ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5629 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

Foster Care

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

P.O. BOX V, JUNEAU 99811
(907) 465-3759

M E M O R A N D U M

TO: HOUSE HESS COMMITTEE MEMBERS OF THE 15TH AND 16TH LEGISLATURES

FROM: REP. JOHNNY ELLIS, CHAIR
HOUSE HESS COMMITTEE

RE: COMMITTEE LEGISLATION RELATED TO FOSTER CARE

DATE: FEBRUARY 9, 1989

During the past interim the House HESS Committee, under th Co-chairmanship of Rep. Koponen and myself, held a series of hearings dealing with the state's foster care system. Based on these hearings, the committee adopted a list of recommendations (attached) suggesting legislative, administrative and funding changes to the foster care system.

We will continue this session to pursue legislative remedies to problems in the foster care system. Attached are three bills and two resolutions, which I plan to introduce as committee legislation next week. This package includes:

* A bill that more clearly declares the best interests of the child in statute and modifies the criteria for termination of parental rights;

* A bill that provides for civil liability protection for foster parents;

* A bill that provides for pre-emancipation services for youths in state custody;

* A resolution that encourages the continuation of demonstration foster care citizen review boards;

* A resolution that encourages the establishment of a master of social work program at the University of Alaska.

In addition to these bills, the committee is supportive of and will hear bills by Senator Fischer, SB 138 regarding foster parent training, and by Representative Collins, HB 19, regarding foster care review boards, as well as a bill that I will introduce establishing an advisory council on foster care. The committee is also interested in other potential legislation, but has refrained from introduction thus far. Measures in this category include expanding the licensure of social workers and easing the confidentiality requirements of minors' records for good cause.

It is my intention to devote a week of hearings to these measures. During that week, we will also receive a briefing from the Division of Family and Youth Services on administrative changes to the system.

At next Tuesday's meeting, we will discuss this and other potential committee legislation. Please contact Jim Nordlund of my staff at 465-3759 with any comments or suggestions regarding the proposed committee legislation.

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
JUNEAU, AK 99811
465-3759

PRELIMINARY RECOMMENDATIONS
for the
STATE FOSTER CARE SYSTEM

October 1988

There are few state responsibilities greater than our obligation to care for our most vulnerable citizens: abused, neglected and abandoned children. The state has the moral and legal duty to provide the best possible care so that these children have the chance to become healthy, happy and productive citizens.

We are not doing the best job of fulfilling this mandate. Many children are inadequately served, many are not served at all. Our child protection system is understaffed, overstressed and lacks the resources necessary to provide adequate protection and care. In particular, the state's foster care system needs to do a better job of providing the nurturing environment that the child lacks in the natural home. State law may need to be changed in order to provide clearer direction for the welfare of children.

Recognizing these problems and the possibilities for positive change, the House Health, Education and Social Services Committee has been conducting a comprehensive review of the state's foster care system. The Committee has been working with the cooperation of the Division of Family and Youth Services, the Alaska Foster Parents Association, the Governor's Interim Commission on Children and Youth, plus other concerned organizations, agencies and individuals. The Committee recently completed two days of hearings on the foster care system. What follows is a preliminary list of recommendations for improvement. The Committee is open to additions and further refinement before we move forward with specific legislative action.

As an introduction, we have proposed basic mission and goal statements which will serve as a foundation for the preliminary Committee recommendations which follow. After each of the recommendations is a code which indicates the type of action(s) necessary. The codes mean: $ = requires funding; L = requires legislation; A = requires administrative regulation, policy or procedural change; ? = action not clear.

Goal Two: IMPROVEMENTS IN FOSTER CARE

Recognizing that temporary foster care placement will always be necessary and that long term foster care is an important permanent placement alternative, the foster care system must be improved to provide better care for children and to enable foster parents to be better guardians.

* Establish expanded and mandatory training for foster parents. L, $
* Provide additional respite care services for foster parents. Include respite on a regular basis, not only in emergencies. Use other services for respite, e.g. Big Brothers/Sisters. Consider using foster parent groups to coordinate respite program. $, A
* Correct problems with late stipends. Examine payment system and possibly contract out. A
* Finalize grievance procedure. Consider using unified form that includes grievances, liability claims, problems with foster kids, and recommendations for change. Provide for stop action clause as part of the grievance procedure or elsewhere. A
* Establish Foster Care Advisory Board. L, $
* Improve foster care liability insurance. Have claims go directly to Risk Management. Dovetail with state self insurance. L?, A, $?
* Insure state defense of foster parents in lawsuits. ?
* Develop a system that combines foster parent training, competency levels and rate augmentation. A
* Develop better targeted recruitment of foster parents. A
* Provide better orientation for foster parents. A
* Establish complaint investigations of foster parents by a neutral party. L?, A
* Provide funding for foster parent networking/support. $
* Examine charges of Department retaliation against foster parents. ?

Goal Three: IMPROVEMENTS FOR DFYS

The fate of foster children lies primarily with the Division of Family and Youth Services. The Division does not have the necessary resources to provide for adequate protection and care of children. Social workers are overworked, largely undertrained and too often mired in paperwork. Huge caseloads do not allow for adequate attention to particular cases. Other aspects of the child protection system should be modified so the state can do a better job.

* Devote additional resources to reduce social worker case loads. $

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

Alaska State Legislature
House of Representatives
COMMITTEE ON HEALTH, EDUCATION
AND SOCIAL SERVICES

OFFICIAL BUSINESS

POUCH V
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As an introduction, we have proposed basic mission and goal statements which will serve as a foundation for the preliminary Committee recommendations which follow. After each of the recommendations is a code which indicates the type of action(s) necessary. The codes mean: $ = requires funding; L = requires legislation; A = requires administrative regulation, policy or procedural change; ? = action not clear.

Mission: THE BEST INTERESTS OF THE CHILD

The mission of the state's child protection system should be to promote the best interests of the child. Preservation of the family or reunification with a child's natural parents is often the best alternative, but these efforts should be driven by and for the best interests of the child.

* The state children's code should be reviewed and possibly modified to insure the promotion of the best interests of the child. L

Goal One: SAFETY, STABILITY AND PERMANENCY FOR CHILDREN

Beyond initial efforts to insure a child's safety, the state's highest priority should be the ultimate stability and permanency of the child. The best efforts must be made to keep families together, if appropriate, or to reunify, if possible. If these options are not possible, the state should consider quick action to terminate parental rights, reduce the length of time a child lingers in temporary foster care, and secure a long-term nurturing home for the child or prepare the child for emancipation.

