ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
4562 HHES HB 409 - HB 411 134

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

February 1, 1988

MEMORANDUM

TO: Representative Johnny Ellis

ATTN: Leola Weimer

FROM: Patricia Brawley pb
Legislative Analyst

RE: **Incentive Programs for Health Care Providers in Rural Areas**
Research Request 88.117

You asked for information about incentive programs used by other states and/or countries to encourage health care providers to practice in rural or medically underserved areas. You also asked who determines what areas are classified as medically underserved.

International Programs

The World Health Organization (WHO), representing 104 countries, offers fellowships worldwide to promote health care in Third World countries. The Ministry of Health for each member country determines the national need and selects applicants for training. Applications are then forwarded to a regional WHO office, which awards fellowships and assists in appropriate placement for training. In return, recipients are obligated to return to their own countries to practice. Each country's Ministry of Health determines length of service obligation and default penalties.

Federal Program

As you may know, Public Law 100-177--which has been signed but not yet funded--replaces the National Health Service Corps (NHSC) Scholarship Program with a Loan Repayment Program. Under the Scholarship Program, contracts made with first year medical students obligated them to serve, upon completion of their medical school and residency training, in a specific discipline and in a specific location designated as a Health

Manpower Shortage Area. Because many medical students change specialties during their seven- to nine-year training, and because personal circumstances often change so much during that time, physicians often chose to default on the service obligations rather than practice in rural areas where their particular discipline might not be in demand or where, because of personal circumstances, they were no longer willing to go. Under the new Loan Repayment Program, the NHSC will contract with health professionals who are either in the final year of training or who are fully certified. Because physicians will be established in their specialties and will more likely know whether their personal circumstances will conflict with service in rural areas, fewer service-obligation defaults are expected.

Under the Loan Repayment Program, the NHSC will be repaying loans while the health professional is providing service, rather than providing educational costs and a stipend prior to service, as was the case under the Scholarship Program. Health professionals will agree to serve for a minimum of two years in a designated shortage area, and for each year of obligated service the Department of Health and Human Services (DHHS) will agree to pay up to $20,000 on behalf of the individual for educational loans. (That amount increases to $25,000 for service in the Indian Health Service, or in a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act.) Under PL 100-177, health professionals who fail to fulfill their obligation would be required to repay the amount of prepaid principal and interest, with interest on that amount, plus a penalty of $500 per month for unserved time.

Public Law 100-177 also provides for a three-year program of grants to support the establishment of state programs similar to the NSHC Loan Repayment Program. According to Mario Manecci, Chief of Assignee Preparation, Health Services Scholarships, Bureau of Health Care, Delivery and Assistance, guidelines for the state grants program will be developed this year, with implementation expected in FY 89. The grant program is intended to begin the process of decentralizing distribution and incentive programs.

Though guidelines have yet to be developed, individual states will be responsible for identifying shortage areas, locating and recruiting appropriate health professionals and contracting with them. The federal share of the costs of any state program shall not exceed 75 percent (as authorized by PL 100-177, sec. 338H). One possiblity described by Mr. Manecci would be 60 percent federal/40 percent state funding for the first year, 40 percent federal/60 percent state funding the second year, 20 percent federal/80 percent state funding the third year, followed thereafter by 100 percent state funding. There is no indication of how funds authorized for this program will be divided among participating states, but consideration of need will no doubt be a factor.

State Programs

The "Compendium of State Health Professions Distribution Programs: 1986," prepared for the Bureau of Health Professions in the Health Resources and Services Administration, Department of Health and Human Services, describes 113 programs in 42 states which attempt to influence health professionals' geographic and specialty distribution. Programs described fall into the following categories:

- selective recruitment to medical schools;
- affecting experiences during education;
- financial incentives to locate in certain areas; and
- aid in establishing and maintaining practices.

The first 37 pages provide an excellent discussion of the range of programs, strategies behind them, and their outcomes. Suggestions to policymakers interested in benefiting from the experience of other states are included on pages 33 through 37. A summary of these suggestions follows.

1) Programs which integrate a number of strategies for attracting and retaining health professionals in shortage areas have more likelihood of success than do programs which rely on a single strategy. Possible strategies include the following:

   - active recruitment and selection of students most likely to prefer specialties in shortage areas;
   - educational experiences such as extended community preceptorships and training curricula which reinforce commitment to shortage areas;
   - financial support for students needing assistance, combined with a service commitment and high buyout penalties;
   - community financial participation in the support of a particular medical student, or in the development of a practice site;
   - aid and support in practice to minimize professional isolation in shortage areas; and
   - continued financial support for health professionals, or for institutions or community groups using their services.

2) Service-contingent programs are an effective but expensive way of covering shortage areas; preceptorships and other curriculum changes are significantly less expensive but may not be as effective.

3) Service-contingent programs with high penalties for buy-out are an effective way of recruiting health professionals to shortage areas for short time periods; however, more permanent retention of professionals may require additional programs and resources.

Designation of Shortage Areas

According to Phil Salladay, Public Health Analyst, the designation used for placement by the NHSC--and by most states--is the Health Manpower Shortage Area (HMSA). Health Manpower Shortage Area designations are made by the Office of Data Analysis and Management, Bureau of Health Professions, Department of Health and Human Services. Annual HMSA updating is based on the most recent available federal census estimates and state population overviews. State medical associations, health planning and development agencies, and regional offices of the National Health Service are also asked for input. Any interested person or group can request an HMSA evaluation at any time.

A comparison of states by number of HMSA designations is not available. However, Alaska currently has the following 14 Health Manpower Shortage Areas:

Geographic HMSA--Aleutian Islands, Bethel, Kobuk, North Slope Borough, Prince of Wales-Outer Ketchican, SE Fairbanks, Wade-Hamption, and Yukon-Koyukuk;

Medical Service Area (HMSA subsection)--Kake;

Population Group--medicade-eligible population of Anchorage; and

Correctional Centers--Hiland Mountain/Meadow Creek, Palmer, Cook Inlet Pre-Trial Facility, and the Anchorage Annex.

Public Law 100-177 makes the ability of an area to pay for health services a criterion for HMSA designation. Also, new considerations for determining the priority of NHSC physician placement include:

1) whether the area is served by at least one health professional and the effectiveness of nonfederal programs in recruiting health professionals for the area;

2) the geographic isolation of the area;

3) the economic need of the population; and

4) the infant mortality rate of the area.

Because there are so many Alaskan communities with population bases unable to support resident physicians, more viable health professionals in most rural Alaska communities will continue to be Physicians' Assistants, Nurse Practitioners, Emergency Medical Technicians, and Community Health Aides. According to Dwayne Peeples, Health Planner, Department of Public Health, rural needs are also better served by the presence of Community Health Aides and mid-level professionals, who can supply regional training, supervision and referral. Mid-level practitioner clinics are also considered more cost-effective and more desirable than placement of physicians in small communities. For these reasons, incentive programs for placement and retention of health professionals in rural areas in Alaska might better focus on mid-level practicioners than on physicians.

I hope this information is useful to you. Please contact me if you have any questions.

Attachment

HMSA

SHORTAGE AREA CRITERIA

SOURCE:
Compendium of State Health Professions Distribution Programs: 1986 US Department of Health & Human Services

STATISTICS:

Of the 113 Compendium programs, 61 (54 percent) have some type of shortage criteria. About a third of programs and states use the federal HMSA criteria or slight modifications of them.

Criteria	Programs	States
HMSA	16	14
HMSA &/or MUA	2	2
Modified HMSA	5	4
Population:physician	3	3
Community size	8	8
Anywhere in State	10	8
State criteria	8	4
Other	9	8
TOTAL	61	51

1. Health Manpower Shortage Areas (HMSA)

Sixteen programs in 14 states (Arizona, Kentucky, Massachusetts, Maine, Nebraska, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia) use HMSA alone. Two programs in two states (Arkansas and Nevada) use HMSA or MUA. No programs use MUA alone.

Those states using HMSA for their own programs report doing so for three reasons:

a) Some say that HMSA methodology, while not perfect, is sound and useful for their purposes.

b) Others indicate preference for having federal program officials expend the necessary resources for undertaking the process, and equally importantly, absorb the dissatisfaction from some professional societies or unsuccessful applicant communities.

c) Finally, at least a few states express preference for developing their own designation process, but lack the necessary staff.

2. HMSA Modifications

Five additional programs in four states essentially use the HMSA designations to place health professionals, modifying the process only slightly to suit their own purposes. These programs are in Maryland, Maine, New Mexico, and North Carolina.

These states accept the HMSA designation of geographic shortage areas. The four states then add their state and local health, mental health, and corrections institutions t a list of acceptable practice sites. Unlike the federal designation process, there are no formal state mechanisms for declaring particular institutions to be lacking sufficient personnel.

a) **Maryland**
HMSA Modification: HMSA, state or local public institution

b) **Maine**
1) HMSA Modification: HMSA, underserved specialty group, population group, or any combination of these.

2) HMSA Modification: HMSA, geographic area, specialty group, population group, or any combination of these.

c) **New Mexico**
approval on a case-by-case basis.

d) **North Carolina**
HMSA Modification: HMSA, rural community of fewer than 10,000 people, state or local institutions.

lmw

10 February 1988

Representative Johnny Ellis
HESS Committee
Alaska State House of Representatives
Pouch V
Juneau, AK

Dear Representative Ellis:

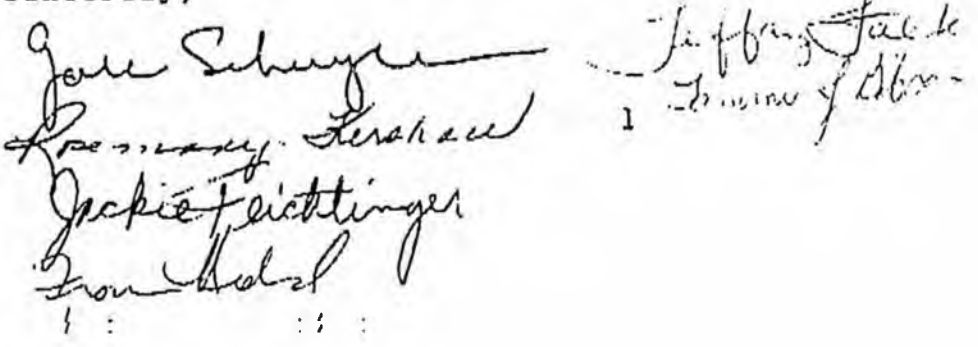
We, the undersigned, are nursing students enrolled in the College of Nursing and Health Sciences at the University of Alaska Anchorage. We are writing to express our support for the passage of HB 409 which establishes the equivalent of a "forgiveness clause" on the State Student Loan Program for graduates in health professions who work in designated medically underserved areas of the State.

It is our view that such a provision would encourage individuals who are already considering a position in a medically underserved area to choose that position over a one that is located in a less rural setting or outside the State. At the same time, it is unlikely that this clause would be the sole factor considered by a graduate of a health professions educational program in making employment decisions.

We also believe that it is imperative to communicate to you that the designated "medically underserved areas" of the State of Alaska are not the only areas in which severe shortages of nursing personnel have become evident. Both in-patient and out-patient faciltiies and agencies located in the Anchorage area have indicated that they are experiencing severe staff shortages; indeed, at one large inpatient facility, a new "patient care assistant" position has been created to take up some of the slack. The creation of this position, which is essentially equivalent to the traditional "nurse aide" position, is a direct reflection of the difficulty that that facility is having in attracting qualified professional nursing staff.

Thank you for the opportunity to offer comment on this bill. We will look forward to its passage.

Sincerely,



February 11, 1988

Representative Ellis:

I'm an Alaska WAMI student (first year) studying at WSU in Pullman, Washington. I plan to practice in Alaska and I am in full support of your proposal, House Bill No. 409.

Jeff Baurick

(undersigned are first year Alaska WAMI students)

February 10, 1988

Alaska WAMI Medical Students
University of Washington
Office of the Dean of
Regional Affairs
Seattle, WA 98105

TO: Representative Ellis

Several of the first year Alaska WAMI medical students met to discuss your proposed House Bill No. 409. Here are a few of our concerns.

Who will fund the practicianers who participate in this program?
Surely the expectation is not for a physician to be given a designated underserved area and then run out to set up a private practice - it would be extremely difficult to make a living much less pay back loans. Since the primary employer of physicians in underserved areas is the Public Health Service, is some sort of arrangement to be worked out with this agency? Also, we were wondering if the Public Health Service has reinstated their own loan forgiveness program?

What does "an area determined to have a health care provider shortage" really mean?
For example, if a neurosurgeon or some other specialist is needed in Fairbanks will this program apply to that position?

Toward which loans will the forgiveness apply?
Does this bill encompass all educational loans incured while attending medical school, including GSL, HPL and any other educational loans? Or does it solely apply to the Alaska Student Loan program? Also, does 'total loans received' include Alaska student loans obtained for undergraduate education? The undergraduate loan issue is not a significant one for those of us currently in the WAMI program (our undergraduate loans had the forgiveness clause), but for future medical students it will be important - the difference between paying back $28,000 or $50,000.

Does this program provide a meaningful incentive?
Our concern is that the lack of an adequate incentive might prevent some individuals from using this program. The salary needs to be competitive with other post-residency health service salaries. Would it be possible to attain total forgiveness in four years instead of five - a year of service for a year of loan forgiveness?

Thank you for your efforts on our behalf. Please keep us posted on the status of this bill and let us know if we can provide you with any further information.

Sincerely,

Denise Dudley
Carolyn Ra[illegible]r
Jeff Edwards
Mark Whipple
Rogin Grendahl

10 February 1988

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HESS Committee
Aslasa State House of Representatives
Pouch V
Juneau, AK

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Thank you for the opportunity to offer comment on this bill. We will look forward to its passage.

Sincerely,

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February 11, 1988

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Jeff Baurick

(undersigned are first year Alaska WAMI students)

February 10, 1988

Alaska WAMI Medical Students
University of Washington
Office of the Dean of
Regional Affairs
Seattle, WA 98105

TO: Representative Ellis

Several of the first year Alaska WAMI medical students met to discuss your proposed House Bill No. 409. Here are a few of our concerns.

Who will fund the practicianers who participate in this program?
Surely the expectation is not for a physician to be given a designated underserved area and then run out to set up a private practice - it would be extremely difficult to make a living much less pay back loans. Since the primary employer of physicians in underserved areas is the Public Health Service, is some sort of arrangement to be worked out with this agency? Also, we were wondering if the Public Health Service has reinstated their own loan forgiveness program?

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Thank you for your efforts on our behalf. Please keep us posted on the status of this bill and let us know if we can provide you with any further information.

Sincerely,

Denise Dudley
Carolyn Rader
Jeff Edwards
Mark Whipple
Rogin Grendahl

1024 WEST SIXTH AVENUE
ANCHORAGE, ALASKA 99501
(907) 274-4031

WHILE IN SESSION
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3704

ALASKA STATE HOUSE

OFFICE OF MAJORITY WHIP

CO-CHAIR
HEALTH, EDUCATION & SOCIAL SERVICES

LABOR & COMMERCE
SUBCOMMITTEE ON FOREIGN TRADE

REPRESENTATIVE JOHNNY ELLIS

February 11, 1988

Alaska WAMI Medical Students
University of Washington
Office of the Dean of
Regional Affairs
Seattle, WA 98105

Dear Denise, Carolyn, Jeff, Mark and Rogin:

Thank you for your letter of February 10, 1988 regarding House Bill No. 409 which is currently before the HESS Committee. The concerns you raise are valid ones and I hope the following explanation helps to clarify the purpose and workings of HB 409.

