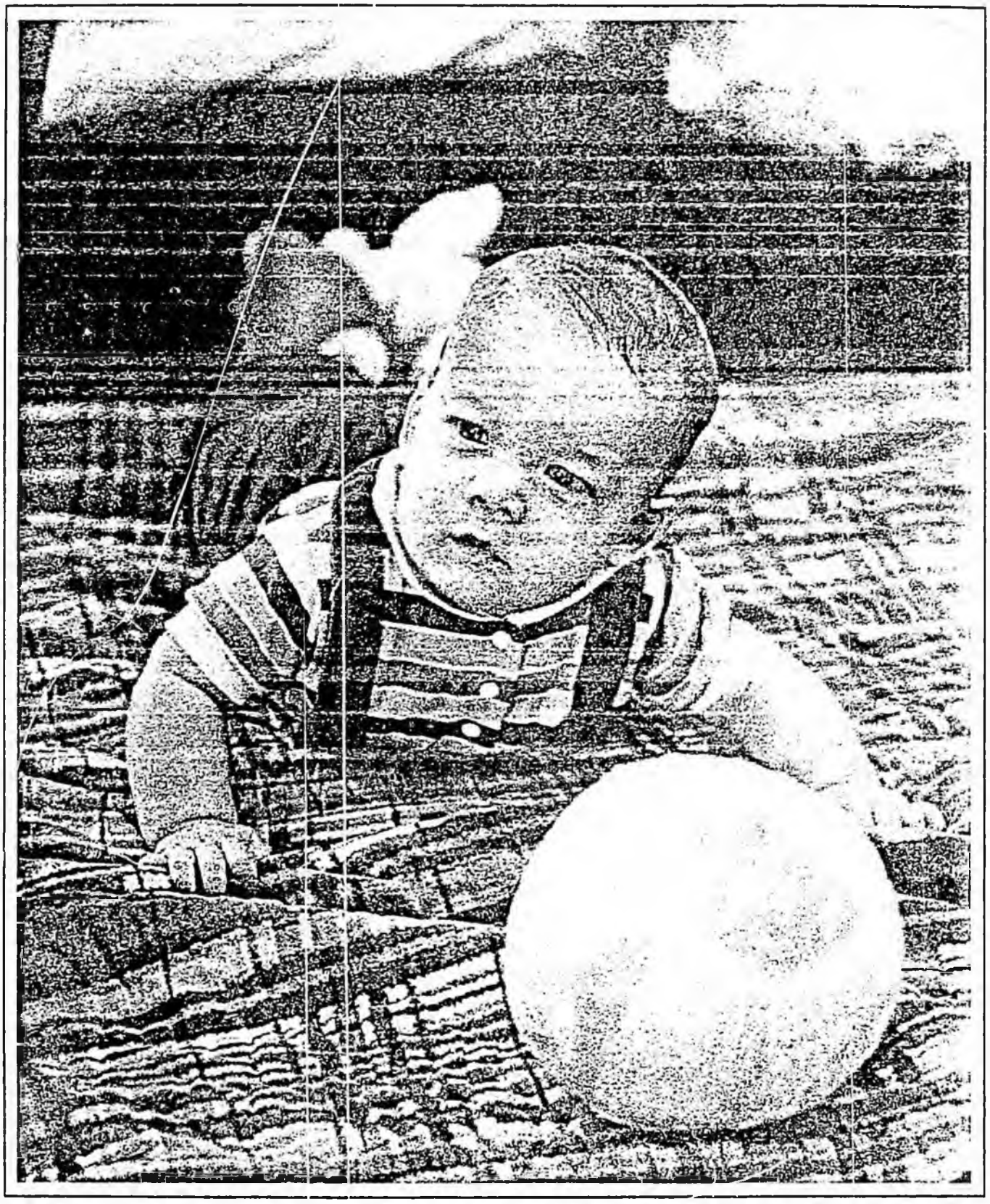
This report addresses the dilemma we find ourselves in today and proposes low-cost, efficient responses. We can no longer ignore the evidence that our health care system is excluding people who are unable to pay for it. Therefore, we all pay:

- by living in a community which can no longer boast that it takes care of those most in need, particularly the children;
- and by paying the costs of emergency care for problems that could have been avoided.

We must face this challenge, welcome public debate, offer appropriate responses and provide the leadership to put Minnesota once again at the forefront, providing the right start for all of our children.

The Right Start Program will provide coverage for prenatal, delivery and postpartum care for pregnant women and health care for children under the age of six who are not eligible for Medicaid and are not otherwise insured.

Minnesota must develop a Right Start Fund, financed through sliding fee premiums paid by Right Start users, expanded and improved use of Medicaid funds, and special dedicated taxes generated from the health care system or general revenue funds.



Introduction

Minnesotans are healthy people. On average, we live longer than people in every state but one. Our infant mortality rate is among the best in the nation. Our use of disability programs is among the lowest in the U.S. One reason for this enviable record is the state's high quality medical care.

But not all Minnesotans have access to our excellent health care system, and not all of our citizens enjoy good health. In 1983 two in five nonwhite babies were born to a woman who did not receive any prenatal care early in pregnancy. In 1983, infant mortality rates in 34 Minnesota counties exceeded the national average. And our rate of progress in improving key health measures for mothers and infants is slow.

Too many Minnesotans are left out of our health system because they have either no or inadequate health insurance and are too poor to pay out-of-pocket for the health care they need. In Minnesota, which has been a leader in developing prepaid health programs such as health maintenance organizations, quality is high, but so is competition. Health plans don't enroll families who are not insured and cannot afford the monthly fees. About 340,000 Minnesotans, 8 percent of the state's people, do not have health insurance. Nearly one-third of our uninsured residents are children even though children comprise only 25 percent of the state's population.[1] Most of these children live in families whose incomes do not allow them to buy health coverage; most of the uninsured adults work in jobs that provide no insurance.[2]

Moreover, these families have few public health programs to fall back on. Public programs such as Medicaid and the Title V Maternal and Child Health Block grant are inadequate. Thirteen other states have higher Medicaid eligibility standards.[3] And very few of our counties furnish comprehensive prenatal and pediatric services for poor and uninsured families.[4]

Finally, even those poor families who do qualify for Medicaid may face serious barriers to obtaining needed care. Some may live too far from a health provider to have access to services. Others live in areas where high quality providers do not participate in the program. Many face racial and cultural barriers that deter them from securing needed services.

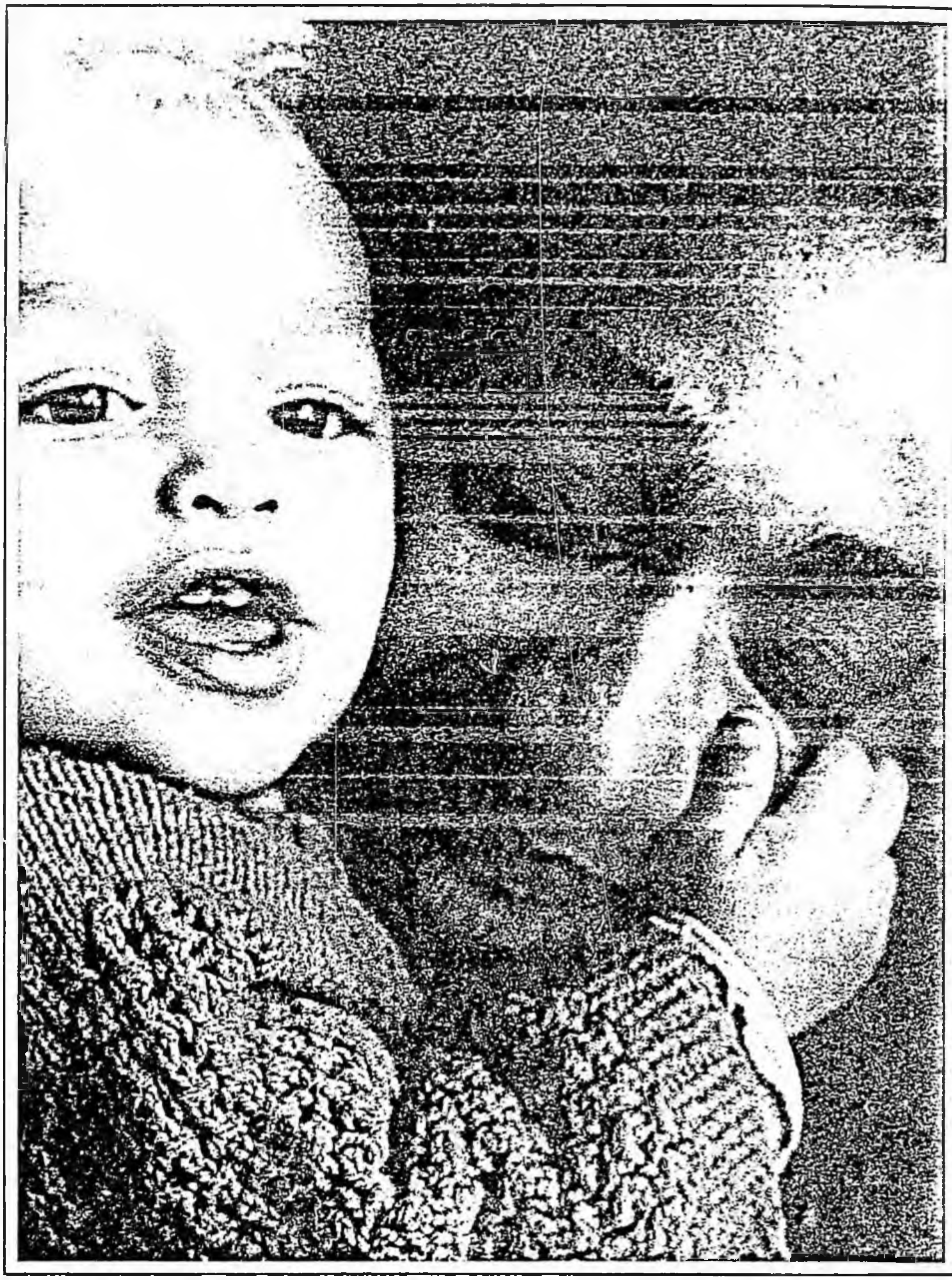
The challenge facing Minnesota is to find a way to provide high quality health care to all our children. We need to develop programs so that young families just starting out in the labor market, people ravaged by economic changes in rural Minnesota and on the Iron Range, and those who work in low wage, part time or seasonal jobs can benefit from our system of health maintenance. We also need to ensure that all Minnesotans, whether their care is publicly or privately financed, have access to the same high quality services.

This report intends to be a step toward ensuring the right start, a healthy start, for all Minnesota's children. The report covers three broad questions:

- Why do so many Minnesota families lack access to necessary health care?
- What are the health and financial consequences for these families and for the state?
- What do we need to do to give all our children the right start?

The Children's Defense Fund is committed to making these facts and needs known to policy makers and the public. We have written this report because of the important role Minnesota plays in shaping the health care financing and delivery system of the future. We have written it now because the progress we have made in infant health has virtually come to a halt both in Minnesota and in the U.S. as a whole. Infant mortality actually rose in Minnesota in 1983.

In the final chapter of the report we will propose several key reforms including a new program called The Right Start. The Right Start program is designed to foster investment in preventive, cost-effective health care for children. Included in the program are prenatal care and delivery services and preventive and primary medical care for infants and preschoolers across the state. We believe that the state cannot afford *not* to make this investment.



CHAPTER 1

Minnesota Mothers and Children Without Health Insurance

Health care in Minnesota is among the most sophisticated in the country. On average, we have more physicians and hospitals per person than in other regions in the country. The quality of our health care is renowned.

Minnesota is also a national leader in the development and refinement of health maintenance organizations (HMOs). In the Twin Cities, where half of the state's population lives, over 40 percent of the residents are enrolled in HMOs, compared to 10 percent of all Americans.[1]

These advances have paid off for Minnesota. We are extraordinarily healthy people. On average, Minnesotans live longer than people in every other state but one.[2] In 1983, our overall infant mortality rate was among the lowest in the nation, and in only six states were a smaller percentage of low birthweight infants born that year.[3]

However, not all Minnesotans are able to benefit from this excellent health care system. These advances and high quality medical plans are not within the reach of hundreds of thousands of Minnesotans because they do not have health insurance or health plan enrollment, nor can they afford to buy medical care out-of-pocket.

Health care is a very expensive commodity. Very few Minnesota families would be able to afford this care if it had to pay for it on an out-of-pocket basis. This is especially true of families earning at or near the minimum wage. For example, health care for even a healthy baby can easily cost $400 per year and complete maternity care (prenatal plus hospital care) can amount to $4,000. Poor families without health coverage are unable to afford care. Yet, in 1985, more than 342,000 Minnesotans were not covered by health insurance. Of these, over 70 percent — approximately 246,000 — were uninsured for the entire year.[4]

Minnesota's most vulnerable citizens — children and mothers — are among the least likely to be insured.

- Over 100,000 children are uninsured.[5] Children represent about a fourth of the state's population but close to a third of the uninsured.[6]
- One fourth of Minnesota's uninsured children are under six years of age.[7]
- Nearly one in five women between the ages of 18 and 24 — those of prime childbearing age — have no medical or hospital insurance.[8]
- According to the Minnesota Maternal and Child Health Task Force, "Poor women and women without adequate insurance are likely to postpone (prenatal) care."
- The extent of uninsuredness among Minnesota's children and women of childbearing age can be seen in the amount of uncompensated inpatient hospital care that is attributable to obstetric and pediatric care alone. In 1983, 43 percent of charity patients and 33 percent of "self-pay" patients (those with no health insurance) at Twin Cities' hospitals were admitted for services related to pregnancy, childbirth or newborn care.[9]

Why Are So Many Minnesotans Without Health Coverage?

Many Minnesotans are without jobs and therefore without health insurance. In Minnesota, like other states, health insurance is available primarily through the workplace. Nationally, 88 percent of all private health insurance is provided through employers' group plans.[10] It is no

SCHOOL CHILDREN IN LOW-INCOME FAMILIES: 1984 COUNTY RANKINGS

RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT
1	Carver	5.9	31	Murray	16.4	59	Pope	23.7
2	Dakota	6.2	32	Stevens	16.6	60	Koochiching	23.9
3	Washington	6.4	32	Mower	16.6	61	Roseau	24.5
4	Scott	7.3		STATE AVERAGE	**16.7**	61	Swift	24.5
5	Rice	8.1	34	Chippewa	16.8	63	Polk	25.2
6	Anoka	8.2	34	Isanti	16.8	64	Mille Lacs	25.3
7	Sherburne	8.6	36	Cottonwood	17.4	65	Otter tail	25.4
8	Olmsted	9.9	37	Stearns	17.6	66	Itasca	26.1
9	Steele	10.8	38	Clay	18.1	67	St. Louis	26.9
			39	Benton	18.2	68	Crow Wing	27.1
10	McLeod	11.3				69	Traverse	28.0
10	Wright	11.3	40	Kandiyohi	18.5			
12	Faribault	11.5	40	Wilkin	18.5	70	Norman	28.8
13	Brown	12.3	42	Watonwan	18.6	71	Big Stone	29.2
14	Martin	12.8	43	Rock	18.8	72	Pine	30.0
15	Freeborn	12.9	44	Douglas	19.1	73	Beltrami	30.2
16	Goodhue	13.1	45	Nobles	19.2	74	Becker	30.7
17	LeSueur	13.2	46	Lyon	19.7	74	Pennington	30.7
17	Waseca	13.2	47	Ramsey	19.9	76	Marshall	31.1
19	Blue Earth	13.7	48	Meeker	20.0	77	Aitkin	32.0
19	Nicollet	13.7	49	Lake	20.1	78	Lake O'Woods	32.6
						79	Wadena	33.9
21	Jackson	14.4	50	Kanabec	20.8			
21	Chisago	14.4	51	Cook	20.9	80	Lincoln	34.2
23	Winona	14.5	51	Grant	20.9	81	Todd	36.0
24	Houston	14.9	53	Lac Qui Parle	21.3	82	Morrison	37.5
24	Wabasha	14.9	54	Fillmore	21.8	83	Cass	37.6
26	Dodge	15.3	55	Pipestone	22.1	83	Hubbard	37.6
27	Sibley	15.4	56	Carlton	22.9	85	Clearwater	39.0
28	Hennepin	15.5	57	Kittson	23.5	86	Red Lake	42.5
29	Redwood	15.6	58	Yellow Medicine	23.6	87	Mahnomen	47.7
29	Renville	15.6						

Rank of 1 is smallest, 87 largest. The same rank for two counties indicates a tie.

Source: Unpublished data, Child Nutrition Division, Minnesota Department of Education. Calculations by Children's Defense Fund using the following formula: K-12 students who applied and were found eligible for free school meals (family income at or below 130 percent of poverty, for example, gross income below $10,686 for a family of three), divided by all students.

surprise, therefore, that a large proportion of Minnesota's uninsured residents — 42 percent — are jobless.[11] The recession of the mid-1980s, the decline of the Iron Range, and the recent farm crisis have left thousands of Minnesotans unemployed. In 1982, 212,000 Minnesotans — or 10.4 percent of the labor force — were without work and therefore without the means to provide for their families. This economic setback, the most powerful in the state since the Depression, reached astonishing proportions in some regions of the state. At the depth of the recent recession, unemployment in the Iron Range rose to 45 percent. By 1984, 41 of the state's 87 counties still had unemployment rates more than 1.5 percent higher than five years earlier. In December of 1985, Minnesota's unemployment rate of 6.9 percent rose to equal the national rate for the first time in 12 years![12]

Among the communities in deepest financial trouble are those dependent on farm income. Net farm income in 1983 fell more than 25 percent

from the year before in 51 of Minnesota's 87 counties.[13] Since then, the rural economy has worsened.

Many working Minnesota families have no health insurance. While the uninsuredness problem among the unemployed is not surprising, especially disturbing is the fact that *so many* of Minnesota's uninsured are in the labor force or are dependents in families who work. Forty-eight percent of all uninsured adults in Minnesota work, and nearly half of these work all year. Farmers are at great risk of being uninsured.[14] Moreover, every worker who is uninsured represents about two dependents who also have no insurance.[15]

- Employers of part-time and minimum wage workers are far less likely to provide health insurance coverage as a fringe benefit. Women are especially affected by this practice. A 1985 study of the working poor found that the occupations in which women tend to be concentrated have much lower rates of job-related insurance than those employing the working poor as a whole.[16] Only 22 percent of persons employed in sales and only 24 percent of persons employed in the service sector were insured, compared to 40 percent of the working poor as a whole.[17]
- Even when a family's primary breadwinner is insured through employment, children and other dependents are not necessarily covered under the policy. A third of uninsured Minnesotans live in families in which someone has health insurance.[18] The worker's employer may not offer family coverage at all, or the cost to the employee of buying additional family coverage may be too high. And there are indicators that, in an effort to lower business costs, many employers in recent years have reduced the size of contribution to their employees' health insurance premiums. As the contribution burden falling onto the employee grows, the percentage of low income employees who can afford to purchase their employers' insurance coverage will decline.