* Expand intensive homebased family treatment programs to more quickly get help to families and determine the fate of the child. Funding could come from saved foster care stipends. Treatment should include an alcohol and drug abuse component. $
* Clarify criteria for termination of parental rights so that the best interests of the child and the child's need for a permanent plan are highest priorities. Consider different standards for different ages. L
* Change confidentiality statutes so that foster parents and others with a "need to know" have access to information. L
* Continue pilot citizen review permanency planning board projects in Anchorage and Sitka. $
* Create a permanent, state-wide citizen review board system. L, $
* Expand the role of foster parents as part of the permanency planning team. A
* Make greater use of subsidized adoption; beyond just hard to place kids. ?
* Establish use of subsidized guardianships to increase stability of certain placements. L, $
* Make long term foster care more viable. A, $
* Establish minimum standards for emancipation. L
* Provide more pre-emancipation services for youth. L.$
* Examine the impediments to adoption. A

Goal Two: IMPROVEMENTS IN FOSTER CARE

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* Develop better targeted recruitment of foster parents. A
* Provide better orientation for foster parents. A
* Establish complaint investigations of foster parents by a neutral party. L?, A
* Provide funding for foster parent networking/support. $
* Examine charges of Department retaliation against foster parents. ?

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* Devote additional resources to reduce social worker case loads. $

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6-0717A
Lauterbach
2/9/89

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to programs and proceedings concerning children; and emphasizing that the best interests of the child must be considered under certain programs and during certain proceedings involving children."

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

* Section 1. AS 47.05.060 is amended to read:

Sec. 47.05.060. PURPOSE AND POLICY RELATING TO CHILDREN. The purpose of this title as it relates to children is to secure for each child the care and guidance [, PREFERABLY IN THE CHILD'S OWN HOME,] that will serve the moral, emotional, mental, and physical welfare of the child and the best interests of the community; to preserve and strengthen the child's family ties <u>to the extent that those ties are in the best interests of the child</u> [WHENEVER POSSIBLE], removing the child from the custody of the parents only <u>when necessary because</u> [AS A LAST RESORT WHEN] the child's welfare or safety or the protection of the public cannot be adequately safeguarded without removal; and, when the child is removed from the family, to secure for the child adequate custody and care.

* Sec. 2. AS 47.10.080(c) is amended to read:

(c) If the court finds that the minor is a child in need of aid, it shall

(1) order the minor committed to the department for placement in an appropriate setting for a period of time not to exceed two

years or in any event past the date the minor becomes 19 years of age, except that the department may petition for and the court may grant in a hearing (A) two-year extensions of commitment which do not extend beyond the minor's 19th birthday if the extension is in the best interests of the minor and the public; and (B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; the department may transfer the minor, in the minor's best interests, from one placement setting to another, and the minor, the minor's parents or guardian, and the minor's attorney are entitled to reasonable notice of the transfer;

(2) order the minor released to the minor's parents, guardian, or some other suitable person, and, in appropriate cases, order the parents, guardian, or other person to provide medical or other care and treatment; if the court releases the minor, it shall direct the department to supervise the care and treatment given to the minor, but the court may dispense with the department's supervision if the court finds that the adult to whom the minor is released will adequately care for the minor without supervision; the department's supervision may not exceed two years or in any event extend past the date the minor reaches age 19, except that the department may petition for and the court may grant in a hearing

(A) two-year extensions of supervision which do not extend beyond the minor's 19th birthday if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past age 19 if the continued supervision is in the best interests of the person and the person consents to it; or

(3) by order, upon a showing in the adjudication by clear

and convincing evidence that there is a child in need of aid under AS 47.10.010(a)(2) as a result of parental conduct and upon a showing in the disposition by clear and convincing evidence that the parental conduct is likely to continue to exist if there is no termination of parental rights, terminate parental rights and responsibilities of one or both parents and commit the child to the department or to a legally appointed guardian of the person of the child, and the department or guardian shall report annually to the court on efforts being made to find a permanent placement for the child; there is a rebuttable presumption in a proceeding under this paragraph that the parental conduct is likely to continue if there is no termination of a person's parental rights upon a showing by clear and convincing evidence that the person has failed, without good cause, to substantially participate in services offered by the department that were determined by a court to be appropriate for facilitating reunification of the child with the parent or in equivalent services; in order to establish the presumption described in this paragraph, the department shall also show by clear and convincing evidence that it provided assistance to the parent to enable the parent to participate in the services offered by the department.

* Sec. 3. AS 47.17.010 is amended to read:

Sec. 47.17.010. PURPOSE. In order to protect children whose health and well-being may be adversely affected through the infliction, by other than accidental means, of harm through physical abuse or neglect or sexual abuse or sexual exploitation, the legislature requires the reporting of these cases by practitioners of the healing arts and others to the appropriate public authorities. It is the intent of the legislature that, as a result of these reports, protective services will be made available in an effort to prevent further

harm to the child, to safeguard and enhance the general well-being of the children in this state, and to preserve family life <u>to the extent that it is in the best interests of the child to do so</u> [WHENEVER POSSIBLE].

6-0752A
Lauterbach
2/8/89

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil liability and uninsured property losses related to foster children."

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

* Section 1. AS 09.65 is amended by adding a new section to read:

Sec. 09.65.093. CIVIL LIABILITY RELATED TO FOSTER CARE. (a) Notwithstanding other provisions of law, the foster parent, a state employee, and a representative of the state are not liable for civil damages as a result of

(1) acts or omissions by a minor placed in the care of the foster parent under AS 47; or

(2) negligent acts or omissions by the foster parent, state employee, or representative of the state that result in harm to a minor placed in the care of the foster parent under AS 47.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct of a foster parent, state employee, or representative of the state.

* Sec. 2. AS 47.35 is amended by adding a new section to read:

Sec. 47.35.110. UNINSURED PROPERTY LOSS. (a) The state shall reimburse a licensed foster parent for the uninsured loss of, or uninsured damage to, tangible property under the lawful control of a foster parent to the extent that the loss or damage exceeds $100 if the loss or damage resulted from the intentional misconduct of a child in the custody of the state who was placed in the care of the foster parent under this title.

(b) Under the conditions described in (a) of this section, the state may reimburse a foster parent for an uninsured loss or uninsured damage that does not exceed $100.

6-0691A
Lauterbach
1/27/89

IN THE HOUSE

BY THE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the pre-emancipation services for certain minors."