<u>"Who will fund the practitioners who participate in this program?"</u>
The funding for Alaska Student Loan Forgiveness for certain health care professionals will be through general fund appropriation in accordance with the fiscal note the Commission on Postsecondary Education has prepared. Enclosed is a copy of that fiscal note and their rational behind it. Please note that HB 409 is dealing ONLY with forgiveness of ALASKA STUDENT LOANS and not in the direct hiring of practitioners.

HB 409 does NOT require physicians to set up private practices in underserved areas. If, however, a physician (or any other health care professional) accepts a contract to work in an area designated to have a shortage in their profession, they may receive up to 100 percent forgiveness on their ALASKA STUDENT LOANS. Public Health Service contracts in shortage areas would therefore qualify.

PL100-177 established the NHSC FEDERAL Loan Repayment Program. This new program is designed to replace the existing NHSC Scholarship Program. Funding for this program allows for only 20 to 30 individual loan repayments per year nation wide. Kenneth Bahm, the NHSC Region X director, has informed us that Alaska can expect to receive NO NEW NHSC Scholarship or Loan Repayment recipients.

NHCS has identified Health Manpower Shortage Areas (HMSA) in Alaska as follows: 50 psychiatry, 20 primary medical care, and 4 dental shortage areas. The National Health Service (IHS) shows a current listing of 27 physician vacancies throughout Alaska. The Alaska Public Health Service lists 59.5 current Nursing vacancies throughout Alaska.

Given the fact that Alaska shall receive no new NHSC Scholarships (upon which IHS has been dependent) and due to the national nursing shortage, recruitment for these positions will be even more difficult. HB 409 has been proposed as an aid to recruiting Alaskans to work in these underserved areas. HB 409 is an incentive program designed to make PHS or IHS jobs more attractive by forgiving up to 100 percent of the borrowers Alaska Student Loans.

<u>"What does 'an area . . . shortage' really mean?"</u>
It means that there is a vacancy in a certain profession that a given health institution cannot fill or in which there is a high turnover. This determination is made by the NHSC. Additional determinations for geographic areas or professions not covered under NHSC will be made through the Alaskan Department of Health and Social Services (HSS).

<u>"Toward which loans will the forgiveness apply?"</u>
Forgiveness will apply toward all undergraduate and graduate Alaska Student Loans taken by a borrower who qualifies.

<u>"Does this program provide a meaningful incentive?"</u>
100 percent forgiveness is undoubtedly a meaningful incentive. Five years of service with increasing percentages of forgiveness for the fourth and fifth years is designed to encourage continutity and lower the high turnover rate found in such areas.

Thank you for your comments. I hope that this answers your questions regarding HB 409. Enclosed is a copy of the proposed committee substitute for HB 409. The House HESS Committee will be taking further testimony on Thursday, February 18 from 8:30 to 10:00 am. I encourage you to read CS HB 409 and submit comments to us before that time. If you have any further questions, please feel free to call Leola at (907) 465-3704.

Sincerely,

Johnny Ellis
Co-chair HESS Committee

encl 2
lmw

Tanana Chiefs Conference, Inc.
201 First Ave.
Fairbanks, Alaska 99701
(907) 452-8251

FEB 11 1988

FEB.8,1988

REP. JOHNNY ELLIS
HOUSE HESS COMMITTEE
ALASKA STATE LEGISLATURE
POUCH V
JUNEAU, ALASKA

REFERENCE: HB 409: HEALTH PROVIDER STUDENT LOAN FORGIVENESS

DEAR REP. ELLIS:

THIS IS IN RESPONSE TO YOUR LETTER OF FEBRUARY 5,1988 REQUESTING COMMENTS CONCERNING HB409, SUPPORTING LOAN FORGIVENESS FOR HEALTH PROFESSIONAL STUDENT LOANS.

THE TANANA CHIEFS CONFERENCE,INC. IS SUPPORTIVE OF THIS PROPOSED LEGISLATION.

HEALTH PROFESSIONAL RECRUITMENT IS AN ON-GOING CONCERN FOR US, ALTHOUGH FAIRBANKS IS GENERALLY ONE OF THE MORE DESIRABLE LOCATIONS FOR PROFESSIONALS IN ALASKA, AND WE HAVE LESS OF A PROBLEM THAN MANY OF THE OTHER REGIONS OF THE STATE.

OUR MOST SIGNIFICANT RECRUITMENT PROBLEM HAS BEEN FOR A REGIONAL PSYCHIATRIST TO SERVE INTERIOR ALASKA VILLAGES. WE ARE A DESIGNATED PSYCHIATRIC MANPOWER SHORTAGE AREA, AND HAVE NOT BEEN ABLE TO FIND A CANDIDATE DESPITE NEARLY TWO YEARS OF ACTIVE RECRUITMENT (FINANCING IS ALSO A PROBLEM: WE HAVE REQUESTED AN INCREASE IN OUR DHSS B.R.U. TO PROVIDE THIS SUPPORT).

OTHER ONGOING RECRUITING NEEDS INCLUDE PHYSICIAN'S ASSISTANTS TO SERVE AS PRIMARY CARE PROVIDERS AND HEALTH AIDE SUPERVISORS (CURRENT VACANCIES IN TOK AND MCGRATH), AND MENTAL HEALTH CLINICIANS (MSW OR PHD). WE HAVE REGULAR VACANCIES IN THESE TYPES OF POSITIONS (EVERY TWO-THREE YEARS).

RECRUITMENT FOR PHYSICIANS, DENTISTS, AND NURSES HAS NOT BEEN A SIGNIFICANT PROBLEM FOR US, ALTHOUGH WE WOULD PREFER TO HIRE INDIVIDUALS WHO HAVE ALASKA EXPERIENCE VS. RELOCATING INDIVIDUALS FROM THE LOWER 48.

ONE AREA OF CRITICAL CONCERN FOR THE TCC IS THE DEVELOPMENT OF ALASKA NATIVE HEALTH CARE PROFESSIONALS. AT PRESENT ONLY TEN PERCENT OF PROFESSIONAL PROVIDERS SERVING THE RURAL INTERIOR ARE ALASKA NATIVE (TWO PHYSICIANS ASSISTANTS AND ONE DEPARTMENT MANAGER IN HEALTH EDUCATION). . SUCCESSFUL NATIVE COLLEGE GRADUATES SEEM TO BE CHOOSING CAREEERS IN EDUCATION AND BUSINESS RATHER THAN HEALTH CARE PROFESSIONS.

THE PROVISIONS OF HB409 WOULD APPEAR TO PROVIDE RELIEF AND SUPPORT FOR OUR EFFORTS TO INCREASE ALASKAN HIRE IN HEALTH PROFESSIONS.

THE FORGIVENESS PROVISIONS WOULD ENCOURAGE COLLEGE STUDENTS TO MORE FAVORABLY CONSIDER HEALTH CAREERS, AND INCREASE THE AVAILABILITY OF PROFESSIONALS WHO WOULD MAKE A LONGER TERM COMMITTMENT TO ALASKAN SERVICE.

YOU HAVE THE SUPPORT OF THE TANANA CHIEFS CONFERENCE, INC. IN YOUR EFFORTS TO ENACT THIS LEGISLATION.

SINCERELY,

PAUL SHERRY, DIRECTOR
DEPT. OF HEALTH SERVICES

CC: SEN. JOHNE BINKLEY
REP. KAY WALLIS
MITCH DEMIENTIEFF, TCC PRESIDENT


HB
410

Official Business

COMMITTEE: HOUSE HESS

DATE: 2-4-88

SIGN-IN

Subject of meeting:

HB 410 Catastrophic Illness
HB 411 State Health Insurance
HB 409 Student Loans
HB 269 Veteran's Interest Rates

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which bill?
JAY Livey	DHSS	3030	DHSS	410 411
DON KOCH	P.O. BOX D [redacted]	2577	DIV. INSURANCE	410
MARTHA STEWART	CAP 507	3706	REP. AL ADAMS	345 IF NECESSARY
Michael Lessmeier	One Sealaska Plaza Suite 303	586-5912	Allstate, State Farm Independent Agents	No.
KERRY ROMESBURG	POSTSECONDARY CMSN	2954	ACPE	409
Jeff Maynard	"	2854	ACPE	no
Gary Brown	Cap. 370	3127	Same	no
BOB STALNAKER	SOB	4470	RETIREMENT + BENEFITS	411
Connie Sipe	OAC Box C	3250		411 & 410

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

May, 1988

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

H HESS	2-4-88	8:30 a.m.
H HESS	4-2-88	10:00 a.m.

Blue Cross,
of Washington and Alaska

15700 Dayton Avenue North/P. O. Box 327
Seattle, Washington 98111-0327
206/361-3000

February 4, 1988

Blue Cross of Washington and Alaska has reviewed House Bill 410 which would set up a catastrophic health care program for the citizens of Alaska. With the short time frames necessary to provide testimony at the hearing on February 4th, this review has not been in depth.

The provision of a state funded program to provide catastrophic coverage would be a major improvement over the earlier catastrophic fund set up by state government. The benefits for this program as detailed in HB 410 are somewhat "rich" but do provide coverage necessary to seriously ill persons.

You have, in Sec. 21.56.050, precluded the use of pre-existing conditions. Blue Cross believes that this provision will be a serious flaw in the coverage. Without pre-existing conditions, any Alaskan could delay enrollment in the program until such time as a medical problem manifests itself. Without pre-existing condition restrictions, a person could be diagnosed with some condition, seek treatment, realize that the costs were becoming excessive and then join the program so that the catastrophic coverage would then phase in and pick up costs in excess of the $5000 deductible. With the costs of premature babies often topping $8000 to $10,000, the state program could be faced with serious adverse selection. The same procedure could happen with any serious illness. A reasonable pre-existing condition limitation would assure that Alaskans would enroll before they need the benefits. You would lessen the tendency for persons to enroll when they need benefits and then disenroll when the treatment is completed. To be actuarially sound, this program will need the type of restriction on adverse selection which pre-existing conditions can provide.

The time frames for implementation can probably be met although they seem to be very short for a program of this magnitude. You may want to consider making the program available by July 1, 1989 in order to allow sufficient time to set up the program, select the insurer and develop enrollment materials for use in selling the coverage.

Recognizing the interest of the Legislature in a program of this sort, we have tried to estimate the costs we think would be involved in this program. We have not had time to do a complete actuarial analysis, however, quick estimates would indicate that the premium for a person in the 40 to 44 age range would be between $100 and $300 per person per month. Since we are using age rating, persons younger than 40 years would have lower premium and those between 45 and 65 would have higher premiums. In both cases, premiums would be age rated in five year bands. Without information about the age mix of Alaskans who would enroll, a more definite guesstimate is difficult to do. Obviously there are other factors which will affect the level of premium including the number of persons who would enroll from the Bush versus the number of enrollees from more urban areas of the state.

In summary, we hope we can work with you as this bill is perfected. This seems to be a positive step forwardtoward providing coverage for catastrophic costs of health care.

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 23, 1986

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM; Jay Livey
Legislative Analyst

RE: Estimate of the Number of Alaskans Without Health Insurance
Research Request 87.012

You asked that we determine the number of Alaskans that do not have health insurance coverage. You also asked that we review the activities of other states regarding health care for uninsured individuals.

Alaskans Without Health Insurance Coverage

We were not able to use existing data to accurately determine the number of Alaskans who do not have health insurance. Determining the number of uninsured Alaskans would require the collection of primary data--an activity that is beyond the current capabilities of this agency. However, we can draw some conclusions based on surveys conducted in other states and discuss a previous study that estimated the number of uninsured Alaskans.

A recent publication by the Intergovernmental Health Policy Project of George Washington University contains summaries of several state and national attempts to count uninsured individuals.[1] These studies are noted below.

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[1] "State Programs of Assistance for the Medically Indigent" Intergovernmental Health Policy Project of George Washington University, Washington, D.C., November 1985.

The Battelle study also analyzed the characteristics of this uninsured group. Approximately 40 percent of the uninsured individuals were children, while 34 percent were heads of households or spouses. Twenty-two percent were single. Nine percent of the uninsured population were health impaired; they were not able to work or go to school.

Of the adults who did not have insurance, 80 percent were employed, 10 percent were unemployed and the rest were not in the labor force. Among the uninsured individuals who were employed, 29.7 percent were employed in business services, 24.7 percent in wholesale or retail trade, 18.8 percent in construction, 7.1 percent in personal services and less than five percent in each of the agriculture, mining, logging and fishing industries. Over 75 percent of the uninsured adults had completed at least one year of college and an additional five percent had completed high school.

In the absence of more recent data, the accuracy of the Battelle estimates of uninsured Alaskans and the validity of the profile of this segment of the population are concerns. Of particular interest is any change in the structure of the economy between 1979 and 1985. If the structure of Alaska's economy has remained reasonably stable from 1979 to 1985, the Battelle findings are more credible than if significant structural change occurred during the period. Table 1 presents employment in Alaska by industrial segment and compares the percentage of total employment each segment comprised in 1979 and 1985.

As the table indicates, total employment in Alaska increased from 166,405 individuals in 1979 to 228,075 individuals in 1985, an increase of approximately 37 percent. Three sectors of the economy--government; manufacturing; and transportation, communications and utilities (T-C-U)--comprised a smaller percentage of total employment in 1985 than in 1979, with government decreasing 3.5 percent, manufacturing 2.4 percent and T-C-U 1.8 percent. Three segments of the economy--trade, construction, and services comprised a greater share of total employment in 1985 than in 1979, increasing 2.3 percent, 2.1 percent and 1.8 percent, respectively. Two segments, finance insurance and real estate (FIRE) and mining showed virtually no change.

In summary, national studies have estimated that the percentage of the American population that is uninsured ranges from 9.5 percent to 16 percent. Among states that have attempted to measure their uninsured populations, Tennessee found seven percent of its population lacked health insurance while New Mexico estimated that between 20 percent and 23 percent of its population were uninsured. Three other states, Colorado, Minnesota and Wisconsin, claimed that 20 percent, 10.2 percent and 8.1 percent of their respective populations were without health insurance. The Battelle study concluded that approximately seven percent of Alaskans were without health insurance in 1982; a finding we speculate is now somewhat low.

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* * * *

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JL

Attachment

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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 23, 1986

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM; Jay Livey
Legislative Analyst

RE: Estimate of the Number of Alaskans Without Health Insurance
Research Request 87.012

You asked that we determine the number of Alaskans that do not have health insurance coverage. You also asked that we review the activities of other states regarding health care for uninsured individuals.

Alaskans Without Health Insurance Coverage

We were not able to use existing data to accurately determine the number of Alaskans who do not have health insurance. Determining the number of uninsured Alaskans would require the collection of primary data--an activity that is beyond the current capabilities of this agency. However, we can draw some conclusions based on surveys conducted in other states and discuss a previous study that estimated the number of uninsured Alaskans.

A recent publication by the Intergovernmental Health Policy Project of George Washington University contains summaries of several state and national attempts to count uninsured individuals.[1] These studies are noted below.

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[1] "State Programs of Assistance for the Medically Indigent" Intergovernmental Health Policy Project of George Washington University, Washington, D.C., November 1985.

Five states have recently finished studies to determine the number of their citizens without health insurance. The results of these studies indicate that the percentage of the population that is uninsured varies considerably. Tennessee found that seven percent of its population was without health insurance while, New Mexico estimated that 20 to 23 percent of its population lacked coverage. Colorado, Wisconsin and Minnesota claimed that 20 percent, 10.2 percent and 8.1 percent of their respective populations were uninsured.