Regardless of employment status, poor Minnesotans are more likely to be uninsured than those of higher socioeconomic status. In 1985, 23 percent of families living below the federal

poverty level were uninsured compared to only 2 percent of families with incomes of four times the federal poverty level.[19]

Children and their mothers are not only likely to be without health insurance, but they are also more likely to be poor. In 1980, prior to the height of the recession, over 50,000 Minnesota families with children under age 18 had incomes below the poverty level. Of these, over 20,000 were headed by women with children over 18 years and no husband present.[20] Thus, while female-headed single-parent families represent only 11 percent of all Minnesota families with children, they account for 42 percent of families in poverty.

Children are among the groups most likely to be poor in Minnesota. More than 10 percent of children in the state in 1979 lived in families with incomes below the federal poverty level.[21] If child poverty in Minnesota increased at the national rate between 1979 and 1983, then 13.4 percent — more than one in eight — of our children were poor in 1983.[22]

Infants of low-income mothers said to face major hurdles

By PAULINE WALLE
Post-Bulletin Spectrum Editor

"A voice for those who have no voice"—low-income mothers and their children— was offered at a Children's Defense Fund hearing Wednesday night at Rochester Public Library.

Testimony dramatized the danger of infant death or chronic illness when mothers can't afford prenatal care.

***

Some 650 Minnesota babies die each year before their first birthday. Low birth weight is the biggest contributor to their death or disability.

Rescue strategies for too-small babies can cost 10 times as much as caring for those whose mothers were taught good nutrition and the hazards of habits such as smoking and drinking, according to defense fund spokesmen. About a third of Minnesota mothers delay prenatal care until the second and third trimester.

***

Dr. Walt Franz, from Mayo Clinic family medicine, testified "we're not hearing fairy tales" about the plight of low-income and minority women and children.

Eleven infant deaths per 1,000 is "almost an epidemic" when compared, say, to 14,000 documented AIDS sufferers, he said. He said 80 percent of the babies with a low birth weight stand the chance of dying and tiny babies "are a self-fulfilling prophecy." Especially in teens, the condition is likely to happen again.

***

"Many of our barriers are financial," said Phoebe Sevaggio, staff person for the Minnesota Maternal and Child Health Advisory Task Force. She cited the increased cost of insurance for farm families in particular.

A former victim of poverty said that when a mother has to choose between feeding her child and getting maternal health care, she will buy food.

***

Clients of the Rochester Women's Shelter may bear added problems of fetal injury and fear of leaving their homes for the doctor's office, said Nancy Kolaas of the shelter. She added they may not have heard of community resources such as the Women, Infants and Children program.

A couple of presenters pointed out that teen-agers with unplanned pregnancies may deny their pregnancies, delaying care into the second trimester. One counselor said women may seek abortions because they can't afford the maternal care.

Excerpted from Rochester Post-Bulletin, October 3, 1985

An indication of how poor Minnesota children are is that in 1984 one of every five elementary or high school-aged children in 40 out of 87 counties qualified for free school lunches because their families had low incomes.[23]

Obviously, poor and near poor families are in no position to buy an individual health insurance policy if no coverage is offered by an employer or if the employer's family coverage plan is too costly. A woman earning the minimum wage, working full time, and supporting two children in 1985 would have had gross earnings of $6,432 for the year — about three-fourths of the federal poverty level for a family of three. An average health insurance family plan purchased privately would have cost her about $1,200, or 19 percent of her gross salary. One year's enrollment in a health maintenance organization would have cost her about $2,000, or 31 percent of her gross salary. Clearly, private insurance coverage would simply be out of the question.

Insurance Needs Are Rising

While there have always been people in Minnesota who did not have insurance, the problem is now on the rise. One way to measure

the growth in uninsuredness is to measure
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Between 1980 and 1983,
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benefits.

- Nationally, only one in four victims of the recent recession who have been able to get another job have health benefits;[25] two in three of those who are still unemployed have no health insurance.[26]
- Half of those who have gone back to work are earning less than they did before, making it difficult to buy health insurance on their own.

Federal Reductions Have Contributed to the Problem

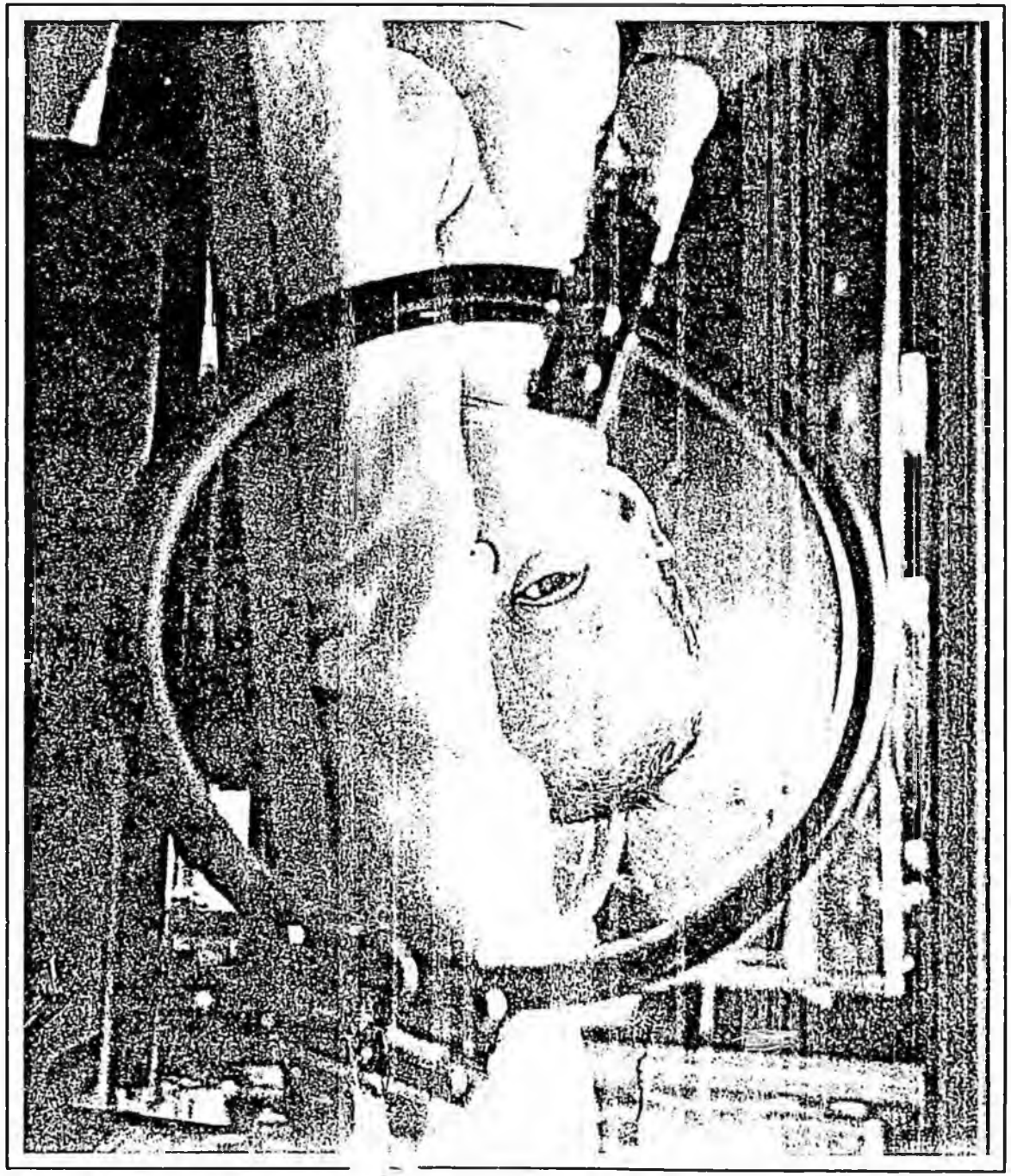
The number of persons in Minnesota who are uninsured has also grown because of federal budget cuts since 1981 that sharply and permanently restricted families' coverage under Medicaid, the nation's largest public health program for pregnant women and children.

Changes in 1981 in eligibility requirements for Aid to Families with Dependent Children (AFDC), eligibility for which generally determines a familiy's eligibility for Medicaid, hurt Minnesota families who relied on Medicaid for health coverage.

These cuts fell with particular severity on the working poor who were otherwise uninsured through the workplace. It is estimated that 13,500 Minnesota households lost Medicaid eligibility between 1982 and 1984.[28] Of those families who were terminated from AFDC, the working poor — the very families that already comprised the majority of Minnesota's uninsured families — were affected the most.[29]

Most families have been unable to replace lost benefits. One year after the 1981 cutbacks, 37 percent of the working adults and 27 percent of their children who lost AFDC and Medicaid had no health insurance. Over 54 percent of these families reported that they delayed visits to a physician because they didn't have enough money to pay the bill.[30]

Even prior to the 1981 AFDC reductions, national statistics indicate that only one in 10 children enrolled in Medicaid and living with a working parent could be expected to have all-year coverage. Because of these new Medicaid restrictions aimed at working poor families, the percent qualifying for all-year (or even part-year) Medicaid coverage since 1981 has dropped further.



CHAPTER 2

Health Consequences for Minnesota, for Families

Insurance is a major determinant of access of health care. Preschoolers who are uninsured make less than half the outpatient visits of those who are insured[1]. Ready access to medical care is especially important for poor children, since poverty itself has an adverse impact on their health status.[2] Poor children are more likely to die before their first birthday and are more likely to suffer from one or more disabilities.[3] They are twice as likely to be hospitalized and 20 times more likely to attend school irregularly because of ill health.[4] Moreover, because of poverty and deprivation, poor children who are ill tend to be sicker for longer periods than non-poor children.[5]

Therefore, it is especially disturbing that the Minnesotans most likely to be uninsured are the very children and their families who are most in need of medical attention and the least able to otherwise afford health care.

The consequences of poverty among children and its effect on their access to health care can be seen by health measurements:

- Since 1978, there has been virtually no improvement in the proportion of babies in Minnesota born at low birthweight (5.5 pounds or less). While 5.3 percent of all births in 1978 were low birthweight, the number had declined to only 5.1 percent by 1983.[6] This is especially important because low birthweight babies are 40 times more likely to die during their first month of life and are at signficantly greater risk for such permanent disabilities as retardation, cerebral palsy, or epilepsy.[7]
- Minnesota's infant mortality rate *actually rose* 4 percent from 9.4 deaths per 1,000 live births in 1982 to 9.8 in 1983.[8] While a single year increase does not represent a trend, we must be concerned.
- Between 1978 and 1983, Minnesota's postneonatal mortality rate (deaths among infants between the ages of 28 days to one year) failed to improve. In 1978, the postneonatal mortality rate was 3.6 deaths per 1,000 live births; in 1983 it remained the same.[9] Failure to make progress in reducing postneonatal mortality is of concern because its causes, such as lack of access of health care, inadequate housing, nutrition and sanitation, are considered

MINNESOTA COMPARED TO ITS NEIGHBORING STATES BY KEY MATERNAL AND CHILD HEALTH INDICATORS: 1983

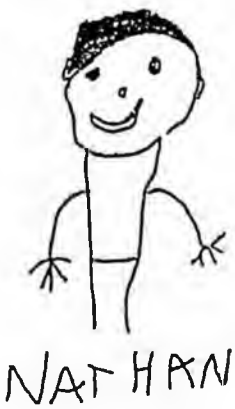
	Low Birth Weight %	Early Prenatal Care %	Late or No Prenatal Care	Infant Mortality Rate
MINNESOTA	5.1	79.1	3.6	9.8
WISCONSIN	5.4	83.8	2.5	9.6
IOWA	5.0	85.6	2.2	8.9
SOUTH DAKOTA	5.1	72.1	7.4	10.8
NORTH DAKOTA	4.7	81.5	2.7	8.9

BABIES BORN TOO SMALL: 1983 COUNTY RANKINGS

RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT
1	Wilkin	1.9	30	Renville	4.1	58	Carver	5.1
1	Lincoln	1.9	30	Mahnomen	4.1	58	Brown	5.1
1	Lake O' Woods	1.9	30	Itasca	4.1			
4	Fillmore	2.2	33	Wright	4.2	61	Carlton	5.2
5	Murray	2.5	33	Lyon	4.2	62	Waseca	5.3
6	Martin	2.6	33	Jackson	4.2	62	St. Louis	5.3
6	Dodge	2.6	36	Yellow Medicine	4.3	62	Polk	5.3
8	Wadena	2.8	36	Stevens	4.3	62	McLeod	5.3
8	Norman	2.8	36	Redwood	4.3	62	Kandiyohi	5.3
			36	Hubbard	4.3	67	Big Stone	5.4
10	Pine	2.9	36	Blue Earth	4.3	68	Anoka	5.5
11	Aitkin	3.0				69	Roseau	5.6
12	Douglas	3.2	41	Stearns	4.4			
13	Kittson	3.3	41	Koochiching	4.4	70	Rice	5.7
13	Faribault	3.3	41	Becker	4.4	71	Pennington	5.8
15	Red Lake	3.4	44	Pope	4.5	71	Hennepin	5.8
15	Marshall	3.4	45	Washington	4.6	73	Olmsted	5.9
17	Traverse	3.6	45	Steele	4.6	74	Lake	6.0
17	Houston	3.6	45	Sibley	4.6	74	Watonwan	6.0
17	Cook	3.6	45	Nicollet	4.6	74	Sherburne	6.0
			45	Clay	4.6	74	Ramsey	6.0
20	Scott	3.7				78	Meeker	6.1
20	Goodhue	3.7	50	Nobles	4.7	78	Todd	6.1
20	Clearwater	3.7	51	Morrison	4.8			
23	Mower	3.8	51	Dakota	4.8	80	Grant	6.6
23	Isanti	3.8	53	Winona	4.9	81	Wabasha	6.9
25	Freeborn	3.9	53	Kanabec	4.9	81	Swift	6.9
25	Crow Wing	3.9	53	Chippewa	4.9	83	Mille Lacs	7.0
25	Benton	3.9		STATE AVERAGE	5.0	84	Pipestone	7.1
25	Beltrami	3.9	56	Le Sueur	5.0	85	Rock	7.5
29	Ottertail	4.0	56	Chisago	5.0	86	Cass	7.6
			58	Cottonwood	5.1	87	Lac Qui Parle	9.1

Rank of 1 is smallest, 87 largest. The same rank for two counties indicates a tie.

Source: *1983 Minnesota Health Statistics*. Calculations by the Children's Defense Fund using the following formula: number of low birth weight babies (less than 5 1/2 pounds or 2,500 grams) divided by the total number of live births, times 100.



preventable. Indeed, experts believe that over 80 percent of America's postneonatal mortality involves babies born at normal weight.[10]

- The disparity between black and white infant mortality rates is greater in Minnesota than for the nation as a whole. While the national black infant mortality rate is slightly less than twice the white rate, in Minnesota it is more than twice as bad — 22.7 deaths per 1,000 live births among black infants versus 9.8 deaths per 1,000 white babies. Moreover black infant mortality rates in Minnesota are above the national average.[11]
- In Minnesota in 1983, one out of every five white women and two out of every five nonwhite pregnant women did not receive prenatal care early in pregnancy.[12] Minnesota's progress in increasing the percentage of pregnant women receiving prenatal care has been very slow. In 1979, the Surgeon General of the United States established several objectives for the nation in the area of maternal and infant health. One of these objectives specified that by 1990, 90 percent of all pregnant women should receive prenatal care early in pregnancy. But Minnesota's annual rate of progress has been so slow that the state will have to improve its annual performance 1.75 times for whites and 9.5 times for nonwhites if the goal is to be met.[13]
- In 1983, compared to its four neighbors (Wisconsin, North Dakota, South Dakota and Iowa), Minnesota had the second highest percentage of babies born to women who had received late or no prenatal care.[14] Only South Dakota's rate exceeded Minnesota's. Minnesota also had a poor showing among the five states in the percentage of babies born to women in 1983 who had received early prenatal care, as well as the second highest infant mortality rate.[15]

The consequences of reduced access to health care can also be seen among children:

- In northwestern Minnesota, untreated dental problems for some children have gotten so bad that a number of children have actually required hospitalization. One little boy had to wait three months to be admitted to the hospital because the family had no way to pay until the father was laid off in the fall and became eligible for Medicaid.[16]
- Five-year-olds coming in for school entry immunizations in rural Minnesota have not seen a doctor since they were six months old. Very young children from poor families will see a doctor only for emergencies, not for the periodic health assessments, immunizations and measurements of growth and development that they so frequently need during the infancy and preschool period. School nurses see kindergarteners with permanent hearing problems because the family could not afford doctors' visits to treat ear infections.[17]

INFANT DEATH RATES: 1981-83 COUNTY RANKINGS

RANK	COUNTY	RATE	RANK	COUNTY	RATE	RANK	COUNTY	PERCENT
1	Kittson	0	31	Anoka	8.6	60	Lake O Woods	11.5
2	Norman	2.7	32	Douglas	8.7	60	Todd	11.5
3	Lincoln	2.8	32	St. Louis	8.7	62	Chisago	11.6
4	Grant	3.0	34	Swift	8.8	63	Traverse	11.7
5	Stevens	3.8	34	Washington	8.8	64	Blue Earth	11.9
6	Murray	3.9	36	Mower	8.9	64	McLeod	11.9
7	Clearwater	4.7	37	Polk	9.0	64	Steele	11.9
8	Jackson	4.8	38	Wright	9.1	67	Nobles	12.0
9	Pennington	5.8	39	Faribault	9.2	68	Goodhue	12.2
						69	Isanti	12.3
10	Kanabec	6.1	40	Scott	9.4			
10	Lac Qui Parle	6.1	41	Hennepin	9.5	70	Chippewa	12.4
10	Renville	6.1	42	Benton	9.6	71	Redwood	12.5
10	Rock	6.1	43	Stearns	9.7	72	Kandiyohi	12.9
14	Ottertail	6.3		STATE AVERAGE	9.8	73	Cass	13.2
15	Cottonwood	6.7	44	Itasca	9.8	74	Wilkin	13.4
16	Dodge	6.8	44	Koochiching	9.8	75	Hubbard	13.6
17	Pine	6.9	44	Lyon	9.8	76	Becker	13.8
17	Sibley	6.9	44	Mahnomen	9.8	77	Waseca	14.2
19	Red Lake	7.1	48	Fillmore	10.0	77	Yellow Medicine	14.2
			49	Meeker	10.1	79	Mille Lacs	14.9
20	Dakota	7.2				79	Nicollet	14.9
21	Carlton	7.7	50	Pope	10.5			
22	Lake	7.8	51	Freeborn	10.8	81	Houston	15.1
23	Watonwan	8.0	52	Pipestone	10.9	81	Beltrami	15.1
24	Olmsted	8.2	53	Brown	11.0	83	Wabasha	16.2
25	Big Stone	8.3	54	Carver	11.3	84	Clay	16.3
26	Aitkin	8.4	54	Crow Wing	11.3	85	Wadena	17.3
26	Martin	8.4	54	Le Sueur	11.3	86	Roseau	18.7
26	Sherburne	8.4	54	Ramsey	11.3	87	Cook	28.6
29	Marshall	8.5	54	Winona	11.3			
29	Rice	8.5	59	Morrison	11.4			

Rank of 1 is smallest, 87 largest. The same rank for two counties indicates a tie.

Source: *1981, 1982, and 1983 Minnesota Health Statistics.* Calculations by the Children's Defense Fund using the following formula: number of infant deaths 1981-1983 divided by the number of live births 1981-1983, times 1,000.

NO EARLY PRENATAL CARE: 1983 COUNTY RANKINGS

RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT	RANK	COUNTY	PERCENT
1	Stevens	7.8	30	Anoka	18.4	59	Swift	25.7
2	McLeod	11.7	32	Pipestone	18.6	60	Lyon	25.8
3	Sibley	12.4	33	Hennepin	19.0	61	Todd	26.4
4	Rock	12.4	34	Mahnomen	19.6	61	Norman	26.4
5	Benton	12.5	35	Cottonwood	20.1	63	Traverse	26.9
6	Cook	13.0	36	Nobles	20.7	64	Chippewa	27.0
7	Redwood	13.7		STATE AVERAGE	**20.9**	65	Rice	27.2
8	Carver	14.0	37	Waseca	20.9	65	Hubbard	27.2
9	Renville	14.8	37	Itasca	20.9	67	Carlton	27.4
10	Douglas	15.1	39	Goodhue	21.1	68	Pennington	27.5
						69	Freeborn	27.6
11	Nicollet	15.5	40	Pope	21.2			
11	Mille Lacs	15.5	40	Clearwater	21.2	70	Lake	27.7
13	Morrison	15.7	42	Becker	21.9	71	Fillmore	28.3
14	Murray	15.8	43	Big Stone	22.0	72	Dodge	28.4
15	Sherburne	16.0	44	Lac Qui Parle	22.2	72	Crow Wing	28.4
16	Wilkin	16.3	45	Beltrami	22.4	74	Yellow Medicine	29.1
17	Brown	16.4	46	Lake O' Woods	22.6	74	Aitkin	29.1
18	Winona	16.5	47	Wabasha	22.8	76	Kanabec	29.3
19	Ottertail	16.6	48	Martin	22.9	77	Kittson	30.3
			49	Marshall	23.0	78	Faribault	30.5
20	Blue Earth	16.7				79	Lincoln	31.1
21	St. Louis	16.8	50	Polk	23.1			
23	Washington	17.3	51	Roseau	23.8	80	Koochiching	32.0
23	Grant	17.3	52	Olmsted	23.9	81	Chisago	32.2
25	LeSueur	17.5	53	Red Lake	24.1	82	Isanti	32.7
26	Jackson	17.6	54	Watonwan	24.2	83	Pine	33.4
27	Stearns	17.8	55	Ramsey	24.3	84	Cass	34.6
28	Wright	18.2	56	Wadena	24.7	85	Meeker	36.1
28	Scott	18.2	57	Kandiyohi	24.8	86	Mower	37.3
30	Houston	18.4	58	Clay	25.5	87	Steele	43.3

Rank of 1 is smallest. 87 largest. The same rank for two counties indicates a tie.

Source: Unpublished data. Center for Health Statistics. Minnesota Department of Health. Calculations by the Children's Defense Fund using the following formula: prenatal care begun later than the first trimester, divided by the total number of live births, times 100.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CHAPTER 3

Existing Programs Can't Fill the Gap

Minnesota's commitment to meeting the health needs of its citizens is undisputed. But current public health programs do not meet the needs of some poor pregnant women and children, particularly working poor families who are without health insurance, largely because there is no systematic approach in Minnesota to addressing this population's health needs.

Instead, a patchwork of programs has grown up. Taken together, these programs do not fill the large gaps left by an employer-based health insurance system that is available only for middle and upper income employees and private insurance and prepayment plans that are prohibitively expensive. While each of these public health efforts is important, they simply are not enough.

Medical Assistance (Medicaid)

Medicaid is the most important source of health coverage for poor mothers and children in Minnesota. Jointly funded by the state, county and federal governments, Medicaid is the state's largest public maternal and child health program. In fiscal year 1982, nearly 165,000 children — more than one of every seven children in Minnesota — had some or all of their medical bills covered by Medicaid.[1] Children make up Medicaid's largest population; 51 percent of all the state's Medical Assistance enrollees are under age 21. Moreover, because health services for children tend to be low cost, children account for only 14.8 percent of Minnesota's Medicaid budget.[2]

However, even though Minnesota exercised its federal option to extend Medicaid to all children and pregnant women who meet the state's eligibility definitions as well as pregnant women and children (known as the medically needy) whose medical bills are so high in relation to their income that they qualify for partial coverage, the program is terribly inadequate. To qualify for Medicaid, a family must have monthly income that is well below the federal poverty levels. This is because the standard of need, which is the maximum established by the state for determining Medicaid eligibility was only $528 per month for a family of three in 1985 — less than 75 percent of the federal poverty level.[3]

Furthermore, while Medicaid is available to help a working poor family weather short-term catastrophic expenditures, it does not represent a continuous source of health coverage because of the penalties for working poor families that are now embodied within the program design. Even a small increase in family income or a few more hours of work, neither of which will yield enough additional income to finance needed medical care, can cost a family its entire Medicaid coverage.

For example, eligibility levels are now so low in Minnesota that a single woman cannot work full-time at a minimum wage job and still qualify for Medicaid coverage for prenatal care. She must wait until her medical bills are large (usually after delivering the baby) before she can qualify for partial coverage as a medically needy beneficiary. And since it is very difficult to obtain medical care on credit, this means that she becomes eligible only after an emergency has occurred and the damage has been done.

Furthermore, Medical Assistance requirements state that in order to qualify for Medicaid, a family with children can have no more than about $6,000 in personal assets. This means that self-employed persons like farmers, loggers or truckers are usually

ineligible for Medicaid because they have a small amount of equity in the tools of their trade. In order to get prenatal care or medical care for their children when times are tough, they have to sell off their tools — their very means of being self-supporting, contributing citizens.

One consequence of these requirements is that in 1983, only 39 percent of Minnesota children with family incomes below the federal poverty level had Medical Assistance coverage in Minnesota.

Finally, even families who are fortunate enough to qualify for Medicaid may still be effectively uninsured. Not all medical providers accept medical assistance. Many doctors and dentists have stopped accepting new Medicaid patients because they believe that payment levels are too low.

Maternal and Infant Care Projects

Maternal and Infant Care (MIC) projects are comprehensive maternity and infant clinics funded under the federal Title V Maternal and Child Health Block grant. MICs are designed to provide high quality prenatal and maternity services to women who are low income and are at high medical risk of delivering an unhealthy infant. In 1984, 770 mothers received prenatal and maternity services through the St. Paul and Minneapolis MIC programs.[4]

Studies show that MIC programs contribute to better health outcomes among their patients.[5] However, existing MIC services are not sufficient to meet the need. Both programs have had to turn some pregnant women away. The Minnesota Department of Health estimates that 18.6 percent of all Minnesota births involve one or more medical high risk factors (such as poor maternal health). But only a small percentage of these babies were born to mothers who benefited from the MIC program. Moreover, the MIC program serves only two counties in the state.

In recent years, federal funding for this program has been severely reduced. Between fiscal years 1982 and 1984 federal Title V funding levels in Minnesota declined by $1.3 million while the need for the services increased because of mounting unemployment and growing numbers of families terminated from the Medicaid program. The state provided no supplementary assistance to replace the lost MIC funds. In all likelihood, federal support for this program will be further reduced, either because of outright cuts in federal appropriation levels through the normal budget process or as part of the Gramm/Rudman/Hollings Deficit Reduction Act. Even if no cuts are made, program funding levels will almost certainly fail to keep pace with inflation.

Community and Migrant Health Centers

Community and migrant health centers are federally funded, comprehensive health clinics located in medically underserved areas. Studies show that community health centers are a valuable source of health care, contributing not

Free or Sliding Fee Care for Pregnant Women and Young Children in Minnesota

1. Cook County Community Clinic, Grand Marais
2. Cook Area Health Services, Cook
3. Duluth Community Health Center, Duluth
4. Community clinics and Minneapolis and Hennepin County programs
5. Community clinics and Ramsey County programs
6. The Mayo Clinic

Note: Migrant Health Services provides free or sliding fee prenatal child health care during the summer to migrant and seasonal agricultural laborers.

only to improved health, but also reducing health care costs through prevention and early treatment.[6]

In 1981, however, there were only five such centers, serving only four of Minnesota's 87 counties, and in recent years these health centers have faced substantial cutbacks. In 1982 alone, federal budget cuts ended support of five community health centers in Minnesota affecting 42,000 patients.[7]

The Hill-Burton Hospital Program

The federal Hill-Burton program has provided millions of dollars to build and expand Minnesota's hospitals. In exchange for these funds, hospitals have agreed to provide a small amount of free or reduced-cost care (this promise is known as the "uncompensated care" obligation). But the program has never worked very well. Even after litigation was brought to promote compliance, among 21 Hill-Burton hospitals monitored between 1981 and 1985, three gave no required notices, nine gave incomplete notices, 13 had not given the level of free care mandated, and four had actually denied benefits to eligible patients.[8] Furthermore, the Hill-Burton uncompensated care obligations is time-limited, and most of this obligation is running out across the state.

The University of Minnesota Hospitals

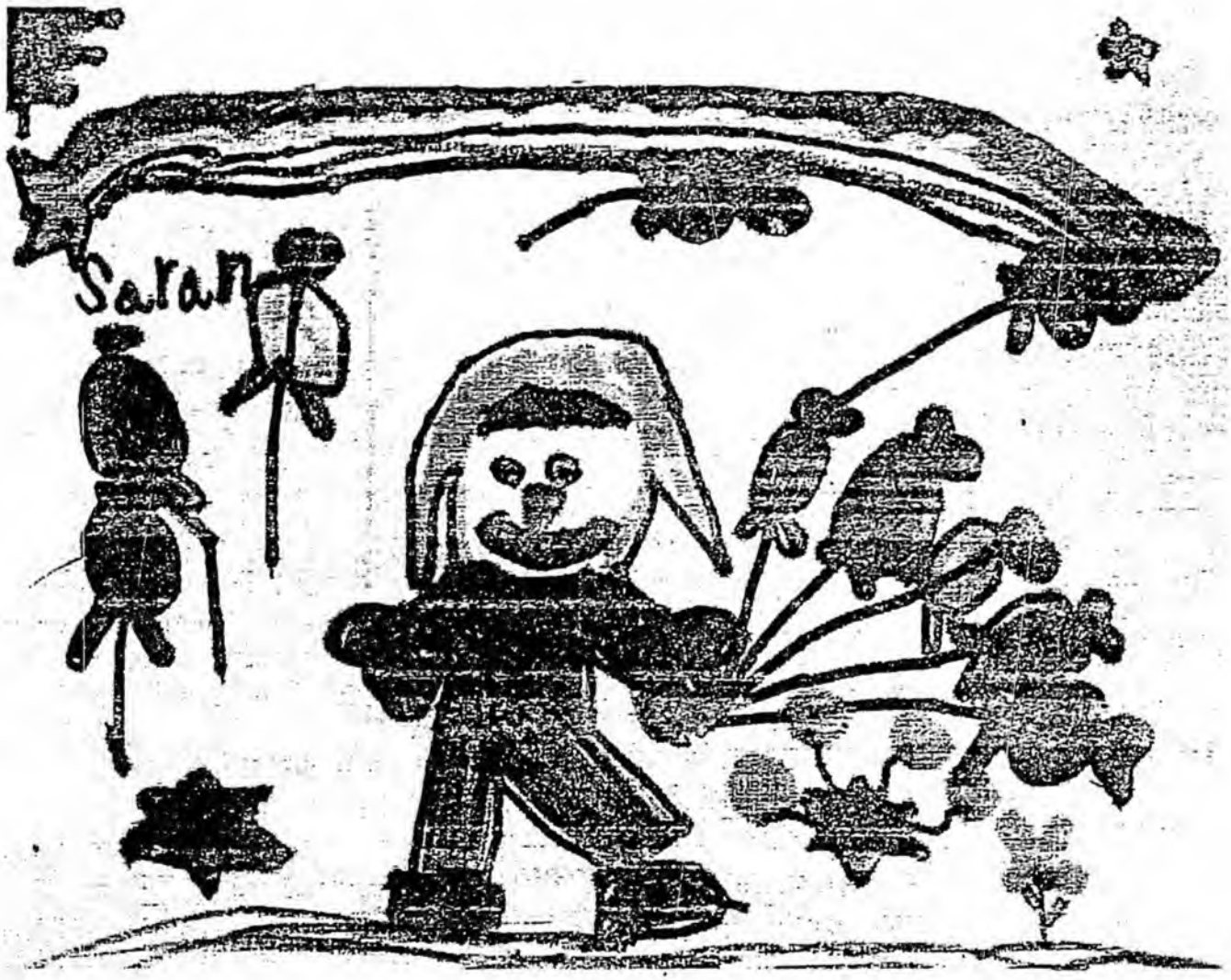
Low-income patients referred to the University of Minnesota by counties are paid for by a direct appropriation from the legislature called "University papers." Most of the care under this program is very complicated, high cost medical services.

Hennepin and Ramsey County Hospitals

Under state law, these two hospitals must accept anyone whether they can pay or not. Care available through these facilities is primarily costly inpatient treatment.

Community Clinics

Community health clinics provide medical care on a free or reduced-cost basis. But these clinics exist for the most part only in Minneapolis and St. Paul. Indeed, only five of the states 87 counties have any free or sliding fee facilities that provide prenatal care.[9]



The Supplemental Food Program for Women, Infants and Children

WIC is a national public health and nutrition program. By providing food, nutrition education and access to health care, WIC improves birth outcome and saves money in medical, special education and long-term care. In 1979, Harvard School of Public Health estimated that for every $1 spent on WIC, $3 are saved in medical costs alone.[10]

In Minnesota, however, WIC administrators have done very little outreach because they fear raising hopes among the 111,000 women and children who are potentially eligible but can't be served because of funding caps. Yet, outreach must be done if we are to reach more WIC eligible hungry pregnant women. Even with little outreach, the WIC waiting list exceeds 7,200 people.[11] An indication of WIC's current inadequacy is that 57 percent of the pregnant women using food shelves in Minnesota are not on the WIC program.[12] Most said they did not know about the program.

The Private Sector

In a state with as much medical wealth as Minnesota, one would think that there are more than enough private resources to fill these public health gaps. But medical care is a *business*, and this fact is particularly evident in Minnesota.

where competition fostered by cost containment and medical care "corporatization" dominate health care.

For example, health maintenance organizations (HMOs) are viewed by some as the answer to the system's current cost excesses and the need to place appropriate emphasis on prevention rather than treatment. As a national leader in developing and promoting cost-containment measures such as HMOs, Minnesota is regarded by people in other parts of the country as showing the way to the future. Unfortunately, however, HMOs were simply never designed to take care of people who cannot pay their way, because they compete in part by eliminating such medical care and its attendant costs. Like insurance companies, HMOs do not enroll members free of charge. Thus, unlike other kinds of health care providers in Minnesota, including private hospitals, HMOs do not care for uninsured patients, or offer services on a sliding fee.

Moreover, HMOs may hold down costs in part because many of the people who use them are young, relatively well off, and healthy. HMOs were designed to care for large groups of employed individuals. These groups were selected in part because they are considered low risk and, therefore, low users of health services. Though many other Minnesotans could benefit from the comprehensive care offered through HMOs, they are sometimes selected out, either because the kinds of jobs they have do not offer HMO enrollment or they are self-employed or, worse, HMOs just do not want them as patients. An Indian clinic that was turned down from HMO membership even after all the financial arrangements had been worked out testified at a CDF hearing that they could only conclude it was because the HMO did not want Indians as patients.[13]

HMOs' zeal to save money can backfire with low-income, high-need families. In one instance, a HMO refused to admit a diarrheal child to the hospital. When the doctor forced the issue on the fourth try and the public health nurse went to the home to provide transportation, it was discovered that the family did not know how to sterilize the baby bottles properly. By delaying prompt attention to the child, the HMO prolonged the amount of time it took to uncover the true cause of the infant's illness.[14]

The Human Costs

As a result of this fragile patchwork of programs, 82 of Minnesota's 87 counties have no recognized system of maternity or pediatric care for those who can't afford to pay the full cost and who aren't fully insured. In these counties, families make do with whatever "charity" medical care they can get from hospitals and doctors. And most of this care is "donated" only when it becomes clear that a family cannot pay its bills:

- Sue, a public health nurse in Beltrami County, reported at child health hearings sponsored by CDF about a family in which the wife, Martha, was seven months pregnant, had never seen a doctor, and planned to have the baby at home because the family had no money to pay for a doctor or hospital care.
- A public health nurse in Washington County reported that she could not get any doctor in the county to see a child with a 104° temperature whose mother had no cash to pay for the office visit. The closest access point was 40 miles away in inner-city St. Paul.

These gaps carry enormous human and financial consequences:

- The doctor pointed out to newly pregnant Ann that her diet was seriously deficient of foods from the fruits and vegetables groups, and asked why. After a long pause, Ann looked up, tears rolling down her face, and said that she and her husband had two other children to feed and almost no money. The doctor, shaken, said she understood and told her "you do what you have to do."
- A pregnant woman in the Rochester women's shelter who discovered she was ineligible for Medicaid went back to her abusing husband to ensure medical care for her unborn child and her other children. The unborn baby was subsequently injured *in utero* by continued battering.
- A mother in northern Minnesota finally found a dentist for her child 100 miles from her home, only to be told when she brought her child in for the appointment, "There must have been some mistake on the phone — we don't take Medicaid."

CHAPTER 4

Preventive Health Care Saves Money

About 3,400 babies weighing less than five and a half pounds are born in Minnesota each year.[1] These low birthweight babies are at great risk of illness, permanent handicaps, and even death. Low birthweight babies are 40 times more likely to die in the first weeks of life than other babies.

Most of the babies born too soon or too small require neonatal intensive services. This costs upwards of $1,250 per day in Minnesota.[2] In 1982, there were 3,083 admissions to neonatal care, and a total of 46,495 patient days.[3] Using $1,250 a day, Minnesota spends more than $58.1 million on neonatal care each year.

Keeping the baby where it belongs — in the mother's womb — through comprehensive prenatal care including preterm birth prevention programs, has been shown to save as much as *$100 an hour* for each hour between the 6th and 7½ months that a premature birth is delayed.[4]

Minnesota also spends preventable dollars on:

- **Rehospitalization.** Too-small babies who have been in intensive care are much more likely to be readmitted to the hospital than other babies.[5]
- **Special Education Costs.** Low birthweight is associated with physical and mental handicaps and developmental delays that require ongoing special education efforts. In 1985, Minnesota spent about $238 million in local, state, and federal taxes on special education.[6] This figure includes both regular and summer school, but does not include funds to teach immigrants English.
- **Long-term Care Costs.** Though more and more too-small babies are being saved with high technology medical advances, for each baby that dies, three more will be left permanently handicapped. Moreover, in fiscal 1986, Minnesota will spend $234.5 million to care for 6,900 mentally retarded institutionalized citizens. The average cost per person is $34,000.[7] It has been found that for every 100 too-small babies born at least two will need lifetime care.[8] That means that right now Minnesota is adding at least 68 children and $2.3 million to our institutional load each year. Much of this suffering, and expense, could be avoided if all mothers had access to preventive health care.
- **Income Support and Social Service.** Some of the babies who are born too small will need income support and social services for the rest of their lives. Minnesota is generous with our social services and income support programs for the handicapped, but it would be even kinder to avoid the problem by fostering more healthy babies.
- **Lost Income and Productivity.** Minnesota's people are its best economic asset. Some economists are projecting a labor shortage. Each too-small baby that is disabled for life means hundreds of thousands of dollars of lost earning power and economic activity to the state.

How Much Can Be Saved?

Cost/benefit analyses from around the country confirm the impressive savings that can result from the provision of comprehensive maternity care.

Numerous local studies, from places as diverse as rural New Mexico[11] and New York City show that prenatal care produces substantial short and long-term savings.

The State of California found that every Medicaid dollar invested in prenatal care and delivery services for high risk, low income women

Spent	Saved	
$1.00	$ 3.38	The Institute of Medicine, part of the National Academy of Sciences, in its landmark study **Preventing Low Birthweight,** found that every dollar spent to provide comprehensive maternity care saves $3.38 in the first year of the baby's life alone.
$1.00	$ 6.17	Michigan reports that by providing prenatal care to all women in need, it will save $6.17 in neonatal care costs for each dollar invested in prenatal care.[9]
$1.00	$11.00	Colorado found it can save $11.00 in medical, and long-term educational, and institutional care for each $1 spent on prenatal care.[10]

who could not otherwise afford such care returned $4 in avoided medical costs.[12]

Providing continuous, preventive health care to children is also a cost saving strategy. Neglecting the health of infants and preschoolers, as Minnesota, and for that matter the nation as a whole, is now doing has both short and long-term negative cost implications.

- It costs about $20 for a doctor's office visit to treat a child with strep throat. It costs about $3,500 to hospitalize a child whose untreated strep develops into rheumatic fever.[13]
- A recent federal study demonstrated that hospital costs were reduced 25 percent for low income people with access to comprehensive primary and preventive health services.[14]
- Children with the least care have been found to cost the most — an average of $638 per year. Those with the most care cost the least — $378 a year, according to the American Academy of Pediatrics.[15]

It is clear that providing comprehensive health coverage for pregnant women, infants and preschoolers is not only the right thing to do, it's the most cost-effective strategy as well.

Preventive care saves money — and lives

By Dave Durenberger

Washington

The Children's Defense Fund has been holding public hearings around Minnesota concerning health care for poor women and their children. A large part of the discussion has centered on preventive or "wellness" care.

Preventive health care is an old idea. We have long known that a healthy life style and regular medical care pay off in the long run. But preventive care is gaining visibility as a necessary part of national health policy, and it's a development with vast implications.

It's no coincidence that this new emphasis on prevention comes at a time of spiraling health-care costs. Our country is seeking ways to cut costs while assuring all Americans access to adequate care.

• • •

Better child and maternal health care is a key element. Few Americans realize that poverty is the biggest single killer of children in our nation. And while we spend roughly $3 billion per year to hospitalize sick infants, the federal health program that is specially targeted to mothers and children receives less than $500 million in annual funding. Our infant-mortality rate has reached a plateau higher than the comparable rate in 12 other industrialized nations.

• • •

The motivation for the preventive-care push isn't solely financial. America is in the midst of a fitness revolution. Exercise and nutrition are common concerns. People are realizing that "wellness care" and health habits — like not smoking — improve the quality of life. They enable us to live longer and more enjoyable lives. And they save lives.

But the gravy is that when we are healthier, the nation can spend less to treat our illnesses. The government spends less, recipients of public and private health insurance spend less, taxpayers spend less. So it's no wonder that we are taking a more active interest in investing our health-care efforts and resources more wisely.

• • •

- Excerpted from Mpls. Star & Tribune, Tuesday, October 22, 1985

CHAPTER 5

Ensuring the Right Start for Every Minnesota Child

Since the state's founding, Minnesota has had a commitment to ensuring that our children get the right start in life. In the past this has meant prairie physicians in our earliest years, the founding of Gillette's Children's Hospital in 1897 and the St. Paul Children's Hospital in 1924, the Maternal and Child Health Division of the State Health Department in 1935, Medicaid in the 1960s, and statewide preschool screening of young children in 1978.

The Children's Defense Fund also wants all Minnesota children to get the right start in life. A healthy start will allow them to take advantage of Minnesota's investment in education, and to go on to become productive adults. The challenge in the 1980s is to ensure that all of Minnesota's families have access to and can afford to go to the doctor for prenatal and preschool child health care. To extend the benefits of preventive health and cost containment strategies to all our children, we must create a new program in Minnesota. Therefore, we are proposing a new program, The Right Start Program.

The Right Start Program

What is it? Simply put, the Right Start Program is prepaid, comprehensive, sliding fee health coverage for pregnant women and preschool children who are currently uninsured or underinsured. Families apply and get care at their provider, and pay what they can. Eligibility ends when families earn more than double the federal poverty guideline, get adequate coverage elsewhere, or children reach age six.

The program has three goals:

- lower infant death and disability;
- increase the overall health and productive capacity of our future labor force;
- contain health, special education, and long-term care costs

The Right Start Plan that we propose is in keeping with the state's long tradition of concern for maternal and child health. It is a humane, simple and cost-effective approach to financing basic health services for our most vulnerable children and pregnant women. It makes maximum use of existing funding resources and medical delivery systems. The purpose of the plan is to provide coverage for prenatal, delivery and postpartum care for pregnant women and health care for children under the age of six who are not eligible for Medicaid and who are not otherwise insured. We propose that the Right Start begin in 1987, and that by 1991 Right Start be extended to cover all children under age 18.

How Would Right Start Be Funded?

Right Start would be funded two ways. First, we are recommending certain low-cost but exceedingly important reforms in the Medicaid program to make its coverage more accessible and attractive to families. There is strong evidence that many pregnant women and young children who are now eligible for Medicaid are not now receiving it either because they do not understand how to obtain coverage or because they are deterred by the need to apply for assistance at a welfare office. Because families covered by Medicaid have half the cost of their care borne by the federal government, and because Medicaid provides coverage for such a broad array of services (as well as coverage for children over the age of six) we believe it is essential for Right Start to make maximum use of this program.

However, we estimate that there are 3,900 pregnant women and 17,000 children under age six who have family incomes below 200 percent of poverty and who are uninsured. Thus, our proposal also calls for the development of a new

Right Start Fund, similar to the high-risk insurance fund which Minnesota maintains for individuals who cannot secure insurance through their employer or the marketplace. This fund would come from the sliding fee premiums paid by those enrollees who, in accordance with Right Start's eligibility standards, are financially able to contribute toward the cost of coverage. Additional sources of funding might include the following:

- **General Revenues.** Many states, including Maine, Michigan, New York, Massachusetts and Ohio, provide general revenues for programs that furnish maternity and pediatric care for poor and uninsured pregnant women and children. A general revenue approach is appealing because our tax structure is a progressive one, and a wide range of payors would contribute.
- **Sin Taxes.** Some states, including Texas and Minnesota, have levied cigarette, liquor or gambling taxes to fund health care.
- **Special Dedicated Taxes Generated from the Health System Itself.** Some states have begun to experiment with special taxes on health insurers and institutional providers to help support health services for the medically needy. These health fund pools are sensible, since the money can then be returned (either through direct grants or expanded insurance coverage) to the providers themselves, thereby reducing the amount of uncompensated care they must provide. States that currently employ such systems include New York, Florida, South Carolina and West Virginia. In Minnesota we currently use a dedicated insurance tax to fund our high risk insurance pool.

A sufficient tax to cover the cost of the Right Start Fund could be modest in size. It would be attractive to those providers now furnishing uncompensated care, because their uncompensated care would decline as a result of the insurance available through Right Start. Moreover, a modest tax would be a fair way of assessing providers such as HMOs that currently pay no state taxes and do not provide uncompensated care. They could in effect have their tax money returned to them in the form of payment for enrollment by Right Start participants.

Who Would Be Eligible for Services Under the Right Start Fund?

Families that include women of childbearing age and children under six would be eligible for Right Start if their income is below 200 percent of the federal poverty line for their family size.

What Benefits Would Be Available Through the Right Start Program?

The Right Start Program would pay for those basic benefits now covered under the Medicaid program that are most important to pregnant women and children. These include:

- services of physicians, certified nurse midwives and clinics (such as public health

clinics, HMOs, private group practices, community health centers and hospital-based maternity and pediatric clinics). Payment would be made not only for diagnosis and treatment but also for services such as check-ups for children, health education and nutrition counseling for pregnant women.

- inpatient hospital services
- prescribed drugs
- laboratory and x-ray services
- family planning services
- preventive health services for children including:
  - periodic health assessment in accordance with the schedule recommended by the American Academy of Pediatrics
  - immunizations
  - vision and hearing care
  - treatment for physical, developmental or other health problems disclosed during assessments
  - mental health services

Though we have not included dental care in the list, it should be strongly considered for part of the pre-school package since dental problems are the single largest untreated health condition among America's children.

How Would Families Apply for Right Start Coverage?

Applications for Right Start should be available through physicians' offices, health plans, public health clinics and programs (such as Head Start or Community Action Programs) serving low income families. *In addition,* in order to encourage families to enroll, applications for *Right Start/M* (that is, Right Start-Medicaid) would be available *in identical locations.* The Right Start-M application should be as streamlined as possible, and the evidence of enrollment in Right Start-M should be a Right Start card identical to the Right Start Program card except for an "M" to indicate that the family has full Medicaid coverage.

What Care Do They Need?

Pregnant Women

All pregnant women need early and continuous prenatal care beginning before the end of the first trimester, but ideally, as early as pregnancy is detected. Women who have low risk pregnancies need between 9 and 11 visits throughout the pregnancy. For women who are high risk, visits may need to be more frequent.

Comprehensive prenatal care includes:

- routine medical examinations, including maternal and pregnancy history
- screening for serious genetic diseases
- screening for maternal diabetes, sexually transmitted diseases, Rh factor, anemia and rubella — all of which can adversely affect fetal development.

Subsequent visits should include monitoring of blood pressure, urine and weight gain, as well as detection of problems, such as toxemia or maternal diabetes, which can lead to birthing difficulties and poor infant health if untreated.[1]

According to the Institute of Medicine, comprehensive prenatal care must also include initial risk assessments followed by prenatal education on:

- behavioral risks in pregnancy (such as drinking, drug abuse and cigarette smoking during pregnancy.
- the early signs and symptoms of pregnancy complications
- the role of good nutrition in good pregnancy outcome, and
- the importance of early and continuous prenatal care.

Such education should begin *early* in pregnancy to achieve the best results. In addition, pregnant women should receive counselling on the emotional and physical side effects of pregnancy and how to prepare for labor and delivery.[2]

Young Children

The American Academy of Pediatrics recommends that infants receive no less than eight health care visits in the first 18 months of life.[3] Among the most important services infants need are:

- regular screenings, including health and developmental histories
- physical examinations
- developmental assessments
- immunizations appropriate for age and health history
- assessment of nutritional status
- vision testing
- hearing testing
- laboratory services appropriate to the child's age and population groups.

Appropriate treatment and follow-up after screening, is, of course, essential.[4]

The Right Start eligibility determination process should be constructed so that Right Start applications that indicate a family income below Medicaid eligibility levels are automatically "rolled over" to the Medicaid agency for the crossover determination. Furthermore, if a family loses automatic Medicaid coverage, then the Medicaid agency should notify the Right Start Program so that the sliding fee can be determined and a Right Start card can be issued with no intervening loss of coverage.

How Much Would Enrollment Cost?

Enrollment in Medicaid is free, of course. For families enrolled through the Right Start Fund, coverage costs would be set every six months based on the family's income at the time of application. The fee structure might begin at 185 percent of poverty, as is done in other states, or it could mirror that currently used in the state's Sliding Fee Child Care program, or it could be based on one of a number of fee structures used by counties or community clinics. If family incomes decline during their enrollment, they could notify the Right Start program for a downward adjustment of their premium fees.

No deductibles would be applied to any services available under the Right Start Fund, and no more than nominal co-payments (in accordance with federal Medicaid standards) could be required for any Right Start Fund item or service. All providers participating in the Right Start Fund would be required to accept an assignment of benefits, so that families would not have to prepay any item or service.

Maine Funds Prenatal Care

In 1983, Maine began a program to help poor and unemployed families get good prenatal care. All services except hospitalization are covered by a set price, and care is given by the private provider of the family's choice. Reimbursement mirrors Medicaid rates and eligibility levels are capped at 80 percent of the state median income. To encourage early care, the program covers only mothers who sign up in the first or second trimester of pregnancy.

The response was so great that publicity was quickly ended. About 500 babies were covered before the one-time-only federal start-up money ran out. The Maine Legislature, recognizing both the need and the cost effectiveness of ensuring adequate prenatal care, has chosen to continue the program using state funds.

What Providers Would Be Eligible to Participate in Right Start?

Any provider furnishing covered services can be a Right Start provider. If a family chooses to enroll with a qualified HMO or other prepaid plan, an annual enrollment fee no greater than the Medicaid capitation would be paid by the Right Start Fund to the plan on the family's behalf. Qualified Right Start plans are those that:

- furnish, or arrange and pay for, all Right Start services
- include specialists in obstetrical and pediatric care in their professional panels
- have affiliations with hospitals furnishing Level I through Level III maternity and newborn intensive care services
- except in the case of health centers funded under Section 330 of the Public Health Service Act, draw no more than 75 percent of their enrollees from publically funded programs
- meet all applicable state licensure requirements

While Right Start encourages enrollment in prepaid plans, we recognize that there are still numerous practicing physicians and clinics who are not yet a part of a formal carefully structured pre-payment system capable of providing and/or

arranging for all necessary care on a capitated basis. Thus, the Right Start Fund could also provide families the option of obtaining regular insurance to cover office-based practitioners on a fee-for-service basis. Providers participating in the insurance portion of Right Start would be also required to accept a direct assignment of benefits and could not bill patients for charges. Payment schedules should be in accordance with the Medicaid program. This may, of course, mean that Medicaid reimbursement schedules for Right Start services may have to be re-evaluated in order to get enough providers to participate.

Other Things That Need to Be Done

In addition to enactment of Right Start in 1987, we make the following recommendations that should be acted on as soon as possible:

Strengthen and enforce medical child support orders.

Minnesota law currently orders parents with child support obligations to cover their children if health insurance is available through work. This is not routinely enforced, however. The Minnesota Non-Tax Revenue Commission has created a plan to extend that requirement to all parents with support orders, define minimum insurance standards, and to simplify compliance and make it as automatic as possible. The federal government has recently ordered all states to include medical child support in their regular enforcement efforts, and has agreed to pay 70 percent of the costs. The new medical child support plan was passed by the 1986 Legislature and should be implemented immediately.

Include community providers in Medical Assistance pre-payment strategies.

Current efforts to move Medical Assistance to a pre-paid basis, and to evaluate the quality of care given by various providers so the state can "buy smart" should be applauded. It is important, however, that community providers be included in any statewide prepayment scheme. These public and smaller community clinics have expertise

with the poor and currently see many of the very people who are Medicaid-eligible or will be served through the Right Start program.

To exclude these providers simply because they are not at this moment members of prepayment plans would be short-sighted. It would also be expensive, since continuity of care, transportation problems, language and cultural differences all affect the use of health care. Denied access to community providers, some people will go without needed care, and would subsequently develop the expensive problems we are seeking to avoid with our preventive strategy.

The Medical Assistance demonstration project now being conducted in Hennepin, Dakota, and Itasca Counties includes community providers, and some HMOs have begun to contract with community providers for certain services. These efforts should serve as models for statewide Medical Assistance prepayment efforts.

Strengthen the WIC program.

Minnesota cannot afford to have poor pregnant women and little children going hungry. Beside the private sector efforts to support food shelves, which we applaud, the Governor and Legislature must make the WIC program work better. Three things need to be done.

First, an intensive information campaign to inform the hungry pregnant women about WIC.

This can be conducted through food shelves, by training people who give obstetrical care about WIC and how to get their patients enrolled, and by supplying WIC information through other systems, such as stuffing flyers in commodity distribution bags and grocery bags in low income communities, and T.V. and radio public service announcements. The State Department of Health, which currently has an unfilled position to do WIC outreach, should use those funds and any other resources available to begin outreach immediately. We cannot afford to wait.

More pregnant women can also be brought into WIC by offering incentives to program administrators. As was done by the MEED program to encourage placement of General Assistance eligibles. WIC should offer a small financial bonus to WIC programs for each new pregnant woman brought into the system.

Second, we should create a WIC reserve.

Minnesota has underspent WIC funds by $991,000 over the last two years. This tragedy has occurred because the WIC funds from the federal government are somewhat unpredictable, and program administrators felt they must budget conservatively in order not to overspend. This underspending in the face of such great need is a shame, but luckily it can be easily remedied. A small WIC reserve, perhaps $50,000, should be set aside. The Legislature should direct that WIC money be spent. Because WIC is carefully administered, the reserve would most likely not even be used.

Third, the state should commit some funds to WIC.

Right now about 111,000 Minnesota mothers and children who are eligible for WIC are not on it because the program is severely under-funded. This large group of people who cannot be served has discouraged administrators from publicizing the program for fear of raising hopes that cannot be met. But the consequences of not doing publicity are that many of the people who could benefit most from the program are not served because they do not know about it. In order to better serve pregnant women and children in need, and to allow the program to fulfill its purpose of building better babies and containing medical costs, the state of Minnesota should allocate $3.1 million for WIC so that all those currently on the waiting list can get help. Further, the state should direct all WIC administrators to publicize the program.

Our children are precious. They are also vulnerable and growing more so. It is up to us as a state to marshall the expertise and resources to provide comprehensive, dependable preventive health care coverage so that all our children can get the right start in life. This is a cost containment strategy both for the health care industry and for the state. It's also the right thing to do. Our children are our future. We can't afford to wait.

Appendices

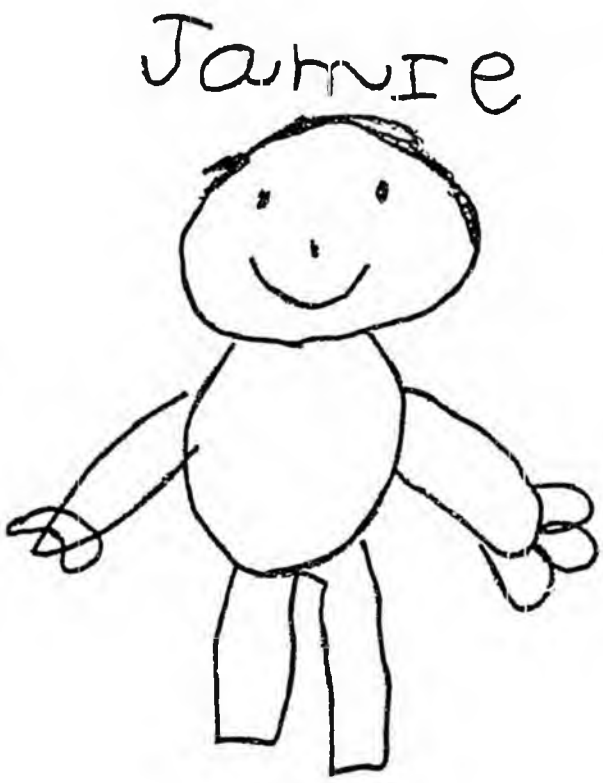
COUNTY FACTS AFFECTING OUR CHILDREN

GENERAL

County	Population[1]	Children[2] 0-4	Unemployment rate[3] 1984	1979
Aitkin	13,595	863	16.8	10.4
Anoka	207,355	17,022	15.0	2.9
Becker	30,972	2,328	13.4	8.2
Beltrami	32,903	2,677	8.9	6.2
Benton	26,434	2,512	8.4	5.6
Big Stone	8,083	571	7.1	4.7
Blue Earth	52,844	4,904	5.1	3.2
Brown	28,617	2,394	6.6	4.0
Carlton	29,342	2,377	11.2	6.6
Carver	39,573	3,107	4.6	2.8
Cass	21,344	1,593	10.8	7.0
Chippewa	14,881	1,269	7.5	4.6
Chisago	27,559	2,315	6.4	3.9
Clay	49,203	4,262	5.5	5.0
Clearwater	9,056	706	19.5	12.0
Cook	4,286	280	11.3	6.9
Cottonwood	14,178	1,014	6.9	3.9
Crow Wing	42,287	3,343	10.2	7.1
Dakota	208,308	18,206	4.6	3.2
Dodge	15,744	1,502	8.4	4.6
Douglas	29,505	2,372	6.9	5.4
Faribault	19,218	1,332	6.2	3.9
Fillmore	21,915	1,702	7.5	4.1
Freeborn	35,398	2,727	8.0	4.8
Goodhue	39,385	3,045	6.5	3.7
Grant	7,209	525	6.7	4.2
Hennepin	945,970	74,001	4.6	3.3
Houston	18,774	1,618	6.0	5.0
Hubbard	15,264	1,013	12.4	8.4
Isanti	25,203	2,191	5.5	5.1
Itasca	45,047	3,473	12.6	8.6
Jackson	13,549	876	5.3	3.0
Kanabec	12,366	1,153	11.4	6.8
Kandiyohi	39,520	2,915	6.7	4.7
Kittson	6,774	437	9.4	5.9
Koochiching	16,759	1,430	10.3	7.2
Lac Qui Parle	10,395	799	6.3	2.7
Lake	12,740	936	16.4	4.0
Lake O'Woods	3,925	290	9.3	5.0
Le Sueur	23,585	1,994	9.1	5.0
Lincoln	7,972	584	6.9	4.1
Lyon	25,770	1,954	6.0	3.9
McLeod	29,971	384	6.3	3.2
Mahnomen	5,677	1,040	11.3	9.5
Marshall	12,804	1,908	13.8	9.3
Martin	24,669	2,049	6.3	3.4
Meeker	20,920	1,727	10.0	5.3

ECONOMIC HARDSHIP					HEALTH			
Single parent families[4]		K-12 students in low-income homes, 1984[5]		Percent change in 1982-83 farm income[6]	Number of 1983 births[7]	Percent no prenatal care in first trimester, 1983[8]	Percent of 1983 babies born under 5.5 lbs.[9]	1981-1983 infant death rate[10]
Number	Percent of all families	Number	Percent					
260	6.8	477	32.0	+6	200	29.1	3.0	8.4
4,943	9.7	3,911	8.2	−265	3,544	18.4	5.5	8.6
680	8.8	1,527	30.7	+104	481	21.9	4.4	13.8
840	11.3	2,141	30.2	+25	583	22.4	3.9	15.4
502	8.1	805	18.2	−23	590	12.5	3.9	9.6
106	5.2	436	29.2	−42	111	22.0	5.4	8.3
1,124	9.1	1,354	13.7	+24	805	16.7	4.3	11.9
561	7.7	717	12.3	−40	491	16.4	5.1	11.0
729	9.3	1,500	22.9	+257	135	27.4	5.2	7.7
748	7.8	489	5.9	−23	645	14.0	5.1	11.3
487	8.4	1,465	37.5	+88	342	34.6	7.6	13.2
247	6.0	433	16.8	−16	203	27.0	4.9	12.4
439	6.4	794	14.4	−54	464	32.2	5.0	11.6
1,089	9.3	1,282	18.1	−35	694	25.5	4.6	16.3
201	8.6	752	39.0	−25	134	21.2	3.7	4.7
90	7.9	141	20.9	NA	56	13.0	3.6	28.6
263	6.3	479	17.4	−29	178	20.1	5.1	6.7
1,028	9.1	2,161	27.1	−45	644	28.4	3.9	11.3
5,047	10.1	2,739	6.2	−38	3,460	16.8	4.8	7.2
244	6.1	550	15.3	−54	273	28.4	2.6	6.8
455	6.1	1,041	19.1	−17	437	15.1	3.2	8.7
364	6.8	548	11.5	−33	269	30.5	3.3	9.2
383	6.4	772	21.8	−38	317	28.3	2.2	10.0
821	8.1	762	12.9	−29	468	27.6	3.9	10.8
752	7.2	900	13.1	−9	598	21.1	3.7	12.2
120	5.9	298	20.9	+21	106	17.3	6.6	3.0
33,143	14.0	20,405	15.5	−31	14,614	19.0	5.8	9.5
399	8.2	468	14.9	−28	307	18.4	3.6	15.1
296	7.5	1,012	37.6	−11	235	27.2	4.3	13.6
410	6.9	748	16.8	+55	416	32.7	3.8	12.3
972	8.3	2,247	26.1	−27	633	20.9	4.1	9.8
226	6.0	320	14.4	−47	190	17.3	4.2	4.8
261	7.9	475	20.8	+7	226	29.3	4.9	6.1
714	7.5	1,197	18.5	−162	606	24.8	5.3	12.9
121	6.5	269	23.5	−31	92	30.3	3.3	0.0
404	8.6	843	23.9	−42	206	32.0	4.4	9.8
150	5.1	366	21.3	−7	133	22.2	9.1	6.1
214	6.0	558	20.1	NA	149	27.7	6.0	7.8
72	6.7	200	32.6	+28	12	22.6	1.9	11.5
422	6.8	619	13.2	−29	419	17.5	5.0	11.3
110	5.0	467	34.2	−48	106	31.1	1.9	2.8
470	7.5	1,051	19.7	−33	403	25.8	4.2	9.8
534	8.8	500	11.3	−27	494	11.7	5.3	11.9
121	5.3	833	47.7	+25	97	19.6	4.1	9.8
187	8.1	910	31.1	−27	179	23.0	3.4	8.5
524	6.7	558	12.8	−28	391	22.9	2.6	8.4
357	6.4	997	20.0	−46	345	36.1	6.1	10.1

COUNTY FACTS AFFECTING OUR CHILDREN



GENERAL

County	Population[1]	Children[2] 0-4	Unemployment rate[3] 1984	1979
Mille Lacs	18,316	1,633	9.0	5.7
Morrison	30,046	2,517	10.7	7.3
Mower	39,816	2,858	6.7	5.1
Murray	11,441	865	8.2	5.1
Nicollet	27,976	2,380	5.0	2.8
Nobles	21,934	1,630	6.8	3.4
Norman	9,534	665	7.0	4.5
Omsted	95,791	8,475	4.6	3.7
Ottertail	54,864	3,825	9.9	6.2
Pennington	14,036	1,282	9.1	5.4
Pine	20,576	1,676	11.2	7.5
Pipestone	11,405	799	5.1	4.9
Polk	34,562	2,667	8.6	5.6
Pope	11,854	884	7.5	4.7
Ramsey	457,123	35,778	4.8	3.8
Red Lake	5,340	413	15.2	10.3
Redwood	18,835	1,518	5.3	3.3
Renville	19,685	1,393	8.5	5.1
Rice	47,012	4,029	7.5	4.9
Rock	10,728	893	4.0	2.9
Roseau	12,845	1,099	11.0	6.2
St. Louis	213,662	3,660	12.2	5.8
Scott	48,885	3,040	5.3	2.8
Sherburne	33,258	1,229	8.0	5.0
Sibley	15,671	16,326	7.3	4.4
Stearns	113,815	11,334	8.0	5.9
Steele	30,498	2,711	6.6	3.7
Stevens	11,191	859	5.6	3.7
Swift	12,776	988	9.5	5.0
Todd	26,034	2,048	8.2	5.4
Traverse	5,402	370	6.3	4.5
Wabasha	19,178	1,732	8.4	4.2
Wadena	14,001	1,124	9.4	5.4
Waseca	18,711	1,838	5.9	3.3
Washington	120,502	9,334	4.4	3.0
Watonwan	12,046	1,000	6.7	3.3
Wilkin	8,348	701	6.3	4.1
Winona	46,478	4,129	7.8	5.3
Wright	62,199	6,353	6.1	3.7
Yellow Medicine	13,095	918	6.2	3.5
STATE	4,145,607	335,104	6.3	4.2

ECONOMIC HARDSHIP					HEALTH			
Single parent families[4]		K-12 students in low-income homes, 1984[5]		Percent change in 1982-83 farm income[6]	Number of 1983 births[7]	Percent no prenatal care in first trimester, 1983[8]	Percent of 1983 babies born under 5.5 lbs.[9]	1981-1983 infant death rate[10]
Number	Percent of all families	Number	Percent					
375	7.6	1,418	25.3	NA	314	15.5	7.0	14.9
560	7.5	2,515	36.2	−21	548	15.7	4.8	11.4
865	7.8	1,125	16.6	−42	554	37.3	3.8	8.9
174	5.5	254	16.4	−28	162	15.8	2.5	3.9
507	8.0	310	13.7	−37	370	15.5	4.6	14.9
429	7.2	755	19.2	−36	320	20.7	4.7	12.0
157	6.2	475	28.8	−19	106	26.4	2.8	2.7
2,200	9.5	1,765	9.9	−21	1,750	23.9	5.9	8.2
892	6.3	2,143	25.4	−19	771	16.6	4.0	6.3
389	9.7	867	30.7	−8	226	27.5	5.8	5.8
431	8.3	1,239	30.0	+6	340	33.4	2.9	6.9
195	6.2	564	22.1	−67	182	18.6	7.1	10.9
793	9.0	1,653	25.2	−30	550	23.1	5.3	9.0
183	5.7	444	23.7	−30	200	21.2	4.5	10.5
17,001	14.8	13,262	19.9	−58	7,710	24.3	6.0	11.3
87	6.2	499	42.5	−18	88	24.1	3.4	7.1
350	6.8	576	15.6	−28	324	13.7	4.3	12.5
313	5.7	591	15.6	−42	340	14.8	4.1	6.1
865	8.1	1,164	8.1	−33	700	27.2	5.7	8.5
156	5.4	349	18.8	−45	160	12.4	7.5	6.1
209	6.2	660	24.5	−14	198	23.8	5.6	18.7
6,451	7.7	9,018	26.9	NA	2,835	16.8	5.3	8.7
850	6.5	737	7.3	−20	793	18.2	3.7	9.4
485	5.5	599	8.6	−306	539	16.0	6.0	8.4
232	11.1	408	15.4	−42	217	12.4	4.6	6.9
1,995	8.2	4,526	17.6	−15	1,952	17.8	4.4	9.7
575	7.2	678	10.9	−25	500	43.3	4.6	11.9
159	5.8	311	16.6	−66	140	7.8	4.3	3.8
231	6.7	670	24.5	−38	174	25.7	6.9	8.8
388	5.9	1,822	36.0	−28	431	26.4	6.1	11.5
103	6.8	208	28.0	−76	83	26.9	3.6	11.7
350	6.8	629	14.9	−8	332	22.8	6.9	16.2
290	7.8	1,153	33.9	NA	213	24.7	2.8	17.3
352	7.3	514	13.2	−38	301	20.9	5.3	14.2
2,408	8.3	1,595	6.4	−61	1,852	17.3	4.6	8.8
226	6.6	401	18.6	−25	199	24.2	6.0	8.0
170	7.8	311	18.5	+10	106	16.3	1.9	13.4
1,044	10.1	1,113	14.5	−37	702	16.5	4.9	11.3
986	6.6	1,502	11.3	−25	1,156	18.2	4.2	9.1
215	5.9	509	23.6	−18	230	29.1	4.3	14.2
107,271	10.3	122,943	16.7	−29	65,559	20.9	5.0	9.8

CHILDREN'S HEALTH HEARINGS

Minnesotans Who Presented Testimony at Children's Health Hearings In
Northwest, Northeast, Southern and Metro Minnesota
September and October, 1985

Children's Health Hearing
Saturday, September 21, Bemidji
Hearing Speakers

Dr. Mark S. Becker
Cass Lake Physician
La Porte

Robin Buchanan
Cass County Nursing Services
Benedict

Alice Collins
Planned Parenthood
Bemidji

Nancy Jacobs Contrucci
Early Childhood Education
Bemidji State University
Bemidji

Steve Engel
WIC Consultant
Bemidji

Bonnie Engen
Clearwater County Nursing Service
Bagley

Patti Haasch
Leech Lake Head Start
Bemidji

Wayne Kuklinski
Tri-Valley Head Start
Crookston

Ruth Nepper
4 County - Early Periodic Screening/WIC
Warren

Blanche Niemi
White Earth Head Start
Callaway

Cathy Nye
Services for Children with Handicaps
Bemidji

Mary Lou Rindahl
Outreach, Inter-County
Oklee

Kathy Simonson
Inter-County, Head Start
Oklee

Roleen Walgenbach
Leech Lake Reservation Health Division
Bemidji

Children's Health Hearings
Thursday, October 3rd
Northeast Minnesota - Grand Rapids
Hearing Speakers

Linda Anderson
Maternal and Child Health Nurse
Aitkin County Public Health Department

Wendy Anderson
Dietician
WIC Project Director
Koochiching, Itasca Action Council

Sue Bounds
Coordinator, Early Childhood Program and
Special Education School District 318
and the Tri-County Cooperative No. 946
Director, Infant and Toddler Center
Grand Rapids High School

Barb Bunte
Public Health Nurse
Big Fork

Sue Erzac
Public Health Nurse
Maternal and Child Health
Itasca County Health Department

Delores Larson
Community Health Representative
Leech Lake Reservation Business Committee
Cass Lake

Jackie Thompson
AFL-CIO Department of Community Services
Duluth

Randy Rehnstrand
Administrator
Community Health Services Board
Aitkin, Koochiching, Itasca Counties

Barb Richards
School Nurse
Big Fork, Effie, and Togo
Itasca County Health Department

Bruce Rowe
Administrator
Community Health Services Board
Carlton, Cook Lake, St. Louis Counties

Dorothy Villock
Director, Teenage Parenting Program
District 318
Grand Rapids

Diana Seeger
parent of handicapped child
Grand Rapids

Southern Minnesota - Rochester
Hearing Speakers

Judith Aarsvald
Licensed Psychologist
Lutheran Social Services
Rochester

Myra Ahrens, R.N.
Minnesota Migrants Council
Dodge Center

Judy Barton
Community Health Service Administrator
Wabasha County

Beulah Estran
WIC Coordinator
Rice County

Dr. Walter Franz
Family Medicine
Mayo Clinic

Kirsten Hall
Community Health Services
Rice County

Barbara Huus
Assistant Director, Parent Child Health
Olmstead County Health Department

Nancy Kolaas
Women's Shelter
Rochester

Amy Miller
Nurse Practitioner
Planned Parenthood
Mankato

Phoebe Selvaggio
Minnesota Department of Health
Maternal & Child Health Division

Lynn Skinner
Regional Director
Planned Parenthood
Rochester

Valerie Strauss
Counselor
Catholic Social Services
Rochester

Lynn Theurer
Community Health Services Administrator
Winona County

Linda Thielbar
Head Start Administrator
Goodhue, Wabasha, Rice County CAP Program
Zumbrota

Trish Townsdin
Outreach Coordinator
Minnesota Valley Action Council
Mankato

Metro Minneapolis - St. Paul
Hearing Speakers

Majel Carroll
R.A.P. Washington County
Cottage Grove

Sarah Brown
new mother
St. Paul

Mary Edwards
Office of Senator Durenberger
Minneapolis

Dr. Betty Jerome
Teen Age Medical Service
Minneapolis

Michelle Johnson
new mother
St. Paul

Margaret Jones
M.N.C.H.I.P.
Minneapolis

Kevin Kenney
Associate County Administrator
Hennepin County

Mayor George Latimer
St. Paul

Wanda Miller
Health Services Supervision
St. Paul Public Schools

Noreen Smith
Indian Health Board
Minneapolis

James Robinson
Loft Teen Center
St. Paul

Ann Ricketts
St. Paul Maternal Infant Care Program
St. Paul

Joan Rambeck
Minneapolis Health Department
Minneapolis

Lenora Sherard
Pilot City Health Center
Minneapolis

Susan St. Fauver
Refugee Clinic
St. Paul

St Vang
Community Nutrition Worker
St. Paul Health Department

Veronica Williams
Minneapolis Urban League

Karen Zeleznak
Parent Child Health
Washington County

Northeast Minnesota - Bemidji
Hearing Panelists

Gladys Drouillard
Leech Lake Reservation Business Committee

Luanne Nyberg
Director, Minnesota Project
Children's Defense Fund

Representative Edgar Olson
Fosston - District 2B

Representative Ted Thorson
Bemidji - District 4A

Judy Weitz
Director, State and Local Affairs
Children's Defense Fund
Washington, D.C.

Senator Gerald Willet
Park Rapids - District 4
Chair Finance Committee

Representative Maurice Zaffke
Backus - District 4B

Northeast Minnesota - Grand Rapids
Hearing Panelists

Senator Ron Dicklich
Hibbing - District 5
Member, Health & Human Services Committee

Dana Hughes
Prenatal Care Campaign Co-ordinator
Children's Defense Fund

Commissioner Marilyn Krueger
Chair, St. Louis County Board

Luanne Nyberg
Director, Minnesota Project
Children's Defense Fund

Representative Paul Ogren
Aitkin - District 14A

Roy Skramstad
Jobs Service Field Office Director
Hibbing

Representative Loren Solberg
Bovey - District 3B

Southern Minnesota - Rochester
Hearing Panelists

Senator Wayne Benson
Lanesboro - District 32
Member, Health & Human Services Committee

Dr. Dan Broughton
Consultant - Department of Pediatrics
Mayo Clinic

Dana Hughes
Prenatal Care Campaign Co-ordinator
Children's Defense Fund

Commissioner Lee Luebbe
Winona County

Luanne Nyberg
Director, Minnesota Project
Children's Defense Fund

Representative Peter Rodosovich
Faribault - District 25B
Member, Health & Human Services Committee

Mary Ann Senjem
Representative Tim Penny's Office
First Congressional District

Metro Minneapolis - St. Paul
Hearing Panelists

Senator Linda Berglin
Minneapolis - District 60
Chair, Health and Human Services Committee

Roy Garza, Director
Community and Government Relations
United Way of St. Paul

Representative David Gruenes
St. Cloud - 17B District
Chair, Health Subcommittee
Health & Human Services Committee

Commissioner Ruby Hunt
Ramsey County Board

Yusef Mgeni
Sabathani Community Center
Minneapolis

Sara Rosenbaum, Director
Child Health Division
Children's Defense Fund
Washington, D.C.

James P. Shannon
Executive Director
General Mills Foundation
Minneapolis

Luanne Nyberg
Director, Minnesota Project
Children's Defense Fund

William Udoka
Health Director
Minneapolis Urban League

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"All children should have quality health care available and accessible."
Minnesota Maternal and Child Health Plan, 1985

"All Americans, rich or poor, deserve access to quality health care."
Senator David Durenberger, 1985

"Finances are the primary barrier to maternity care in Minnesota."
American Academy of Pediatrics, Minnesota Chapter, 1984

"Comprehensive prenatal care is a key to healthier babies and mothers."
House DFL Committee on Families, 1985

"The Minnesota Legislature [should] make statutory and regulatory changes to provide comprehensive prenatal care for all pregnant women in Minnesota not covered by third-party payers."
Minnesota Coalition on Health Care Costs, 1984

"Consumers should have basic health care benefits and catastrophic coverage. The state government should cover those who are unable to pay."
Minnesota Medical Association, 1983

"Prenatal care for uninsured pregnant women with incomes below 200 percent of poverty is a top priority."
Commission on the Economic Status of Women, 1986 Legislative Agenda

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

September 29, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Sandi Depue SmQ
Administrative Officer

RE: **Components of Health Care Costs in Alaska**
Research Request 88.051

You asked us to find out what items make up the column "Health Care" in Table 2 on page 2 of the September 1987 issue of Alaska Economic Trends (article entitled "The Cost of Living in Alaska"). You also requested a comparison of those costs between Alaska cities and other cities in the United States.

Mr. Ed Eboch, editor of Alaska Economic Trends, told me they had quoted figures from the American Chamber of Commerce Researchers Association's "Inter-City Cost of Living Index," First Quarter 1987. Attachment A is copies of pages from this document. The first page explains that the following items are encompassed in the heading "Health Care":

- Hospital Room - Average cost per day of semi-private room;
- Office Visit, Doctor - General practitioner, average charge;
- Office Visit, Dentist - Teeth cleaning and inspection: no x-ray or fluoride treatment; and
- Aspirin - 100-tablet bottle, Bayer brand.

The remaining six pages of Attachment A list the cost of various items for 247 cities within the United States. I have highlighted the costs for hospital rooms, doctor visits, dentist visits and aspirin.

I hope this information is useful to you. Please contact me if I can be of further assistance.

Attachments

ATTACHMENT A
American Chamber of Commerce Researchers Association
Inter-City Cost of Living Index
First Quarter 1987

Price Report Column Headings

The items and specifications in this pricing study are listed below. The descriptions for HOUSING and UTILITIES are briefly highlighted, since pricing is based on explicit procedural instructions and very detailed specifications. Monthly housing payments and utility use charges are not community-wide averages and should not be construed as such. • Pricing is based on sampling averages. The concept of a mid-management executive household is the guideline for selecting establishments and neighborhoods in which to price, and the minimum number of establishments to be surveyed depends upon the size of each community. • To ensure uniformity, national brands are stipulated whenever possible, and "lowest price" is the reported average of the lowest prices found in all stores surveyed. • Housing prices are published in whole dollars. All other items are presented in dollars and cents and published without the decimal point.

GROCERY ITEMS

Column Number		
	MEATS	
1	T-Bone Steak	Price per pound, USDA Choice
2	Ground Beef or Hamburger	Price per pound, lowest price
3	Bacon	Price per pound, rashers, Oscar Mayer Hormel Black Label, Armour or Field's
4	Frying Chicken	Whole fryer, price per pound
5	Chunk Light Tuna	6½ oz. can, Starkist or Chicken of the Sea, packed in oil
	DAIRY PRODUCTS	
6	Whole Milk	One-half gallon carton
7	Eggs	One dozen, grade A, large
8	Margarine	One pound, Blue Bonnet or Parkay
9	Parmesan Cheese, Grated	8 oz. canister, Kraft brand
	PRODUCE	
10	Potatoes	10 pound sack, white or red, lowest price
11	Bananas	Price per pound
12	Head Lettuce	Head (approx. 1¼ pound size)
	BAKERY PRODUCTS	
13	Bread, White	24 oz. loaf, lowest price
	TOBACCO	
14	Cigarettes	Carton, Winston, king-size (85mm.)
	MISC. GROCERY PRODUCTS	
15	Coffee, Vacuum-Packed	One pound, Maxwell House, Hills Brothers or Folgers
16	Sugar	5 pounds, cane or beet, lowest price
17	Corn Flakes	18 oz. Kellogg's or Post Toasties
18	Sweet Peas	17 oz. can, Del Monte or Green Giant
19	Tomatoes	14½ oz. can, Hunt's or Del Monte
20	Peach Halves	29 oz. can, Hunt's, Del Monte or Libby's
21	Facial Tissue	175-count box, Kleenex brand
22	Washing Powder	12 oz. or 49 oz., Tide, Bold or Cheer
23	Shortening	3 pound can, all-vegetable, Crisco brand
24	Frozen Orange Juice	12 oz. can, Minute Maid brand
25	Frozen Corn	10 oz. whole kernel, lowest price
26	Baby Food	4½ oz. jar, strained vegetables, lowest price
27	Soft Drink	2 liter Coca-Cola, excluding any deposit

HOUSING

28	Apartment, Monthly Rent	Two bedroom, unfurnished, excl. all utilities except water. 1 or 1½ baths, approx. 950 sq. ft.
	Home Purchase	
29A	Total Purchase Price	1,800 sq. ft. living area new house, approx. 10,000 sq. ft. lot, urban area with all utilities.
29B	Monthly Payment	Principal and interest, 25-year first mortgage based on 75 percent loan at current conventional fixed-rate of interest or adjustable rate mortgage plan

UTILITIES

Column Number		
30	Electric Power	Monthly costs calculated at current rates for average monthly consumption during the previous 12 months in the type of home specified in Item 29. All-electric homes are reported in 30A; electricity costs where other energy fuels are used are reported in 30B.
31	Other Fuel Sources: oil, natural gas, coal, wood, etc.	
30 + 31	Total Energy Costs	
32	Telephone	Private residential line; customer owns instruments. Price includes: basic monthly rate; additional local use charges, if any, incurred by a family of four; Touch-Tone fee; other mandatory monthly charges, such as long distance access fee or 911 fee; and all taxes on the foregoing.

TRANSPORTATION

33	Bus Fare	Typical one-way commuting fare, up to 10 miles
34	Auto Maintenance	Average price to balance one front wheel
35	Gasoline	One gallon unleaded regular, national brand, including all taxes; cash price at self-service pump if available

HEALTH CARE

36	Hospital Room	Average cost per day of semi-private room
37	Office Visit, Doctor	General practitioner, average charge
38	Office Visit, Dentist	Teeth cleaning and inspection; no X-ray or fluoride treatment
39	Aspirin	100-tablet bottle, Bayer brand

MISC. GOODS & SERVICES

40	Hamburger Sandwich	¼ pound patty with cheese, McDonald's Quarter-Pounder with cheese, where available
41	Pizza	12" - 13" thin crust cheese pizza, Pizza Hut, Pizza Inn or Shakey's where available
42	Fried Chicken	Thigh and drumstick, with or without extras, Kentucky Fried Chicken or Church's, where available
43	Haircut	Man's barbershop haircut, no styling
44	Beauty Salon	Woman's shampoo, trim and blow dry
45	Toothpaste	6 oz - 7 oz. tube, Crest or Colgate
46	Shampoo	11 oz. bottle, Johnson's Baby Shampoo
47	Dry Cleaning	Man's two-piece suit, average price
48	Man's Dress Shirt	Arrow, Enro, Sear's Best or Van Heusen brand, White, poly/cotton blend, long sleeves, size 15/32 - 16/34
49	Boy's Underwear	Package of three briefs, cotton, size range 28/30 - 34/36, lowest price
50	Man's Denim Jeans	Levi brand, Straight Leg, size range 28/30 - 34/36
51	Major Appliance Repair	Home service call, clothes washing machine; minimum labor charge but excluding parts
52	Newspaper Subscription	Home delivery for daily and Sunday of large-city newspaper, monthly rate
53	Movie	First-run, indoor, evening price
54	Bowling	Average price per line (game), evening rate
55	Tennis Balls	Wilson or Penn brand, can of three extra-duty, yellow
56	Board Game	Parker Brothers' "Monopoly," No. 9 edition
57	Liquor	Seagram's 7 Crown, 750 ml. bottle
58	Beer	Schlitz or Budweiser, 6-pack, 12 oz. containers excluding any deposit
59	Wine	Paul Masson Chablis, 1.5 liter bottle

PRICE REPORT

QUARTER 1, 1987	24	25 FPZ	26 BD	27	28 APT	29A HOME	29B HOME	30A ALL-	30B PART	31 OTHER	30+31 TOTAL	32 TELE	33	34	35	36	37	38	39
CITY AND STATE	ORJ	CRN	FD	COK	RENT	PRICE	P+I	ELECT	ELECT	ENRGY	ENRGY	PHON	BUS	DAL	LINE	[illegible]	[illegible]	[illegible]	[illegible]
ANNISTON AL	111	55	23	143	305	77833	490		6929	4660	11589	2257		400	839	[illegible]	[illegible]	[illegible]	[illegible]
BIRMINGHAM AL	108	52	23	129	364	86400	555		6929	4660	11589	2579	100	540	807	[illegible]	[illegible]	[illegible]	[illegible]
DOTHAN AL	106	51	22	157	250	88250	568	11408			11408	1719		540	849	[illegible]	[illegible]	[illegible]	[illegible]
FLORENCE AL	100	45	22	121	270	70600	470		9075	2792	11867	2248		390	921	[illegible]	[illegible]	[illegible]	[illegible]
GADSDEN AL	115	63	22	88	263	67000	434		6929	4660	11589	2163		490	869	[illegible]	[illegible]	[illegible]	[illegible]
MOBILE AL	102	50	21	132	317	80325	531		7257	4787	12044	2392	50	590	851	[illegible]	[illegible]	[illegible]	[illegible]
ANCHORAGE AK	154	69	35	209	629	131633	841		5334	6475	11809	1156	75	800	856	[illegible]	[illegible]	[illegible]	[illegible]
FAIRBANKS AK	121	69	34	241	594	126725	814		5538	7260	12798	1524	100	639	991	[illegible]	[illegible]	[illegible]	[illegible]
JUNEAU AK	146	62	34	186	575	133500	866	14691			14691	2660	75	836	1266	[illegible]	[illegible]	[illegible]	[illegible]
LAKE HAVASU AZ	132	62	28	99	400	76667	505	11066			11066	1475		467	882	[illegible]	[illegible]	[illegible]	[illegible]
PHOENIX AZ	119	59	27	121	453	94583	615	10707			10707	1630	75	600	761	[illegible]	[illegible]	[illegible]	[illegible]
TUCSON AZ	126	57	27	109	448	98750	632		5450	2471	7921	1425	50	550	806	[illegible]	[illegible]	[illegible]	[illegible]
FAYETTEVILLE AR	121	55	25	124	320	79000	529		6509	4557	11066	2685		467	844	[illegible]	[illegible]	[illegible]	[illegible]
FORT SMITH AR	120	54	25	98	309	81500	540		6720	2880	9600	1920		488	799	[illegible]	[illegible]	[illegible]	[illegible]
JONESBORO AR	123	53	27	122	256	69833	496		7062	5206	12268	1877		432	842	[illegible]	[illegible]	[illegible]	[illegible]
BAKERSFIELD CA	118	58	25	145	430	109600	723		9591	2283	11874	1170	50	630	839	[illegible]	[illegible]	[illegible]	[illegible]
BLYTHE CA	126	59	26	195	354	75000	501		10289	2051	12340	1736		592	785	[illegible]	[illegible]	[illegible]	[illegible]
FRESNO CA	139	50	27	149	374	104200	689		7218	2359	9577	1197	50	670	773	[illegible]	[illegible]	[illegible]	[illegible]
INDIO CA	135	55	25	191	535	90000	610		8595	2107	10702	1256	50	675	741	[illegible]	[illegible]	[illegible]	[illegible]
LOS ANGELES CA	126	46	25	169	754	131947	906		5330	3188	8518	1056	85	583	745	[illegible]	[illegible]	[illegible]	[illegible]
ORANGE COUNTY CA	126	46	25	169	709	150833	1035		5330	3188	8518	1056	75	667	802	[illegible]	[illegible]	[illegible]	[illegible]
PALM SPRINGS CA	143	54	26	185	600	136000	884		9220	1522	10742	1337	50	633	753	[illegible]	[illegible]	[illegible]	[illegible]
RIVERSIDE CA	144	52	26	194	485	121515	799		8661	3815	12476	1326	60	633	786	[illegible]	[illegible]	[illegible]	[illegible]
SACRAMENTO CA	128	54	26	163	472	93800	617	9780			9780	1152	100	660	739	[illegible]	[illegible]	[illegible]	[illegible]
SAN DIEGO CA	129	55	26	198	850	147500	954		6742	2467	9209	1230	125	695	837	[illegible]	[illegible]	[illegible]	[illegible]
SAN JOSE CA	144	56	26	156	715	156000	1015		3733	2580	6313	1246	60	725	815	[illegible]	[illegible]	[illegible]	[illegible]
TEMECULA CA	134	66	26	194	492	113334	756		6067	3045	9112	1478		550	1112	[illegible]	[illegible]	[illegible]	[illegible]
VISALIA CA	127	52	26	124	327	98000	632		8654	3192	11846	1245		620	753	[illegible]	[illegible]	[illegible]	[illegible]
BOULDER CO	100	54	26	142	475	114000	731		5547	4687	10234	1440	50	600	853	[illegible]	[illegible]	[illegible]	[illegible]
COLORADO SPRINGS CO	102	54	26	169	309	85000	550		3586	3292	6878	1223	60	544	931	[illegible]	[illegible]	[illegible]	[illegible]
DENVER CO	105	55	27	126	378	109102	713		5547	4687	10234	1440	88	599	853	[illegible]	[illegible]	[illegible]	[illegible]
FORT COLLINS CO	99	53	26	139	375	80000	511		4893	4217	9110	1291	55	537	899	[illegible]	[illegible]	[illegible]	[illegible]
GRAND JUNCTION CO	126	58	32	168	318	70790	470		5321	3493	8814	1250		533	882	[illegible]	[illegible]	[illegible]	[illegible]
LONGMONT CO	102	55	27	144	415	82625	530		4543	4149	8692	1130		600	839	[illegible]	[illegible]	[illegible]	[illegible]
LOVELAND CO	102	55	26	151	346	85634	551		4474	4018	8492	960		217	865	[illegible]	[illegible]	[illegible]	[illegible]
PUEBLO CO	102	54	27	138	278	67680	443		5448	4133	9581	1414	50	500	842	[illegible]	[illegible]	[illegible]	[illegible]
DOVER DE	133	57	29	121	362	80167	535		5609	4299	9908	1435		600	759	[illegible]	[illegible]	[illegible]	[illegible]
WILMINGTON DE	137	62	30	116	400	119133	795	14468			14468	1410	75	450	794	[illegible]	[illegible]	[illegible]	[illegible]
BRADENTON FL	106	54	23	133	400	96000	634	11340			11340	1654		517	845	[illegible]	[illegible]	[illegible]	[illegible]
FORT MYERS FL	101	52	23	160	390	80000	523	12731			12731	1341	75	495	819	[illegible]	[illegible]	[illegible]	[illegible]
LAKELAND FL	108	51	22	161	357	84633	558	10306			10306	1630	75	460	853	[illegible]	[illegible]	[illegible]	[illegible]
AMERICUS GA	118	65	26	119	330	78460	502	12195			12195	1631		600	821	[illegible]	[illegible]	[illegible]	[illegible]
ATHENS GA	106	62	19	147	327	81000	518		8414	6032	14446	1852	60	468	792	[illegible]	[illegible]	[illegible]	[illegible]
ATLANTA GA	102	65	25	119	508	119000	771		8463	6432	14895	1987	60	508	736	[illegible]	[illegible]	[illegible]	[illegible]
AUGUSTA GA	101	49	18	139	385	96860	631		9090	4100	13190	1856	60	520	757	[illegible]	[illegible]	[illegible]	[illegible]

PRICE REPORT

QUARTER 1, 1987	24	25	26	27	28	29A	29B	30A	30B	31	30+31	32	33	34	35
		FRZ	BB		APT	HOME	HOME	ALL-	PART	OTHER	TOTAL	TELE		TIRE	GASO
CITY AND STATE	ORJ	CRN	FD	COK	RENT	PRICE	P+I	ELECT	ELECT	ENRGY	ENRGY	PHON	BUS	BAL	LINE
CALHOUN GA	124	58	23	112	350	100000	658	10715			10715	1696		417	859
COLUMBUS GA	126	59	25	119	349	90500	593		8129	3143	11272	1849	65	450	745
DALTON GA	112	51	24	89	338	91850	600		6210	3599	9809	1869		540	833
MACON GA	113	59	25	123	350	80120	507		9092	5460	14552	1856	50	560	849
ROME GA	116	61	23	118	320	86500	569	11827			11827	1782	50	562	849
CHAMPAIGN IL	121	55	26	177	370	104600	713		6807	5968	12775	1473	50	667	899
CHARLESTON IL	116	56	25	110	395	79667	554	11384			11384	2116		500	886
DECATUR IL	110	50	28	114	277	71937	412		6807	5968	12775	1584	50	550	907
QUAD-CITIES IL-IA	114	50	24	110	342	82800	558		7659	4407	12066	2049	62	530	883
QUINCY IL	115	51	24	140	341	79200	528	12676			12676	1439	40	550	853
ROCKFORD IL	117	58	27	136	375	87567	584		10155	5628	15783	1536	60	724	864
SPRINGFIELD IL	131	54	20	125	364	84560	569		4668	6713	11381	1503	50	610	867
ANDERSON IN	126	60	22	116	303	80000	521		4856	6642	11498	1579	50	570	845
BLOOMINGTON IN	126	56	27	111	361	78906	535	13065			13065	1646	50	540	861
FORT WAYNE IN	109	57	27	152	420	76024	493		5815	5666	11481	2284	50	475	879
INDIANAPOLIS IN	109	58	26	115	382	86963	561		5421	5594	11015	1922	105	600	847
MARION IN	122	55	27	136	364	80700	546		5298	5241	10539	1659	50	500	909
SOUTH BEND IN	115	53	22	131	417	74040	479		4815	5089	9904	1765	50	524	831
WARSAW IN	142	56	23	171	350	95667	655		7140	5055	12195	1783		308	892
AMES IA	113	53	22	128	399	119233	795		5979	4650	10629	1867	60	739	855
CEDAR RAPIDS IA	121	56	21	143	373	97720	640		6108	4126	10234	1915	50	600	867
CLARINDA IA	140	60	24	134	250	65000	431		8380	4832	13212	741		350	844
CLINTON IA	123	52	25	106	325	75000	517		5941	4811	10752	1867	50	583	862
COUNCIL BLUFFS IA	123	56	24	163	366	72667	477		6950	4977	11927	1915	75	648	869
FORT DODGE IA	111	53	25	119	325	90000	637		6376	4085	10461	1140	50	567	869
IOWA CITY IA	117	52	20	138	375	105000	692		6462	3924	10386	1875	50	667	899
MARSHALLTOWN IA	122	53	21	136	293	69000	444		6042	4395	10437	1760	50	492	929
MASON CITY IA	101	51	22	119	292	84791	566		5821	4329	10150	1915	50	627	859
GARDEN CITY KS	133	59	23	146	330	71150	481		8630	2765	11395	1520		488	835
GREAT BEND KS	136	56	28	153	348	84500	559		6207	3242	9449	1265		542	822
LIBERAL KS	137	60	27	121	311	87000	566		5973	3837	9810	1532		533	876
SALINA KS	123	54	22	102	281	78600	527		7053	2973	10026	1553		490	799
WICHITA KS	111	54	23	159	335	39000	517		10339	2980	13319	1515	75	450	762
LEXINGTON KY	135	58	26	129	443	97215	642	11442			11442	1933	60	549	813
LOUISVILLE KY	127	55	23	117	371	81300	528		5549	5530	11079	2070	60	540	847
MAYFIELD KY	119	67	27	119	253	69700	469		6395	4664	11059	1857		500	832
OWENSBORO KY	133	61	26	173	312	81922	550		4619	3506	8125	2506		530	833
SOMERSET KY	146	58	24	132	266	71200	486	9891			9891	2185		413	891
BATON ROUGE LA	118	47	20	128	296	89100	568		9731	1793	11524	1840	55	500	759
LAFAYETTE LA	125	51	24	137	331	79058	516	14086			14086	1816	45	600	765
LAKE CHARLES LA	126	60	19	128	339	71467	467	13178			13178	1774		600	843
MONROE LA	129	54	22	114	336	77600	501	14639			14639	1720		490	849
MORGAN CITY LA	130	66	23	127	340	72667	505		8280	3700	11980	1667		524	912
NEW ORLEANS LA	118	50	22	137	334	87600	580	11978			11978	1940	80	539	745
LEWISTON ME	111	54	29	179	379	72380	456		6323	5415	11738	1584		456	829

PRICE REPORT

QUARTER 1, 1987

CITY AND STATE	24 ORJ	25 FRZ CRN	26 BB FD	27 COK	28 APT RENT	29A HOME PRICE	29B HOME P+I	30A ALL-ELECT	30B PART ELECT	31 OTHER ENRGY	30+31 TOTAL ENRGY	32 TELE PHON	33 BUS	34 TIRE DAL	35 GASO LINE	[illegible] HOSP ROOM	[illegible] DOC TOR	[illegible] DENTASP TEST RIN
BALTIMORE MD	124	64	26	105	498	97460	637	11145			11145	2084	90	599	803	3450	140	2800 223
BOSTON MA	134	79	29	129	1200	225000	1504		6495	8196	14691	1957	120	600	823	6740	380	4040 348
FITCHBURG-LEOMINSTER MA	112	48	25	119	500	171667	1122		9490	5580	15070	1482	100	515	855	5990	320	2540 307
BENTON HARBOR-ST JOSEPH MI	115	56	24	125	326	88500	600		5957	5387	11344	1548	90	549	921	3000	2650	2980 270
JACKSON MI	103	60	25	186	295	78408	535		5185	6019	11204	1530	60	458	892	2550	2267	2633 274
LANSING MI	134	59	27	152	450	90000	622		3500	6029	9529	1603	75	665	869	2800	2500	4375 328
MARQUETTE MI	122	60	30	153	374	73933	502		5471	7525	12996	1438	100	500	919	1950	3300	4100 368
TRAVERSE CITY MI	134	58	28	129	467	93333	635		7329	7775	15104	1757	100	525	946	2600	2100	2900 336
ST CLOUD MN	117	57	25	162	386	75741	493		7062	5500	12562	1960	25	590	849	4400	2137	3325 296
ST PAUL MN	109	54	25	163	485	96400	626		5244	7249	12493	2056	75	710	843	6900	2280	3440 239
GULFPORT MS	124	88	20	104	376	79000	515		9533	2935	12468	2489	75	569	829	3600	2200	2567 [illegible]
LAUREL MS	122	68	21	122	258	75460	495	9157			9157	2539		510	893	9800	1900	2440 [illegible]
CLINTON MO	126	57	25	127	289	74150	494		8824	3189	12013	1069		470	779	5500	1800	2200 150
COLUMBIA MO	121	57	20	145	314	83250	556		6092	3244	9336	1201		620	747	2500	810	3480 237
JEFFERSON CITY MO	114	64	17	106	295	90000	614		5763	4295	10058	813	50	563	847	5600	85	3000 280
JOPLIN MO	98	62	26	105	332	75550	500	10552			10552	1325		460	759	9863	348	2500 280
KIRKSVILLE MO	130	58	26	124	338	82667	552		6150	4417	10567	1530		390	729	9350	680	2725 300
POPLAR BLUFF MO	140	59	27	125	310	68400	466	9817			9817	1558		600	789	6100	93	2600 328
ST JOSEPH MO	122	52	24	114	314	86400	568		5691	4542	10233	1489	50	550	739	2250	1940	3000 362
ST LOUIS MO	117	53	26	151	408	85510	570		6047	6439	12486	1304	75	508	795	2010	318	3160 207
SPRINGFIELD MO	111	59	24	139	277	78800	533		4751	4002	8753	1660	50	420	735	1700	2600	2440 230
BILLINGS MT	137	48	23	169	379	93900	601		5618	4970	10588	1707	50	510	829	8060	2260	3620 336
GREAT FALLS MT	136	49	23	129	373	75000	492		4510	4427	8937	1784	50	600	766	4900	2467	3933 363
MISSOULA MT	123	48	26	139	310	63500	417		5170	3883	9053	1732		520	783	2000	2060	5700 314
HASTINGS NE	130	54	25	147	330	70195	451		5796	5522	11318	1361		450	829	8000	2200	2400 [illegible]
KEARNEY NE	127	57	28	166	314	72000	477		5300	3961	9261	1132		515	907	7000	1770	1880 [illegible]
LINCOLN NE	118	55	21	127	358	87000	570		5329	5013	10342	1497	65	603	819	8000	2100	2740 [illegible]
OMAHA NE	111	50	24	113	399	80900	551		4926	4635	9561	2140	75	540	845	8500	2190	3340 [illegible]
WAYNE NE	124	57	32	139	340	82500	550		6069	5054	11123	1963		493	889	3700	1400	3700 162
RENO-SPARKS NV	99	52	28	125	481	103760	675		7885	3094	10979	1435	100	600	819	7853	3180	3425 [illegible]
NEWARK-ELIZABETH NJ	128	56	30	124	709	132200	860		8662	8528	17190	1297	120	554	799	5256	3575	4925 288
ALAMOGORDO NM	129	56	27	150	351	93833	625		6647	3407	10054	2227		544	827	8000	2987	2945 [illegible]
ALBUQUERQUE NM	118	60	26	169	410	103923	681		6711	2916	9627	1684	60	633	747	3250	2476	3625 [illegible]
CLOVIS NM	126	54	26	138	350	85590	564	11000			11000	2410		510	863	1500	2562	2820 346
FARMINGTON NM	135	59	29	165	359	95667	615		5271	3614	8885	2252		628	849	1800	2122	3612 277
LOS ALAMOS NM	126	63	26	172	438	135000	883		3666	3214	6880	2156		583	876	3000	2455	4700 303
ROSWELL NM	123	58	25	145	299	84020	558		4203	2963	7166	2325		480	823	1850	2190	2560 325
ALBANY-COLONIE NY	125	52	25	134	456	113750	766		7605	5763	13368	2034	60	694	763	3413	3241	3120 321
BINGHAMTON NY	106	51	28	124	381	89267	587		8520	6208	14728	2268	50	500	855	8600	2700	3133 282
BUFFALO NY	129	48	30	149	306	68072	435		5235	6679	11914	2657	100	587	839	1200	2583	2662 199
CHENANGO COUNTY NY	120	60	29	132	294	92074	609		7660	7592	15252	1749		499	857	8200	1820	3388 [illegible]
ELMIRA NY	130	52	29	127	369	79140	528		7673	8115	16308	2105	75	388	899	[illegible]	[illegible]	[illegible]

PRICE REPORT

QUARTER 1, 1987 CITY AND STATE	24 ORJ	25 FRZ CRN	26 OD FD	27 COK	28 APT RENT	29A HOME PRICE	29B HOME P+I	30A ALL-ELECT	30B PART ELECT	31 OTHER ENRGY	30+31 TOTAL ENRGY	32 TELE PHON	33 BUS	34 TIRE BAL	35 GASO LINE	HOSP ROOM	37 DOCTOR	38 DENTIST	39 SP IN
GLENS FALLS NY	119	54	32	151	405	76660	503		5125	8450	13575	2058	50	579	824	[illegible]	[illegible]	2300	[illegible]
NEW YORK NY	139	55	31	109	991	135000	927		10865	10697	21562	2436	100	670	817	[illegible]	[illegible]	3900	[illegible]
SARATOGA SPRINGS NY	114	54	31	142	483	114800	757		9800	4534	14334	3170		402	816	[illegible]	[illegible]	2067	[illegible]
SCHENECTADY NY	131	55	32	161	439	109800	745		4744	10430	15174	2736	90	570	803	[illegible]	2900	3580	[illegible]
SUFFOLK COUNTY NY	141	55	29	123	786	189500	1216		16344	6542	22886	3698	75	760	799	[illegible]	3700	4667	[illegible]
SYRACUSE NY	88	59	28	125	344	70960	462		5391	8351	13742	2659	60	489	809	[illegible]	2540	2380	[illegible]
CHAPEL HILL NC	112	48	22	159	444	120667	798	12132			12132	1562	50	600	820	[illegible]	2633	2967	[illegible]
CHARLOTTE NC	109	46	20	124	395	93000	597	12132			12132	1829	70	490	849	[illegible]	2700	3225	[illegible]
ELIZABETH CITY NC	103	53	22	106	380	80000	529	12587			12587	1803		504	928	[illegible]	2500	2880	[illegible]
GREENSBORO NC	116	42	20	116	344	95075	607	12125			12125	1792	50	500	856	[illegible]	[illegible]	2540	[illegible]
GREENVILLE NC	115	50	21	95	324	94400	619	10802			10802	1581	50	525	872	[illegible]	[illegible]	2900	[illegible]
HICKORY NC	118	47	19	92	330	82967	537	12132			12132	1665		723	866	[illegible]	[illegible]	2867	[illegible]
HIGH POINT NC	115	44	19	123	360	102500	667	12171			12171	756	75	480	845	[illegible]	[illegible]	2340	[illegible]
RALEIGH NC	109	49	19	131	452	104340	671	11290			11290	1817	60	530	851	[illegible]	[illegible]	2950	[illegible]
ROANOKE RAPIDS NC	121	52	21	137	265	82398	556	13948			13948	1602		530	859	[illegible]	[illegible]	3600	[illegible]
ROCKY MOUNT NC	122	54	21	104	362	89820	579	10975			10975	1933	50	475	846	[illegible]	[illegible]	3000	[illegible]
WILMINGTON NC	111	51	21	122	345	94978	622	10971			10971	1687	50	470	852	[illegible]	[illegible]	[illegible]	[illegible]
WINSTON-SALEM NC	109	49	21	131	355	106750	701	12132			12132	1650	50	495	856	[illegible]	[illegible]	[illegible]	[illegible]
AKRON OH	100	50	19	104	399	80850	537		7311	6204	13515	1925	65	649	819	[illegible]	[illegible]	3125	[illegible]
ASHLAND OH	134	59	22	158	290	84000	564		7352	5862	13214	1702		500	852	[illegible]	[illegible]	2567	[illegible]
BUCYRUS OH	113	63	21	129	266	76000	534		6362	6484	12846	1863		475	846	[illegible]	[illegible]	2500	[illegible]
CANTON OH	107	51	20	110	360	77167	513		6404	4852	11256	1983	40	460	835	[illegible]	2700	2400	[illegible]
COLUMBUS OH	136	59	27	145	355	82750	543		6440	6175	12615	2503	60	645	859	21100	[illegible]	2860	[illegible]
DAYTON OH	126	66	23	109	446	93333	601		6771	4938	11709	1982	60	575	853	[illegible]	[illegible]	2400	[illegible]
FINDLAY OH	122	56	26	106	342	95487	647		5423	5360	10783	1964		550	841	16500	[illegible]	2680	[illegible]
LIMA OH	128	61	24	119	330	85400	569		6047	6169	12216	2127	60	550	809	18100	2400	2550	[illegible]
LORAIN OH	122	54	24	142	322	90133	609		6245	6131	12376	1620		650	821	[illegible]	2167	3033	[illegible]
YOUNGSTOWN OH	116	51	20	134	295	84500	576		7628	4380	12008	1983	60	367	832	[illegible]	[illegible]	[illegible]	[illegible]
OKLAHOMA CITY OK	123	60	27	177	321	73300	492		9309	3310	12619	1739	75	450	769	16560	2300	3000	[illegible]
TULSA OK	126	59	25	131	336	81434	536		8284	3774	12058	1702	60	556	783	[illegible]	[illegible]	3012	316
EUGENE OR	127	56	25	157	383	95525	616	6452			6452	2072	60	600	782	[illegible]	[illegible]	[illegible]	309
SALEM OR	120	51	24	134	313	78000	513	8651			8651	1976	50	570	789	10900	[illegible]	[illegible]	[illegible]
ERIE PA	119	53	22	145	385	85500	577		5670	6241	11911	1912	75	490	829	[illegible]	[illegible]	[illegible]	[illegible]
HARRISBURG PA	134	52	27	123	432	87940	561	14635			14635	1445	120	539	827	16500	2140	3660	339
HAZLETON PA	134	51	27	113	395	69500	493	17296			17296	1315	75	360	893	15450	1980	2625	369
LANCASTER PA	132	63	28	129	375	84250	557	13809			13809	1437	130	574	772	17167	[illegible]	2550	[illegible]
LEBANON PA	134	53	28	115	400	85000	562	11965			11965	1192		570	843	20250	[illegible]	2960	351
MONTGOMERY COUNTY PA	116	52	29	133	499	119000	774	19185			19185	1305	125	539	797	27580	2600	4300	[illegible]
PHILADELPHIA PA	128	56	30	124	571	102280	660	19185			19185	1345	130	474	804	[illegible]	3100	3980	290
WAYNESBORO PA	136	45	27	149	362	98333	691	11689			11689	1354		367	902	17000	[illegible]	2650	315
WILKES-BARRE PA	128	57	28	108	410	78640	529	15066			15066	1240	90	395	785	21500	1960	2640	295
YORK PA	129	50	27	139	402	87150	581		6523	5405	11928	1941	65	500	811	17500	2300	2500	[illegible]
COLUMBIA SC	105	52	21	147	369	80140	573	14683			14683	1710		565	861	[illegible]	[illegible]	3100	[illegible]
FLORENCE SC	112	54	22	112	375	90167	509	10814			10814	2523		450	836	15500	[illegible]	2767	[illegible]
GREENVILLE SC	90	60	15	100	315	86400	560	11539			11539	2371	75	525	817	16000	[illegible]	[illegible]	[illegible]
MYRTLE BEACH SC	112	56	20	121	412	103525	678	10212			10212	1736	50	470	844	[illegible]	[illegible]	[illegible]	[illegible]
SPARTANBURG SC	92	57	16	111	385	82200	531	11539			11539	2052		480	841	[illegible]	[illegible]	[illegible]	[illegible]

PRICE REPORT

QUARTER 1, 1987	24	25	26	27	28	29A	29B	30A	30B	31	30+31	32	33	34	35	38	39
		FRZ	DB		APT	HOME	HOME	ALL-	PART	OTHER	TOTAL	TELE		TIRE	GASO	DOC	DEN
CITY AND STATE	ORJ	CRN	FD	COK	RENT	PRICE	P+I	ELECT	ELECT	ENRGY	ENRGY	PHON	BUS	BAL	LINE	TUR	TIST
ABERDEEN SD	123	53	20	150	320	78125	531		8529	6304	14833	1736		475	789	1600	3033
RAPID CITY SD	127	58	29	176	406	67433	444		5159	5789	10948	2071	85	450	859	2400	3900
VERMILLION SD	146	59	25	134	270	68500	456		4404	5230	9634	1642		467	859	1900	3600
BRISTOL TN-VA	112	46	16	117	358	83667	541	10436			10436	1984		490	897	2225	2700
CLEVELAND TN	116	55	25	116	284	83750	550	13877			13877	1723		583	832	2420	2560
JACKSON TN	136	61	27	125	318	73800	474	12533			12533	1612		600	919	2013	2783
KINGSPORT TN	112	44	15	136	330	80000	551	10325			10325	1881		625	869	2350	2200
KNOXVILLE TN	110	51	19	130	393	78622	519	12021			12021	1799	85	500	809	2260	2400
MORRISTOWN TN	142	59	25	112	279	78667	526	9703			9703	2155		425	839	2067	2267
MEMPHIS TN	116	58	29	122	364	87000	570		7332	2717	10049	1665	85	579	745	2200	2160
MORRISTOWN TN	110	48	18	144	262	71967	481	12448			12448	1596		520	882	2040	2200
NASHVILLE-DAVIDSON TN	129	59	27	132	435	99850	678		7532	4536	12068	1811	85	500	879	2400	2540
PARIS TN	129	65	27	112	342	70000	463	10733			10733	1592		400	842	2000	2800
ABILENE TX	113	54	27	131	287	84000	551		8370	2608	10978	1269	60	580	831	1900	2780
AMARILLO TX	122	56	26	139	348	84400	549		7098	2925	10023	1319	45	500	847	2380	2720
AUSTIN TX	112	56	24	139	468	99500	635		5765	5589	11354	1349	50	649	799	1820	3580
BEAUMONT TX	117	57	22	135	375	75000	489		6900	3317	10217	1300	50	502	791	1540	2820
BROWNSVILLE TX	124	58	28	143	305	74100	506	14543			14543	1242	50	570	912	1500	2420
BRYAN-COLLEGE STATION TX	129	57	29	176	357	96680	626	12708			12708	1561		569	829	1620	4340
DALLAS TX	129	61	27	156	447	94391	605		9992	2612	12604	1462	100	594	779	2260	3760
EDINBURG TX	124	58	30	132	326	73640	454	12800			12800	1235		594	932	1100	2120
EL PASO TX	112	51	26	141	321	91000	587		6789	2783	9572	1323	75	590	905	2800	2730
FORT WORTH TX	128	52	30	148	345	78800	492		8323	4524	12847	1368	75	430	795	2560	2720
HARLINGEN TX	120	59	30	129	333	79867	529	11089			11089	1373	95	606	914	2479	2767
HOUSTON TX	123	61	25	136	308	72902	469		9646	2393	12039	1546	88	669	726	2780	3350
HUNTSVILLE TX	127	62	25	139	389	73947	486	12356			12356	1257		635	856	2750	3040
KERRVILLE TX	132	57	31	146	405	84600	552		7760	1272	9032	906		550	819	2600	3100
KILLEEN TX	133	64	27	138	408	88440	565	10953			10953	1505		520	879	2120	2550
LUBBOCK TX	113	53	26	141	325	76480	487		7248	3443	10691	1194	75	539	839	2200	2680
LUFKIN TX	125	60	23	133	380	75000	477		9202	3608	12810	1125		400	904	2000	2440
MCALLEN TX	122	56	20	139	321	78200	502	12185			12185	1235		480	899	2060	2580
NACOGDOCHES TX	126	59	29	140	398	82167	534		9202	3608	12810	1113		510	833	2180	2360
ODESSA TX	135	54	29	131	318	77180	501	11073			11073	1301		625	899	2325	3600
SAN ANTONIO TX	123	51	27	139	302	92500	604		9779	2768	12547	1310	58	620	757	2700	2480
SHERMAN TX	125	63	26	162	320	85800	551		8917	4193	13110	1733		448	834	1500	2475
TEMPLE TX	137	58	25	149	304	75967	494	11385			11385	1291		500	839	2000	2600
TEXARKANA TX-AR	130	60	27	136	349	76000	503		7070	2809	9879	1584		533	829	2200	2625
TYLER TX	121	57	28	152	300	72500	473		7122	3861	10983	1498		570	896	2620	2975
VICTORIA TX	127	57	24	162	330	89500	587	10990			10990	1243		723	869	2583	3067
WACO TX	120	54	24	151	360	76900	496	12518			12518	1235	75	500	875	2785	2650
WICHITA FALLS TX	126	59	28	156	308	88540	586	14412			14412	1235	75	679	914	2320	2920
SALT LAKE CITY UT	114	50	26	120	336	80969	533		5106	4712	9818	2269	50	610	799	2260	3525
MONTPELIER-BARRE VT	135	51	25	139	438	94000	603		14984	2500	17484	1711	90	383	819	2006	2267
HAMPTON ROADS/SE VIRGINIA	125	54	22	100	361	95030	615	10878			10878	2152	130	530	839	2570	2690
PRINCE WILLIAM VA	118	61	26	124	495	122630	783	10876			10876	2107		600	845	2620	3500
ROANOKE VA	118	52	20	109	366	99100	634	9109			9109	1748		574	857	1820	2960
OLYMPIA WA	120	52	28	138	323	84600	553		3301	4069	7370	1572		429	779		

PRICE REPORT

QUARTER 1, 1987

CITY AND STATE	24 ORJ	25 FRZ CRN	26 DB FD	27 COK	28 APT RENT	29A HOME PRICE	29B [illegible]	30A ALL-ELECT	30B PART ELECT	31 OTHER ENRGY	30+31 TOTAL ENRGY	32 TELE PHCN	33 BUS	34 TIRE BAL	35 GASO LINE	[illegible]	DOC TOR	DEN TIST	ASP [illegible]
RENTON WA	125	53	28	124	416	90000	597		5803	4464	10267	1825	85	624	784	[illegible]	[illegible]	[illegible]	[illegible]
RICHLAND-KENNEWICK WA	120	51	22	118	277	72950	484	8621			8621	1635		538	844	[illegible]	[illegible]	[illegible]	[illegible]
SEATTLE WA	125	63	30	152	429	92341	597	5915			5915	1756	100	667	764	[illegible]	[illegible]	[illegible]	[illegible]
SPOKANE WA	119	48	24	106	322	84072	555		4976	3419	8395	1638	60	518	831	[illegible]	[illegible]	[illegible]	[illegible]
TACOMA WA	129	59	29	136	396	92160	592	7037			7037	1848	60	489	781	[illegible]	[illegible]	5220	[illegible]
WALLA WALLA WA	126	53	26	144	315	85689	563	10097			10097	1609		567	897	[illegible]	[illegible]	4567	[illegible]
WENATCHEE-EAST WENATCHEE WA	112	55	24	149	380	78625	517	6547			6547	1450		612	869	[illegible]	[illegible]	[illegible]	[illegible]
CHARLESTON WV	142	59	28	169	383	73967	483	9416			9416	2797	60	529	859	[illegible]	[illegible]	[illegible]	[illegible]
HUNTINGTON WV	122	53	24	141	383	75000	486	9416			9416	3060		475	831	[illegible]	[illegible]	[illegible]	[illegible]
APPLETON WI	104	52	26	103	305	90000	597		4698	5733	10431	1939	50	462	899	[illegible]	[illegible]	[illegible]	[illegible]
EAU CLAIRE WI	106	66	24	106	390	70640	469		6230	5132	11362	2009		460	879	[illegible]	[illegible]	[illegible]	[illegible]
FOND DU LAC WI	110	56	29	107	371	98133	668		4375	5522	9897	1850	50	593	907	[illegible]	[illegible]	[illegible]	[illegible]
GREEN BAY WI	114	55	26	107	280	87250	578		4727	6777	11504	2052	50	667	919	[illegible]	[illegible]	[illegible]	[illegible]
JANESVILLE WI	107	54	27	128	345	75362	497		4375	5522	9897	2009	50	320	855	[illegible]	[illegible]	2660	[illegible]
LA CROSSE WI	112	52	26	106	342	78975	517		5183	4317	9500	1452	50	600	883	[illegible]	[illegible]	3300	[illegible]
MANITOWOC-TWO RIVERS WI	108	58	27	106	293	88125	578		4727	6777	11504	1998		470	919	[illegible]	[illegible]	2853	[illegible]
MARINETTE WI	117	50	28	96	292	80250	526		4727	6777	11504	1835		592	859	[illegible]	[illegible]	[illegible]	[illegible]
NEW LONDON WI	112	57	28	109	312	87900	562		4401	7149	11550	1854		450	886	[illegible]	[illegible]	3300	[illegible]
WAUSAU WI	111	59	27	112	346	80000	533		4727	6777	11504	2159	50	490	869	[illegible]	[illegible]	[illegible]	[illegible]
CASPER WY	106	58	24	164	326	69500	484		3833	7360	11193	1487		533	717	[illegible]	[illegible]	[illegible]	[illegible]
GILLETTE WY	137	49	26	157	320	73700	487		5029	5990	11019	1510		608	769	[illegible]	[illegible]	[illegible]	[illegible]
NUMBER OF CITIES	247	247	47	247	247	247	247	83	164	164	247	247	149	247	247	[illegible]	[illegible]	247	[illegible]
MINIMUM	88	42	15	88	250	63500	417	5915	3301	1272	5915	741	25	217	717	[illegible]	[illegible]	[illegible]	[illegible]
MAXIMUM	154	88	35	241	1200	225000	1504	19185	16344	10697	22886	3698	130	836	1266	[illegible]	[illegible]	[illegible]	[illegible]
MEDIAN	122	55	26	133	357	84500	556	11442	6323	4557	11381	1690	60	540	843	[illegible]	[illegible]	[illegible]	[illegible]
MEAN	121	56	25	135	379	89163	587	11715	6686	4738	11522	1722	68	542	840	[illegible]	[illegible]	[illegible]	[illegible]
STANDARD DEVIATION	12	5	3	24	111	2725	132	2302	1949	1686	2300	434	21	87	59	[illegible]	[illegible]	[illegible]	[illegible]

DRAFT

A COMPARISON OF
STATE INDIGENT CARE

Division of Planning

Department of Health and Social Services

April 1986

STATE OF ALASKA

BILL SHEFFIELD, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PLANNING

P.O. Box H-01A
JUNEAU, ALASKA 99811
PHONE: 465-3030

May 2, 1986

Ms. Lisa McLaren
Representative Koponen's Office
P.O. Box V
Juneau, Alaska 99811

Dear Ms. McLaren:

Enclosed is a copy of the draft report, A Comparison of State Indigent Care. This report describes research the Division of Planning conducted to ascertain how Alaska's General Relief Medical (GR-M) Program compares to other state indigent care programs.

The Division of Planning is currently working on an addendum to the enclosed report, An Analysis of Benefit Options for FY 87 GR-M, that will compare possible outcomes for the FY 87 GR-M Program to programs in other states. You will be provided a copy of the addendum when it is available.

Sincerely,

Patricia R. Alexander
Director

Enclosure

06-F76LH

DRAFT

EXECUTIVE SUMMARY

Most state governments administer statewide indigent health care programs. The State of Alaska for instance, administers the General Relief Medical (GR-M) Program. To ascertain how the current GR-M Program compares to other state indigent care programs, the Department of Health and Social Services analyzed three components of each state indigent care program.

The review of the benefit coverage component indicates GR-M ranks Alaska in the upper one-fourth of all states in regards to the quantity of services provided. The type of benefit coverage provided by GR-M places the program in the upper one-third of all programs.

The review of the eligibility standards component reveals that only one program allows substantially more income and assets than Alaska's GR-M. Fourteen other programs have income and asset criteria similar to those of GR-M, while 21 programs have more restrictive criteria.

The review of the source-of-funding component shows 26 programs, including Alaska's GR-M, are solely funded by state government, and 26 are jointly funded by state and local government. Six depend on local funding only.

DRAFT

A COMPARISON OF STATE INDIGENT CARE

The State of Alaska currently administers a state indigent care program, the General Relief Medical (GR-M) Program. For indigents who qualify, GR-M provides benefits similar to those of the state's Medicaid Program. The similarity between the benefits of these two programs is explained by reviewing their history.

When GR-M began in 1953, it offered major medical care to two groups of people: those not covered by private health insurance and those covered under other federal programs, such as the Indian Health Service. In 1972 Alaska entered the federal Medicaid program, and GR-M changed in two ways: first, all GR-M recipients were moved to Medicaid; next, GR-M was redefined to cover only low income adults and children who did not qualify for Medicaid and who had no other coverage. After 1972, GR-M recipients were provided similar medical services to those available to Medicaid recipients. The last major change to GR-M was made in 1982: two groups, low income children and pregnant women who did not qualify for Aid to Families with Dependent Children, were moved from GR-M to Medicaid. However, another major change now seems inevitable.

The Governor's FY 87 budget calls for a 45 percent reduction from FY 86 spending for GR-M. Anticipating this budget reduction, the Division of Medical Assistance requested research to ascertain how Alaska's GR-M Program compares with other state indigent care programs. This report describes the methodology used for the comparison and highlights the results.

Methodology

A format for the comparison was adopted first. Since many states have a residual statewide program like GR-M based on their respective Medicaid programs, the chart of "Medicaid Services State by State" was selected for the format. This chart, a copy of which is located in Appendix A, lists the eight mandatory basic services and the 32 optional services provided by Medicaid.

The Medicaid format was used to tally each progam's benefits. The Intergovernmental Health Policy Project's document, State Programs of Assistance for the Medically Indigent[1] was used as a source. This report is an up-to-date compendium of statewide programs that are designed to assist the medically indigent and are administered or funded wholly or in part by the state government. The document profiles each state's program(s). A program profile includes a description of eligibility standards, administrative responsibilities, benefit coverage, source of funding, recipient counts and total expenditures. The benefit coverage component of a profile was used to tabulate each program's benefits. Appendix B contains the tabulation, Figure 1: State Indigent Care Services.

Several benefits listed in the source document did not match with benefit categories in the Medicaid format. Two methods were used to include these services in the tally. First, to accommodate benefits beyond Medicaid, three additional categories--transportation, medical equipment and supplies, and kidney dialysis--were added to the format. A second method was used for services similar to Medicaid benefit categories; here, two types of assumptions were made. The first type assumes that a given benefit from the source document can be equated with a Medicaid benefit category. The second assumes that a given benefit constitutes only part of a Medicaid benefit category; this report designates the latter as a partial service. Appendix B lists both types of tabulation assumptions.

method used to categorize and rank benefits was based on several assumptions as well as information from a document with a few incomplete entries. Further, the ranking assumes equal weight for all service categories.

Reviewing Column 5a of Table 1 in conjunction with a state's ranking will reveal a program's focus. For example, compare Michigan's General Assistance-Medical (GA-M) Program with Missouri's GR-M Program. According to Table 1, both programs offer five "Basic" services. However, Michigan's GA-M Program has three times as many "Optional" services as Missouri's GR-M Program, and thus ranks higher than Missouri. Column 5a indicates that Michigan's program provides "Ambulatory" services whereas Missouri's provides "Basic Coverage."

The type of benefits provided by state indigent care programs range from those that are the same as a state's Medicaid program to those that provide ambulatory services only. Table 3 lists all benefit types in ascending order of services as well as their distribution among the states. Alaska's GR-M Program, which is similar to Medicaid, is situated in the upper one-third of all state indigent care programs.

Table 3: The Distribution of State Indigent Care Programs by Benefit Type

Benefit Type[2]	Number of Programs
Varies by County	10
Ambulatory	5
Inpatient Hospital	5
Hospital (Inpatient and Outpatient)	8
Hospital and Physician	1
Hospital and Ambulatory	1
Basic Coverage	6
Similar to Medicaid	11
Same as Medicaid	9
TOTAL[3]	56

The "Scope of Eligibles" category in Table 1 reveals that only one program, California's County Medical Services Program, allows substantially more income and assets than Alaska's GR-M. To qualify for California's County Medical Services Program, an adult must earn less than $484 a month and have liquid assets under $1,500, excluding the home and autombile. To qualify for Alaska's GR-M Program, income must be less than $300 a month and liquid assets less than $500, excluding the home and vehicle. Fourteen other programs have income and asset criteria similar to those of the GR-M Program, while 21 progams have more restrictive criteria.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

DRAFT

A COMPARISON OF STATE INDIGENT CARE

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For instance, when a state's profile is listed as "Home Health" in the benefit coverage, the service was tabulated as a partial "Skilled Nursing Facility and Home Health Services" (a Medicaid category). Figure 1's Key (in Appendix B) explains the symbols used to distinguish between partial and complete services.

To determine how Alaska compares to other states, the chart of State Indigent Care Services (Figure 1) was summarized. The 43 benefit categories were condensed into three groups: "Basic" and "Optional" (both based on Medicaid services) and "Other" (the additional categories added to the Medicaid format). There are eight basic and 32 optional services under Medicaid, and three other services beyond Medicaid. The total number of services in each group is shown in Columns 5b, 5c and 5d of Table 1, Appendix B.

A ranking of states by program benefits was selected as the method for comparing services. The total of all services--the "Basic", "Optional", and "Other" service categories--was used to assign position. That is, the state with the most services in a single program was listed first in Table 1, the state with the next highest follows, etc. The ranking explanation in Appendix B explains how ties were resolved.

Two other state profile components were compared in Table 1. To show how other states' eligibility criteria compare to GR-M's, a "Scope of Eligibles" was included. Asset and income requirements in the eligibility standards component of the state profiles (in the source document) were reviewed to derive the comparison shown in Column 3. Categories for comparison include:

- "More" (those states with less restrictive eligibility requirements, such as allowing more assets and higher income than GR-M's criteria),
- "Equal" (those states with criteria the same or similar to Alaska), and
- "Less" (those states with more restrictive criteria).

The "Scope of Eligibles" analysis does not influence the ranking in Table 1.

To show how other states pay for state indigent care programs, Column 4, "Financing," was included in Table 1. The source-of-funding component of the state profiles (in the source document) was reviewed to determine whether state and/or local governments provide financial support for the care.

The state profiles in the source document also describe other state programs or policies that assist the medically indigent. These include limited state indigent care programs, indigent care provisions in rate-setting states, alternatives to impose private health insurance coverage, and certificate-of-need provisions affecting indigent care. The Director of the Division of Medical Assistance expressed interest in the limited state indigent care programs. These are summarized in Table 2, Appendix C.

Results

The analysis indicates that benefits provided by state indigent care programs vary in both quantity and type. The number of services provided range from New Jersey with 35 to Florida, Mississippi and Nevada each with three. Alaska ranks ninth with 25 services, placing it in the upper one-fifth of all states. Column 6 in Table 1, Appendix B contains the complete ranking. Note that the