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

* Section 1. AS 47.10.080(b) is amended to read:

(b) If the court finds that the minor is delinquent, it shall

(1) order the minor committed to the Department of Health and Social Services for a period of time that does not [TO] exceed two years and that does not [OR IN ANY EVENT] extend past the minor's 19th birthday [DAY THE MINOR BECOMES 19], except that the department may petition for and the court may grant in a hearing (A) two-year extensions of commitment that [WHICH] do not extend beyond the minor's [CHILD'S] 19th birthday if the extension is in the best interests of the minor and the public; and (B) an additional one-year period of supervision past the minor's 19th birthday [AGE 19] if continued supervision is in the best interests of the minor or the minor is receiving pre-emancipation services, [PERSON] and the minor [PERSON] consents to the additional period of supervision [IT]; the department shall place the minor in the juvenile facility [WHICH] the department considers appropriate, [AND] which may include a juvenile correctional school, detention home, or detention facility; the minor may be released from placement or detention and placed on probation on order of the court and may also be released by the department, in its discretion, under AS 47.10.200;

(2) order the minor placed on probation, to be supervised

by the department, and released to the minor's parents, guardian, or a suitable person; if the court orders the minor placed on probation, it may specify the terms and conditions of probation; the probation may be for a period of time that does [,] not [TO] exceed two years and that does not [IN NO EVENT] extend past the minor's 19th birthday [DAY THE MINOR BECOMES 19], except that the department may petition for and the court may grant in a hearing

(A) two-year extensions of supervision that [WHICH] do not extend beyond the minor's [CHILD'S] 19th birthday, if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past the minor's 19th birthday, [AGE 19] if the continued supervision is in the best interests of the minor [PERSON] and the minor [PERSON] consents to it;

(3) order the minor committed to the department and placed on probation, to be supervised by the department, and released to the minor's parents, guardian, other suitable person, or suitable non-detention setting such as a family home, group care facility, [OR] child care facility, or supervised independent residence, whichever the department considers appropriate to implement the treatment plan of the predisposition report; if the court orders the minor placed on probation, it may specify the terms and conditions of probation; the department may transfer the minor, in the minor's best interests, from one of the probationary placement settings listed in this paragraph to another, and the minor, the minor's parents or guardian, and the minor's attorney are entitled to reasonable notice of the transfer; the probation may be for a period of time that does not [, NOT TO] exceed two years and that does not [IN NO EVENT] extend past the

minor's 19th birthday [DAY THE MINOR BECOMES 19], except that the department may petition for and the court may grant in a hearing

(A) two-year extensions of commitment that [WHICH] do not extend beyond the minor's [CHILD'S] 19th birthday, if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past the minor's 19th birthday, [AGE 19] if the continued supervision is in the best interests of the minor or the minor is receiving pre-emancipation services, [PERSON] and the minor [PERSON] consents to the additional period of supervision; [IT; OR]

(4) order the minor to make suitable restitution in lieu of or in addition to the court's order under (1), (2) or (3) of this subsection; or [.]

(5) order the minor committed to the Department of Health and Social Services for placement in an adventure-based education program established under AS 47.21.020 with conditions the court considers appropriate concerning release upon satisfactory completion of the program or commitment under (1) of this subsection if the program is not satisfactorily completed.

* Sec. 2. AS 47.10.080(c) is amended to read:

(c) If the court finds that the minor is a child in need of aid, it shall

(1) order the minor committed to the department for placement in an appropriate setting, which may include a supervised independent residence, for a period of time that does not [TO] exceed two years and that does not extend [OR IN ANY EVENT] past the minor's 19th birthday [DATE THE MINOR BECOMES 19 YEARS OF AGE], except that the department may petition for and the court may grant in a hearing

(A) two-year extensions of commitment that [WHICH] do not extend beyond the minor's 19th birthday, if the extension is in the best interests of the minor and the public; and (B) an additional one-year period of supervision past the minor's 19th birthday, [AGE 19] if the continued supervision is in the best interests of the minor or the minor is receiving pre-emancipation services, [PERSON] and the minor [PERSON] consents to the additional period of supervision [IT]; the department may transfer the minor, in the minor's best interests, from one placement setting to another, and the minor, the minor's parents or guardian, and the minor's attorney are entitled to reasonable notice of the transfer;

(2) order the minor released to the minor's parents, guardian, or some other suitable person, and, in appropriate cases, order the parents, guardian, or other person to provide medical or other care and treatment; if the court releases the minor, it shall direct the department to supervise the care and treatment given to the minor, but the court may dispense with the department's supervision if the court finds that the adult to whom the minor is released will adequately care for the minor without supervision; the department's supervision may not exceed two years and may not [OR IN ANY EVENT] extend past the minor's 19th birthday [DATE THE MINOR REACHES AGE 19], except that the department may petition for and the court may grant in a hearing

(A) two-year extensions of supervision that [WHICH] do not extend beyond the minor's 19th birthday, if the extension is in the best interests of the minor and the public; and

(B) an additional one-year period of supervision past the minor's 19th birthday, [AGE 19] if the continued supervision is in the best interests of the [illegible]

[PERSON] consents to it; or

(3) by order, upon a showing in the adjudication by clear and convincing evidence that there is a child in need of aid under AS 47.10.010(a)(2) as a result of parental conduct and upon a showing in the disposition by clear and convincing evidence that the parental conduct is likely to continue to exist if there is no termination of parental rights, terminate parental rights and responsibilities of one or both parents and commit the child to the department or to a legally appointed guardian of the person of the child, and the department or guardian shall report annually to the court on efforts being made to find a permanent placement for the child.

* Sec. 3. AS 47.10.230 is amended by adding new subsections to read:

(h) The department shall provide appropriate pre-emancipation services to a child 16 years of age or older who has been committed to the custody of the department and who makes a request to receive the services, unless the department finds that pre-emancipation services are inappropriate for the child. The commissioner shall adopt regulations establishing criteria for determining whether pre-emancipation services are inappropriate for a child. The services may include

(1) assistance in completing academic or vocational training designed to make the child employable;

(2) assistance in acquiring suitable housing;

(3) training in skills needed for independent living;

(4) assistance in petitioning for removal of the disabilities of minority; and

(5) social support and services coordination.

(i) The department may award a grant to or contract with a municipality or with an entity incorporated under AS 10.20 to provide pre-emancipation services under (h) of this section. The commissioner

shall adopt regulations establishing criteria for the award of grants under this subsection.

Governor's Interim Commission on Health Care

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE

THE BEST OF CARE

The Challenge of Providing Health Care to Alaskans

A Report of the
Governor's Interim Commission on Health Care

September
1988

Health Care Access for Alaskan's - 3/31/90

MEDICAL INDIGENCY PROJECT

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

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

TECHNICAL ASSISTANCE

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

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

PUBLICATIONS

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

INFORMATION CLEARINGHOUSE

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

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

MEETINGS AND SEMINARS

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

National Conference
of State Legislatures
1050 17th Street, Suite 2100
Denver, Colorado 80265

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MEDICAL INDIGENCY ProjectNotes

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

RIGHT OR PRIVILEGE:
SHOULD EVERYONE HAVE ACCESS TO BASIC HEALTH CARE?