In 1977, the National Medical Care Expenditures Survey found that 9.5 percent of the U.S. population under age 65 were always uninsured and an additional 8.3 percent was uninsured for part of the year.[2] A recent article in the National Journal estimates that 12 percent of all Americans are without health insurance.[3] Katherine Swartz, of the Urban Institute, used the Census Bureau's Population Survey to estimate that approximately 16 percent of the nation's population under 65 years of age is uninsured.[4] A Census Bureau report found that 15 percent of Americans did not have health insurance during the fourth quarter of 1983.[5]

An estimate of the number of uninsured Alaskans was made in the Alaska Health Care Financing Study (Battelle Study) completed in 1982.[6] That study, using U.S. Bureau of the Census information gathered in 1976 and 1980, found that approximately 29,000 Alaskans (seven percent of the population) were uninsured. Based on current population estimates of 540,000 people, the Battelle findings would suggest that approximately 37,800 Alaskans may currently be without health insurance coverage.

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[2]"Who Are the Uninsured?", J. Kasper, D. Walden and G. Wilensky, National Health Care Expenditures Study, National Center for Health Services Research, U.S. Department of Health and Human Services.

[3]"Health Insurance for the Unemployed and Uninsured", R.J. Blendon, D.E. Altman, S.M. Kilstein, National Journal, Vol.15, No.22, p.1146-59.

[4]"The Changing Face of the Uninsured", Katharine Schwartz, Urban Institute, June 1986.

[5]" Economic Characteristics of Households in the United States: Fourth Quarter 1983", U.S. Bureau of the Census, U.S. Department of Commerce, Washington, D.C., 1985.

[6]Alaska Comprehensive Health Care Financing Study: Final Report Volume 1, Battelle Human Affairs Research Center, Seattle, Washington, March 1982.

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As the table indicates, total employment in Alaska increased from 166,406 individuals in 1979 to 228,075 individuals in 1985, an increase of approximately 37 percent. Three sectors of the economy--government; manufacturing; and transportation, communications and utilities (T-C-U)--comprised a smaller percentage of total employment in 1985 than in 1979, with government decreasing 3.5 percent, manufacturing 2.4 percent and T-C-U 1.8 percent. Three segments of the economy--trade, construction, and services comprised a greater share of total employment in 1985 than in 1979, increasing 2.3 percent, 2.1 percent and 1.8 percent, respectively. Two segments, finance insurance and real estate (FIRE) and mining showed virtually no change.

Table 1
Comparison of Shares of Employment By Industrial Sector
1979 and 1985

Industrial Sector	1979 Number	1979 Percent	1985 Number	1985 Percent	Change 1979 to 1985
Mining	5,773	3.5%	9,513	4.1%	+0.6%
Construction	10,092	6.1	18,609	8.2	+2.1%
Manufacturing	12,818	7.7	12,109	5.3	-2.4%
Trans., Communications, Utilities	16,704	10.0	18,685	8.2	-1.8%
Trade	29,388	17.7	45,800	20.0	+2.3%
Finance, Insurance, Real Estate	8,035	4.8	11,624	5.1	+0.3%
Services	28,345	17.0	43,014	18.8	+1.8%
Government	54,532	32.8	66,765	29.3	-3.5%
Miscellaneous	720	0.4	1,956	0.8	+0.4%
Totals	166,406	100.0	228,075	100.0	

Source: Statistical Quarterly, Alaska Department of Labor, 4th quarter reports for 1979 and 1985.

Note: Number of individuals employed is the monthly average of nonagricultural employment.

Overall, the shares of total employment attributable to these industrial sectors were relatively unchanged from 1979 to 1984. In terms of the impact on the number of uninsured Alaskans, the most significant changes were the declining share of government emlployment and the increasing share of the trade and services sectors. Virtually all government employees are insured through employment while a significant number of trade and service sector employees are not.

In the absence of more recent data, we conclude that the Battelle study provides a reasonable starting point for estimating the number of Alaskans who do not have health insurance coverage. The current Alaska economy is similar in structure to the the 1979 economy, lending credibilty to the assertion that approximately seven percent of the population may be uninsured. However, we speculate that because of minor shifts in economic structure since 1979 and recent increases in unemployment, the percentage of uninsured Alaskans within the population is probably somewhat higher than seven percent.

In summary, national studies have estimated that the percentage of the American population that is uninsured ranges from 9.5 percent to 16 percent. Among states that have attempted to measure their uninsured populations, Tennessee found seven percent of its population lacked health insurance while New Mexico estimated that between 20 percent and 23 percent of its population were uninsured. Three other states, Colorado, Minnesota and Wisconsin, claimed that 20 percent, 10.2 percent and 8.1 percent of their respective populations were without health insurance. The Battelle study concluded that approximately seven percent of Alaskans were without health insurance in 1982; a finding we speculate is now somewhat low.

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Attachment

STATE PROGRAMS of ASSISTANCE
for the
MEDICALLY INDIGENT

November 1985

by

Randolph A. Desonia

and

Kathleen M. King

of the

Intergovernmental Health Policy Project
The George Washington University

cutbacks and cost containment efforts clearly were taking place before 1981, but both intensified with the advent of the recession.

Since 1975, Medicaid -- the largest governmental health program for the poor -- has become less effective in its ability to cover the medically indigent population. In 1975, 63 percent of the population near or below the poverty line were eligible for Medicaid; in 1983, the number covered fell below 50 percent.[5] This occured during a period when the number of people in poverty increased. The decline was a result of a combination of federal cutbacks in Medicaid and declining state revenues that forced many states to reduce the scope of their Medicaid programs.

Government spending cuts and increases in the unemployment rate have occured before and most likely will occur again. When the economy improves -- which it has -- federal and state governments frequently reinstate coverage of benefit and eligibility cuts -- which many have. Still, improvements in the economy and restoration of program cuts have not bumped the issue of health care for the medically indigent from the states' legislative agendas. It is a third factor, public and private sector efforts to control health care costs, that appears to explain why health care for the medically indigent continues to attract policy-makers' attention.

A decade of inflation in medical costs that consistently exceeded the general inflation rate propelled businesses and governments to aggressively search for and adopt policies to control their health care costs. Such cost containment initiatives as Medicare's prospective payment system (based on Diagnosis Related Groups), selective contracting in California and competitive bidding in Arizona under Medicaid, record growth in HMO membership and the proliferation of preferred provider organizations have put enormous pressure on providers to deliver health care in a more cost efficient manner. Under these new conditions, the efficient provider is rewarded with adequate reimbursement that assures continued survival in the competitive market place.

For the most part, the new competitive reimbursement systems do not cover bad debt or charity care, and they preclude the provider from charging higher rates in order to cover bad debt or charity care (commonly referred to as cost-shifting). Thus providers, particularly public hospitals, who continue to serve everyone, regardless of their ability to pay, are at risk of not covering their costs. It is not surprising that many providers have grown increasingly reluctant to provide charity care to the medically indigent. In fact, many of the states that have examined the issue of indigent care were originally studying cost containment proposals.

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EXECUTIVE SUMMARY

Background

Assuring access to health care for the medically indigent -- people with little or no public or private health insurance and without resources to pay for essential medical services -- has become one of the most pressing health care issues of the 1980s. In their 1984 legislative sessions, 22 states introduced legislation with the objective of improving the medically indigents' access to health care. Since 1984, 20 states have organized legislative or gubernatorial study commissions with financing health care for the medically indigent as the primary focus or an important secondary concern of medical care cost containment efforts.[1] The primary objective of this report is to identify and document the major state policies and programs designed to improve access to health care for the medically indigent.

Although the provision of funding of health care services for the medically indigent has long been a concern of national, state and local policymakers, recent events have brought it to the forefront. A major catalyst appears to have been the recession of 1981-82 when the nation experienced a slowdown in the growth of the economy and high unemployment levels. The Employee Benefit Research Institute, using the Current Population Survey Statistics of the U.S. Census Bureau, found that about 14 percent of the nonelderly population were without health insurance coverage from any source in 1979. That proportion rose to 15.5 percent in 1982 and 16.5 percent in 1983.[2] The uninsured, especially when unemployed, are at great risk of becoming medically indigent.

Although the nation's unemployment rate has returned from a high of 10.8 percent to the pre-recession level of 7 percent, millions of people are still without jobs. Despite the fact that 1983 marked an upturn in the nation's economy, the Employee Benefit Research Institute noted nearly one million fewer people were covered by employer plans in 1983 than had been covered in 1982.[3] Since 85 percent of those with private sector health coverage obtain it through job related health plans, any unemployment rate above the full employment level will contribute to the number of uninsured and therefore to those at risk of medical indigency.[4]

The recession also gave rise to two other pressures that exacerbated the medical indigency problem: federal and state cutbacks in programs assisting the medically indigent; and private and public efforts to control continually rising health care costs. Governmental

other. For example, the recession gave employers a rationale for instituting major cost-saving changes in their employee benefit plans to cut business expenses. But taken together, the recession (and continued unemployment), governmental program cutbacks and cost containment efforts have focused renewed attention on the long-standing problem of assuring the medically indigent access to necessary health care.

Who are the Medically Indigent?

The report briefly summarizes the numerous national and state studies that identify and describe the medically indigent population. Although different studies often yield seemingly conflicting results, discrepancies usually arise because the studies adopt different definitions of indigency, draw from different data bases, or were conducted in different years.

Nationally, according to two studies, 15 to 16 percent of people under the age of 65 lack health insurance at any given time (Kasper et al, and Schwartz).[6] This percentage translates into about 35 million people. Another study estimates that an additional 13 percent of the nation's population under age 65 has inadequate health insurance coverage (Farley).[7] That is, the insurance policy fails to cover major health costs and the policyholder is in danger of financial hardship or even ruin in the event of a major illness.

At the state level, however, variations in the estimates of the size of the medically indigent population can be significant. For example, New Mexico and Colorado estimate that 20 percent of their population lack health insurance coverage, while Minnesota puts its level at 8 percent.

Although the specific characteristics of the medically indigent vary by state -- depending on the type of employment common to the particular state (manufacturing, construction, retail, etc.), the comprehensiveness of Medicaid coverage, and the average income of the residents -- the key determinants of medical indigency are unemployment, employment in small or low-wage firms, and income status. One national study estimated that 13 percent of those who lost their jobs during the 1982 recession were left without any insurance coverage (Wilensky).[8] A study in a major metropolitan area found that 38 percent of the unemployed had neither private health insurance nor Medicaid coverage (Berki).[9] And a study by the Urban Institute estimated 25 percent of uninsured adults worked full-time for 40 weeks or more (Schwartz),[10] presumably because they worked for small firms that do not offer health insurance as a fringe benefit.

In examining the health insurance coverage of the poor, one national study estimated that 15 percent of the poor -- people at or

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Government spending cuts and increases in the unemployment rate have occured before and most likely will occur again. When the economy improves -- which it has -- federal and state governments frequently reinstate coverage of benefit and eligibility cuts -- which many have. Still, improvements in the economy and restoration of program cuts have not bumped the issue of health care for the medically indigent from the states' legislative agendas. It is a third factor, public and private sector efforts to control health care costs, that appears to explain why health care for the medically indigent continues to attract policy-makers' attention.

A decade of inflation in medical costs that consistently exceeded the general inflation rate propelled businesses and governments to aggressively search for and adopt policies to control their health care costs. Such cost containment initiatives as Medicare's prospective payment system (based on Diagnosis Related Groups), selective contracting in California and competitive bidding in Arizona under Medicaid, record growth in HMC membership and the proliferation of preferred provider organizations have put enormous pressure on providers to deliver health care in a more cost efficient manner. Under these new conditions, the efficient provider is rewarded with adequate reimbursement that assures continued survival in the competitive market place.

For the most part, the new competitive reimbursement systems do not cover bad debt or charity care, and they preclude the provider from charging higher rates in order to cover bad debt or charity care (commonly referred to as cost-shifting). Thus providers, particularly public hospitals, who continue to serve everyone, regardless of their ability to pay, are at risk of not covering their costs. It is not surprising that many providers have grown increasingly reluctant to provide charity care to the medically indigent. In fact, many of the states that have examined the issue of indigent care were originally studying cost containment proposals.

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below 125 percent of the poverty level -- were ineligible for Medicaid and lacked private health insurance (Wilensky and Berk).[11] In surveying people with incomes below 150 percent of the federal poverty level, Colorado found that 38 percent did not have private health insurance and were ineligible for Medicare and Medicaid.

Other characteristics of people at risk of being medically indigent are age and place of residence. Depending on the state, the two age groups most frequently identified as having the lowest levels of health insurance coverage are children under the age of 18 and young adults age 18 to 24 (or frequently, 18 to 35). People living in rural areas and those residing in the southern and western regions of the country also have lower health insurance coverage levels (Mulstein).[12]

State Indigent Care Programs: Findings

It is not widely understood that for years many states -- often in conjunction with local units of government -- have operated programs to assist medically indigent residents. This report is an initial effort to document these programs in order to assist federal, state and local policymakers in developing or modifying their policies affecting health care delivery to that group. The emphasis of this report is on statewide programs; programs supported by local or county governments independent of state efforts are not included due to the lack of data and limited staff resources.

Every state has adopted legislation authorizing various levels of government to provide certain health and medical services for its residents. And in all but three states, either the state or local government is expressly obligated by law to provide at least some health services to some indigent populations (Butler).[13] The report found that as of July 1985, 34 states had state indigent care programs, which are state programs designed to assist the medically indigent and administered or funded wholly or in part by the state government. Programs that rely on federal monies -- Medicaid and the maternal and child health block grant, for example -- were specifically excluded as were local programs that serve only a limited region of the state.

In the 16 states that do not have a state indigent care program, counties and municipalities generally have some legal responsibility for providing medical care to their residents. However, those requirements tend to be rather general and imprecise leading to broad variations in benefit coverage, eligibility standards and program administration. Also, it is rather common that counties supporting a public hospital are not only required to provide care to resident indigents but are often expected to provide care to nonresident indigents. Recent changes in Florida and Texas programs were, in part, caused by this movement of indigents across counties.

Of the 34 states with indigent care programs, IHPP identified 41 programs (five states had more than one program). Although each of the programs is unique, they do have several features that allow comparison including such program components as financing, eligibility standards, administration and benefit coverage. In any indigent care program, the state or the county must assume certain administrative functions: establishing the eligibility standards, deciding which medical services will be reimbursed, and processing providers' claims. Seventeen states administer all components of their indigent care program; in the remaining seventeen, the state and the counties share the administrative responsibilities.

Eighteen states totally funded their indigent care programs, and 15 states financed the programs jointly with local governments, usually counties. The state-local share in those states ranged from 50 percent state and 50 percent county, to 92 percent state and 8 percent county. While most of the funds for these programs are derived from state general revenues, a few states rely on other funding sources. Those counties sharing in the financing of a state indigent care program raise revenue through a sales tax or a property tax. South Carolina's program, to be implemented in 1986, has the most unique means of funding making separate assessments on the counties and on hospital net patient revenues. Two other states -- Florida and West Virginia -- have adopted an assessment on hospital revenue, but in both states the revenue is used as the state match for recent expansions in their Medicaid programs.

Frequently, states with shared responsibility delegate responsibility for determining eligibility to the counties, and assume responsibility for the other administrative duties themselves. In twenty six states, the state government is responsible for establishing eligibility standards for the indigent care programs while in the other eight, the counties are totally or partially responsible for establishing eligibility standards. The advantage of the state setting the eligibility standards is that the standards will more likely be uniform across county lines.

Twenty-two states have indigent care programs associated with state or county general assistance programs. General assistance programs (also called general relief, home relief, and poor relief) provide continuing or emergency income assistance and serve as the ultimate "safety net" for poor individuals and families ineligible for federally-supported assistance programs like AFDC and SSI. In most instances, the general assistance program has a medical component so that all those who qualify for aid are entitled to receive some medical benefits.

A common variation of the state indigent care program is the state created optional program providing state assistance for participating counties or towns. In these states, the local unit of government is

legally responsible for providing care to their medically indigent residents. An optional state program offers to assist the local units of government in meeting their obligation, usually through administrative or financial assistance. If the local unit of government elects not to participate, it must then administer its own program.

Eight states offer optional indigent care programs, four of which are tied to their general assistance program. New Jersey's General Assistance-State Medical Match program, for example, provides a 75 percent state match for medical services provided to any indigent meeting state eligibility criteria. Nonparticipating municipalities must fund such programs totally with their own dollars.

Sixteen of the 34 states with indigent care programs cover both hospital and ambulatory services similar to those mandated services provided under Medicaid. By law, Medicaid must provide inpatient and outpatient hospital services, physician services, lab and X-ray procedures, rural health clinics, home health services, and skilled nursing facility services. Frequently, however, states put greater restrictions on services provided under their indigent care programs. For example, Oregon limits inpatient hospitalization to 18 days per year for Medicaid recipients and 12 days per year for general assistance recipients. Maryland's general assistance program requires a $0.50 copayment on prescription drugs but makes no such demand under its Medicaid program.

Another nine states have more limited coverage of inpatient and hospital services, and physician services. Of the remaining nine states, Vermont and Massachusetts cover ambulatory services only, and South Carolina, Louisiana, Mississippi, and Oklahoma limit coverage to hospital services. Maine, Wisconsin and Montana assist the counties in financing indigent care but allow counties to decide which services to reimburse. The state programs rarely cover long term care. In those that do cover such services, it usually accounts for only a small percentage of program expenditures.

During fiscal year 1983, the states and counties spent more than $2.3 billion on the 41 programs. This is in addition to the states' share of $16 billion for the Medicaid program in FY 1983. The $2.3 billion is undoubtedly low because not all county contributions to the programs were available. Nor does the $2.3 billion take into account state spending on programs for specific diseases or populations such as for renal dialysis, sickle cell anemia and hemophelia or pharmaceutical assistance to the elderly. Finally, it does not include the funds counties give directly to hospitals to help them offset the cost of uncompensated care.

Other State Policies and Programs

Financing and administering statewide indigent care programs is certainly the most significant option the states have chosen to assist the medically indigent, although other alternatives do exist. For example, several states have health programs designed to reach a small target population or supplement existing federal, state or locally funded medical service programs. Since the range of services and numbers of people they serve can be quite limited, these programs should be viewed as supplementing rather than substituting for state indigent care programs.

Many programs attempt to provide some assistance for people suffering from specific diseases or afflictions such as sickle cell anemia, cancer, hemophilia, blindness, and tuberculosis. Another approach is to provide assistance to a specific population. Five states fund pharmaceutical assistance programs for low income aged or disabled, for instance.

Another alternative involves the application of the state's authority to expand the availability and comprehensiveness of insurance coverage through the private health insurance market place. As of April 1985, nineteen states had enacted laws requiring insurers to permit those whose health insurance policies have been terminated, usually as the result of lay-offs, to continue their policies for anywhere from 30 days to one year. Policyholders pay the entire premium but benefit from group rates rather than having to pay more expensive individual rates. Thirty-one states have also enacted conversion statutes requiring insurers to permit those whose policies have been terminated to convert from group to individual policies.

Nine states (Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island and Wisconsin) have established comprehensive health insurance associations, more frequently called "risk pools." These pools are designed to make available a health benefit plan to individuals unable to obtain coverage, even though they can afford reasonable premiums, because of their poor health status. The premiums, set under these state programs for the so-called "un-insurables" tend to be expensive, ranging from 125 to 150 percent of those charged to standard-risk policyholders. So far, no state has been willing to subsidize the cost of premiums for low-income people.

Alaska and Rhode Island operate catastrophic health insurance programs designed to mitigate the financial effects of lengthy, costly illnesses. (Maine operated a program for several years, but it was amended in 1985 to cover only ambulatory care. Catastrophic inpatient hospital costs are covered under the state rate setting program.) These state catastrophic programs are designed to be the payer of last resort. That is, all third party insurance coverage, if any, must be fully exhausted before the state's contribution begins, and the person

is liable for sizable deductibles and copayments. The state program then assumes responsibility for a portion of the remaining expenses. Setting the deductible high -- that is, requiring the applicant to spend a certain amount before becoming eligible -- discourages participation by people who are poor. In Rhode Island, for example, the minimum deductible is the greater of $1,035 or 10 percent of income for those with comprehensive health insurance. Those without health insurance are required to pay the greater of $10,350 or 50 percent of allowable income. Both programs have substantially increased their deductibles in the past few years to target benefits to people suffering catastrophic illnesses and to control costs.

The final options discussed involve the use of the states' regulatory authority to extract some level of charity care from institutional providers or to ensure that all third party payers share evenly in the burden of financing care for the medically indigent. Four states plus the District of Columbia have adopted policies that, under certain circumstances, tie certificate of need (CON) approval to the applicant's commitment to providing charity care. Georgia issued a regulation in 1984 that requires parties purchasing or leasing a public hospital to provide an amount of charity care equal to 3 percent of the hospital gross revenue for the sale or lease to be approved. South Carolina has adopted a policy that requires all health care facilities to include an indigent care plan in their CON applications.

Four states -- Maryland, Massachusetts, New Jersey, and New York -- have implemented so-called all-payer hospital rate setting programs. (During the preparation of this report, however, Massachusetts' and New York's Medicare waivers were terminated and not renewed.) Each system operates differently, but all include some provision for uncompensated care. For example, New Jersey's system is based on DRGs. There, hospitals' payments are increased by an uncompensated care factor that reflects its ratio of uncompensated care to gross revenues. Massachusetts -- which has a state indigent care program that covers only services delivered outside of a hospital setting -- requires hospitals to provide charity care in order to receive payment for uncompensated care. Wisconsin and Washington have rate setting mechanisms that do not include a Medicare waiver. Three other states -- Connecticut, Maine, and West Virginia -- are in the process of implementing multiple or all-payer hospital rate setting programs.

In 1984, 14 states had organized gubernatorial or legislative study commissions to develop policy recommendations. By August 1985, an additional 8 states had adopted legislation requiring the state to study the issue and four of the 14 states of 1984 had adopted legislation requiring further study of the issue.[14] With 15 to 16 percent of the nation's population uninsured, and with the public and private sectors continuing to implement cost containment strategies, the search for solutions to ensure greater access to health care services for indigents will undoubtedly remain one of the major priorities of federal, state and local policy makers over the next few years.

Executive Summary Endnotes

1. J. Luchrs and R. Desonia. A Review of State Task Force and Special Study Recommendations to Address Health Care for the Indigent, Center for Health Policy Analysis, National Governors' Association, and Intergovernmental Health Policy Project, George Washington University, Washington, D.C., November 1984: and Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey, December 1984, Appendix I, "State Indigent Care Programs, New Laws of 1984" Intergovernmental Health Policy Project, George Washington University and Center for Policy Research, National Governor's Association, Washington, D.C.

2. "Financing Indigent Health Care", EBRI Issue Brief, Employee Benefit Research Institute, No. 44, July 1985.

3. Ibid..

4. "Providing Health Coverage for the Unemployed", Staff Memorandum by the Congressional Budget Office, Washington, D.C., p.2, May 1983.

5. From "Chart 1: Medicaid Recipients as a Percentage of the Poverty and Near-Poverty Population," 1969-1985, as reported in the July 1985 EBRI Issue Brief, see endnote 2.

6. J. Kasper, D. Walden and G. Wilensky, "Who are the Uninsured?" National Health Care Expenditures Study, Data Preview 1, National Center for Health Services Research, Department of Health and Human Services: and Katherine Schwartz, Urban Institute, "The Changing Face of the Uninsured", Paper presented at the Annual Meeting of the Association for Health Services Research, June 1984.

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13. Patricia Butler, "Legal Obligations of State and Local Governments for Indigent Health Care", Access to Care for the Medically Indigent: A Resource Document for State and Local Officials, Academy for State and Local Government, 444 N. Capitol Street, N.W., Washington, D.C. 20001.

14. Major Changes in State Medicaid and Indigent Care Programs, July 1985, Appendix I, "Indigent Care", Intergovernmental Health Policy Project, George Washington University, Washington, D.C.

PART B: LIST OF PROGRAMS IN STATE PROFILES

The following table lists the programs included in each state's profile. This table represents the programs identified by the states as of June 1984 plus recently (1985) adopted legislation creating a state indigent care program for the states of Arkansas, South Carolina, and Texas.

All findings in the Executive Summary and Chapter III are based on these programs as they existed in June 1984. Initials in brackets indicate the shorthand notation used to identify the programs listed in the chart "Characteristics of State Indigents Care Programs." Other 1985 legislation making significant changes in state indigent care programs or indigent care policies (such as Nevada) are also included.

PROGRAMS IN THE STATE PROFILES

JUNE 1984

Leon Wyszewianski

Financially Catastrophic and High-Cost Cases: Definitions, Distinctions, and Their Implications for Policy Formulation

To facilitate discourse and improve the formulation of policy, a clear distinction should be made between financially catastrophic and high-cost health care expenditures. I propose that "financially catastrophic" be used to describe cases whose expenditures are large relative to ability to pay (e.g., when out-of-pocket medical expenditures exceed 15% of annual family income) and that "high cost" describe cases whose total expenditures exceed a set amount (e.g., $10,000 in a year's time) regardless of source of payment or ability to pay. Using these distinctions, I show how third-party coverage and other resources determine whether a high-cost case or illness is also financially catastrophic. I illustrate the usefulness of the proposed categorization by applying it to several current policy issues.

The mid-1980s are seeing a resurgence of concern about catastrophic health care expenditures and a consequent increase in the attention given to catastrophic health insurance proposals. However, despite the familiarity of the topic—interest in these issues has been ebbing and flowing for decades—or perhaps because of it, the meaning of terms like catastrophic illness, catastrophic medical expenses, and catastrophic health care costs is not as unambiguous as might be expected. Often such terms are associated with cases of serious injury from traffic accidents, newborns with severe congenital problems, persons afflicted with lingering cancers, and, lately, victims of acquired immune deficiency syndrome (AIDS). Some would argue, however, that much less dramatic illnesses can also be catastrophic if they strike people who are poor and have no health care coverage, not even Medicaid. For such people, even relatively modest amounts of medical care for common illnesses like an acute urinary tract infection and a strep throat are apt to be financially ruinous and, in that sense, catastrophic.

Distinguishing from one another such differing conceptions of what constitutes a catastrophic health care expenditure is important because it influences how we approach public policy issues that involve large sums of money and affect some of our most vulnerable citizens. This article offers a classification scheme and a definitional guide intended to facilitate the analysis and formulation of policy in this area.

Financially Catastrophic Cases and High-Cost Cases

Some of the work on catastrophic health insurance makes an explicit distinction between health care expenditures that are large in relation to the patient's ability to pay and those that are deemed high because they exceed a specified amount.[1] Because no labels have been applied consistently to these two categories, I propose that the term

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financially catastrophic case be restricted to situations in which expenditures are considered large relative to the patient's ability to pay, as determined by the extent of third-party coverage and other resources available to pay for care. The term applies, for example, to out-of-pocket medical expenditures that exceed 15% of annual family income.[2] Similarly, I propose that the term *high-cost case* refer to instances where expenditures exceed an amount considered to be large, without regard to source of payment or ability to pay. By that definition, Birnbaum's study of persons with more than $5,000 in total annual health expenditures incurred in 1974 was an examination of high-cost cases.[3]

Distinctions and Basic Pairings

It is important to distinguish between financially catastrophic and high-cost cases because all too often it is assumed that the two are identical. They are not; rather, as Figure 1 illustrates, they overlap. A case that is high cost is not necessarily catastrophic as well. Whether it is or not often depends on third-party coverage. To take an obvious example, someone who has truly comprehensive health care coverage with no cost-sharing features will never face catastrophic health care expenditures, even if the expenditures for that person greatly exceed the high-cost threshold. That is one of the situations that arise from the relation among high-cost cases, financially catastrophic cases, and the combination of third-party coverage and other resources that determines ability to pay for care. All possible combinations of these factors are identified in Figure 2, including the following three basic pairings of catastrophic and high-cost attributes:

Simultaneously catastrophic and high cost. High-cost cases are financially catastrophic whenever third-party coverage proves inadequate and there are insufficient other resources to cover costs without creating hardship (cell 1 in Fig. 2) or when there is no coverage at all and other resources are not enough to compensate (cell 2).

High cost but not catastrophic. A high-cost case will not be financially catastrophic if the combination of coverage and other resources is adequate to cover the expenditure (cell 3) or, in the absence of coverage, if the other resources alone are sufficient (cell 4).

Catastrophic yet not high cost. A case can be financially catastrophic even though it is not high cost when the combination of coverage and other resources is inadequate even for expenditures that are below the high-cost threshold (cell 5) or when the lack of any coverage is not made up by other resources, even when expenditures are not high cost (cell 6).

The relative size of all these categories depends in part on how certain elements of the definition

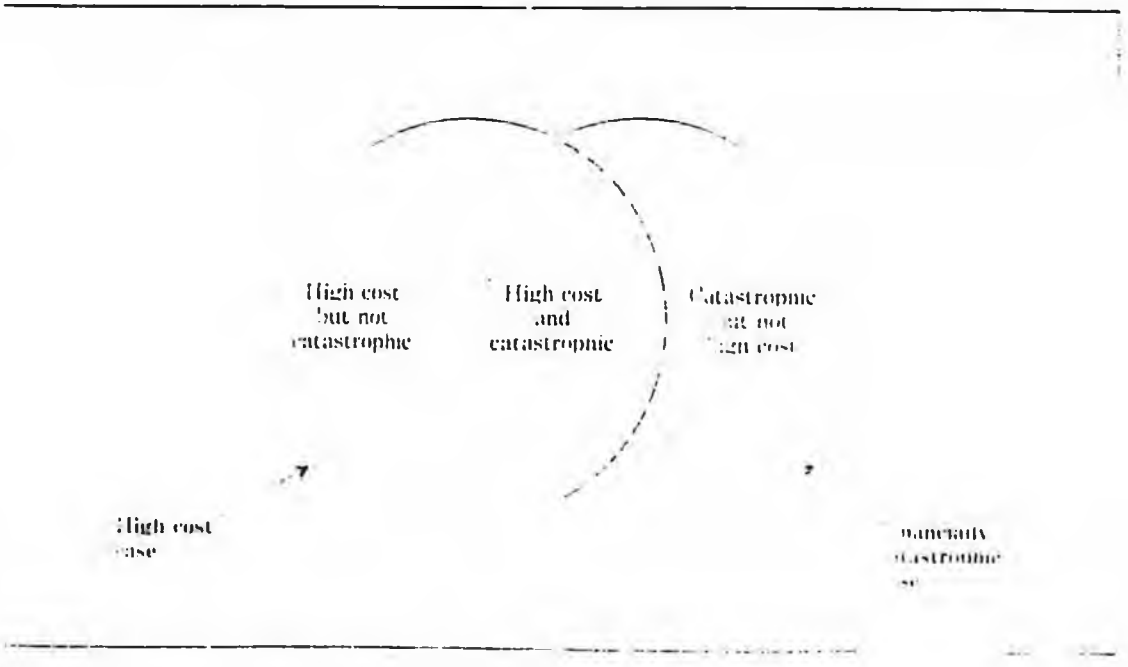

Figure 1. The relation between high-cost and financially catastrophic cases

	Financially catastrophic		Not financially catastrophic	
	Covered by third party	Not covered by third party	Covered by third party	Not covered by third party
High cost	1	2	3	4
Not high cost	5	6	Neither high cost nor catastrophic	

Figure 2. The relation among high-cost cases, financially catastrophic ones, and third-party coverage

are specified, including setting the threshold for separating cases into those that are high cost and those that are not and determining how ability to pay for care is to be determined. Such definitional issues are examined separately in this article, following further discussion of the need for and utility of the basic conceptual distinctions just made.