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

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

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

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

Who are the medically indigent?

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

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

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

Should the health system be restructured ?

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

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

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

Can change be expected?

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

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

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

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

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

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

Conclusion

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

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

FYI

For further information on project activities, contact:
Shelda L. Harden
Policy Specialist
Health Services Program
Human Services Department
1050 Seventeenth Street,
Suite 2100
Denver, Colorado 80265
(303) 623-7800

STATE ACTIVITY

Hawaii

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

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

Massachusetts

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

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

California

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

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

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

Oregon

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

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

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

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

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

Other

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

FISCAL NOTE CALCULATIONS

	sal/w-perq	12 months	6 months	3 months
Research Analyst III	3336/4237 mo	50,844	25,422	12,711
Research Analyst II	2702/3431 mo	41,172	20,586	10,293
Clerk Typist III	1731/2198 mo	26,376	13,188	6,594

PERSONNEL		1st year	2nd year
RAIII 18 months	= $ 76,266	$ 25,422	$ 50,844
RA II 15 months	= 51,465	10,293	41,172
C T 15 months	= 32,970	6,594	26,376
total personnel	$160,701	$42,309	$118,392

TRAVEL	(18 MONTHS)
5 meetings, plus 3 exec. meetings with chair Evenings will be public meeting & discussion Next day is education/work session 3 days per diem; avg. fare $400	$ 6,750
Staff & advisory commission (6 plus 3) 9 @ $90 X 3 X 5 =	12,150
4 out-of-state trips by staff	4,000
total travel	$22,900

CONTRACTUAL	1ST YEAR	18 MO
Printing	$ 1,000	
4 X $5,000 for expert testimony & task force education	20,000	
Advertizing (display ads)	3,000	
Telephone long distance calls	1,000	
office space (500 sq. ft. lease @ 1.50 per sq ft)	9,000	
total contractual	$31,000	46,500

SUPPLIES	1ST YEAR	18 MO
paper goods, office supplies	$ 600	
reference books	300	
total supplies	$ 900	1,350

EQUIPMENT	
Word processor	$ 4,200

GRAND TOTAL FOR PROJECT	$235,651

FINANCING HEALTH CARE FOR ALASKA'S UNINSURED AND UNDERINSURED

A Technical Assistance Program
for the Alaska State Legislature

March 30 - 31, 1990

Health Care Financing Project
Medical Indigency Project

Health Services Program
Human Services Department

National Conference of State Legislatures
1050 17th St., Suite 2100
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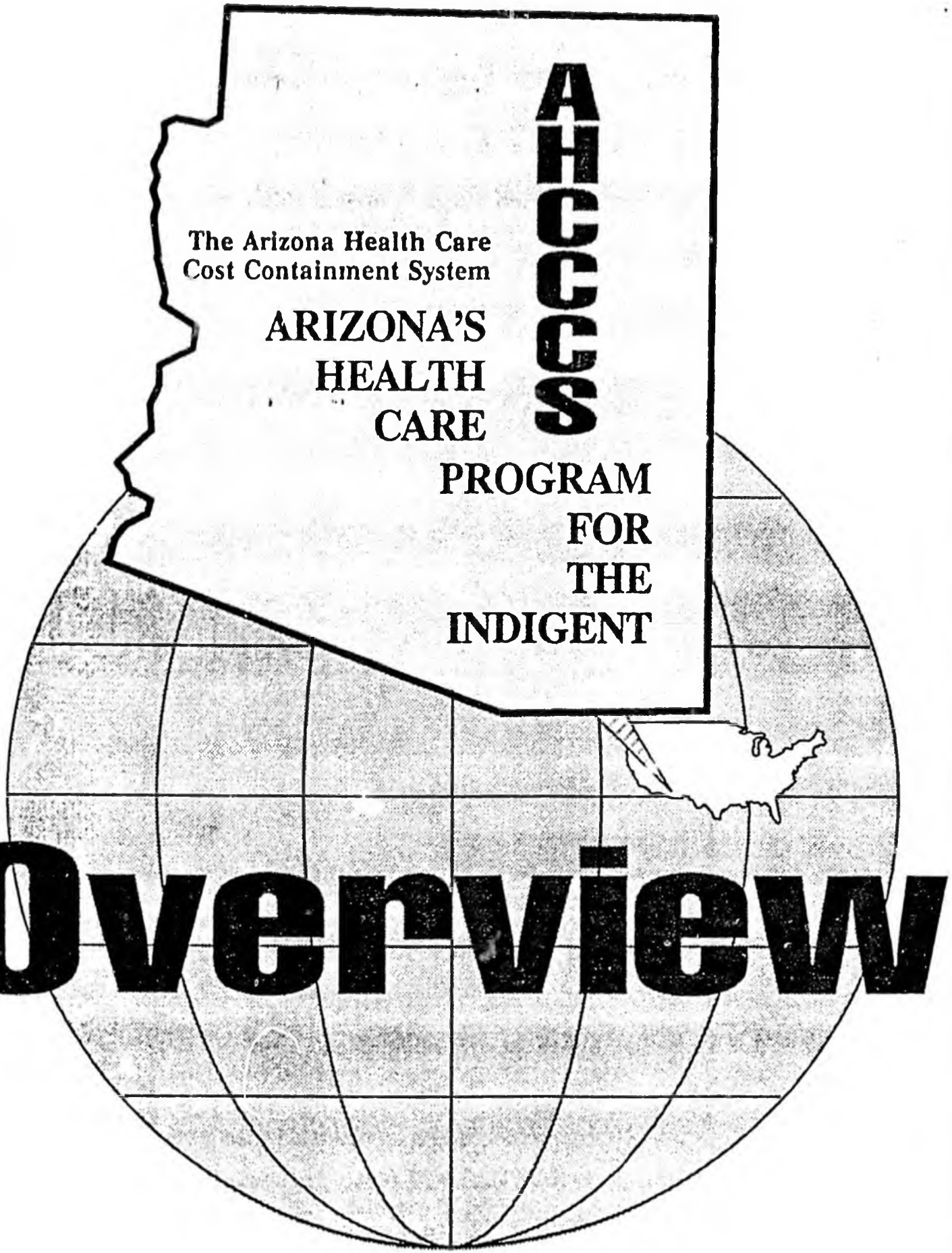
AHCCCS
The Arizona Health Care
Cost Containment System
ARIZONA'S
HEALTH
CARE
PROGRAM
FOR
THE
INDIGENT
Overview

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

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

BACKGROUND

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

A statewide county government fiscal crisis in 1980-81, due in part to

escalating health care costs and a new law that limited county budget increases, compelled the Legislature to propose a Medicaid demonstration project funded by federal, state and county governments.