Applicability to Catastrophic Health Coverage

The framers of some catastrophic health coverage proposals and programs assume implicitly that a financially catastrophic case is nothing but a high-cost case for which third-party coverage proves inadequate in financially shielding the person or family, resulting in out-of-pocket expenditures that outstrip the person's or the family's ability to pay. Given this perspective, it is an unintended and unexpected outcome when the catastrophic program turns out to apply to cases that are not high cost but are nevertheless catastrophic because coverage is inadequate or nonexistent and income and other resources are so low that even small expenditures can be overwhelming (this corresponds to cells 5 and 6 in Fig. 2).

A case in point is the Catastrophic Illness Program (CIP) passed by the Maine legislature in 1974. Deprez et al., in their evaluation of the CIP, characterized the early experience of that program, from 1975 to 1980, as follows: "The legislature intended the program for persons with extraordinary medical expenses whose private health insurance benefits were not adequate to cover their expenses, leaving them vulnerable to a loss of their assets (house, car, etc.) However, most of the beneficiaries of the program were not among this group; it was the poor, the unemployed, the uninsured, and those without resources who were the primary beneficiaries of the Maine CIP during this time period."[4]

Between 1975 and 1980, the average amount paid per recipient was $2,110, and 95% of claims were for amounts under $1,000. In 1981, eligibility rules for CIP were reformulated to conform more closely to the original intent of providing relief only for financially catastrophic cases that result from high-cost expenditures not sufficiently covered by insurance. This kind of redirection of the program five years into its existence would not have been necessary if the original design had been based on a clear understanding that not all financially catastrophic cases are also high cost.

Data on Subgroups

Another indication that the distinctions between financially catastrophic and high-cost cases are often overlooked is the lack of data on how many people fall into each of the cells in Figure 2, even though four major efforts were made in the past decade to estimate the number of people who

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might qualify for catastrophic health insurance in the United States. In two instances the focus was exclusively on high-cost cases, yielding only estimates of the number of persons who incurred annual medical expenditures in excess of specified amounts.[5]

The other two studies went further and considered both high-cost cases and financially catastrophic ones.[6] One of the two, by the Congressional Budget Office (CBO), estimated that in 1978 about 9% of all families would incur catastrophic expenditures, which the CBO defined as out-of-pocket expenditures greater than 15% of gross annual income. The CBO also estimated that 28% of families with incomes below $5,000 would have catastrophic health expenditures in 1978, in contrast to only .2% of families with incomes above $20,000, which is consistent with higher-income families having better health insurance coverage and generally greater financial resources. None of the CBO estimates, however, provide counts of persons or families for the cells in Figure 2, such as the number of people who are both high-cost and catastrophic cases or who incur financially catastrophic expenditures even though they are not high-cost cases. Yet, as Maine's CIP experience illustrates, knowledge about such subcategories is important if reasonable predictions are to be made about the effects of any catastrophic health program.

Differences in Policy Concerns

From a broader perspective, the basic policy concerns associated with financially catastrophic cases differ from those that relate to high-cost ones. The long-standing interest in those who incur financially catastrophic health care expenditures stems from a desire to protect people stricken by illness from bearing the additional burden of severe financial hardship or even financial ruin brought on by the costs of care. The continued interest in catastrophic health insurance over the years — and its recent reemergence into the spotlight — attests to the strength of this social objective.

By contrast, the concern with high-cost cases is more recent and is more closely associated with efforts to control health care costs, largely because high-cost cases account for a disproportionate share of total health care expenditures. Because [illegible] tribution,[8] any success in reducing expenditures for this relatively small group will have a large effect on the system as a whole. It is therefore an inviting target for cost control efforts, even if, as a CBO study found, the amounts spent on such high-cost cases are not growing faster than total health care expenditures.[9]

Financially Catastrophic Illness and High-Cost Illness

Basic Definitions

Although catastrophic illness is often used synonymously with both financially catastrophic cases and high-cost cases as those terms have been defined here, it is more meaningful to reserve the term financially catastrophic *illness* for diseases or conditions that have a high probability of resulting in financially catastrophic cases. By the same token, high-cost illness ought to refer to diseases that frequently result in high-cost cases.

To illustrate, a financially catastrophic illness might be one for which more than half the patients must pay out-of-pocket expenses that are greater than 15% of family income. Similarly, high-cost illness may be defined as any illness or condition that requires average total expenditures per case of more than $10,000 per year. End stage renal disease (ESRD) would easily fit this definition of high-cost illness, since mean health care expenditures associated with the disease exceeded $23,000 per person per year in 1981.[10] However, ESRD stopped being a financially catastrophic illness in 1973, when the Medicare program was extended to cover virtually anyone afflicted by ESRD. The subsequent shift in the focus of policy illustrates some key differences between high-cost and catastrophic illnesses.

Prior to 1973, ESRD was recognized as both a high-cost and a financially catastrophic illness, but it was discussed primarily in terms of its catastrophic attributes and attention centered on the adequacy of coverage for the disease. [illegible] when almost everyone with ESRD was provided relatively comprehensive coverage through Medicare, the disease ceased to be a financially catastrophic illness, and because it continued to be a high-cost one, policy [illegible]

Because the definitions of financially catastrophic illness and high-cost illness given here incorporate, respectively, the earlier definitions of catastrophic and high-cost cases, predictable parallels exist between the two sets of concepts. Catastrophic illnesses, like financially catastrophic cases, can be divided into those that are high cost and those that are not, reflecting differences in the coverage available for the disease and in the resources of those afflicted. Conversely, the levels of coverage and other resources of those who are afflicted by a given high-cost illness will determine whether that illness is also financially catastrophic.

There are, however, also differences between the two sets of concepts. The focus of financially catastrophic and high-cost cases is on the individuals or families who incur total health expenditures that exceed either their ability to pay or a set, large amount. By contrast, financially catastrophic and high-cost illnesses focus on specific diseases, those likely to result in expenditures that are high in relation to either ability to pay or a set threshold. In other words, the unit of observation for financially catastrophic and high-cost cases is the individual or the family, whereas for financially catastrophic and high-cost illnesses it is the disease.

Consistent with this, the time span used in defining each may differ. The episode of illness, where it can be readily specified, is a more apt definitional basis for diseases than a calendar year or other fixed time span. These and other basic differences and similarities in definitional terms are summarized in Table 1.

Specification of Definitional Elements

Although the characteristics in Table 1 are helpful in distinguishing among the four major categories of cases and illnesses that are financially catastrophic or high cost, further specification of these and other characteristics is needed to fully define each category.

Unit of Observation

For high-cost or catastrophic cases, the unit of observation can be either the individual or the family. If income, third-party coverage, and all the other resources that may be called upon to pay for health care costs are important considerations—as when the focus is on financially catastrophic cases—the family is likely to be the more meaningful unit of observation. More often than not, resources to pay for care are pooled at the family level.

Time Span

Although one year is the time span most commonly used when considering health care expenditures, it may prove more meaningful, for both high-cost and financially catastrophic illnesses, to add up expenditures over the episode of illness. Similarly, if the concern is adequacy of protection, it may be more useful—though not necessarily easily accomplished—to consider expenditures accumulated during the variously defined

Table 1. Categorization of large health care expenditures: Definitional characteristics

Category	Unit of observation	Health care expenditures considered		
		Type	Time span	Referent
Financially catastrophic case	Individual or family	Out-of-pocket expenditures	Year or other fixed period	Ability to pay of individual or family
High-cost case	Individual or family	Total medical expenditures	Year or other fixed period	When explicit, overall distribution of expenditures
Financially catastrophic illness	Disease category	Mean out-of-pocket expenditures per case for the disease	Episode or fixed period	Ability to pay of individual or family
High-cost illness	Disease category	Mean total expenditures per case for the disease	Episode or fixed period	When explicit, overall distribution of expenditures

"benefit periods" stipulated in many types of third-party coverage.

Expenditures can also be examined over periods longer than one year, to identify those cases that are high cost not as a result of a single, costly hospitalization but, rather, through a long succession of relatively small but frequent expenditures. If even a stream of expenditures is evenly divided between two years, for example, an examination of each year's expenditures may not reveal the presence of the high-cost case. Similarly, if the expenditures end shortly after the start of a calendar year, or begin toward the year's end, the case will not emerge from analyses of that single year. Multiyear expenditures may also help identify high-cost cases that involve very large expenditures, since it has been shown, at different times and in different settings, that people with high expenditures in one year are much more likely to have high expenditures in subsequent years as well.[12]

Ability to Pay

By the definition proposed here, a case is financially catastrophic if health care expenditures exceed the affected person's or family's ability to pay. Much depends, therefore, on how ability to pay is defined. In general, ability to pay for health care is viewed in terms of a person's or family's total financial resources minus total nonhealth, nondiscretionary expenditures.

It is useful, in this context, to divide total resources into three components: third-party health care coverage; income from all sources; and wealth, consisting of all accumulated assets. To date, most catastrophic health insurance programs and proposals have taken into account only the first two components, third-party coverage and income. They consider third-party coverage inasmuch as they focus on out-of-pocket health expenditures, thereby deducting from the obligation for health expenditures the amount covered by any third party. Income is usually the measure by which an out-of-pocket expenditure is considered financially catastrophic (see the examples in Table 2). Given the potential for income to be substantially reduced by illness, it is important to measure the actual income while health care expenditures are being accumulated, rather than for some prior period.

Although some catastrophic health insurance proposals, such as the Martin bill (see Table 2), recognize ability-to-pay differences across income groups, very few do within income groups. One

Table 2. Criteria for defining catastrophic expenditures from a sample of actual and proposed catastrophic health insurance plans

Source	Out-of-pocket limits (not adjusted for inflation)
Long-Ribicoff bill (S. 350, 1979): Catastrophic Health Insurance and Medical Assistance Reform Act	$2,000 per family
Wisconsin Comprehensive Health Insurance Plan	$500 for eligible person receiving Medicare $1,500 for any other eligible person $3,000 for all eligible persons in a family
Goldstein's Major Risk Insurance Proposal	10% of income
Maine Catastrophic Illness Program	5% of net income plus [illegible] not $20,000
Minnesota Catastrophic Health Expense Protection Program	[illegible] of household income [illegible] 25% of household income [illegible] [illegible] of household income [illegible]
Pauly's prototype plans	[illegible]
Martin bill (H.R. 5405, "1980 Medical Expense Protection Act of 1980")	[illegible]

that did is Maine's Catastrophic Illness Program. Between 1981 and when it was discontinued, in 1984, that program required that, to qualify, a person have out-of-pocket expenditures for health care that exceeded a sum equal to 30% of net income plus 10% of net worth over $20,000. Although differences in wealth were recognized in this particular program, variations in the obligations people face have not been taken into account in this or other similar programs, except somewhat indirectly in Alaska's Catastrophic Illness Program. To qualify for that program, as of 1985 a person had to exceed $5,000 in out-of-pocket expenditures ($7,500 in cases of pregnancy and childbirth). Beyond that amount the program covers only a portion of the expenditures, and the state's share is determined according to a formula that takes into account family size—representing one form of obligation—in addition to gross family income and assets.[13]

From the perspective of differences in ability to pay, most catastrophic health coverage programs are structured differently from our taxation system. In determining our liability, the tax code makes allowance for individual differences in obligations by, for example, granting exemptions for dependents, and certain types of casualty losses are similarly recognized. In addition, property taxes give explicit recognition to wealth as a resource. Within health care, eligibility rules for the Medicaid program take into account assets such as bank accounts and life insurance policies, as well as differences in obligation represented by family size. Although most current definitions of ability to pay for catastrophic health expenditures could be broadened to encompass differences in wealth and obligations, it is never easy to settle on a satisfactory definition of ability to pay, whether for taxation or for any other purpose, even when the basic objectives to be served are relatively clear.[14]

High-Cost Threshold

Setting a threshold for high-cost cases presents a different problem. It is not clear, a priori, at what point a health care expenditure ought to be considered high. Some of the thresholds used in the past seem to owe more to numerology than to theoretically based rationales.[15] For example, there seems to be a preference for round numbers that are multiples of five, with $5,000 finding particular favor in the mid-1970s.[16]

To be meaningful, the specification of high-cost thresholds has to reflect the underlying concerns that have drawn attention to high-cost cases. Because the worry is that these cases are straining society's resources, the specific focus of policy is on containing expenditures for what are perceived to be a relatively small number of very costly cases, to thereby achieve disproportionately large savings. A threshold based on this cost containment focus therefore must capture the group of cases that accounts for a disproportionate amount of resources. One approach is to set the threshold to correspond to the 90th, 95th, or even the 99th percentile of the distribution of individual expenditures (or any other percentile, whether divisible by five or not). The top 10% of cases have been found to account for up to 70% of total expenditures, whereas the top 5% and 1% account for up to 50% and 25%, respectively, of the total.[17]

Inclusiveness of Expenditures

The inclusiveness of health care expenditures can also be an issue. Ideally, all health care expenditures incurred by a person or a family should be taken into account. A number of studies of high-cost cases, however, have been based only on expenditures for hospital care, mostly because of the more ready availability of data from hospitals.[18] In some instances the exclusions are more deliberate, as when expenditures for nursing homes or mental health institutions are not included because the focus is on the type of acute care that most health insurance mechanisms cover.[19] A more difficult issue is whether to include, under a broad definition of health care expenditures, what many consider to be largely discretionary expenditures, such as those for orthodontia, cosmetic surgery, and psychotherapy.

Implications for the Formulation of Policy

The foregoing has direct implications for the formulation of policy in several areas, including such current issues as health care coverage for victims of AIDS, the design of a national catastrophic health care coverage program, and catastrophic coverage for Medicare beneficiaries.

AIDS as a High-Cost and a Financially Catastrophic Illness

One aspect of the current epidemic of AIDS that has received relatively little systematic examina-

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tion is the cost of health care services for the disease and the ways in which this care has been financed. To date only hospitalization costs for AIDS have been reported in the literature, and, characteristically for the examination of a high-cost illness, they are expressed as costs per case, rather than per hospitalization or per year. The figures span a broad range, from a mean hospitalization cost per case of $27,500 based on data from Maryland[20] to an estimate of $142,000 derived from New York and San Francisco data.[21] More generally, it has been suggested that every case of AIDS can be thought of as costing the same as a heart transplant.[22] Even though the information on health care costs for AIDS is not complete or definitive, AIDS is certainly a high-cost illness, and there is growing concern about the very large resources needed to care for the victims of the AIDS epidemic.[23] The usual concomitant proposals to reduce the costs of care are also surfacing, most of them focused on minimizing the use of hospital inpatient services by relying on less costly alternatives, such as hospices, nursing homes, and home care.[24]

Because AIDS cases are high cost, and possibly also because AIDS is such a disabling and ultimately fatal condition, some policy makers have apparently concluded that all AIDS cases are financially catastrophic, in effect concluding that AIDS is a catastrophic illness. This view is most clearly reflected in legislation such as H.R. 2380, introduced in 1983, whereby Medicare would cover all AIDS cases, much as it already does for ESRD. However, because the high-cost and financially catastrophic categories are only partly overlapping (see Figure 1), a high-cost AIDS case, or any case of AIDS, for that matter, is not necessarily also financially catastrophic.