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

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

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

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

During its first 18 months the program was beset with a number of administrative and budgetary problems, which resulted with the termination of the private administrator's contract less than halfway through the term. There was a tremendous amount of negative press about the program, resulting

in a lack of confidence by elected officials, the medical community and the public at large.

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

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

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

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

-- Quality control review of the county eligibility systems.

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

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

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

FUNDING

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

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

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

AHCCCS BUDGETS
by fiscal year

(000)

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

* Primarily county funds

** Includes long term care

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

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

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

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

ANNUAL COUNTRY CONTRIBUTIONS
TO AHCCCS ACUTE CARE PROGRAM

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

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

ELIGIBILITY GROUPS

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

Eligibility groups are briefly described below:

1. Categorically eligible

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

EXPANDING ACCESS TO HEALTH CARE

FOR CALIFORNIA'S

UNINSURED POPULATION

Prepared by:

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

484-S

C A L I F O R N I A L E G I S L A T U R E

SENATE OFFICE OF RESEARCH

Elisabeth K. Kersten, Director

March 9, 1990

Dear Friend:

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

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

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

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

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

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

Sincerely,

Elisabeth Kersten

ELISABETH KERSTEN

EK:gd

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

EXPANDING ACCESS TO HEALTH CARE FOR CALIFORNIA'S UNINSURED POPULATION

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

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Executive Summary

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

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

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

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

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

The report:

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

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

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

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

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Colorado's Indigent Care Program

Background

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

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

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

Providers

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

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

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

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

Patient Eligibility

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

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

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

Services Covered

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

Provider Payment

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

Reporting Requirements

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

For further information on the Indigent Care Program, contact:

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

SCOPE
(Shared Cost Option for Private Employers)

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF BENEFITS

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

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

EXCEPTIONS: Medical Care Provided By A Nonparticipating Physician

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

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

DEFINITIONS

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

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

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

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

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

FAMILY DEDUCTIBLE

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

BENEFITS FOR PERSONS ELIGIBLE FOR MEDICARE

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

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

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

PREGNANCY BENEFITS

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

WELL BABY CARE

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

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

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

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

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

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

MAJOR MEDICAL BENEFITS

COVERED CHARGES

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

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

Covered Charges Include Charges For:

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

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

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

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

Covered charges for treatment of alcoholism and drug addiction include:

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

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

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

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

Covered charges for psychiatric treatment include:

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

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

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

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

PREAUTHORIZATION

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

LIMITED BENEFITS ARE PAYABLE FOR:

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

MAJOR MEDICAL BENEFITS (Continued)

PRE-EXISTING CONDITIONS

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

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

within 3 months before he became insured under this plan.

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

1. the person has not:

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

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

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

CHARGES NOT COVERED

1. Charges to buy or rent:

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

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

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

BENEFITS AFTER INSURANCE ENDS

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

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

GENERAL EXCLUSIONS FOR ALL MEDICAL CARE BENEFITS

No medical care benefits will be paid for treatment which:

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

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

PAYMENT FROM A THIRD PARTY

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

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

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

SCHEDULE OF PREVENTIVE SERVICES

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

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

December 1987

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

A Summary of Findings

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

PURPOSE

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

INTRODUCTION

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

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

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

SURVEY METHODS[3]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SURVEY RESULTS

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

TABLE 3

Proportion of Small Employers by Size Offering Insurance to Employees

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

TABLE 4

Percent of Employers in Each Industry Offering Health Insurance

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

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

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

TABLE 5

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

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

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

EMPLOYEES OF SMALL COMPANIES: AGE, SEX AND TURNOVER

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

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

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

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

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

TABLE 7
Turnover Among Small Employers

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

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

COSTS EMPLOYERS NOW PAY

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

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

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

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

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

FACTORS THAT INFLUENCE THE DECISION TO OFFER INSURANCE

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

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

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

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

IMPLICATIONS

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

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

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

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

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

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

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

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

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

THE COLORADO HEALTH CARE ACCESS ACT: HB 1034

By Rep. Carol Taylor-Little
and Senator Sally Hopper

Questions and Answers

1. What is the purpose of the bill?

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

2. Why is this bill needed?

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

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

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

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

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

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

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

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

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

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

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

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

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

7. Does this bill benefit business? How?

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

8. Who can take advantage of the tax credit?

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

THE COLORADO HEALTH CARE ACCESS ACT: HB 1034

by Representative Carol Taylor-Little
and Senator Sally Hopper

I. Medicaid Expansion

A. Health Services Commission

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

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

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

B. New, Expanded Medicaid Program

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

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

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

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

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

II. Employer Insurance

A. Insurance Pool

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

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

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

B. Small Business Health Insurance Tax Credits

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

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

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

A Recent Development . . .

HAWAII'S UNIVERSAL HEALTH CARE PROGRAM: BRIDGING THE GAP

By Susan Claveria

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

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

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

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

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

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

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

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

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

Position Opening

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

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

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

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

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

March 2, 1990

THE UNINSURED IN IOWA

DEFINITION:

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

ESTIMATED SIZE:

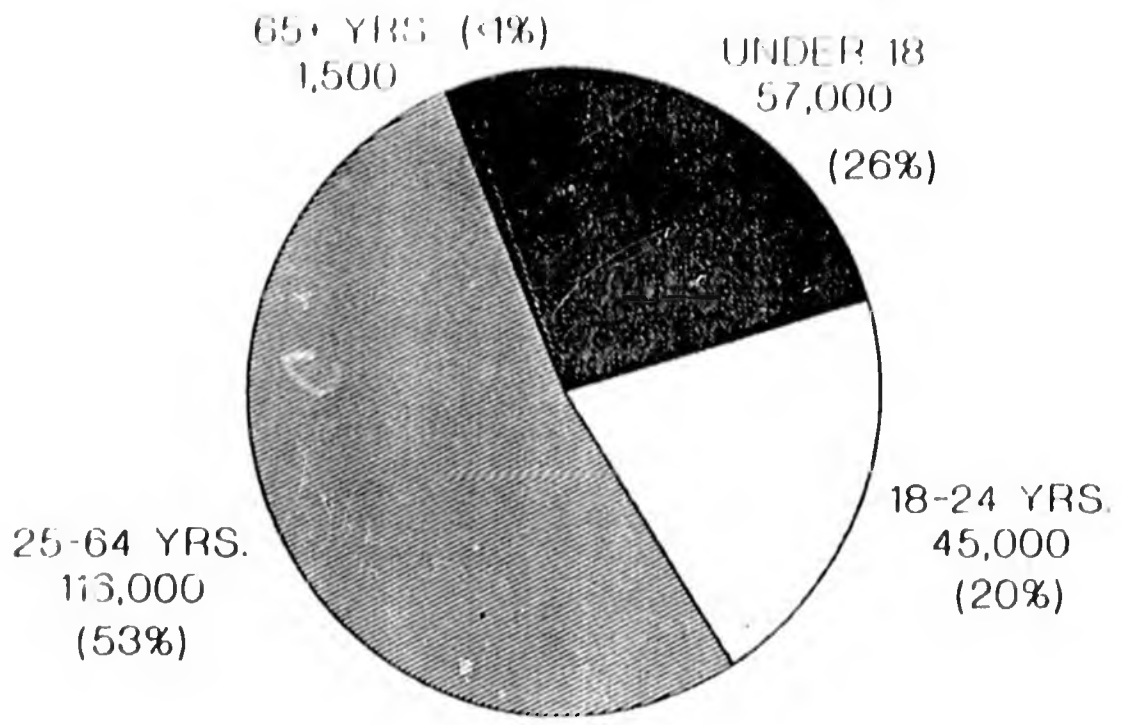
ACCORDING TO DATA FROM THE IOWA PORTION OF THE 1989 CURRENT POPULATION SURVEY, APPROXIMATELY 220,000 IOWANS ARE UNINSURED.

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

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

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

UNINSURED IOWANS:
By Age

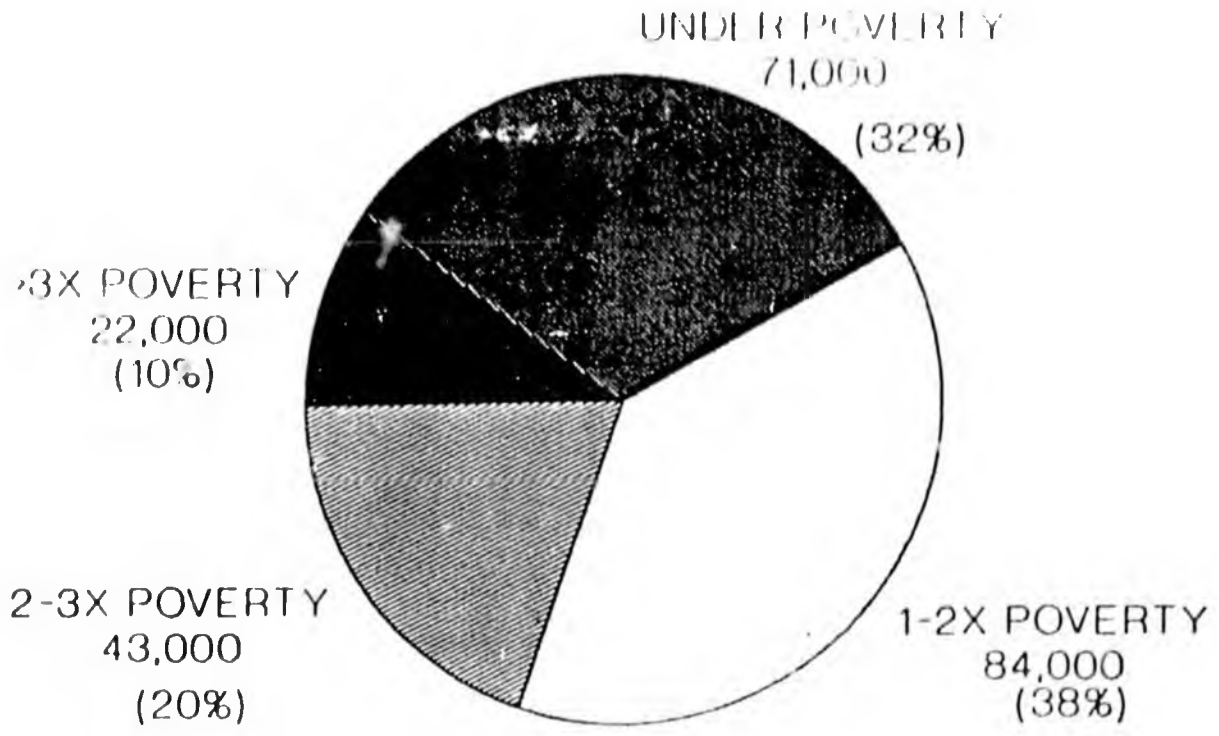


Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

1988 FEDERAL POVERTY GUIDELINES

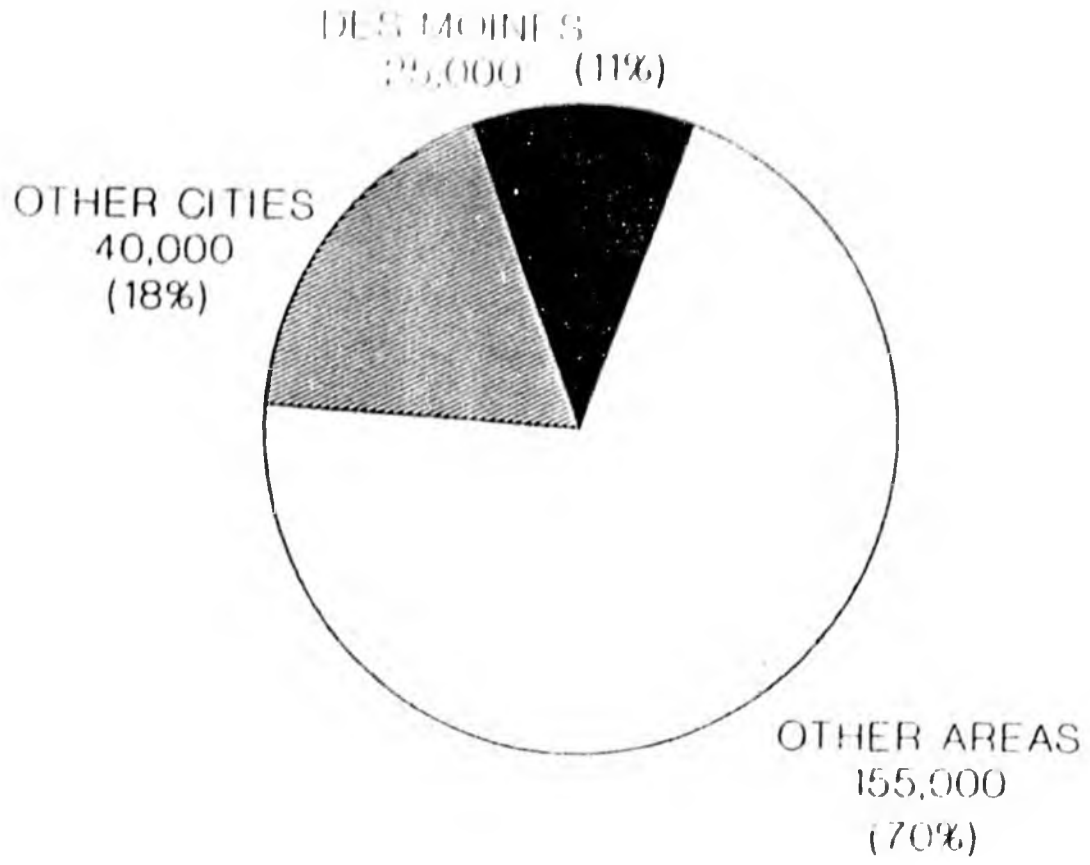
HOUSEHOLD SIZE	ANNUAL INCOME
1	$ 5,770
2	$ 7,730
3	$ 9,690
4	$11,650

UNINSURED IOWANS:
By Poverty Status



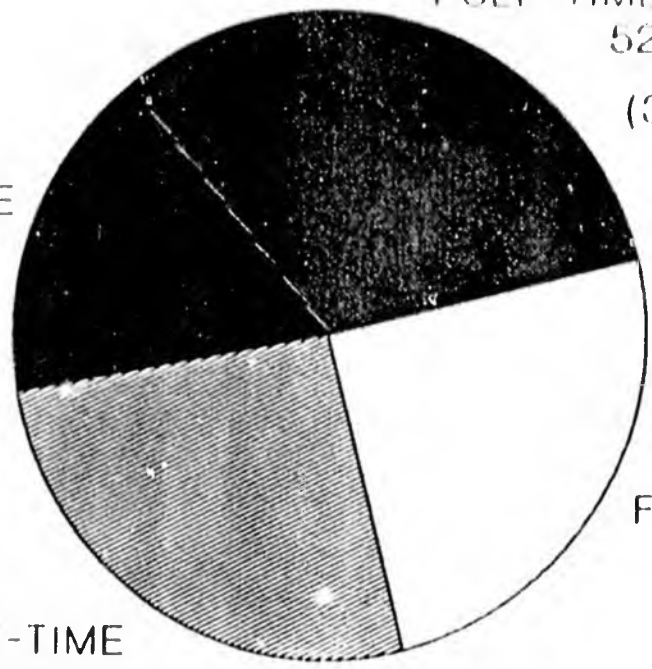
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED IOWANS:
By Place of Residence



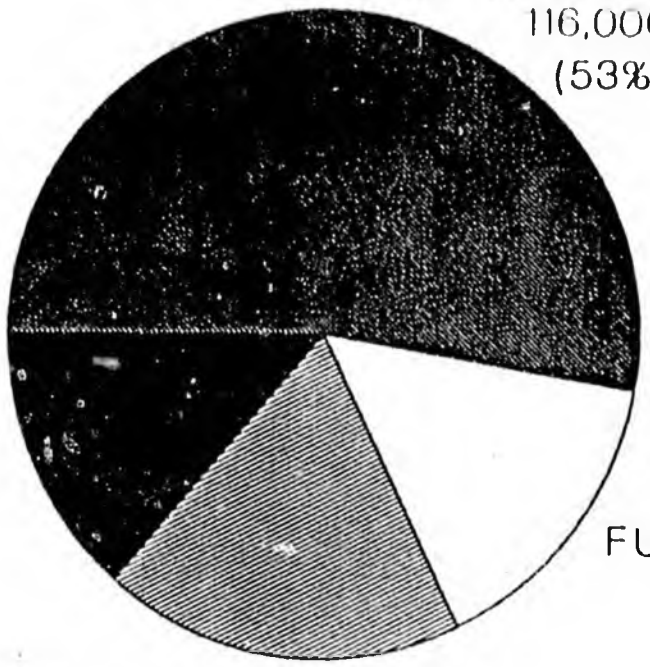
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

EMPLOYMENT STATUS OF UNINSURED IOWANS:
Ages 18-64
(N=161,000)



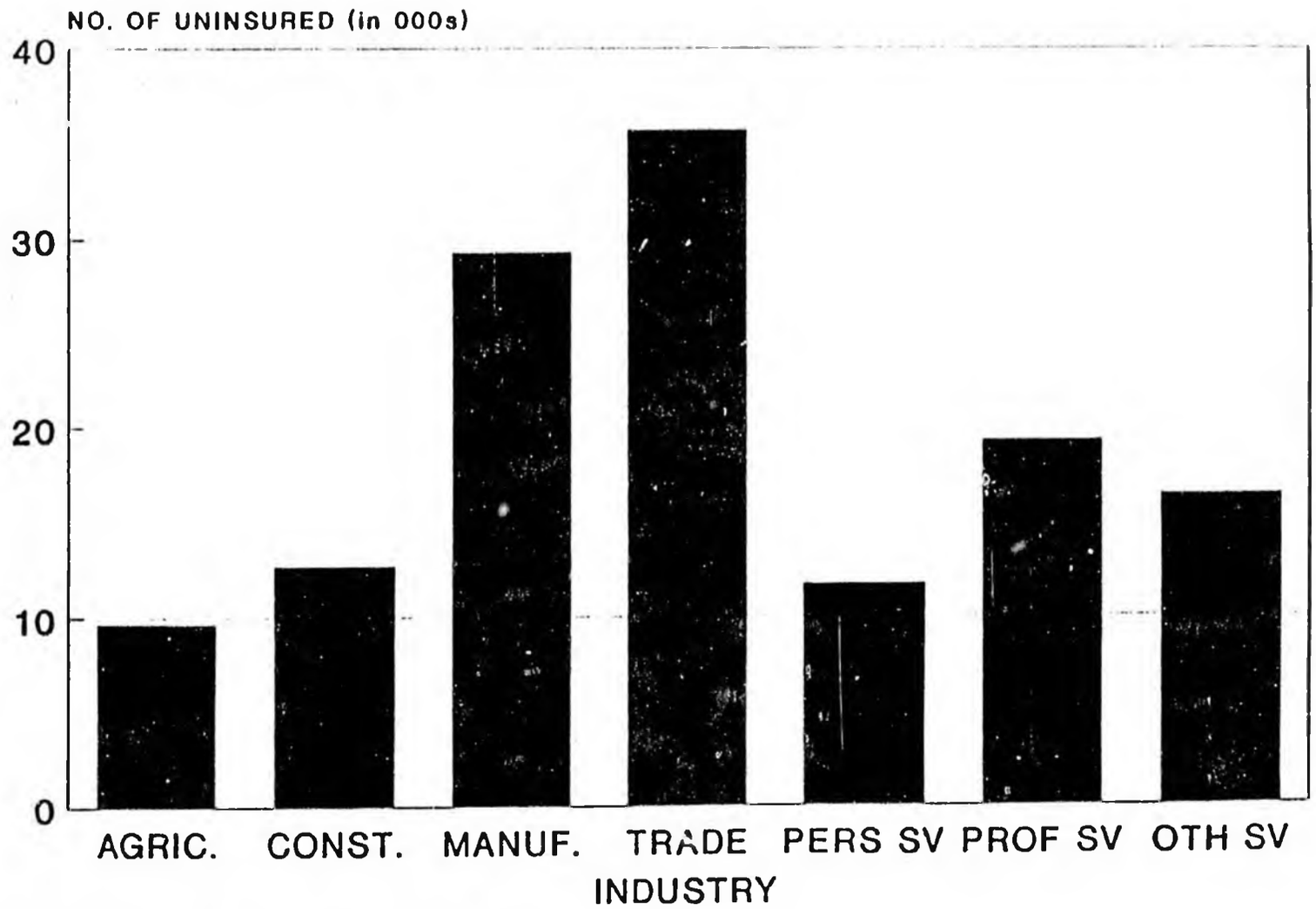
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

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



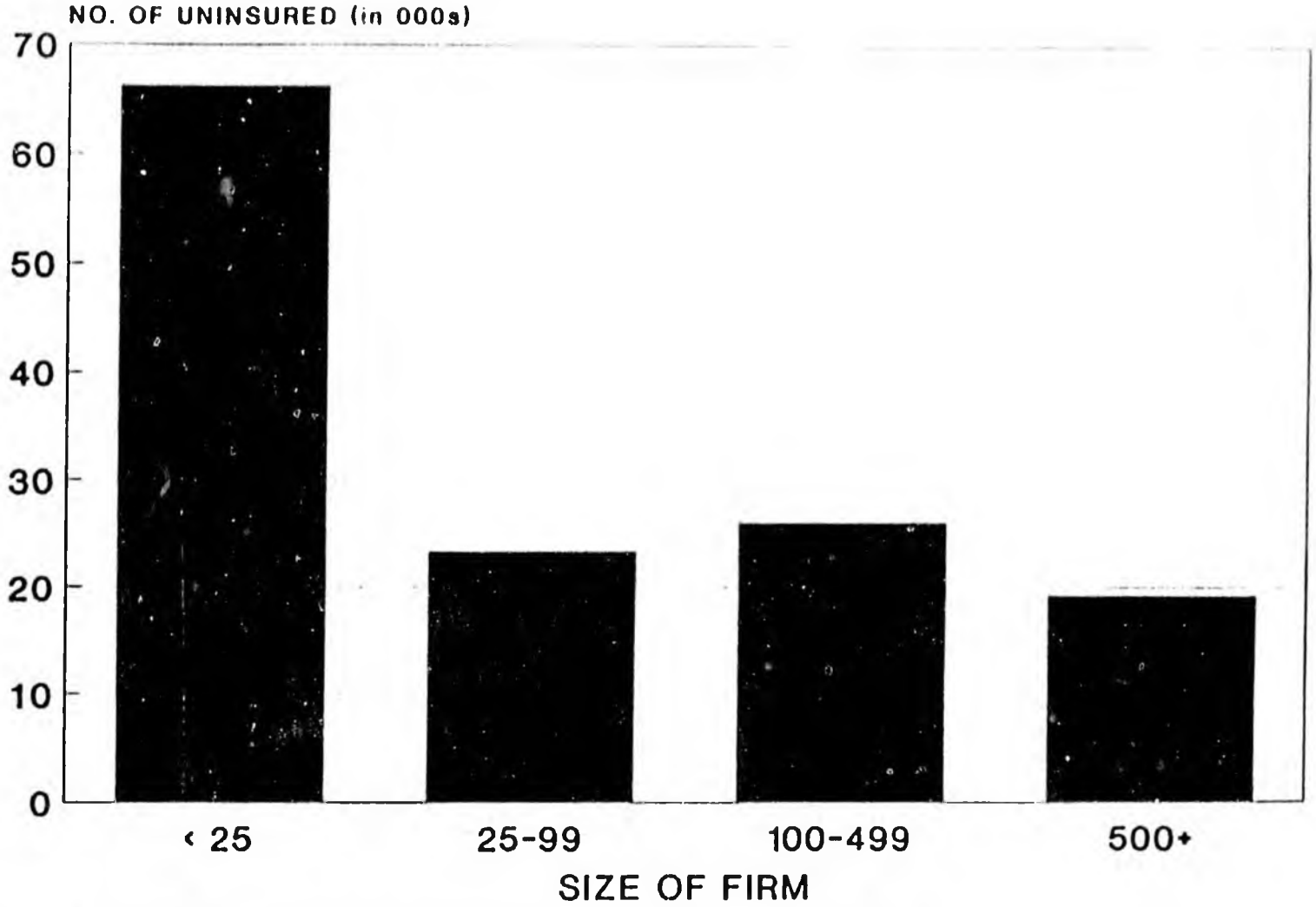
Source: Health Systems Research, Inc.
Analysis of March, 1989 CPS

UNINSURED WORKERS IN IOWA:
By Industry



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

UNINSURED WORKERS IN IOWA:
By Size of Firm



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

Medicine & Health

PERSPECTIVES

December 18, 1989

EYES ON THE MASSACHUSETTS MIRACLE

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

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

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

OFF THE GROUND

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

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

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

CenterCare, the expanded community center program, has gotten care to 4,000 city dwellers. But the largest private program to be implemented requires that all full-time college students have health coverage through their parents, guardians, or schools. Of 400,000 students, 60,000

have bought insurance they otherwise would have eschewed. Most policies tend to be lean-- premiums average $270 a year. Besides lining insurers' pockets, the student mandate saves money. Before the law took effect, uninsured students ran up $15 million a year in bad debts for hospital and physician care. That sum cut into the state's $300 million bad debt payment pool derived from a 10 percent surcharge on all hospital bills.

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

BIG PIECES, BIG PROBLEMS

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

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

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

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

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

A CRUMBLING COALITION

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

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

The payment system rewrite attracted the attention of businesses tired of higher medical costs, as well as labor and consumer groups nervous about access to care. In 1984, the consumer

movement had been energized when it successfully fought for a mandatory assignment rule for doctors treating Medicare patients. Consumer groups urged Dukakis to use payment reform as a wedge to start movement on universal insurance. Initially reluctant, he signed on when it looked like a good agenda entry in his run for the presidency.

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

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

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

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

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

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

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

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

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

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

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

THE BATTLES TO COME

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

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

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

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

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

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

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HEALTHCARE INFORMATION CENTER

STATE HEALTH NOTES

INTERGOVERNMENTAL HEALTH POLICY PROJECT

The George Washington University
WASHINGTON DC

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

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

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

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

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

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

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