Only through systematic investigation can the proportion of AIDS cases that are in fact financially catastrophic be reliably established. Because this has not been done, only tentative inferences can be drawn from the fragmentary information available about who pays for AIDS patients' health care. To go beyond that, more information will be needed on how much of the total bill is covered by each payer and, most importantly, on how out-of-pocket expenditures for AIDS [illegible] patients' incomes.

[illegible]

also reports of insurers who deny coverage to AIDS patients on various grounds, and several states have set up insurance pools for AIDS victims who have been denied private insurance.[25] The Health Care Financing Administration reportedly estimates that 40% of the AIDS population is on Medicaid and that the Medicaid program will spend at least $200 million on AIDS patients in fiscal 1986.[26] The study of hospitalizations for AIDS patients in Maryland, however, puts the percentage of cases covered by Medicaid in that state in 1985 at closer to 19%.[20]

Thus, although it appears that without Medicaid coverage a large proportion of AIDS cases would be financially catastrophic, it is not clear just how large that proportion is. Nor is it clear how many catastrophic cases of AIDS do not qualify for Medicaid. In any event, more complete and compelling evidence that all or nearly all AIDS cases are financially catastrophic—in addition to being high cost—ought to be required before Medicare coverage is extended to all cases of AIDS, thereby shifting the entire financial burden for AIDS on already hard-pressed public sources.

There have always been pressures to provide universal, publicly funded coverage for certain diseases that are high cost, particularly those that are disabling or fatal. After such coverage was provided for ESRD, the same was advocated for hemophilia and end stage heart disease. Almost immediately the wisdom of this disease-by-disease approach was questioned,[27] and later the experience with the ESRD program and its unexpectedly high cost further undermined support for such initiatives.

Whatever the arguments for and against the specific proposals, it must be recognized that true protection against financially catastrophic health care expenditures cannot be based on specific diseases. Consistent [illegible] financially catastrophic expenditures [illegible] defined here, catastrophic coverage [illegible] protect against health care expenditures that [illegible] otherwise exceeded a person's ability [illegible], regardless of whether or not the expenditures were incurred because of a disease [illegible].

[illegible]

1986, President Reagan gave renewed prominence to catastrophic health coverage. Citing his awareness that "devastating illness can destroy the financial security of the family," the President told the nation he was asking the Secretary of Health and Human Services for a report "on how the private sector and government can work together to address the problems of affordable insurance for those whose life savings would otherwise be threatened when catastrophic illness strikes."[31] In terms of the definitions and distinctions discussed here, the President's focus appears to be on all instances where health care expenditures exceed a person's or a family's ability to pay—that is, on financially catastrophic cases.

If this interpretation is correct, the President's concern encompasses a larger category of cases than do many of the catastrophic coverage proposals and plans of the preceding decade. The Long-Ribicoff bill of 1979 (S. 350) is representative of an important class of such catastrophic coverage proposals. It provides for virtually full coverage for all out-of-pocket health care expenditures that in any year exceed $2,000 (in 1979 dollars). Any coverage that simply limits out-of-pocket expenditures, however, is technically a form of stop-loss insurance, which has narrow goals and is therefore relatively ineffective as protection against all financially catastrophic expenditures.

Stop-loss insurance is usually meant to protect those who already have coverage but who, because of cost-sharing features or upper limits on their coverage, can incur large out-of-pocket expenditures when the total expenditures for their care fall into the high-cost range. In terms of the four categories of financially catastrophic cases discussed earlier, stop-loss insurance is intended for the category of cases that have third-party coverage and are high cost, represented by cell 1 in Figure 2. But even within that target population, a dollar threshold of $2,000 or any similar amount will result in overinsurance for some people and underinsurance for others, since a $2,000 expenditure is not necessarily catastrophic for everyone. Some individuals and families may be able to pay more than that amount without seriously disrupting their financial situation, in which case they actually belong in cell 3 in Figure 2, rather than in cell 1. But for others, a smaller amount, such as $1,000, may already exceed their ability to pay.

For the other three categories of financially catastrophic cases in Figure 2 (cells 2, 5, and 6), the typical stop-loss insurance plan provides no relief. It is not meant to protect against financially catastrophic expenditures associated with cases that are not high cost, thus excluding the categories represented by cells 5 and 6. Nor is stop-loss coverage usually intended for catastrophic cases attributable to the absence of any coverage. Therefore it is also inapplicable to the categories that correspond to cells 2 and 6.

Despite these limitations, stop-loss insurance is still commonly equated with catastrophic health coverage. That perspective endures most likely because it accords with a widely held perception that catastrophic health coverage is not meant to apply to financially catastrophic cases associated with lack of insurance, low income, and similar causes of medical indigency. For example, Desonia and King point out that all three of the state catastrophic health programs still functioning as of 1984—those in Alaska, Maine, and Rhode Island—were "restructured in recent years to prevent them from serving as health insurance programs for indigents."[32]

This inclination to exclude from the notion of financially catastrophic events anyone whose predicament stems from a lack of coverage or poverty is not based, in all probability, on taxonomic considerations. More likely, it is rooted in the age-old practice of dividing the poor into those who are worthy and those who are not. People who, in spite of having been provident and of having obtained health insurance, find themselves overwhelmed by their share of the expenditures for a high-cost case are seen, much like the "worthy poor," as victims of fate, and therefore especially deserving of society's help. By contrast, those who are at high risk for catastrophic health expenditures because they are poor and have no health coverage are not perceived in the same light.

Yet it is consistent with the basic definition of financially catastrophic cases given here—which simply relates health expenditures to ability to pay—to conceive of catastrophic health coverage as providing protection against all financially catastrophic expenditures, including those of the uninsured and the medically indigent. One proposal that takes this view is the bill introduced in 1982 by Representatives James Jones and James Martin to provide catastrophic cov[illegible] for both those currently insured and the [illegible] d (H.R.

7000). Because this kind of across-the-board catastrophic coverage tends to reduce the incentive to obtain health insurance, it often incorporates provisions that encourage people to maintain their own health insurance. But such provisions are unlikely to have any effect on the estimated 5 to 10 million people who, in addition to being poor, have no health care coverage, not even Medicaid,[33] and who clearly cannot afford to purchase health insurance. They and others who are uncovered are at high risk for catastrophic health expenditures, and their needs, which are receiving a great deal of attention,[34] inevitably loom large in any consideration of catastrophic coverage that does not deliberately restrict itself to the insured group with high-cost expenditures represented by cell 1 in Figure 2.

Catastrophic coverage programs that take into account all relevant subgroups defined in Figure 2 raise the issue of how many persons or families are in each subgroup. To estimate these numbers, information must be obtained on levels of third-party coverage, total and out-of-pocket health care expenditures, and income of families or individuals. That kind of information has already been collected for nationally representative samples both in the 1977 National Medical Care Expenditure Survey (NMCES)[35] and the 1980 National Medical Care Utilization and Expenditure Survey (NMCUES).[36] Information on expenditures for nursing home care, however, is not included in either NMCES or NMCUES, thus leaving out an important component of both high-cost and financially catastrophic expenditures.[37] It is conceivable that the successor survey to NMCES, now being designed, will include information on expenditures for nursing homes. In the meantime, we will either have to settle for estimates that take into account only acute care expenditures or have to resort to the artful splicing of data sources that characterized some earlier efforts to derive national estimates of how many people might qualify for catastrophic health coverage.[38] Obtaining estimates at the state level could prove even more difficult, since the sample sizes of surveys such as NMCES and NMCUES are usually insufficient to yield reliable state-by-state estimates.

Medicare and Catastrophic Coverage

The "catastrophic" health coverage proposal most [illegible] Medicare [illegible] 90 days of hospitalization.

in part to offset increases in premiums and enrollee cost sharing. At present Medicare coverage is limited to 90 days of hospitalization during each benefit period plus an additional lifetime reserve of 60 days.

The Medicare catastrophic coverage proposal is similar to stop-loss plans in its focus on high-cost cases, but is restricted to very long hospitalizations. Also, much like the stop-loss plans discussed earlier, it does not take into account differences in ability to pay, and therefore makes no allowance for the supplementary coverage provided by the "Medigap" policies that are held by some two-thirds of Medicare enrollees.[39] Yet ability to pay ultimately determines whether unlimited hospitalization coverage actually protects any given Medicare enrollee from financially catastrophic health care expenditures. In any event, the number of those who would actually benefit from unlimited hospitalization coverage is likely to be relatively small. In 1978 only .2% of Medicare enrollees used any of their lifetime reserve hospital days.[40] Those who exhaust their lifetime reserve *and* have no Medigap policy to cover the resulting liability must be, therefore, an even smaller group.

Although the proposal for unlimited hospital coverage under Medicare has not been enacted, premiums and cost-sharing levels have risen substantially in recent years. The effect has been a steady increase in the out-of-pocket expenditures of Medicare enrollees and a consequent growth in the proportion of enrollees for whom such expenditures reach financially catastrophic levels. By one estimate, the overall out-of-pocket expenditures of the elderly represented 12% of their total income in 1977. That grew to 15% in 1985, and at the current rate is expected to be nearly 19% by 1990.[41] Although out-of-pocket expenditures are especially burdensome for the more than one-fifth of the elderly who are poor or just above the poverty line,[42] enrollees at all income levels are affected. In terms of the relationships shown in Figure 1, increasing the cost-sharing level for Medicare enrollees, holding all else the same, shifts cases from the high-cost but not financially catastrophic category to the [illegible] and financially catastrophic one.

Recognition of this [illegible] has prompted additional proposals [illegible] Medicare [illegible]

similar to the stop-loss arrangements discussed earlier, and like them they do not necessarily eliminate all financially catastrophic cases, because they do not take into account ability to pay. This weakness has been recognized, and among the options for changing Medicare benefits that the Congressional Budget Office examined was a plan that set maximum liability limits that vary by income level.[43] But even that arrangement would not eliminate all financially catastrophic cases among Medicare beneficiaries. Catastrophic cases could still occur because the liability limits in all these plans do not apply to out-of-pocket expenditures for services Medicare does not cover. The plans are also not designed to recognize the reductions in disposable income that result from increasing Medicare premiums. Among the 2.8 million enrollees currently at immediate risk for spending large sums on intermediate care nursing homes, which are not covered by Medicare, a great many face total impoverishment without ever exceeding the proposed Medicare liability limits.[44] Nearly half the victims of Alzheimer's disease are likely to fall into this category within a year of contracting the disease, given their high need for long-term care services not covered by Medicare.[45]

For a Medicare plan to fully prevent financially catastrophic cases as defined here, it must do more than remove current limits on the number of hospital days covered. It must also include provisions to counteract the effect of rising premiums and cost-sharing levels and take into account out-of-pocket expenditures for the full range of health services actually used by Medicare enrollees. A recent proposal for reforming Medicare does virtually all of that. It calls for reduced cost sharing, for premiums adjusted to ability to pay, and for expanded coverage of long-term care services.[46] The recommended changes stand a good chance of eliminating financially catastrophic cases among Medicare beneficiaries. Yet this set of recommendations does not label itself, as it could, a catastrophic coverage plan for Medicare enrollees. That may be because its aims are broader, and protection against financially catastrophic expenditures is just one element, albeit a key one, of a truly comprehensive coverage program.

Summary and Discussion

The basic distinction between high-cost cases and catastrophic ones provides useful insights on several current issues:

- Just because all or nearly all cases of AIDS are high cost does not necessarily mean they are all financially catastrophic as well. Only by relating expenditures to ability to pay can financially catastrophic cases be reliably identified. Studies that do so for AIDS victims are urgently needed, both to determine which cases require catastrophic coverage and to ensure that scarce public funds are not allocated to cases that, although high cost, would not be catastrophic because they are already covered by a private third-party payer.
- Stop-loss insurance with a single-amount liability limit does not provide complete or effective catastrophic coverage. It focuses only on high-cost cases that are insufficiently covered. Stop-loss insurance thus leaves out catastrophic cases among the uninsured poor and similar groups, which usually are not high cost. Yet from the perspective of definitional consistency, the problems of the uninsured and the medically indigent that are currently getting a great deal of attention are inextricably entwined with the issue of coverage for financially catastrophic cases.
- The catastrophic coverage proposals for Medicare illustrate why all relevant expenditures must be included when determining whether a case is financially catastrophic or, for that matter, high cost. Because Medicare does not cover expenditures for certain services, such as those provided by intermediate care nursing homes, out-of-pocket expenditures for those services are particularly likely to be large, and therefore it is all the more important to include them in attempts to identify financially catastrophic cases.

As this last point illustrates, making a clear distinction between what is high cost and what is financially catastrophic requires that the key elements of each of those terms be explicitly defined, including: the types of expenditures considered, the unit of observation (i.e., the individual versus the family), the time span over which expenditures are considered, and what is meant by ability to pay and by an expenditure being high. Unforeseen and unintended policy outcomes will be minimized if each of these individual elements is specified so as to be consistent with the values and

broader objectives that motivated the formulation of policy to begin with. Definitions of ability to pay, for example, must reflect a consensus about the types of resources that a person should use in defraying the costs of care and, more broadly, about what constitutes an equitable financial burden.

The formulation of policy that takes proper account of the distinctions, components, and relations on which this paper focuses is less likely to lead to proposals for catastrophic coverage that ignore differences in ability to pay. It is also more likely to result in efforts to obtain estimates of the numbers of people in each category represented by the relevant cells in Figure 2 *before* a catastrophic coverage program is formulated. Although the underlying dilemmas about equity and other social values will always remain, the difficulty in grappling with them is less apt to be compounded by terms and concepts that are poorly specified.

Notes

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18 [illegible] Cook and Moore (note 5); Berki et al. (note 8); and [illegible] Kopriski and A. [illegible], "Characteristics of High Cost Treatment [illegible]," *Inquiry* 21 (Summer 1984): 150-154.

19 [illegible], CBO (note 5).

20 [illegible], "Cost Analysis of [illegible]," *Harvard Medical [illegible]*

21 [illegible] [illegible] United States, [illegible]

Mass health insurance

BOSTON

Massachusetts, ever in the socially progressive vanguard, is considering becoming the first state to provide universal health insurance. At the moment, some 10% of the state's residents are uninsured, covered by neither federal nor private health plans (in the country as a whole, the figure is 16%). These people are mostly the working poor, many of them part-timers, though they also include students, housewives and the jobless. The numbers of uninsured have been rising, in spite of falling unemployment. This seems to be because so many new jobs—80% of those created in Massachusetts over the past three years—are in low-paying industries such as construction, trade and services, which skimp on fringe benefits.

Federal law prevents state governments from compelling employers to provide health insurance. Massachusetts legislators are lobbying for a change in that law. In the meantime they are proposing a payroll tax on businesses which do not offer their own health plans, with extra money for those which do.

Under the present state scheme for paying for care for the uninsured, hospitals pay about 11% of their fees into an "uncompensated care pool" which covers bad debts and free care. The cost is then passed on to the consumer in the form of higher insurance premiums. This scheme not only allows non-insuring employers to get away scot-free; it also encourages the most expensive forms of treatment, since it covers only hospital care.

The pool system is due to expire in September. Several members of the state legislature are introducing bills to replace it with state insurance. One plan would extend coverage to outpatient care and to the non-indigent at twice the present cost. The largest share of the extra money, $180m a year, not quite 5% of Massachusetts's annual medical bill of $4 billion, would be paid by the state; the rest would come from non-insuring employers and their workers. The senators had assumed a 2.5% levy (plus 1% paid by employees) would be enough until they realised that so low a tax might induce "good" employers to drop their own benefits (which typically cost about 10% of wages) and let the state do their work for them. The final charge is likely to be higher. Small and new businesses might be given temporary waivers.

The starting-point for the proposed reform is that people who work should not be worse off than those on welfare. But this laudable aim conflicts with another, which is that costs must be contained. The state's insurance commissioner points to the experience of Medicare and Medicaid as "a bargain with the devil" which has driven up medical expenses for everybody. He says that the uninsured may well have pent-up demand for medical services which will push up costs in the early years. If costs run away, so will political support.

Universal health insurance would seem to be a natural issue for Governor Michael Dukakis, who has been touting his state's pioneering workfare project as part of his presidential platform. But, perhaps out of fiscal caution, he has yet to lend his support to any of the plans. A commission will be reporting to him soon, with modest proposals for two-year experiments with state insurance in Worcester and Boston. Since any statewide insurance scheme would probably take at least two years to get off the ground, proponents are willing to compromise on a commitment now and a launching date in 1989. The governor would hope to be somewhere else by then.

STATE OF ALASKA
THE LEGISLATURE

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May, 1988

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Mary Van Nimwegen

House Hess:

February 4, 1988

April 8, 1988

Official Business

COMMITTEE: HOUSE HESS

DATE: 2-4-88

SIGN-IN

Subject of meeting:

HB 410 Catastrophic Illness
HB 411 State Health Insurance
HB 409 Student Loans
HB 269 Veterans Interest Rates

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY? if yes, which bill?
JAY Livey	DHSS	3030	DHSS	410 411
DON KOCH	PO BOX D [redacted]	2577	DIV. INSURANCE	410
MARTHA STEWART	CAP 507	3706	REP. AL ADAMS	345 IF NECESSARY
Michael Lessmeier	One Sealaska Plaza Suite 303	586-5912	Allstate, State Farm Independent Agents	No.
KERRY ROMESBURG	POSTSECONDARY CMSN	2954	ACPE	409
Jeff Maynard	"	2854	ACPE	no
Dana Bruno	Cap. 570	3727	Juneau	no
BOB STALNAKER	SOB	4470	RETIREMENT + BENEFITS	411
Connie Sipe	OAC Box C	3250		411 + 410

Blue Cross
of Washington and Alaska

15700 Dayton Avenue North/P. O. Box 327
Seattle, Washington 98111-0327
206/361-3000

February 4, 1988

Blue Cross of Washington and Alaska has reviewed House Bill 411. We are opposed to the enactment of this bill.

HB 411 would allow any resident to enroll in the state employees coverage program. The premium would be paid by the enrollee. Whenever a program is offered where there is individual selection for coverage and where the costs of the coverage are born by the enrollee selecting to be covered, the persons who elect coverage are those who have need of the benefits. With that adverse selection, the rate impact on the coverage of state employees could be significant.

Current rates for the state coverage range from $308.45 to $346.50 per employee per month. That is a substantial premium rate. We believe that persons who would enroll at those rates would probably need the coverage and would utilize benefits heavily.

With the addition of a selective group of residents, the ability of any carrier to project costs and rates would be difficult. With a group of employees, a carrier knows several things about the enrollees. They are employed and so have a health status which allows them to work. They live in areas of the state where their jobs are located and, for the majority of those employees, probably are located in areas where health care facilities are also located. These new factors for residents who elect the program may mean that these people are less well and less able to work or they may be located further from health care providers necessitating more transportation costs or more delay before seeking care. Changes of this sort in the basic makeup of the group could increase utilization and costs.

Blue Cross believes that this solution to the need for health care coverage for Alaskan citizens would increase costs to the state for their employees' coverage by a substantial amount and would jeopardize the ability of the state to get carriers who will bid on that contract.

TO NEIGHBOR

THE NO-INSURANCE NIGHTMARE

Lack of health plan turns medical bills into prescriptions for poverty

By LARRY CAMPBELL
Daily News reporter

One evening a few weeks back, Dorothy Schooler finally said the word out loud — bankruptcy. After all, husband Dave was the one bringing home the paychecks, but she was the one who saw all the doctors' and hospital bills, the one who went to the pharmacy all the time.

"Well, at this point we're thinking about it," Dave Schooler said. "But it's hard. It's a situation you really don't want to go through. I mean, it's something that'll stick with you for a long time. I mean, a long time."

Dorothy shook her head. "It's crazy. We don't owe a thing to anyone. We don't have any credit cards. No car payments. No mortgage.

"It's all just in medical bills. Just medical bills — doctors, hospital, the kids' medicine. You know? People just wouldn't believe us."

Medical bills, big ones, about $12,000 worth, are slowly driving the Schooler family to desperation. The youngest boys have been ill all their lives. Blond Clint, 5, suffers chronic ear infections. Doctors implant special tubes behind his eardrums to let fluid drain and fight off infection. Jake,

Anchorage Daily News/Michael Penn

The Schooler family (from left) in their Eagle River home: Dorothy and Dave with Jake, 11 months; Clint, 5; and Joe, 13.

NEIGHBOR TO NEIGHBOR: HOW YOU CAN HELP

WHAT IT IS

The Neighbor-to-Neighbor fund is a group of five community agencies that work together during the holiday season to raise money for people who need help. The groups are: Abused Women's Aid in Crisis, Association for Stranded Rural Alaskans, Catholic Social Services, Providence Hospital Social Services and the Salvation Army. During the fund-raising effort, the Daily News will publish stories about people in need in our community.

WHERE YOUR DONATIONS GO

Every penny contributed goes to those in need. The Daily News donates all administrative costs. Unless designated for a particular organization, contributions to the fund will be apportioned among the agencies. Checks made out specifically to the Neighbor-to-Neighbor fund are tax-deductible.

HOW TO CONTRIBUTE

Checks should be made payable to the Neighbor-to-Neighbor fund and sent to the P.O. Box 149001, Anchorage, Alaska 99514-9001, or brought to the Daily News at 1001 Northway Drive. Donors' names, but not the amount of donations, will be published in the Daily News unless anonymity is requested.
Participating agencies are:

- Abused Women's Aid in Crisis, 100 W. 13th Ave.
- Association for Stranded Rural Alaskans, 2701 Denali St.
- Catholic Social Services, 225 Cordova St.
- Providence Hospital Social Services, 3200 Providence Drive
- Salvation Army, 726 E. Ninth Ave.

If you know of a family or an individual who needs help this holiday season, please contact one of these agencies.

DONORS, DEC. 21-22

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night a few weeks ago it got so hard for him to breathe that his parents rushed him to Providence Hospital.

Then, last August, Dorothy needed an emergency appendectomy. More bills. Big, four-figure ones.

Fortunately, Dave Schooler and his oldest son, 13-year-old Joe, are healthy.

"God knows what would happen if something went wrong with me," Dave said.

Lots of families in Anchorage have no idea what the Schoolers are going through. Lots of families have something that, nowadays, seems a guaranteed right — medical insurance. For a few dollars a month, lots of working people just have to fill out a form, and visits to the doctor, medicine and hospital stays are all paid for.

The Schoolers, working-class and modest, have no insurance. So now they are talking bankruptcy.

Tall, lanky Dave Schooler, 38, works at a local feed and seed store. He brings home about $1,500 a month. The store is barely a year old and small, with only two employees. The owners have been searching for affordable protection for their workers. But for such a small concern, employee insurance rates are high.

"They'd like to find some kind of insurance for us," Schooler said. "They've even been looking into a policy where I'd pay a portion. But even then, we're talking $150 to $200 a month I'd pay. And we'd have to find a company that would cover the boys."

Insurance companies routinely restrict coverage on what are termed "pre-existing conditions," meaning if you're already sick when the policy takes effect, insurance won't pay as much or at all.

It was shortly after Dorothy's appendectomy that the couple started taking a hard look at other bills. They pay rent for a two-bedroom apartment in Eagle River, buy food and gasoline. What's left over seems to get sucked up fast — a few dollars to one doctor, a few more to another, some to the anesthesiologist, $30 for Jake's asthma medicine.

See Page E-2, NIGHTMARE

Radio

Lessons for us all: More Christmas music from KSKA, which plans to run "A Festival of Nine Lessons and Carols" twice today. This joint Minnesota Public Radio/BBC program features a live broadcast of the Christmas service from King's College in Cambridge, England.

Frolics

Wheel fun: Dimond Skateland is running matinee skating sessions on weekdays during the school holidays. If your kids need to work off some excess energy, send them over. Tonight, a Christmas party takes place from 7 to 9:30 p.m. Information: 349-8825.

The tube

Holiday sentiment: Good family fare is "The Homecoming," the 1971 movie that was the pilot for "The Waltons." Patricia Neal is the mother of a large family during the Depression; Richard Thomas originates the role of biggest-brother John-Boy. Show time is 8 p.m. on Channel 11.

Last chance

Oh, you beautiful dolls: Tonight's the last performance of "Small World," which features performers in bright costumes representing dolls from many nations. Show time is from 7 to 8 p.m. at Egan Center. The state troopers will be on hand too, giving away free "Safety Bear" reflectors.

Presents

Breakfast toast: It's probably too late to pick up Rock Maple Liqueur, but there's always *next* Christmas. The Howard family of Belmont, N.H., produces the stuff from maple syrup at the New Hampshire Winery. It's a 50-proof libation that, according to Roger Howard, gets "the frost off

LD AND WOUNDED

an operation efuge, rehab, ured animals

N.Y. — Mary Lou Riccardo waking up every two hours aby raccoon. She's even e mice for a hungry owl. ngs even the most devoted do.

e foods of the great horned k," Riccardo said. "That's I will not pick up a dead

fe rehabilitator, an unpaid tate and federal agencies to phaned animals until they eturned to the wild.

. often 16-hour-a-day job, occasional donations. But wing number of others who a consuming passion.

hausted, I think I can't do id at her home in suburban little animal comes along now that if I'm not here for o. And I get all fired up

nter is in the back yard of oaks and cedars conceal a complete with treehouse, pool; an aviary where n exercise their wings; and sizes to shelter squirrels, whatever else arrives in citizen.

oubles as a clinic, crowded young or very ill. A bag of dangles over the washer e as treatment tables. A tank seethes with black rae, the mealworms con- uperating songbirds.

he gets about 1,000 calls a just need advice: skunks raccoons are nesting in a ecking at a window.

an 200 animals a year. All ets to be turned in to the vironmental Conservation, ators. She refuses nothing. ough to bring it to me, no lo my best to save it," she h sparrows, pigeons, nut- fawns, great blue herons, field mice. There's nothing

licensed rehabilitators in many of them limit the animals they will take, most veterinarians won't on't know how to."

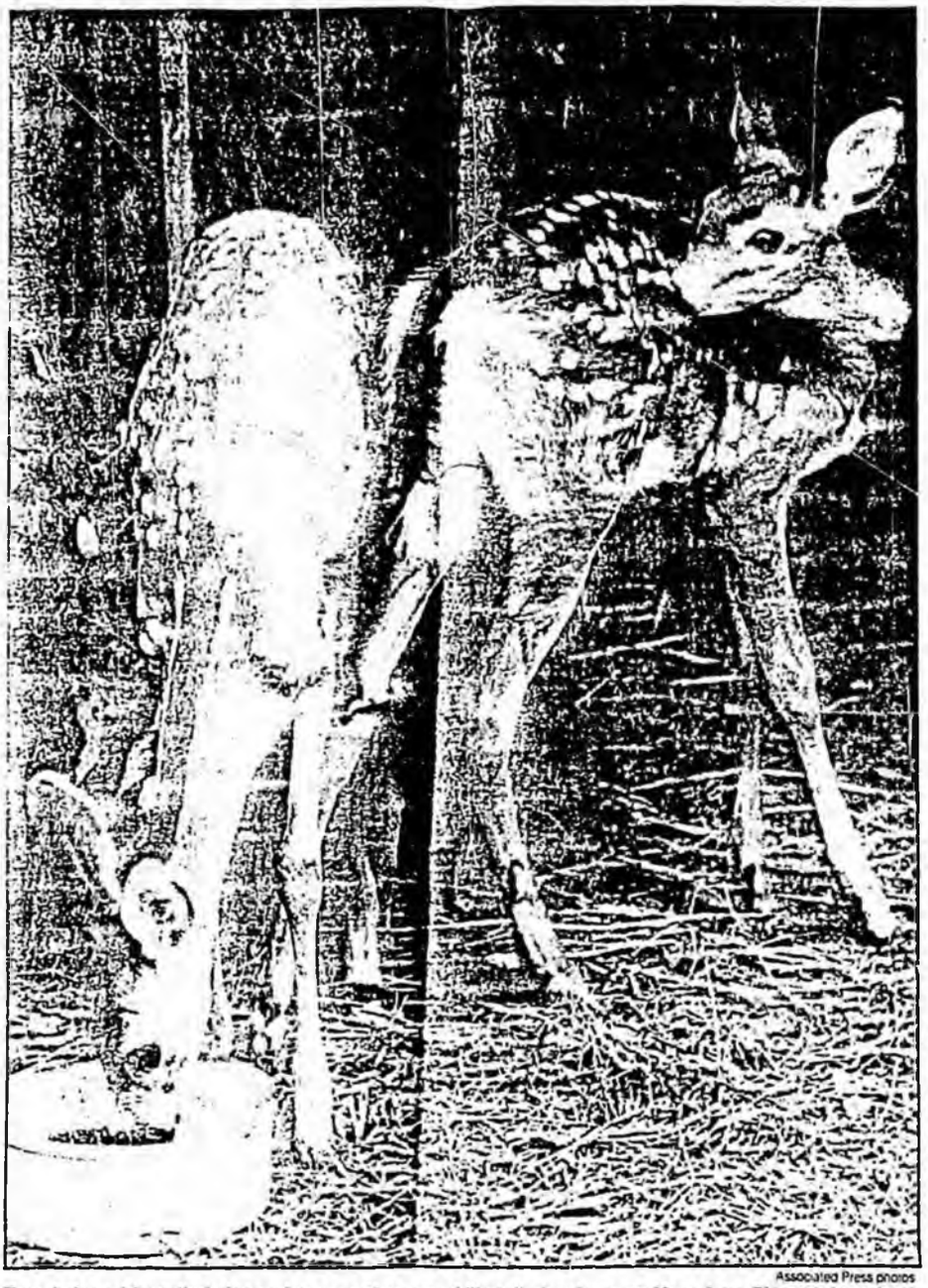
ber of the International n Council, a California- trains and certifies reha-

med a coalition of rehabil- ea called Wildlife Rehabil- l Network Inc., or WREN ion will serve as a means expertise.

he International Wildlife include hands-on training ion of medicine dosages, n of subcutaneous fluids, g.

e deadly. Meat can kill a o digest it. A dehydrated if given cow's milk.

in a blender to feed baby them to hunt, using live s learn to catch frogs and ool. Riccardo also brings killed animals and other introduce them to things



Associated Press photos

Two baby white-tailed deer whose mother was killed find refuge at Mary Lou Riccardo's animal convalescent center in Glenmont, N.Y.

Riccardo examines an injured baby raccoon she's nursing back to health.

Riccardo has a few favorite stories of amazing recoveries.

There was the baby raccoon found lying in the road, emaciated and infested with maggots. "He apparently had crawled onto the warm pavement to die," Riccardo said. "He was so dehydrated his skin was just glued to his skeleton." But she managed to get a needle under the skin to administer subcutaneous fluids, and the animal survived.

Last May, someone brought Riccardo a baby red-tailed hawk that apparently had fallen out of a nest; it was starving. With tube-feeding and tender care, the scrawny bird grew strong. But its flight feathers had been weakened for lack of minerals.

With the help of a falconer, Riccardo replaced the damaged plumage with feathers from a dead hawk of the same species, a procedure called "imping."

But her favorite story is that of a common pigeon, brought to her by an elderly man two summers ago. It had been shot by a pellet gun, its wing tip nearly severed. The man had taped the wing and rushed to Riccardo's house.

"I had to amputate half the wing," she said. "I told the man the bird would never fly with half its flight feathers gone." But when she saw the man's eyes, misty and pleading, she said she'd do her best.

"All winter, that bird exercised his half a wing," she said. In the spring, she took the bird back to the man's house and let it go.

"That bird flew!" she said. "I couldn't believe my eyes."

Doctors' bills overwhelm family

Continued from Page E-1

Last month, Humana Hospital Alaska sent the Schoolers a bill for Dorothy's operation. The hospital wants $400 a month. The Schoolers can't afford it.

Dorothy tried finding some social service agency, some welfare outlet that could help them. She'd call one agency; it would say "Sorry, no," and give her another phone number. She ended up with a long list of phone numbers, but no help.

"Everyone said they couldn't do anything," she said. "Welfare? No way. We've got an income. We're working folks."

Dave shook his head. "You know, I could nickel-and-dime these bills to death and still never get ahead."

The Schoolers feel alone in their dilemma, but so many others are just as alone. Social service workers say they see folks like these constantly — people who are scraping by and proud, only to have their lives eroded by the high cost of health care.

Humana, for example, has seen a definite increase in cases such as the Schoolers, said hospital spokeswoman Lynn Whitley.

"We're seeing more and more of them show up on the books in just the past 12 or 18 months," Whitley said.

While she couldn't discuss the Schoolers' case, she said Humana will work with patients up to a year, on average, trying to come up with payment plans before finally referring cases to collection agencies or writing them off as losses.

One state Department of Health and Social Services study suggests that 10 percent of all Alaskans, perhaps 40,000 people, have no form of health insurance. They are people who could suddenly find themselves in the same predicament as the Schoolers.

But as bleak as things look financially, Dave Schooler said there are always other things he takes care of first.

"There's always going to be food on the table," he said. "We don't eat like kings or anything like that, but we eat. We got a roof over our heads. Everybody else can wait, but my family will have basic needs met first.

"And these kids are going to have a Christmas. You don't have to worry about that. But there will be a few presents under the tree for the kids; clothes, mainly, and a few toys. But mostly the necessities."

Catholic Social Services is the agency helping the family.

The couple said they aren't exchanging gifts themselves this year. The one thing Dave and Dorothy could use under their tree is a health plan.

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

February 17, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Karen Oakley
Legislative Analyst

RE: Health Insurance Costs in Alaska
Research Request 87.105 (Supplemental Information)

You asked us to compile further information on health insurance costs in Alaska, specifically: 1) the total amount paid by school districts to insure their employees; and 2) the total amount paid by the federal government to insure their employees and to provide health care to the military.

Health Insurance Costs of Alaska School Districts

The Alaska Department of Education annually compiles information on the operating budgets of each school district. Each district must report how much was spent in each of 14 instructional or support service areas (e.g., regular instruction, special instruction, pupil transportation). Life and health insurance are one component of the expenditures that districts are required to report for each of these service categories. We tallied FY 86 figures as reported by 52 of the 55 school districts (see table on next page). The total amount spent by these school districts on life and health insurance was $23 million; their total expenditures were $725 million. In FY 86, Alaska school districts, on average, spent 3.8 percent of their operating budgets on life and health insurance for their employees.

FY 86 Operating Expenditures and Revenues of Alaska School Districts--Percentage of Expenditures Spent on Life and Health Insurance for Employees

School District	Life & Health Insurance ($)	Total Expenditures ($)	% of Expenditures for Life & Health Insurance	Local Revenue ($)	State Revenue ($)	Federal Revenue ($)	Percent of Revenue from State
Ada*	76,065	4,678,057	1.6	305,434	2,611,471	2,069,611	52.4
Alaska Gateway	175,003	5,409,762	3.2	171,690	4,339,214	742,014	82.6
Aleutian Region	66,193	2,023,182	3.3	22,123	1,554,613	354,438	80.5
Anchorage	10,423,135	216,148,561	4.8	63,305,348	154,237,713	854,229	70.6
Annette Island	136,136	3,371,474	4.0	90,927	1,535,752	1,486,491	49.3
Bering Straits	350,569	16,989,849	2.1	636,454	12,150,049	4,328,862	71.0
Bristol Bay	44,019	3,011,686	1.5	170,722	2,320,586	330,587	82.2
Chatham	96,589	3,161,377	3.1	154,072	1,976,536	759,990	68.4
Copper River	160,314	5,119,356	3.1	113,185	4,765,899	113,591	95.5
Cordova	95,482	2,979,573	3.2	570,964	2,281,060	13,145	79.6
Delta/Greely*	304,455	7,265,415	4.2	17,483	6,462,700	326,555	94.9
Dillingham	177,179	4,483,202	4.0	167,739	3,990,942	384,886	87.8
Fairbanks*	3,142,439	82,055,480	3.8	21,782,886	61,085,984	105,111	73.6
Galena	68,279	2,241,583	3.0	27,768	1,566,026	567,339	72.5
Haines	133,551	3,367,511	4.0	563	2,630,962	48,714	98.2
Hoonah	55,901	1,871,591	3.0	45,983	1,505,501	304,628	81.1
Hydaburg	22,324	928,058	2.4	19,143	924,410	23,349	95.6
Iditarod	184,644	6,486,052	2.8	202,959	5,219,174	1,089,146	80.2
Juneau	1,111,145	27,048,333	4.1	7,403,483	18,634,883	56,690	71.4
Kake	116,470	2,269,799	5.1	46,436	1,690,296	456,056	77.1
Kashanamuit	68,061	1,775,007	3.8	0	1,559,368	0	100.0
Kenai Peninsula	2,315,890	56,410,879	4.1	18,614,347	38,446,708	195,792	67.1
Ketchikan Gateway	264,577	13,817,478	1.9	4,277,176	10,016,184	9,350	70.0
King Cove	50,103	1,458,852	3.4	42,944	1,289,951	40,801	93.9
Kodiak Island	664,710	15,577,440	4.3	1,553,099	13,682,537	334,930	87.9
Kuspuk	224,424	6,844,974	3.3	237,849	5,123,219	1,100,660	79.3
Lake and Peninsula	104,982	6,291,687	1.7	204,679	6,113,187	286,709	92.6
Lower Kuskokwim*	768,426	29,889,271	2.6	1,257,422	24,524,292	6,544,681	75.9
Lower Yukon	325,560	16,352,231	2.0	1,000,617	13,352,046	1,139,866	86.2
Matanuska-Susitna	2,363,949	49,574,216	4.8	13,973,823	35,638,331	56,175	71.8
Nenana	61,249	2,728,467	2.2	1,309,058	1,315,314	6,270	50.0
Nome	292,213	6,928,066	4.2	630,223	6,251,042	89,547	89.7
North Slope*	698,039	28,246,009	2.5	13,792,598	10,601,352	4,050,362	37.3
Northwest Arctic	405,700	17,198,882	2.4	483,614	13,024,232	3,665,619	75.8
Pelican	26,819	668,003	4.0	25,977	671,786	0	96.3
Petersburg	123,892	3,366,394	3.7	484,261	2,821,303	9,852	85.1
Pribilof	34,881	2,025,772	1.7	70,454	2,085,278	149,756	90.4
Railbelt	101,924	3,846,368	2.6	107,672	3,692,088	5,959	97.0
St. Mary's	49,199	1,905,884	2.6	31,210	1,725,384	475,116	75.6
Sandpoint	44,306	1,071,658	4.1	32,500	1,004,124	0	96.9
Sitka	411,239	9,829,913	4.2	3,123,118	6,893,040	147,942	67.8
Skagway	36,853	928,244	4.0	63,933	915,533	0	93.5
Southeast Island	71,760	5,773,677	1.2	180,605	4,250,190	1,132,307	76.4
Southwest Region	167,347	8,461,334	2.0	476,010	4,926,360	2,205,091	64.8
Tanana City	40,854	1,278,975	3.2	62,196	1,065,407	234,464	78.2
Unalaska	57,265	1,902,784	3.0	33,379	1,372,148	267,642	82.0
Valdez*	288,631	8,174,698	3.5	3,301,718	4,486,425	27,893	57.4
Wrangell	106,859	2,590,254	4.1	454,596	2,528,098	0	84.8
Yakutat	51,646	1,570,259	3.3	43,184	1,354,036	76,213	91.9
Yukon Flats	196,171	5,988,550	3.3	71,000	5,414,370	716,465	87.3
Yukon Koyukuk*	260,908	8,552,788	3.1	171,958	6,149,618	1,921,418	74.6
Yupiit	100,154	3,030,295	3.3	87,345	3,859,896	0	97.8
TOTAL	27,718,483	724,969,210	3.8	161,504,427	527,636,698	39,306,812	72.4

Data are from unaudited FY 86 reports from each district to the Alaska Department of Education. Insurance data for Chugach and Craig were not available.

*Self-insured

Prepared by the House Research Agency, February 1987 (Health4;010787-08).

The State provides much of the funding for operation of schools in Alaska, and you were interested in how much State money is used to provide health insurance to school employees. Schools receive revenues from local and federal sources as well as the State, and there is considerable variation among districts in the proportion of total revenues received from the State. Thus, it is not possible to make a definitive statement about the amount of State money that goes to provide health insurance to school district employees in Alaska. The State provided approximately 72 percent of the revenues received by Alaska school districts. If one assumes that 72 percent of school district expenditures on life and health insurance was paid by the State, the State contributed approximately $20 million of the $28 million spent by school districts in FY 86 for life and health insurance.

Health Insurance Costs of the Federal Government in Alaska

The federal government is self-insured. They provide several options to their employees which vary in the amount of coverage and in cost to the employee. The federal government contracts with several insurance companies and health care service organizations for processing of claims. Since the companies do not actually provide insurance, the amount of business they do for the federal government does not show up in their reports to the Alaska Division of Insurance. Thus, the values in Table 1 of my memorandum of February 5, do not reflect the amount of business that Blue Cross or Aetna, for example, did for the federal government.

Through Congressman Young's office, we have requested assistance from Congressional Research in obtaining recent figures on the amount spent by the federal government to insure their employees and the military in Alaska. They expect it will take one to two weeks to retrieve these data.

Electrical Workers Insurance

I was able to obtain further information about health insurance costs for the International Brotherhood of Electrical Workers. They are self-insured and currently have about 4,400 participants. Their premiums for members in the Plan 10 and 20 groups have increased in the following manner since 1983:

Year	Monthly Premium
1983	$241.20
1984	263.10
1985	274.95
1986	325.29
1987	343.63

The premiums are based entirely on the actual costs to provide health care. They feel that the increases are largely due to increased doctors' fees which they attribute to increased costs of malpractice insurance. They are so concerned about the increasing costs of providing health insurance that they are placing some cost containment measures on an upcoming ballot.

* * * *

I hope you find this information useful. Please let me know if we can provide any further information.

FY 86

Gen. Govt	$19,048,100
Supervisory	2,828,100
Confidential	503,600
Exempt	4,921,100
Excluded	34,000
PSEA	871,200
IBU	1,330,600
Teachers	173,500
MEBA	187,200
Local 71	$3,965,300
MMP	163,300

Total health insurance premiums pd. $34,029,000 / 13,500 people

Retirees (state) 7500 people 20 000 000 FY 85

" (teachers) 6 000 000

60 million

60 municipalities participating - (16 million in agreement covered

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

April 13, 1987

MEMORANDUM

TO: Representative Niilo Koponen

ATTN: Lisa McLaren

FROM: Karen Oakley KO
Legislative Analyst

RE: Health Insurance Costs in Alaska
Research Request 87-105 (Supplemental Information)

Attached is a letter from Senator Ted Stevens transmitting the information you requested about health insurance costs for federal government employees and for the military in Alaska.

I hope this information is useful. If we can provide any additional information, please let me know.

Attachment

United States Senate

COMMITTEE ON APPROPRIATIONS
WASHINGTON, DC 20510-6025

March 26, 1987

Karen Oakley
House Research Agency
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Karen:

Thanks for contacting my Juneau office requesting information on how much money has been spent to provide health benefits to federal employees and the military employees in Alaska in the past few years.

The spending in Alaska for military health benefits in 1986 was $9.4 million, in 1985 it was $7.3 million, and in 1984 it was $5.2 million.

For federal employees health benefits, the spending in 1986 was $9.9 million, with $2.2 million in annuitants. In 1987 the allocation is $12.2 million, with $3.5 million in annuitants. I hope this information proves useful. Thanks for letting me be of assistance.

With best wishes,

Cordially,

Ted Stevens

TED STEVENS

Blue Cross
of Washington and Alaska

3111 C Street, Suite 100
P.O. Box 10-2480
Anchorage, Alaska 99510-2480
(907) 561-5065

April 23, 1986

Representative Niilo Koponen
The Alaska State Legislature
Pouch V (M.S. 3100)
Juneau, Alaska 99811

Dear Representative Koponen:

Blue Cross of Washington and Alaska generally agrees with the legislative findings that there are persons in Alaska with limited access to health care services. We do not have any reference to numbers of persons in need, but feel that it is right and proper for the State to provide incremental support when necessary.

Blue Cross of Washington and Alaska supports the utilization of a managed health care system to meet the requirements for programs directed toward those in need. Not only is a managed system a device for cost control, it puts the patient in partnership with the health care provider in developing a course of action in response to illness. This partnership will provide for the best possible care in the most appropriate setting, thusly conserving dollars and providing personal and professional satisfaction to the provider and patient.

Blue Cross of Washington and Alaska questions the inclusion of the psychological associate in the table of providers. We feel the scope of practice of the psychological associates precludes them from rendering a full measure of care. The psychological associate requires supervision of a psychologist, the work plan must be approved and cognizant department must be kept informed of the individual's area of practice. This use of the associate may violate the concept of the managed health care systems approach.

Blue Cross of Washington and Alaska will cooperate with the Legislature, and the Health, Education and Social Services Committee in particular, in developing a program of assistance

POSITION PAPER/Department of Health & Social Services

POSITION PAPER

HOUSE BILL 675

I. Purpose of HB675

HB675 establishes a comprehensive program to address the unmet medical needs of those Alaskans who are not otherwise protected by a private or group health care plan.

II. Discussion

The number of medically uninsured individuals has been steadily increasing nationally due to unemployment, cuts in state and federal programs, and inability of many self-employed individuals to afford continued health care insurance premiums for their families.

Many states have established task forces to define the scope of the problem, and to make recommendations for reducing the number of persons at risk.

HB675 would make a major state commitment to addressing this problem in Alaska. In short, HB675 directs the Department to design a comprehensive medical program that would be offered to all at risk Alaskans at a price they are able to afford. This effort would be directed by a Basic Health Plan Board composed of nine members appointed by the Governor.

The new program would be based on an insurance model that would depend on individuals recognizing their lack of medical protection, and taking steps to correct that by enrolling in the new program. Those "risk-takers" who chose not to take advantage of this special program would remain vulnerable to the financial catastrophe that almost certainly comes with a major medical problem for those who are not prepared for it.

The program would capitalize on new health care financing ideas being used around the nation, and encourage competitiveness in purchasing health care for the persons covered under it.

HB675 is a broad, straightforward approach to addressing the needs of medically at risk individuals. The sponsors of HB675 clearly espouse the view that no Alaskan should be confronted with difficulty receiving quality medical attention when confronted with a major medical problem solely due to their inability to purchase adequate health care protection. The Department shares this point of view.

III. Department Position

A detailed analysis of HB675 and its financial implications has not been done by the Department. This analysis would be largely dependent on an assessment of the number of individuals who are medically at risk due to lack of medical coverage, or inadequate medical coverage. The Department believes that medical indigency is a serious problem and should be addressed by the Legislature. The Department supports

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY