ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672

5630 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES

34

Management of the uncompensated care pool by the new Department of Medical Security (DMS) has also helped soften business opposition, the Governor said. The pool, established in 1985 to more evenly distribute the burden of bad debts and charity care across all hospitals, is financed by a 13 percent surcharge, paid by all insurers, on hospital bills. In October 1988, when the department took over, the obligation of private payers was capped and is being trimmed over time – from $325 million in FY 88 to $277 million in FY 91 – to reflect the drop in demand.

"One of the things we are trying to do here is to make this a fairer system," Dukakis stressed. "There are an awful lot of small businesses that do provide insurance." They are paying a "substantial surcharge on their premiums" to pay for uncompensated care, thereby "footing the bill" for others that do not subsidize employee insurance, he said.

Reservations expressed by the hospital industry also seem to have abated, the Governor noted. For one thing, he said, the state was finally able to pay hospitals $50 million, to make up for federal cuts in Medicare – money it had promised to win support for the Health Security Act. Initially, hospitals had also resisted the state's management of the uncompensated care pool and tried – and failed – to deny the DMS authority to issue performance standards governing the amount of bad debt they may charge to the pool. The standards are expected to save the pool $40 million, savings that will be passed along to the state and private businesses.

An analysis of the way in which hospitals were collecting bad debt found "enormous variations" in the amount of debt recovery, Dukakis said, with no pattern. "It wasn't that some were urban and some were suburban. It obviously had something to do with the management of the hospitals," he observed. After a good deal of consultation with the industry, standards were approved and to the hospitals' surprise, "are working better than they thought they would."

Other components of the law include:

- the CommonHealth program (July 1988), administered by the Public Welfare Department, provides coverage to three groups: those who leave the welfare rolls to work; disabled adults who want to work; and disabled children of working parents. The program was the first phase of the act to be implemented. As of the end of February, more than 17,000 individuals had been enrolled.
- CenterCare (May 1989), run by the DMS, contracts with community health centers to provide primary care to uninsured residents with incomes at or below 200 percent of poverty. Currently, more than 5,300 people are enrolled in 23 centers across the state.
- Student Health Insurance (September 1989) requires all college students in Massachusetts to either buy insurance through their institution or demonstrate they are covered by a comparable plan. An estimated 55,000 students who had no insurance before the law was enacted are now covered; savings to the uncompensated care pool are estimated at $15 million.

Effective in January of this year, employers also began paying a 0.12 percent tax on the first $14,000 of employee wages ($16.80 per employee) into a special health insurance account, to pay premiums for residents receiving unemployment compensation. Contributions to the account are expected to generate $34 million in 1990. A recent survey found that at any one time, 40 percent (130,000) of those claiming unemployment compensation are without insurance.

By the end of 1990, the state also expects to be insuring an estimated 10,000 residents under so-called phase-in initiatives, designed to test various approaches to providing insurance. In round one, the DMS is contracting with HMOs and insurers for comprehensive insurance, targeted primarily to businesses with fewer than 25 employees. In the second round, the department will try to find plans with premiums at roughly $1,680 – the same level of contribution to be required of employers in 1992.

Is the Massachusetts plan a model that could be emulated on a national level? "It's one model, yes," Dukakis said. "If people are looking for an example of an employer-based system, using private insurance principally, this is the most advanced version."

Why hasn't the federal government succeeded in pulling together the diverse factions, as several states have, and developed a plan that addresses the needs of the uninsured on a national level? "You have chief executives at the state level who are willing to take leadership on the issue," Dukakis said. "During the Reagan years, it was impossible to get the Administration to seriously consider the problem ... I hope President Bush, with the directive he has given [HHS Secretary Louis B.] Sullivan, is going to take this seriously."

There is, he said, "tremendous congressional interest, on both sides of the aisle" in fashioning a national plan for the uninsured. If the Bush Administration is equally interested, he said, the governors – whose budgets are riding on a solution – can play a pivotal role. "We have an opportunity to do here exactly what we did on welfare reform and what we've done now on education, which is to be the catalyst that drives this ... and brings a Republican Administration and a Democratic Congress together."

GAIL L. CHATFIELD
STATE REPRESENTATIVE
DISTRICT 64

State Capitol - Room 114C
Jefferson City, MO 65101
(314) 751-2103

3872 Louis
St. Louis, MO 63116
Home Phone (314) 353-7770

MISSOURI
HOUSE OF REPRESENTATIVES
JEFFERSON CITY 65101

COMMITTEES
Chairman
Retirement
Vice Chairman
Public Employee Retirement
(Joint Statutory Committee)
Member
Energy & Environment
Labor
Workers Compensation

To: Interested parties December 4, 1989
From: Rep. Gail Chatfield
Re: Proposed "Missouri Health Assurance Plan"

Enclosed is a draft of legislation creating a "Missouri Health Assurance Plan" which I intend to file by the end of this month. The basic idea of this bill is to establish a Canadian st_ie comprehensive health program for our state. I would like to emphasize that this enclosure is a draft, not a finished product. The development of this bill is going to be an ongoing process which will just start with the filing of the initial version. I am circulating it to you, and other interested parties, in the sincere hope that you will help with this process by offering your comments, criticisms, and suggestions for improvement each step of the way.

<u>**Summary**</u>

The central idea behind this bill is to address our state's serious health care problems through a basic structural reform of the system, rather than continuing to attempt to apply bandaids to each individual crisis as it arises. This is not just an indigent care progr- 1, or just a cost containment program, or just a reform of Medicaid. It is a serious attempt to meet all of these, and many other, concerns by remodeling our system along the lines of one that is a proven success; i.e. the Canadian national health insurance program. The bill has three guiding principles. They are u.iversal access, cost containment, and quality assurance.

Universal Access The bottom line here is that every resident of Missouri will be covered by the Plan. It is intended to basically replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible. There will be no means test or eligibility standards to differentiate one person in need of care from another on the basis of income, age, pre-existing condition or anything else. Every resident of our state will have access to a basic package of health care services.

Cost Containment One of the biggest successes of the Canadian system is that it is able to offer coverage to every Canadian citizen while costing proportionally far less than our system here in the U.S. The basic reason for this is that their system is based on a unified source of payment. Rather than trying to deal with patchwork of hundreds of private and public insurers and programs, the Canadians channel all of their health dollars through a single fund. This saves them money in two ways. First, it eliminates the tremendous administrative costs associated with maintaining hundreds of overlapping private and government insurance bureaucracies. Second, it puts a single payor in the position of containing costs by negotiating budgets and fee schedules with providers. Thus cost savings can be achieved by increased efficiency and consumer bargaining power, rather than by rationing care on the basis of ability to pay. The proposed Plan will consolidate all of the money presently being payed by private companies and individuals, as well as the state, Federal, and local governments into a single fund.

Quality Assurance Surveys show that consumer satisfaction with the quality of the Canadian system runs a well over 90%. This is achieved in two ways. First, their program (like this proposed Plan) contains provisions for constant monitoring and improvement of the quality of care. Once again, the unified source of payment plays a critical role in enforcing quality standards. Second, the program eliminates financial incentives for piling on medically unnecessary, and often harmful, procedures just because of their profitability. For example, studies show that unnecessary surgeries, such as hysterectomies and Caesarean sections, are among the most serious quality problems infecting our current system.

As I said at the beginning of this memo, the proposal that you have in your hand is a draft. Our hope is to involve you, and other key individuals and organizations in the process of improving and refining the program so that it will meet the needs and concerns of each, while keeping its basic principles intact. I look forward to hearing from you and working with you on this project.

Sincerely,

Rep. Gail Chatfield

Description
Missouri Health Assurance Plan

<u>Section A</u>

Section 1 contains the title of the bill, outlines its purposes, and defines its most important terms.

Section 2 is enabling language needed for a statute of this type.

Section 3 sets up a Board of Governors for the Plan. It will have 21 members including the heads of four departments, two members of the Certificate of Need board, and fifteen appointees. The appointees will include five provider representatives and ten consumers. Among the consumers must be at least one poor person and one senior citizen.

Section 4 outlines the powers and responsibilities of the Board. It requires them to hold hearings on several of their more important duties.

Section 5 allows the appointment of an Executive Director for the Plan. It allows the Board to delegate powers to him/her, excluding the issuing of rules and the allocation of funds.

Section 6 sets up a Missouri health care trust fund. It includes in the fund money which comes into the state for Medicaid and Medicare payments, subject to a waiver issued by the Federal Department of Health and Human Services. This allows the inclusion of Medicaid and Medicare money in the unified source of payment. The section also requires the establishment of a reserve fund to protect the solvency of the program.

Section 7 creates a "Prevention Account" within the fund to earmark resources for preventive and primary care. It also sets up a "Health Services Account" from which to reimburse providers for the basic services covered by the plan.

Section 8 sets up a "Health Professional Education and Training Fund" to allow the dedication of resources to this purpose.

Section 9 states that all state residents are eligible for the Plan. It forbids providers from charging eligible persons more than they are reimbursed by the Plan.

Section 10 outlines covered services. Basically, all medically necessary services are covered. Prescription medications, most outpatient mental health services, and a limited amount of alcohol or drug rehabilitation are included. Basic nursing home care, elective or cosmetic services are not.

Section 11 prohibits discrimination by providers, allows freedom of consumer choice for covered persons, and sets up a mechanism

for paying for the care of Missourians while outside the state.

Section 12 sets up the payment and cost containment system. Hospitals are paid on the basis of annual "global budget" which is meant to cover all of their costs (including justifiable capital needs) for each year. Individual providers are paid on a "fee-for-service" basis. Fee schedules are to be negotiated with the Board. Multispecialty provider groups may elect to be reimbursed on a "capitation" basis.

Section 13 is enabling language allowing the assignment of revenue raised by the state for the Plan to go into the trust fund.

Section 14 redirects state and local funds currently going for employee health care into the program. It includes a phase-in for units of government which have collective bargaining agreements with their employees.

Section B sets the effective date of the program two years after the receipt of the necessary Medicaid and Medicare waivers.

Section C increases corporate and individual income tax rates to fund part of the cost of the program. **Note: The intent of this tax is not to increase the health care expenditures of employers or individuals, but simply to redirect the money that they are already paying toward health insurance through the single state payment source, the trust fund. The tax will replace existing premium payments, not be added to them. The "blanks" have not been filled in because guidance is needed from industry and taxpayers on how this tax should be structured so as to ensure that the program does not increase the health care burden of individuals or employers that are already doing their share to pay for coverage. It is intended that this system will offer universal coverage and still reduce the overall amount Missourians pay for care.**

Section 15 instructs the Department of Social Services to apply for the necessary Medicare and Medicaid waivers.

Section 17 sets the timeline for the governor's appointments to the Board.

Section D submits the Plan to a vote of the people.

The Oregon Health Standard

Prepared at the direction of the Joint Legislative Committee on Health Care

©1990 Health Care Access

The Oregon Health Care Challenge.

Government, Business and Labor working together to:

- Promote access to health care for all Oregonians.
- Agree on a standard package of health care benefits for all Oregonians.
- Restrain health care cost inflation.
- Equitably share responsibility in financing health care.

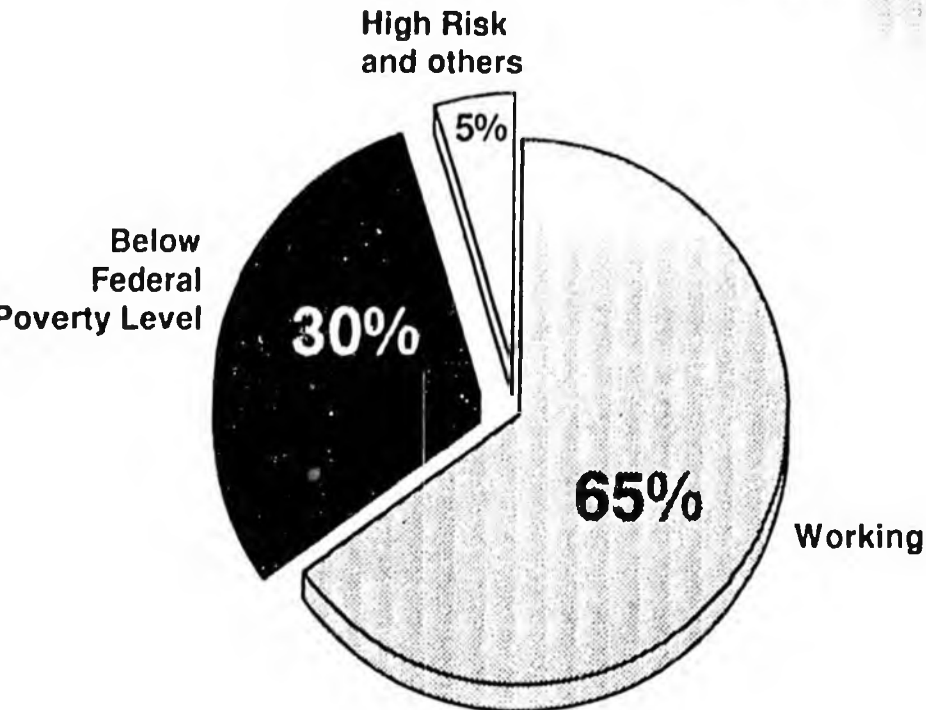
400,000 Oregonians are without any health insurance.

One out of six Oregonians under 65 are without health insurance.

120,000 are earning below the Federal Poverty Level.

260,000 are adults and families earning above the Federal Poverty Level.

20,000 are High Risk individuals and others.

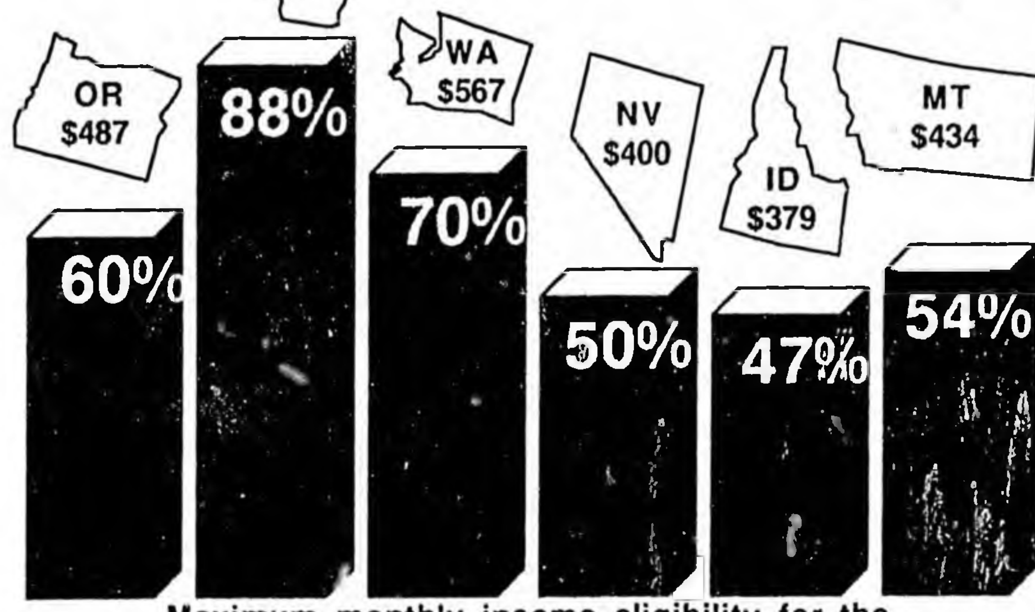


SYMPTOM

120,000 Oregonians below the Poverty Level cannot receive Medicaid.

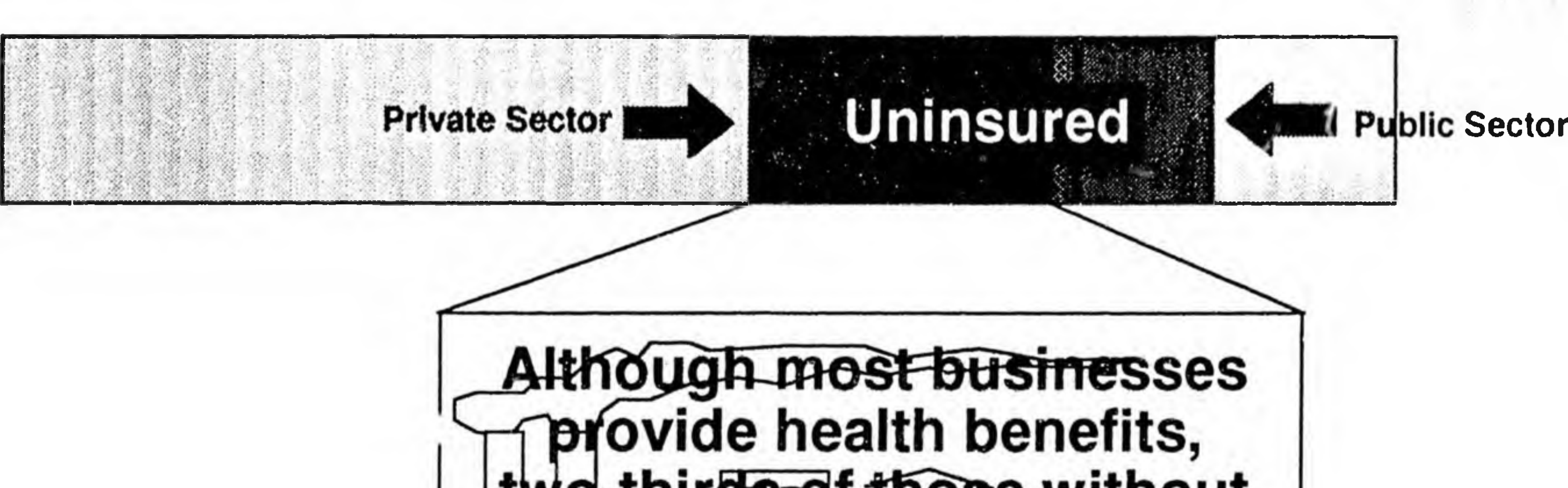
Congress passed Medicaid to provide health care for families living in poverty. Income levels used to determine Medicaid eligibility vary from state to state. The range is from Alabama's 24% to Utah's 95% of the Federal Poverty Level.

Oregon has provided sufficient matching funds to cover the poor with incomes up to only 60% of the Federal Poverty Level.



Maximum monthly income eligibility for the typical Medicaid family of three as a percentage of the 1988 Federal Poverty Level (Medicaid Source Book, Congressional Research Service)

260,000 of those without insurance are workers and their dependents.



SYMPTOM

Employers pay the health care bills of 400,000 uninsured Oregonians.

The way health care for those without health insurance is paid for is unfair.

Employers who provide health benefits subsidize uninsured workers through higher premiums for their own workers.

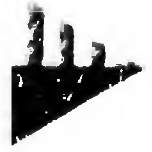
These employers also pay the difference when Medicaid and Medicare don't cover all the costs.

Annual Insurance Bill
Your Health Care Insurer
Anytown, OR

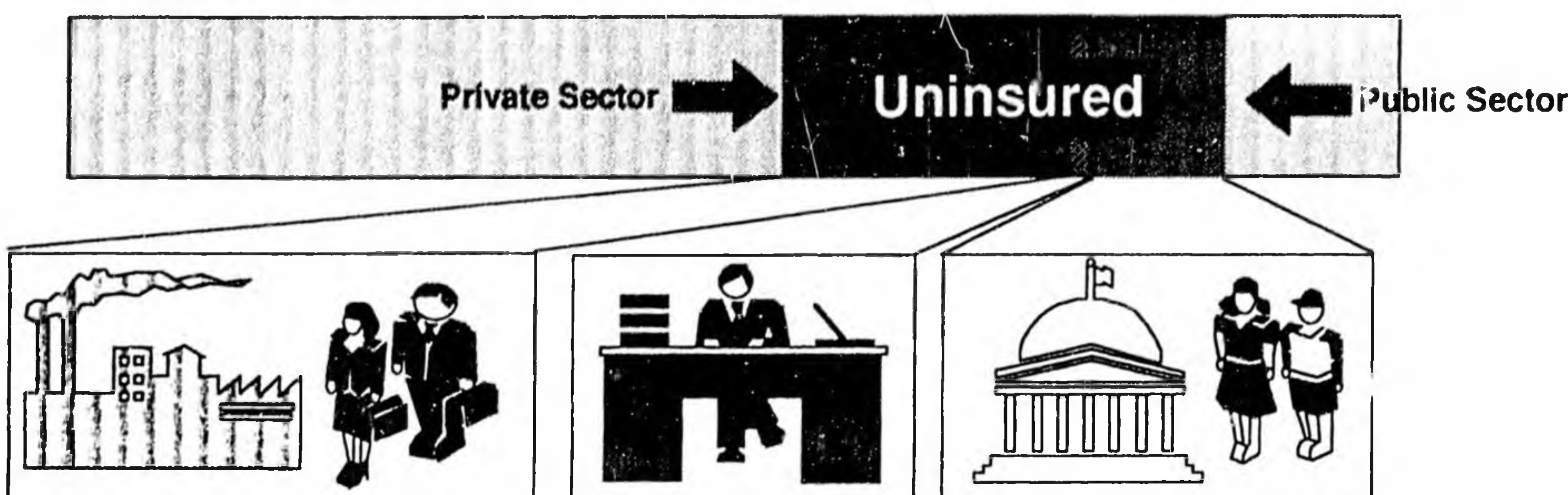
To: Oregon Employers
1,500,000 families @ $2,000 = $3.0 Billion
Unpaid health care bills @20% = .6 Billion

Total: $3.6 Billion

PRESCRIPTION



The Oregon Health Standard will expand access to care, covering nearly all Oregonians.



Business and Labor
Insurance Pool

Insurers
High Risk Pool

Government
Expanded Medicaid

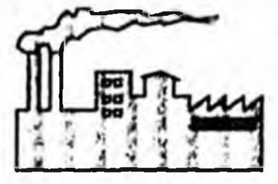
The Oregon Health Standard will assure health care for workers, the poor and the sick.

The Legislature established a partnership to provide health care access for the 400,000 uninsured Oregonians.

Business' responsibility is to provide standard health coverage for workers and their dependents.

Government's responsibility expands to all those living in poverty and is shared with Insurers for coverage of the chronically ill.

Senate Bill 935



Employers provide health care benefits for all permanent workers and dependents.

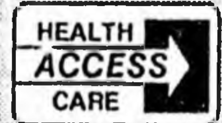
Senate Bill 534

Insurers provide risk pool coverage for the uninsurable, chronically ill. The State subsidizes the pool.

Senate Bill 27

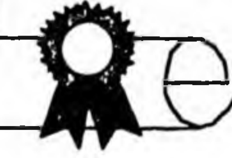
Government expands Medicaid to cover all those below the Federal Poverty Level.

PACKAGE



The Oregon Health Standard links programs together to gain access for everyone.

Oregon
Health
Standard



SB 935

Employer Pool

Oregon Health Standard benefits are required to be provided by employers participating in the Pool.

SB 534

High Risk Pool

Health care will be available for Risk Pool participants regardless of their medical conditions.

SB 27

Expanded Medicaid

The Health Standard becomes the Medicaid benefit package, rationalizing services and promoting cost containment through managed care.

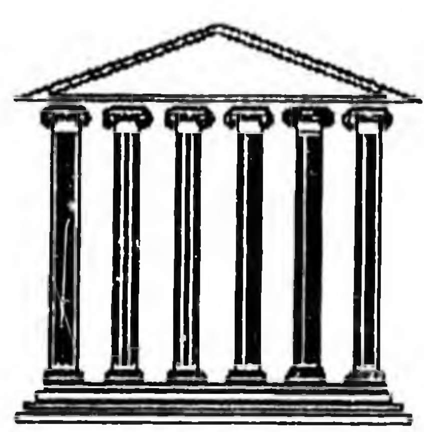
Congress is asked to approve the Oregon Health Standard.

The Oregon Health Services Commission:

Establishes a set of health care services in rank order of priority, based on the effectiveness of health care treatments and on societal expectations for an Oregon health care system.

Identifies costs for each prioritized medical procedure.

Presents its report to the Legislature and to the Governor for funding to begin July 1, 1991, pending Federal approval.



Federal Medicaid requirements may stand in the way of the Oregon plan. Congress needs to waive eligibility barriers for single adults and childless couples living in poverty. The Federal Government must agree to the Oregon Health Standard benefit package.

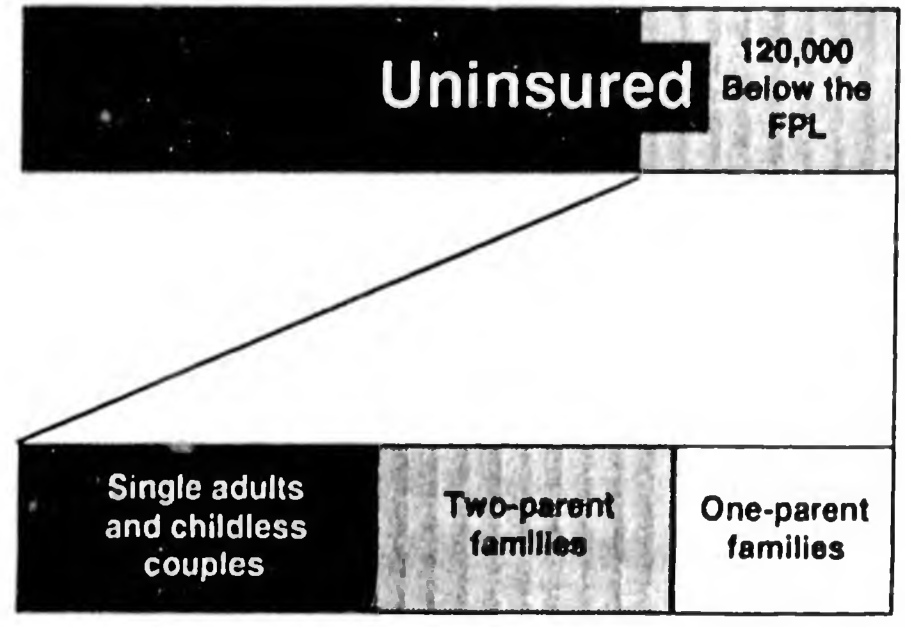
Oregonians living in poverty will benefit from the Oregon Health Standard.

Oregon's Medicaid Program will be expanded to cover all families with incomes below the Federal Poverty Level.

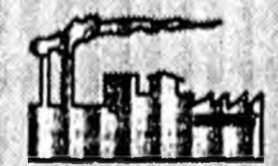
120,000 additional Oregonians will be eligible for Health Standard benefits through Medicaid.

59% of those to be covered are in families with children.

Children living in poor two-parent families, now uninsured because Medicaid is tied to welfare cash assistance, will be covered.



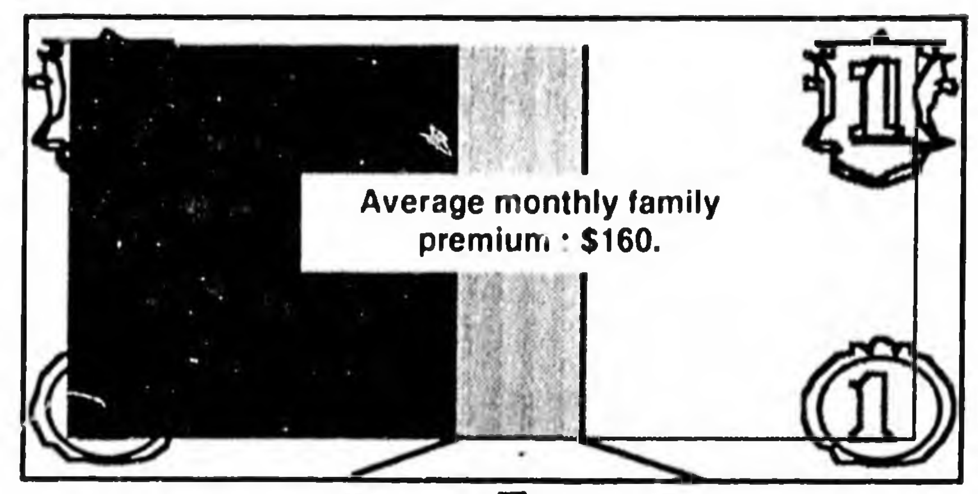
Oregon Expanded Medicaid



Oregon businesses will provide health benefits for all workers.

An Employer Pool has been established offering affordable and comprehensive health plans. These plans must provide at least Oregon Health Standard benefits, but not necessarily other health care mandates.

$45 million in tax credits per year is available to encourage small businesses to provide health benefits now. The 1994 requirement that all employers provide health benefits would be repealed only if most uninsured workers become covered through voluntary efforts.



Employer

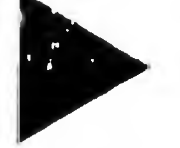
Pays 75% of the workers premium, 50% for dependent coverage, receives $25 tax credit, net cost: $70 per employee per month.

Tax Credit

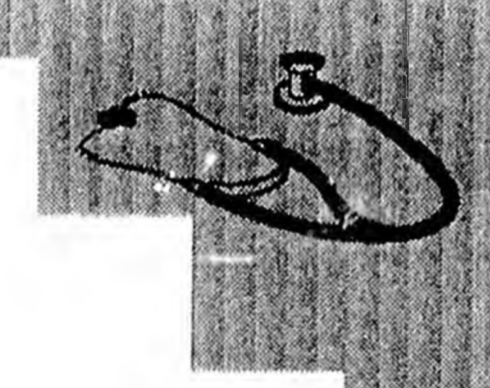
Pays maximum $20 for worker and $5 towards dependents, net $25 per month.

Worker

Pays 25% of own premium, 50% for optional dependent coverage, net cost: $65 per month.



Oregon's High Risk Pool reaches thousands who need health insurance.



About 15,000 Oregonians are unable to obtain health insurance because of pre-existing medical conditions.

Oregon has taken the first step in helping the chronically ill get the care they need. Many can now be enrolled in the new High Risk Pool.

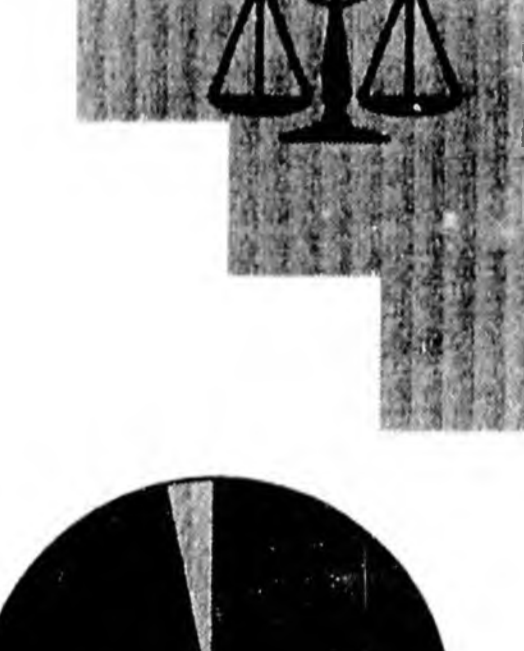
The State has appropriated a $1 million subsidy and provided for an assessment on insurance company revenues to start up the Pool. Participants pay no more than 150% of a standard premium.

Oregon's High Risk Pool reaches thousands who need health insurance.

About 15,000 Oregonians are unable to obtain health insurance because of pre-existing medical conditions.

Oregon has taken the first step in helping the chronically ill get the care they need. Many can now be enrolled in the new High Risk Pool.

The State has appropriated a $1 million subsidy and provided for an assessment on insurance company revenues to start up the Pool. Participants pay no more than 150% of a standard premium.



In 1994, nearly all Oregonians will have access to health care.

The Oregon Health Standard's benefits and managed care will make the best use of health care dollars.

Private and public insurance expansions will provide access for all workers and their dependents, all those living in poverty, and the chronically ill.

Some unemployed and self-employed persons, and some college students, would continue to be without coverage.

1990

Covered

1994

THE WASHINGTON UNIVERSAL HEALTH ACCESS ACT OF 1990

[CONCEPTUAL OUTLINE]
*** not written in statutory syntax ***

Proposed by

Representative Dennis Braddock
Chair, Committee on Health Care
Washington State House of Representatives

Staff Contact:
William J. Hagens
Senior Research Analyst
House Committee on Health Care
Mail Stop AS-33
Olympia, Washington 98504
206-786-7131 SCAN 298-7131
FAX 206-786-7998

FINDINGS AND CONCLUSIONS

The Legislature finds Washington state has been an innovator in health care.

Over the past three years the state has pioneered several nationally recognized model programs, including: the **Basic Health Plan** and the **High Risk Health Pool** to provide access to health services for the uninsured; the **Omnibus AIDS Act** to provide a prevention and treatment framework to address that serious disease; the **Maternity Care Access Act** to provide needed prenatal care to low income women and health care to poor children; **Rural Health Legislation** to meet the health needs of rural communities; the **Health Care Authority**, a single payer administration, to improve the efficiency of health benefit plans for public employees; and a **state Department of Health** to provide greater focus and leadership regarding health matters.

These accomplishments, although significant, are piecemeal attempts to address pervasive problems of access, equity, quality of care, and cost control.

Close to 700,000 Washington state citizens are without access to health services. This number is growing as increased health insurance costs push low wage earners off health insurance rolls, administrative and bureaucratic costs continue to rise, and the multi-tiered complex system breeds additional inequities in access and quality.

Problems of access, quality, and cost also have a detrimental effect on the state's economy. Washington state, and the nation as a whole, cannot gain a competitive edge when health care costs continue to grow at an alarming rate and workers cannot access health services. On a per capita basis, the United States spends 41% more on health services than Canada, 61% more than Sweden, and 131% more than Japan. All of these countries have universal health coverage while this country fails to provide coverage for an estimated 37 million of its citizens. Also, in some areas of health outcomes, e.g. infant mortality, these countries fare better than the United States.

The Legislature concludes that any future reforms must be systemic, encompassing all the major components of health service delivery and finance. It must also result in universal coverage for state residents, insure quality of care, and include effective cost controls.

INTENT

It is the intent of the Legislature that by 1995 the Washington Universal Health Access Program [**WUHAP**] be fully implemented, incorporating the following principles.

1. Comprehensive health service and long term care coverage for all residents of the state.

2. Annual premium participation for all enrollees based on income, except for those of the lowest income levels.

3. Minimal co-payments to be paid at the point of service for all enrollees, with a sliding fee schedule for those enrollees whose income is below 200% of the federal poverty level [FPL].

4. An efficient single administrator, with uniformity of billing, payment, and data collection.

5. A global state health service budget based on a percentage of the gross state product or revenue capacity.

6. Freedom of choice of provider.

7. Funding through employers, individual premiums and payments, and state and federal governments.

8. Development of a state universal coverage program in anticipation of some form of national health insurance.

DEVELOPMENTAL PROCESS

The elements of WUHAP will take several years to put in place. Most likely, it will need to be phased in over a multi-year period.

The responsibility for overseeing the development of WUHAP is given to the **Health Care Access and Cost Control Council [HCACCC]** recently created by SB 6152 [Sec 503]. Present membership includes the Secretary of Health; the Secretary of Social and Health Services; the Administrator of the Basic Health Plan; the Administrator of the Health Care Authority; the Director of Labor & Industries; and one public member. The statute should be amended to include the Insurance Commissioner, since the development of the WUHAP will require significant modification of the insurance system.

The developmental process will involve the participation of several groups and organizations including the Board of Health, through the State Health Report; business, labor, the pubic at large, and the health provider community.

ADMINISTRATION

The **WUHAP** shall be organized as a single administrative entity, encompassing the following elements:

1. Uniform benefits package;

2. Simplified uniform billing and payment procedures;

3. Complete and timely access to all health data;

4. Complete authority to make operational decisions regarding the program.

The **WUHAP** may contract with existing health entities to perform financial intermediary or "Administrative Services Only" [ASO] functions, if necessary for the effective and efficient operation of the program.

SERVICES COVERED

Covered health services shall include those that are determined to be effective in the following categories.

1. Inpatient hospital;
2. Outpatient hospital;
3. Physicians services;
4. Other licensed health professional services;
5. Prescription drugs;
6. Health promotion and illness and injury prevention;
7. Long term care, including nursing homes and community-based services.

The secretary of Health, pursuant to her or his authority to evaluate outcomes of health service intervention [SB 6152 (Sec 107 &9)], shall periodically recommend to the WUHAP health services and medical technologies to be covered. Such determination shall be conducted through the public process.

SERVICE DELIVERY AND REIMBURSEMENT

Global State Health Service Budget [GSHSB]: This budget will reflect the total amount to be spent on health services in the state. It will be developed on a per capita basis, taking into consideration an established percentage of the gross state product or revenue capacity. Premiums and co-payments with be established based on a fixed portion of the GSHSB.

Health providers: Health providers will be reimbursed on a fee for service, salaried, or capitation basis set uniformly by the **WUHAP**.

Hospitals: Hospital budgets will be set on a GSHSB basis for each hospital, using historical data, and projected changes. Retrospective adjustment will be permitted for unforseen circumstances.

Trauma and tertiary care services, where efficiency is sensitive to volume of service, will be designated among hospitals based on geographic distribution and need.

Capital projects would be approved separately.

Funds for graduate medical education will be excluded from hospital budgets and separately approved.

Hospital budgets will include a factor for uncompensated care to provide emergency services to those who are not enrolled.

Drugs and durable goods: Prescription drugs, durable medical equipment and supplies, eyeglass, hearing aids, oxygen, and related services will be provided through a uniform state contracting process.

Long Term Care: The HCACCC shall consider the recommendations of the Long-Term Care Commission [HB 1968] in determining service delivery and reimbursement for LTC consistent with the intent of this act.

After 1995, no insurer, health service contractor, nor health maintenance organization may independently insure, contract or provide those health services included in the WUHAP benefits package.

HEALTH PROFESSION RECRUITMENT

The secretary of Health shall identify shortages of needed health providers and, with universities, colleges, and vocational technical institutes, shall develop proposals for training, recruitment, and retention.

HEALTH SERVICE UTILIZATION MANAGEMENT

The secretary of Health, with the state's academic health science programs, shall develop training and continuing education programs that incorporate utilization management schemes to improve timeliness and efficiency of health services interventions and cost controls. The results of this effort shall include practice guideline development, on a consensus basis, using available data on efficacy.

PHASE-IN OF EXISTING PAYMENT SYSTEMS

The HCACCC shall develop a time line and method for incorporating the following

payment systems into the **WUHAP**:

Medicaid and state funded indigent health programs;

Medicare;

CHAMPUS;

State Employee Health Plans;

Common School Employee Health Plans;

Basic Health Plan;

High Risk Health Pool;

Labor and Industries health services;

Veteran health services;

Department of Correction health services; and

All other private coverage.

FEDERAL WAIVERS AND STATUTE CHANGES

The state of Washington shall seek waivers and federal statutory changes necessary to incorporate Medicaid, Medicare, ERISA, Veteran Health Services, and CHAMPUS into the **WUHAP**.

FUNDING

Participation:

Except for persons of the lowest income, all enrollees or their employers will pay premiums. There will be a sliding fee scale for enrollees with income between 100% to 200% of the FPL, with a maximum out-of-pocket limit. For families over 200% of the FPL, premiums will be actuarially set based on family size; this amount will be capped.

A minimal co-payment will be collected at the point of service.

Funding sources:

Federal: Medicare; Medicaid; CHAMPUS; Veterans Administration.

State General Fund: Existing sources.

Employers: Participation in premium and/or WUHAP fees. Possible sliding scale based on company size and gross revenue.

Enrollees: Participation in premium and copayments.

Fund Administration:

Funds shall be deposited into the Washington Universal Health Access Trust Fund.

Amounts shall be allocated on a formula basis to the following four accounts.

I. **Health Services:** health providers, hospitals, drugs, etc.

II. **Prevention and Education:** wellness, illness and injury prevention, and health promotion.

III. **Capital Projects:** renovation, construction, and major equipment.

IV. **Graduate Medical Education:** funding of medical schools, hospitals, and other health professional training.

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.

- o 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.
- o One in three Americans is without adequate insurance coverage and millions go without basic health care services.
- o Nearly one-third of Hispanic Americans are uninsured.
- o More than one in five African Americans do not have health insurance.
- o 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).
- o Forty-four percent of uninsured children live in families with incomes below the federal poverty level.
- o Almost 20 percent of uninsured children live with an adult who is insured through the workplace.
- o The incidence of uninsured residents is almost twice as high in the Western and Southern states than in the North Central and Northeastern states.
- o 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.
- o 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 b[illegible]gain 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 care services to the uninsured and uninsurable and the need to spread the cost to 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.

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 state need, issue area, potential impact on the 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

Non-Profit Organization
U.S. Postage
PAID
Denver, Colorado
Permit No. 3534

MEDICAL INDIGENCY ProjectNotes

National Conference of State Legislatures Vol. 1, No. 2 February 1990

HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;" and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was $600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately $2,400 per person. 1990 health spending is expected to reach $661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.[1]
- Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- o Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.[3] Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.[1]
- o Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- o Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

[1] Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).
[2] Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in Hunger Action Forum, Vol. 2, No. 8, August 1989.
[3] Paula Braveman, MD, et al., *"Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," The Western Journal of Medicine,* 1988 December: 149: 708-11.

FINANCING INSURANCE COVERAGE

> *"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace."* John C. Goodman and Gerald L. Musgrave, Freedom of Choice in Health Insurance, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- o One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- o Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- o Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- o The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- o Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- o At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- o The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- o Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (HB 1034) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes 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. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal 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.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (1989 Georgia Laws, p. 1749, HR 162). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (1989 Indiana Acts, P.L. 327, SEA 385) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (HB 1127). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of **North Carolina** either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be $1.4 billion, but institute officials contend that the net cost would be much lower -- about $700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In Washington state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of $3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g. "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care,

and eliminate unnecessary procedures."

"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do no offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs." Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more co-payments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.

FYI

For further information, contact:
Shelda L. Harden, Policy Specialist
NCSL Health Services Program
1050 17th Street, Suite 2100
Denver, Colorado 80265
(303) 623-7800

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in **Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina, and Wisconsin.** The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

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 state need, issue area, potential impact on the 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

Non-Profit Organization
U.S. Postage
PAID
Denver, Colorado
Permit No. 3534

Access Issues Continue to Command Attention

With anywhere from 31 million to 37 million Americans still without basic health insurance, "access" -- the code word of the 1980s for making certain that the poor and uninsured receive health care -- appears likely to remain the dominant health policy issue of the new decade.

At the federal level, the Bipartisan Commission on Comprehensive Health Care (called the Pepper Commission after its first chairman, the late Rep. Claude Pepper) weighed in with its long-awaited report. The report which spells out a detailed -- and costly -- plan for guaranteeing access, not only to basic health services but to long-term care services as well. But because it will almost certainly require new taxes to finance it, the plan is not considered likely to advance far, at least in this election year.

In the states, meanwhile, a wide range of bills aimed at reducing the number of uninsured are undergoing legislative scrutiny. This edition of State Health Notes summarizes proposals to establish universal access modeled after the Canadian system other "gap group" proposals that use a combination of strategies to provide health coverage; and programs targeted to employers and the working uninsured, such as tax credits and subsidies, "play-or-pay" incentives and mandated coverage for part-time workers. The next issue of the newsletter will look at the remaining access proposals, including state indigent care programs; hospital-based programs; approaches targeted to special populations; private sector plans; demonstration projects to provide coverage to low-income individuals who for one reason or another fall through the "safety net"; and work being undertaken by various task forces and study groups.

Pepper Commission Report

With respect to health care, the Pepper Commission voted 8-7 in favor of universal health care coverage for all Americans through a job-based, public system. Net new federal costs to implement the access provisions would total an estimated $23.4 billion. Some of the key features of the plan include:

- Businesses with more than 100 employees would be required to provide private insurance (for a minimum benefit package) or contribute to the public plan for all employees and non-working dependents.

- Businesses with fewer than 100 employees would be encouraged to provide insurance. Tax credits or subsidies would be available for certain small employers.

- The public plan would cover employees and dependents who contribute and non-working individuals who buy in or are subsidized. States would no longer have responsibility for providing the specified benefit package for their low-income residents. The new plan would replace Medicaid for those services, though a residual Medicaid program would remain to cover services not included in the package. State contributions equal to Medicaid expenditures for covered services (adjusted for inflation) would be maintained. States could opt to administer the public plan, subject to federal guidelines.

- The minimum benefit package includes primary and preventive care, physician and hospital care and other services. Services would be subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

With regard to long-term care, the Commission emphasized the need for home and community-based long-term care services and protection against impoverishment for people in nursing homes. Net new federal costs associated with implementing the long-term care recommendations, which were endorsed by a vote of 11-4, would be an estimated $42.8 billion. The key elements of the plan include:

- Social insurance for home and community-based care would be available to severely disabled persons of all ages.

- A nursing home program would provide an ample floor of financial protection, ensuring that no one faces impoverishment. All nursing home users would be entitled to social insurance for the first three months of nursing home care.

- The federal government would assume responsibility for financing the home and community-based program and the three-month "front-end" nursing home care; it and the states would share financial responsibility for the nursing home program.

- Development of private long-term care insurance would be encouraged to fill gaps not covered by the plan, subject to government standards and oversight.

Commissioners voting for the plan focused on the consensus around the need for universal access and coverage, reliance on the current employer-based insurance system and the principle that no one should face impoverishment in order to get nursing home care. Said Rep. Henry Waxman (D-CA): "We have a minimum wage and therefore we ought to have a minimum health care benefit for everyone."

Commissioners opposing the plan zeroed in on the $66.2 billion price tag and the fact that the Commission was silent as to how the federal monies ought to be raised. Said Fortney (Pete) Stark (D-CA), "Without a way to pay for it, it's a non-starter; it's dead legislatively even before it's introduced." Rep. Willis Gradison (R-OH) noted that the cost translates into $750 a year in new taxes for the average taxpayer.

Universal Access Proposals

So far in 1990, the legislatures in seven states – OHIO, WASHINGTON, FLORIDA, MISSOURI, INDIANA, MINNESOTA and ARIZONA – have taken up universal access legislation. The OHIO, WASHINGTON, FLORIDA and MISSOURI bills are patterned after principals of the Canadian system, which promotes consumer education and responsibility as key factors in controlling costs; the availability of appropriate services to all residents, with an emphasis on preventive care; health promotion programs and quality assurance; fair reimbursement rates and the freedom of providers to choose practice settings, with incentives to participate in cost-effective managed care systems where provider shortages exist; and a global and finite health care budget.

The OHIO, WASHINGTON, FLORIDA and MISSOURI measures propose giving a single public or private administrative organization complete operational authority over the plan, including uniform budgeting, billing, payment and data systems.

WASHINGTON's plan, which was passed by the House but rejected by the Senate, would be financed through a combination of government sources (Medicaid, Medicare, public employee benefits and other sources); employer contributions based on a set per capita basis, with special consideration given to small businesses; and individual premiums based on family size, with reduced or no premiums for low-income families. Health providers would have the option of being reimbursed on a fee-for-service, global or capitated basis, but fees will be set uniformly and capitation rates will be uniform and based on the number of eligible persons enrolling in the plan. While the bill has not been adopted, sources indicate that the legislature is likely to agree to the creation of a Universal Access and Cost Containment Commission (proposed by the bill), which will examine the feasibility of a universal health plan for state residents as well as other proposals.

OHIO's plan, which is similar to WASHINGTON's, sets out a broad concept of universal access and establishes a commission to determine the range of services to be provided in the basic benefit package. Individuals would be able to choose their providers; the plan would be financed through a combination of sources, including an eight percent payroll tax on employers and a one percent payroll tax on employees; a two percent tax on interest and dividends in excess of $1,000; and a 10 percent excise tax on alcohol and cigarettes. As in WASHINGTON, OHIO's plan additionally calls for federal waivers to include Medicaid and Medicare funds. The bill, which has the apparent support of grassroots organizations, is currently being studied by the House Insurance Committee's Health Insurance Subcommittee.

Both the FLORIDA and MISSOURI plans would be financed through taxes on employers. FLORIDA's bill, which is modeled after OHIO's, calls for an eight percent payroll tax on employers to supplant the existing private insurance system. Under the proposal, money generated from the tax would be used to reimburse providers for their services, and providers would be prohibited from billing patients or insurance plans. All state residents would be eligible for coverage; there are an estimated 2.5 million uninsured individuals in the state. The state will hold a workshop in late April to take testimony from insurers, providers and consumers but sources say there is a high level of support in both the legislature and local communities for the bill.

In MISSOURI, the employer tax would be levied at a rate of 75 cents for each hour an employee works (about $2,100 per year for full-time salaried workers). Efforts are also underway to implement a personal income tax, which would be levied on a sliding scale basis. Under the legislation, the proposal would be put to a vote in the November general election.

Another MISSOURI bill would establish a system to provide access to health insurance for all state residents, regardless of health or economic status. Individuals with incomes below $6,000 for the last calendar year may apply for a waiver of premium payments; those with incomes of more than $6,000 will be required to pay a monthly premium of $30. Individuals who have covered medical expenses in excess of the maximum limitation of $20,000 will be eligible for increased coverage by paying a premium of $50 per month, thereby doubling their maximum coverage. The legislation includes co-payments for physician services and outpatient hospital care and sets limits on benefits for home health, outpatient care, prescription drugs, clinical laboratory services, mental health services and nursing home care. The system will be financed by increasing by one percent the tax on retail and property sales; the basic rate for sale of gas, electricity, water and telephone services; sales associated with recreation services, travel and entertainment; and vehicle registration.

Like MISSOURI, a MINNESOTA proposal would put the question of universal access up for a vote in the November election. A bill introduced in the House asks voters to amend the state's constitution to require the state to guarantee affordable health insurance for all residents. The bill stipulates that this be the first question on the ballot. Sources indicate that sufficient support for the bill is lacking in the Senate; further initiatives targeting access for children's services may be introduced later this year, however.

A bill introduced in INDIANA this year proposes to create a state-administered health plan that would provide uniform access to comprehensive care for all residents, regardless of disability or pre-existing conditions. The plan would be financed through a combination of sources, including income taxes, alcohol and tobacco taxes, a per capita employee tax on employers and other government and private funding sources. Cost containment measures built into the legislation include pre-admission certification for hospital care; discharge planning; claims data analysis; protocols for preventive care and common acute care; and spending limits for reimbursement of non-institutional providers.

An omnibus bill in ARIZONA seeks to assure essential and affordable health care to all state residents. The bill, which includes a provision that requires all employers to provide coverage for their workers, establishes an oversight commission; a state medical assurance corporation to implement the commission's policies and to provide a catastrophic and uninsurable risk pool; and a state medical fund to provide health care to uninsured, underinsured or uninsurable individuals in the state.

Other Access Proposals

In four states – NEBRASKA, WEST VIRGINIA, NEW JERSEY and RHODE ISLAND – legislation has been developed to fill in gaps in coverage for those individuals who do not qualify for public programs and do not have access to health insurance through the private sector.

The bills in both NEBRASKA and WEST VIRGINIA would assist low-income uninsured residents. NEBRASKA's "Health Insurance Access Act" would subsidize individuals and families whose family incomes are below 185 poverty of poverty and who do not qualify for Medicaid or Medicare, while WEST VIRGINIA's "Health Insurance Program Act" would help uninsured residents pay part or all of their health insurance premiums.

A measure pending in NEW JERSEY would establish a state "Group Health Insurance Plan," to be administered by the Commissioner of Insurance, to provide unemployed residents who are unable to obtain group coverage with access to insurance. The plan is intended to be self-supporting and would be rated on an expense incurred basis, with premiums adjusted annually to reflect the actual medical experience of enrollees.

Legislation in RHODE ISLAND would provide health coverage to all uninsured workers whose income is below the federal poverty level. The bill specifies services to be covered; cost containment measures such as the use of a primary care gatekeeper; pre-admission certification, concurrent utilization review and discharge planning; and employee responsibility for premium payments. The program would be financed through the state's temporary disability insurance fund; participating employees would make a contribution equal to 1.25 percent of their wages, up to a maximum wage base (defined as the annual earnings an individual needs to qualify for the maximum weekly temporary disability benefit).

Employer-Based Initiatives

Play-or-Pay Programs: A number of states have based new legislation on the "play-or-pay" scheme developed by MASSACHUSETTS in 1988. Such programs give employers the option of providing insurance coverage for their workers and generally include incentives to participate – tax credits or subsidies, for example – or pay a specified fee, which the state then uses either to subsidize coverage directly or reimburse providers for uncompensated care.

A 1990 DELAWARE bill offers an example of the approach of requiring mandatory health insurance for workers. Under the plan, employers could elect to either offer health insurance to employees and pay at least 75 percent of the premium or pay a fee of up to 50 cents for each hour that an employee worked. The money from the fees would be put into a "Medicaid Supplement Trust Fund" and used to subsidize coverage of uninsured employees with incomes below 300 percent of poverty whose employers do not participate in the state plan. Workers receiving coverage through the trust fund would be required to contribute to the premium on a sliding scale, based on their family income.

A series of bills in MISSOURI also target employer-based health coverage for uninsured workers. One bill proposes to establish an "Employers Health Insurance Purchasing Group" through which employers may provide a low-cost health insurance package to uninsured workers. The purchasing group would

contract with an insurer to provide an essential benefit package to members on a managed care basis and a limited indemnity plan, including a $500 deductible and a 20 percent co-payment, not to exceed total year out-of-pocket expenditures of $1,500.

The plan excludes routine services and contains utilization review, mandatory second opinion for certain procedures and certification of medical necessity for certain services. The employee's contribution would be based upon the number of hours worked per week, with a 20 percent premium contribution for those employed for more than 34 hours per week and a 40 percent contribution for those working less than 23 hours per week. Eligible participants must have worked at least 17 1/2 hours per week for three consecutive months; dependent children under the age of two are also eligible. To encourage participation, employers that do not elect to join the purchasing group will face a tax of $100 per month per employee.

Another **MISSOURI** measure designed to give employers a strong incentive to offer their workers insurance coverage would require all companies with more than 15 employees to make a "medical security contribution" for each uninsured employee, equal to six percent of the worker's wages. Finally, a third proposal would allow employers that provide health insurance that is at least as comprehensive as the state employee's retirement system a tax credit of $25 per month for each month of coverage during the taxable year.

Small Employers: Although mandatory employer insurance plans are an intriguing option that many states are considering, one argument against them is that smaller firms are put at a disadvantage for a variety of reasons – the costs associated with overhead and administration, search and information costs, limited benefit plans offered by insurers and smaller pools for determining risk, to name a few – when they attempt to purchase insurance on the open market.

As a result, many states are trying to eliminate these inequities by targeting smaller firms for tax credits and subsidies. The states in which such legislation has been introduced include **CALIFORNIA, COLORADO, GEORGIA, KANSAS, MARYLAND, MINNESOTA, MISSOURI, NEW MEXICO, SOUTH CAROLINA** and **WASHINGTON**.

While states are using a combination of cut-off points for firm size, income thresholds, cost-sharing requirements and tax credit levels, there seems to be some consistency to the overall method. The bills introduced this year, for example, generally target firms with fewer than 25 workers, although **MARYLAND** uses 50 employees as a limit and **WASHINGTON** uses 100. The cost-sharing requirements most often stipulate that employers are responsible for paying 75 percent of premium costs and employees the remaining 25 percent, but giving employers the option of picking up more. One exception is in **COLORADO**, where the bill being considered sets cost-sharing at 70 percent for employers and 30 percent for employees.

The amount of tax credits being proposed also varies but generally ranges from $25 per month per employee or 50 percent of the total premium cost, whichever is more. Variations on this are found in **COLORADO**, which uses $25 for individuals, $65 for families or 50 percent, and in **GEORGIA**, which uses $25 or 25 percent, respectively. To encourage employers to participate as soon as possible, most states considering this approach have included a provision reducing the amount of the tax credit in subsequent years.

There are other variations as well. The legislation introduced in **COLORADO, KANSAS** and **NEW MEXICO**, for example, proposes a dual structure – one plan that is mandatory and covers catastrophic care, with additional benefit plans that employees may elect to purchase at their own expense. The **GEORGIA** bill allows employers to receive an additional credit of $5 per month per employee for providing supplemental benefits, defined as prenatal and well-baby care and mental health services. The credit is in lieu of any deduction to the which the employer may be entitled. The **WASHINGTON** bill also contains a provision that allows participating employers to deduct the entire cost of the premiums as a business expense. Currently, small businesses may only deduct 25 percent of health insurance premiums as a business expense.

Part-Time Workers: Following the lead of **VERMONT**, which last year enacted a law that mandates coverage of certain part-time workers, the **NEW HAMPSHIRE** and **WASHINGTON** legislatures are debating bills to require employers that offer group insurance to full-time workers to make similar policies available to part-time employees who would be eligible if they were working full-time.

The **NEW HAMPSHIRE** bill would apply only to firms with more than 15 employees; both states include only those employees who work at least 15 hours per week. Like **VERMONT**, neither requires the employer to pay any part of the premium; rather, cost-sharing requirements are left to the employer's discretion. – Michele Solloway and Dick Merritt

StateSide

Discussions with Health Policymakers

by Linda Demkovich

March 1990

Governors' Goals: Improve Access, Cut Costs

The nation's governors are preparing to declare war on a common enemy -- rising health costs -- and are looking to enlist a frequent adversary -- the federal government -- as their leading ally.

Without controlling costs, the governors contend, there will be little hope of helping the millions of Americans who have no health insurance and who must, as a result, often forego care. And without a helping hand from the federal government, they add, both of those goals will be out of reach.

To begin the strategic planning, the National Governors' Association (NGA) last summer created a new subcommittee on health, lodged under its standing Committee on Human Resources. According to Washington Governor Booth Gardner, the subcommittee's co-chairman, the panel's mission is two-fold: to compile the record on what states have done already in the areas of access and costs and, working with the federal government, to develop options that will promote universal access and cost containment.

Gardner, a Democrat, who will take over the chairmanship of the NGA in July and who has put health issues at the top of his agenda, says the states "will be limited only by our ability to gain consensus amongst ourselves." The most divisive issue, he predicted in a recent interview, "will be who will pay." But, he added, "the driver is the fact that all of us are looking at tremendous budget increases in the area of health, if we don't do something. That's the bond that ties us together. We have got to find the ground that we can all stand on together."

The subcommittee's other co-chairman is Maine's Governor, John R. McKernan Jr., a Republican. Also serving on the panel are Governors Bill Clinton of Arkansas (D) and Edward D. DiPrete of Rhode Island (R). Ohio Governor Richard F. Celeste (D), chairman of the full Human Resources Committee, serves as an ex officio member.

Gardner and McKernan, who were in Washington, D.C. in late February to attend the NGA's winter meeting, talked with State Health Notes about the scope of the problems facing the states and about their expectations for solving those problems.

Fostering Dialogue

The opening volley in the cost war was fired last August, when 49 of the 50 governors (only New York's Governor, Mario M. Cuomo, abstained) petitioned Congress for a two-year moratorium on additional mandates requiring the states to expand Medicaid eligibility. Figures compiled by the National Association of State Budget Officers (NASBO) show that the mandates enacted between 1984 and 1988 will add $1.5 billion to state Medicaid expenditures by 1991, pushing total state spending close to the $39 billion mark.

From a strictly financial standpoint, McKernan observed, Maine has probably benefitted from the mandates, since it covers most of the options states can offer under Medicaid and has therefore reaped the matching federal funds. But, he noted, support for an incremental approach to extending coverage to the poor and uninsured had worn increasingly thin in most of the states.

"What we said was that rather than continuing to nickel and dime the issue, Congress ought to understand that this is a very serious national problem that needs to be addressed in a new way ... and that it ought to postpone any new mandates until it's done that," he said.

Although they were spared major mandates last year, the point the states were -- and still are -- attempting to drive home, Gardner added, "is that a lot of states are doing a lot of things in the health field, but there are others that can't get there yet." A state like North Dakota, for instance, "is just strung by its thumbs financially. To add an extra burden and force them into a situation where they can't comply [with the mandates] because of internal financial problems is unreasonable," he stressed. The federal government must "be sensitive to the financial situation of states and to acknowledge what's already been done."

With the mandate battle behind them for now, the states hope to move on to a more productive debate with Congress and the Bush Administration over ways to improve access and cut costs. What the governors want next, McKernan said, is the "beginning of a

dialogue in which there is a general consensus reached by the end of this summer on the direction we ought to be going ... so that we can arrive next January at the point where the only debate is on the specifics and maybe even the technical aspects of the program, as opposed to the overall direction."

Thus far, the NGA health subcommittee has held meetings with other groups -- including the Pepper Commission -- that have also been looking into the access issue. Sometime in early April, the members hope to sit down with key congressional health leaders and, after that, with Administration officials, for what Gardner describes as "basically a get-acquainted session."

The reason the states have taken the lead, Gardner noted, is that they "are on the firing line as far as delivery of services. We're far more sensitive to the problems that impact on our budgets." But, he stressed, there is a growing realization on the federal government's part that "we are in this together and that the only way we're going to get an answer that is satisfactory is that we work very closely together."

Fashioning Solutions

What kind of answer would be satisfactory to the states? Gardner was circumspect, saying only that "the wider the circle gets, the more I realize what I don't know."

According to McKernan, however, a consensus seems to be emerging among the governors "that the current system is inadequate to deal with the problem, that we can't continue to tinker around the edges and think we're going to be able to fill the gaps that way [and] that a new new program is probably needed."

Any new program, he speculated, will probably "use the components that are already in place and will be employer driven, for the most part." The federal role, he added, will be to set standards for a basic minimum insurance plan, guaranteed across all states. "I don't think any of us want to tell employers and states they can't give more benefits if they want to pay for them. We have to be careful not to run the red flag of a two-tiered health system up the flagpole too soon."

On the issue of access, according to McKernan, most of the evidence suggests that the problem is not with hospitals but rather with the lack of availability of outpatient care. "That looks like the hole we really have to plug," he said, plus finding a better way of distributing the cost of the hospital care that the uninsured are currently receiving.

Gardner agrees. The demand for universal access is manifesting itself in the high cost of emergency medicine, he said. "People who are uninsured or underinsured don't get care in early stages and end up in our emergency wards and we pay for that, at a higher cost." It may be, he added, that even with the best cost containment efforts, government will have to expend more resources to ensure access, "but at least you'll be doing that on a basis where you control the growth."

Will the new subcommittee's effort to achieve a consensus on two such pressing issues succeed? Gardner said it is too soon to say. Complicating the process, he stated, is the fact that 36 governorships are up for grabs in the November elections (11 incumbents have already announced they will not seek reelection) "and anybody new is going to want to take time to study the issues." But the bottom line, he said, "is what their budget directors will be telling them."

In Washington State, for instance, health costs currently represent from 12-14 percent of the state's total budget (Medicaid and employee health insurance); by the year 2000, Gardner said, "we're looking at 23-24 percent." Those figures coincide with NASBO figures, which show that on average, Medicaid costs accounted for 13 percent of total state budgets in 1989 and that by 1994 -- without any new expansions -- they will reach 17 percent.

Designing and implementing a plan of national scope may be difficult, McKernan conceded. "That's the reason the states are the crucibles, designing new policy on pressing issues facing the country. But at some point, you have to decide whether the problem is so big that you have to take the best of the state models and craft an appropriate national model." In McKernan's view, that point has now been reached.

Added Gardner: "I think the awareness and the need for cost containment and better access are becoming more and more clear. And the only way we can get there is for the states and the federal government to work together," he stressed again. "We have to begin to act."

StateSide ... Discussions with Health Policymakers is a periodic feature of State Health Notes. Both publications are supported by Contract # 500-86-0009 from the Office of Intergovernmental Affairs, Health Care Financing Administration. The views and opinions expressed in these publications belong to the authors and those who are interviewed and should not be construed as representing the thinking and policies of the Health Care Financing Administration.

THE FISCAL LETTER

A Bi-Monthly Report on Government Finance Issues in the States

Editor: Martha A. Fabricius
Assistant Editor: Judy Zelio

January/February 1990 Vol. XII, No. 1
ISSN 0197-288XI

Medicaid Mandates and Fiscal Federalism

By Tony Hutchison

Due in part to the National Conference of State Legislatures' role in promoting a compromise with congressional advocates of extensive mandated expansions in the Medicaid program, the states have temporarily avoided a series of budget shocks set to take effect by 1991.

The compromise included reducing a proposed Medicaid eligibility level from 185 percent of poverty to 133 percent, with the proviso that states cover pregnant women and infants and children up to age six who fall under the new income guidelines. The compromise also extended Medicaid coverage to several other health services.

These changes will still cost states money but not nearly as much as the earlier congressional proposals would have. This article examines the potential impact of all the proposals for expanded Medicaid mandates that Congress seriously considered in 1989. States have not heard the last of these specific proposals: Their proponents see them as a major building block of a national health policy. Even more important, this debate over Medicaid programs is a debate over fiscal federalism as well. It raises the fundamental but rarely addressed issue of whether states should continue to decide health policy for themselves in line with their fiscal abilities and policy preferences. State analysts should be concerned that the congressional debate overlooked the states' ability to pay for expanded programs, as well as differences among the fiscal conditions of the states.

The mandates being debated included the 1991 costs of welfare reform, Medicare catastrophic coverage, nursing home reform, and improved programs for pregnant women, children, the mentally retarded or developmentally disabled, and the frail and elderly, designed to reach millions of poor citizens across the United States.

While not many opponents of the mandates would argue with the need for additional medical care for the poor, particularly for children and pregnant women, policymakers at the state level opposed the Medicaid expansions as another unfunded mandate imposed by the federal government. Opponents further argued that many states would not be able to afford the mandates without raising taxes or cutting back in other important areas of state funding. Proponents argued, however, that the states have the financial resources to fund the expansions if they were willing to make the effort and should therefore be required to take on this responsibility because of national needs.

Could states have afforded the proposed mandates? By analyzing state Medicaid spending on both a national aggregate basis and on a state-by-state basis, it is possible to develop some indicators of how the proposed Medicaid expansions would have affected state budgets. This study of the question uses estimated state costs prepared by the Congressional Budget Office and the National Association of State Budget Officers (NASBO). The analysis applies only to the 29 states for which NASBO prepared cost estimates.

Proposed Expansions as a Percent of Current Medicaid Spending

The proposed expansions would, on average, increase state Medicaid spending by 12 percent (see Table 1 on page 2). There would be wide variations from this average. In Alabama the expansions would have resulted in a 50 percent increase in that state's FY89 Medicaid expenditures. On the other

(continued on page 2)

Tony Hutchison is a senior fiscal policy specialist for NCSL in Denver.

Table of Contents

Features

1 Medicaid Mandates and Fiscal Federalism
3 Did the Windfall Stay or Blow Away?
5 The Fiscal Perspective: Minnesota Adopts Reciprocal Non-Retaliatory Insurance Taxation
7 Hawaii's Universal Health Care Program: Bridging the Gap
10 1990 Fiscal Issues Identified

Departments

6 Book Review
6 Commentary
8 The Fiscal Letter 1989 Index
11 Calendar of Upcoming Meetings
12 NALFO News

hand, Minnesota's increase would have been only 0.3 percent of FY89 Medicaid spending.

This variation is due almost entirely to current state administrative and policy choices about the Medicaid program and who and what services it will cover. States that have chosen to limit eligibility and constrain the number of services offered through Medicaid would have had the hardest fiscal hit from the mandated expansions. States that have elected to participate in optional Medicaid programs (the medically needy program for example) would have suffered fewer budget consequences as a result of the mandates.

In many cases it is the poorer states that would have felt the biggest budget hit from the Medicaid expansions. Proponents of the mandated expansions tend to view these states as those most likely to have citizens in need of increased services. Of course, these states are also less likely to have the budgetary resources to fund their share of the mandates.

Medicaid Spending as a Percent of General Fund Spending

Currently state Medicaid spending takes about 8 percent of state general funds a year. Without the proposed expansions, Medicaid would probably grow to about 9 percent by 1991. If all the expanded mandates were to take effect for 1991, the percentage would jump to 10.7 percent. There would again be wide variations among the states. Michigan would spend the equivalent of 18.2 percent of its general fund on Medicaid, while South Carolina would spend 4.3 percent of its general fund on Medicaid.

Were the Mandated Expansions Affordable?

Many of the states that would have experienced large increases in their state spending for Medicaid due to the proposed expansions are currently spending significantly below the national average for Medicaid. Although Utah and South Carolina would both experience 22 percent increases in Medicaid spending, both still would be spending only slightly more than 4 percent of their general fund on Medicaid. This is significantly below the national average of 10.7 percent.

Of the 13 states that would experience

(concluded on page 11)

TABLE 1

Medicaid Expansion as a Percent of State Medicaid Expenditures in 1991 (estimated)

State	Percent	State	Percent
New England		**Southeast**	
Connecticut	0%	Alabama	50%
Maine	6	Arkansas	19
Massachusetts	NA	Florida	2
New Hampshire	NA	Georgia	9
Rhode Island	NA	Kentucky	5
Vermont	3	Louisiana	NA
		Mississippi	6
Mid-Atlantic		North Carolina	12
Delaware	NA	South Carolina	22
District of Columbia	2	Tennessee	NA
Maryland	7	Virginia	24
New Jersey	NA	West Virginia	18
New York	2		
Pennsylvania	8	**Southwest**	
		Arizona	NA
Great Lakes		New Mexico	7
Illinois	13	Oklahoma	18
Indiana	NA	Texas	NA
Michigan	8		
Ohio	14	**Rocky Mountain**	
Wisconsin	NA	Colorado	NA
		Idaho	22
Plains		Montana	15
Iowa	17	Utah	22
Kansas	12	Wyoming	23
Minnesota	0		
Missouri	18	**Far West**	
Nebraska	7	Alaska	NA
North Dakota	NA	California	4
South Dakota	17	Hawaii	5
		Nevada	NA
Puerto Rico	NA	Oregon	10
		Washington	10
U.S. Total	7%	**Average of State Percentages**	12%

NA - Not available

Source: National Association of State Budget Officers and National Conference of State Legislatures.

Calendar of Upcoming Meetings

AOL to Meet April 19-21 in Boise, Idaho

The Assembly on the Legislature is scheduled to meet April 19-21 in Boise, Idaho. The 11 AOL committees and four task forces will convene to discuss a wide variety of issues of interest to state legislators and legislative staff.

The AOL serves as a major forum for the exchange of ideas and information among state legislatures. It allows each legislature to benefit from the experiences of other states in shaping public policy, experimenting with new laws, and managing the legislative institution.

Among the standing committees meeting in Boise are the Fiscal Affairs and Oversight Committee and the State-Local Relations Committee. These committees examine issues that are of interest to readers of *The Fiscal Letter*. For Boise, the tentative agendas for these committees are:

Fiscal Affairs and Oversight Committee --
- Forging an Effective Public-Private Partnership;
- Higher Education Finance and Accountability;
- Fiscal Implications of Demographic Changes; and
- Workers Compensation: An Idaho Case Study.

State-Local Relations Committee --
- The Cost of Deferred Maintenance;
- Rural Economic Development;
- Legislative Planning in Intergovernmental Relations; and
- What's New in State-Local Relations.

In addition to meeting in Boise, the AOL will meet in conjunction with NCSL's **Annual Meeting in Nashville (August 14) and in Chicago (November 8-10).**

For more information regarding the Fiscal Affairs and Oversight Committee contact Corina Eckl; for more information about the State-Local Relations Committee contact Martha Fabricius at (303)623-7800.

NALFO to Meet in Boise

All members of the National Association of Legislative Fiscal Officers are invited to attend a NALFO/NCSL Annual Meeting planning session on April 19 in Boise, Idaho, during the spring Assembly on the Legislature. Session topics, time slots, and the time and logistics for the annual business meeting in Nashville in August will be discussed. There will also be a demonstration of Idaho's new computer network that allows fiscal staff to communicate with committee members' computer monitors during committee meetings.

Details of the NALFO meeting can be obtained from Tony Hutchison at (303)623-7800.

"Beyond Welfare" is Theme of May Conference in Washington, D.C.

NCSL will sponsor a major conference on policies that could eventually replace welfare. The conference, May 16-17 in Washington, D.C., will focus on state innovations aimed at reducing poverty and dependency. It will highlight such promising ideas as the earned income tax credit, reform of child support, health care, child care, and job training.

Speakers will be experts who are in the forefront of these important policy innovations, including David Ellwood (Harvard University), Judith Gueron (Manpower Demonstrations Research Corporation), Robert Greenstein (Center on Budget and Policy Priorities), Larry Bartlett (Health Systems Research, Inc.), and David Riemer (City of Milwaukee).

Further details will be available from Steven Gold or Tony Hutchison at (303)623-7800. ■

Medicaid (conclusion)

greater than 12 percent increases (the national average) in their Medicaid programs, only three states (Illinois, Ohio and Oklahoma) are currently spending more than the national average. For the 10 states with below average Medicaid expenditures, proponents of expansion can continue to argue that budget effort, not affordability, is the key issue.

But with the average state budget reserve standing at 4.5 percent in mid-1989 (below the recommended level of 5 percent), few states were in a position to fund expensive expansions. In the 10 states that spend below the national average on Medicaid as a percent of their general budget (Alabama, Arkansas, Iowa Missouri, Montana, South Carolina, South Dakota, Vermont, Virginia, and Wyoming) the average surplus was 4.2 percent, including a healthy 17.1 percent reserve in Montana. Without Montana the average would be 2.8 percent. Of the ten states spending below the national average on Medicaid, only Virginia has a per capita income above the national average. In general, the states that would be hit hardest by the mandated expansions would be the states least able to afford it.

Nor is it reasonable to expect all states to be able to absorb the Medicaid budget increases that would have been forced on them, ranging from 12.6 percent (the national average) to 49.5 percent increase (the high in Alabama). Arkansas' 1991 bill for Medicaid for the proposed mandates was $29.5 million, or roughly equivalent to 60 percent of that state's entire corrections budget, an area of state expenditure growing at an even faster rate than Medicaid. In the state of Virginia, the proposed mandates would have cost 6.5 percent of that state's K-12 education budget and 13 percent of its higher education budget.

Conclusion

While an improved national health policy makes good sense, it makes no sense for Congress to mandate one that states cannot afford. Policies that were adopted by the U.S. House of Representatives in 1989, attractive as their beneficial effects would have been, could have completely disrupted budget policies in a number of states. The policy of using unfunded federal mandates to express national policy holds disastrous potential for the states. The desirability of a policy should not be allowed to hide the question of who pays, or state budgets will collapse into chaos just like the federal government has. ■

advertising sections

The New England Journal of Medicine

Established in 1812 as The NEW ENGLAND JOURNAL OF MEDICINE AND SURGERY

VOLUME 322 | FEBRUARY 22, 1990 | NUMBER 8

Original Articles

Successful Allogeneic Transplantation of T-Cell–Depleted Bone Marrow from Closely HLA-Matched Unrelated Donors 485
R.C. Ash and Others

A Randomized Trial of Surgery in the Treatment of Single Metastases to the Brain 494
R.A. Patchell, P.A. Tibbs, J.W. Walsh, R.J. Dempsey, Y. Maruyama, R.J. Kryscio, W.R. Markesbery, J.S. Macdonald, and B. Young

Increase in Glomerular Filtration Rate in Patients with Insulin-Dependent Diabetes and Elevated Erythrocyte Sodium–Lithium Countertransport............ 500
S. Carr, J.-C. Mbanya, T. Thomas, P. Keavey, R. Taylor, K.G.M.M. Alberti, and R. Wilkinson

Staphylococcus aureus Nasal Carriage and Infection in Patients on Continuous Ambulatory Peritoneal Dialysis 505
M.A. Luzar, G.A. Coles, B. Faller, A. Slingeneyer, G. Dah Dah, C. Briat, C. Wone, Y. Knefati, M. Kessler, and F. Peluso

Mechanisms of Disease

T-Lymphocyte–Antigen Interactions in Transplant Rejection 510
A.M. Krensky, A. Weiss, G. Crabtree, M.M. Davis, and P. Parham

Medical Intelligence

Drug Therapy: Propafenone 518
C. Funck-Brentano, H.K. Kroemer, J.T. Lee, and D.M. Roden

Genetic Linkage of a Polymorphism in the Type II Procollagen Gene (COL2A1) to Primary Osteoarthritis Associated with Mild Chondrodysplasia 526
R.G. Knowlton, P.L. Katzenstein, R.W. Moskowitz, E.J. Weaver, C.J. Malemud, M.N. Pathria, S.A. Jimenez, and D.J. Prockop

Case Records of the Massachusetts General Hospital

A 45-Year-Old Woman with Hodgkin's Disease and a Neurologic Disorder............................ 531
H.R. Jones, Jr., and E.P. Richardson, Jr.

Editorial

Surgery for Metastases to the Brain........ 544
J.B. Posner

Sounding Board

The Doctor–Nurse Game Revisited 546
L.I. Stein, D.T. Watts, and T. Howell

Correspondence

The Ethics of Liver Transplantation from a Living Donor................................ 549
Nonresponse to Hepatitis B Vaccine........... 550
Autosomal Dominant Spondyloarthropathy: No Linkage to the Type II Collagen Gene 552
Reduction of Nosocomial Infection during Pediatric Intensive Care by Protective Isolation............................. 553
Can Maternal Alcoholism Cause Spasmus Nutans in Offspring?......................... 554
Inappropriate Secretion of Vasopressin in Patients with Hypopituitarism 554
A Caution about the Use of MRI to Diagnose Spinal Cord Compression 556
Relations between Physicians and Pharmaceutical Companies: Where to Draw the Line 557
Fast-Food Fare 557

Book Reviews 558

Notices 561

Health Policy Report

[illegible] 562
J.K. Iglehart

Owned, Published, and ©Copyrighted, 1990, by the Massachusetts Medical Society

The New England Journal of Medicine (ISSN 0028-4793) is published weekly from editorial offices at 10 Shattuck Street, Boston, MA 02115-6094. Subscription price: $79.00 per year. Second-class postage paid at Boston and at additional mailing offices.
POSTMASTER: Send address changes to P.O. Box 803, Waltham, MA 02254-0803

AESTHETIC SURGERY OF THE FACE

The symposium will take place in San Francisco, March 23 and 24.
Contact Extended Programs in Med. Educ., Univ. of California, Rm. C-124, San Francisco, CA 94143-0742; or call (415) 476-4151.

UNIVERSITY OF LOUISVILLE-OPHTHALMOLOGY

The "18th C. Dwight Townes Seminar" will be held in Louisville, Ky., on March 24.
Contact Nancy Rodman, 301 E. Muhammad Ali Blvd., Louisville, KY 40202; or call (502) 588-5466.

MOUNT SINAI SCHOOL OF MEDICINE

A course, entitled "Modern Management of Malignant Melanoma," will be held in New York on March 24.
Contact Virginia Harrison, Post-Grad. School, Box 1193, Mount Sinai School of Med., 1 Gustave Levy Pl., New York, NY 10021; or call (212) 241-6737.

INTERVENTIONAL RADIOLOGY

The 15th annual meeting will take place in Miami Beach, Fla., March 26–29.
Contact Soc. of Cardiovascular and Interventional Radiology, 1891 Preston White Dr., Reston, VA 22091; or call (703) 648-8953.

TEMPORAL BONE DISSECTION

The course will be offered in New York, March 26–30.
Contact New York Univ. Medical Center, Post-Grad. Medical School, 550 First Ave., New York, NY 10016; or call (212) 340-5295.

HEALTH POLICY REPORT

CANADA'S HEALTH CARE SYSTEM FACES ITS PROBLEMS

JOHN K. IGLEHART

CANADA'S provincial health insurance plans have demonstrated an impressive capacity to operate successfully despite a basic policy conflict that says health care funding must be public and universal, physicians must retain their professional autonomy, consumers must have free choice of doctors and first-dollar coverage, and provincial governments must control their budgets. But now provinces are finding it increasingly difficult to maintain this equation, because a variety of factors are perturbing its balance. In the face of a large budget deficit, the national government continues to reduce its financial commitment to the plans, patients and practitioners are demanding better access to the latest forms of medical technology, the supply of physicians continues to increase at a rate outstripping the growth of the population, and doctors are restive as provinces work more aggressively to stem the rise in health expenditures.

Among industrialized nations, such conflicts are certainly not unique. Indeed, every major Western country grapples with similar issues to one degree or another. But when tax-financed programs in most nations are stretched to the limit, their stewards usually turn to private funding for relief. What is unique to Canada is the virtual absence of private-sector involvement in health insurance and the unwillingness of policy makers to encourage the development of such alternatives, which could ease the financial pressure on the provincial health plans. These plans account for 75 percent of the nation's total expenditure for medical care, which amounted to $50.4 billion (Canadian) in 1988, or 8.7 percent of the gross domestic product. The remainder of the health expenditure purchases services not covered by the plans, such as outpatient prescription drugs, dental care, cosmetic surgery, optometry, and physiotherapy.

Canada designed its provincial health insurance plans this way because of a strong belief that all citizens should have equal access to medical care, regardless of ability to pay. In essence, Canadian policy says that simply because people can afford to pay, they should not be able to purchase care that is better or more readily available than that available to the less well off. Canada has further discouraged private payment by requiring physicians who bill patients directly to leave the provincial health insurance plans altogether. As a result, such doctors are few.

Canada's refusal to allow private health insurance to be sold, except for incidental items not covered by the provincial plans, arises from "deep-rooted suspicion of class-based systems of any kind," economist Robert G. Evans wrote recently.[1] Private schools are only a small part of Canada's educational system before college, private universities do not exist, and in public transportation only a single class of travel is usually available, except in some air and train travel. As Evans put it, "equality before the health care system" in Canada is a political principle similar to equality before the law.

This policy contrasts markedly with the method by which the bulk of care is financed in the pluralistic system of the United States and is contrary to the direction in which the socialized health schemes of Sweden and the United Kingdom are moving. Most U.S. policy makers and representatives of private-sector interests believe that except in the case of poor people, consumers should be directly responsible for a portion of the cost of care. The board of trustees of the American Medical Association (AMA), in a 1989 report to its House of Delegates about Canadian health care, characterized the absence of a direct economic link between payer and patient in the provincial health plans as "a structural defect which leads directly to an excessive demand for services, and will be a growing source of conflict between government and consumers."[2]

Whether Canada, faced with a budget deficit, general opposition to higher taxes, and real resistance to reducing the scope of covered medical benefits, can maintain a health care policy that relies on public expenditures and strongly discourages the infusion of private resources is a question asked more frequently there. At this point there is certainly no clamor for major change among private corporations; they seem well satisfied with letting government finance the bulk of medical care and limiting their involvement to pay-

ing for part of it through taxation.[3] The Progressive Conservative government of Prime Minister Brian Mulroney has shown no disposition to propose that Canadian medical care be made more readily available through private alternatives, but in other spheres of the economy it has demonstrated a philosophical preference for private investment. For example, 18 crown corporations have been privatized since Mulroney assumed office in 1984. Thus far, Canada has been able to finance its system of universal access to health care by constraining medical expenditures in various ways, as Evans outlined recently in the *Journal*: keeping its insurance overhead low through the administrative simplicity of its provincial plans, controlling payments to physicians and hospitals through negotiated fees and global budgets, and restraining the diffusion of forms of technology.[4]

In this report, I cover some of the major issues that are enlivening Canada's health care debate, particularly as they apply to Ontario, which is the most populous province (with 9 million residents), the seat of the nation's capital (Ottawa), and the place where the largest number of physicians practice (about 40 percent). For a variety of reasons, conflict between provincial governments and organized medicine is more pronounced in Ontario, British Columbia, and Quebec than in the seven other provinces. As I have pointed out elsewhere,[2] some American health policy makers have become fascinated with Canada's ability to balance a host of conflicting interests and objectives on behalf of the provision of medical care to its entire population. These cross-national pursuits are not necessarily welcomed by many physicians in either country. The AMA has made it clear that philosophically, Canada's model is repugnant to its leadership and probably most of its members. Dr. David K. Peachey, director of professional affairs of the Ontario Medical Association, provided a Canadian perspective on the subject in a speech last October to the Roanoke (Va.) Academy of Medicine: "The managed care component of American medicine is being held like a Damocles' sword over the heads of Canadian physicians, while our universal health insurance is held like a Damocles' sword over you."

The Principles of Canadian Health Insurance

Canada's debate has not prompted many second thoughts about the basic conditions that Parliament established in 1965 when it created the framework of the provincial health insurance plans. To qualify for federal support, the plans must provide universal access to care with equal terms and conditions for all, cover all medically necessary services as determined by physicians, provide portable benefits (those that are in effect throughout the country), and be publicly administered on a nonprofit basis. The insured services of physicians include all medically required services rendered by licensed practitioners in hospitals, clinics, and doctors' offices. The insured services of hospitals include all inpatient services provided at the standard ward level, unless private or semiprivate accommodation is considered medically necessary, and all necessary drugs, biologic products, supplies, and diagnostic tests, as well as a broad range of outpatient services. The services of psychiatrists and mental hospitals are fully covered. There are no upper limits to the provision of care, as long as it is deemed medically necessary.

Despite Canada's universal coverage, the life expectancy of its citizens continues to vary according to income, although the disparity has decreased over the past 15 years. All industrialized countries report a similar phenomenon, underscoring the fact that life expectancy is derived from a variety of factors, including wealth, lifestyle, social policy, and access to medical care. In 1971, the difference in life expectancy at birth between earners of the highest and lowest incomes in Canada was 6.3 years for men, and 2.8 years for women. By 1986, according to a new study produced by the government, these differences had decreased to 5.6 years for men and 1.9 years for women.[5]

In sharp contrast to the United States, where the federal government holds far more authority over the financing of medical care than the states, Canadian health care is dominated by the provinces. The provincial medical associations are more influential than the Canadian Medical Association. In both domains, governmental and professional, the provincial entities strive to guard their prerogatives. The provinces have a broad constitutional authority to tax their citizens and private corporations. In consequence, they spend more in total tax revenues than the national government. Increasingly, the proportion (ranging from one fifth to one third) of tax revenues expended by the provinces is consumed by the provincial health insurance plans.

When Parliament established the conditions for the financing of Canadian medical care, government prohibited private insurers from paying for care already covered by the provincial plans. Thus, all funding for covered services flows through the provincial plans, which wield their monopsony powers (power of one buyer) to constrain expenditures. In this regard, the contrast with the United States is obvious, but as Evans recently pointed out, the comparison with the United Kingdom is more instructive.[1] The British National Health Service (NHS) is a public program, funded from tax revenue, and accessible to all. But if they so choose, people can seek care from a private system, to which about 8 percent of England's citizens have access — usually through their employers — as a way to avoid queues and receive care provided with more amenities.

In most Canadian provinces, it is not prohibited for patients to pay privately for medical or hospital care. What is prohibited is for physicians or hospitals to treat both patients whose care is financed by the provincial plans and patients who pay directly, as is the case in Britain. Evans views this prohibition as a critically important constraint. He writes:

The British private consultant can use his dual role to select and steer patients according to their resources and the nature of their problems. He can even use his position within the NHS to manipulate waiting lists and other aspects of access so as to ensure that private care will be preferable to those who can afford it. The Canadian physician who decides to "go private" must go all the way. He cannot use a strategic position within the public system to cream off only the profitable patients for his private services.[1]

Canada's capacity to protect all its citizens against the economic consequences of illness at a cost that is socially acceptable has been widely admired, but its resistance to private funding makes it an exception in the Western world. Even in Sweden, a generous welfare state and one of the world's most highly taxed nations, the governing Social Democrats are promoting health care alternatives in the private sector and lower taxes. Kjell-Olof Feldt, Sweden's minister of finance and a leading advocate of private-sector alternatives to the nation's welfare state, said recently: "The squeeze in funds for the public sector has forced people to think in new ways."[6]

At both the national and the provincial levels, Canada's medical associations have been cautious in advocating multiple-source funding out of concern that such a stance would be seen more as promoting their members' self-interest than as bringing financial relief to the stressed provincial plans. One outspoken physician, Dr. John O'Brien-Bell, did express this view in 1989 in his farewell speech as president of the Canadian Medical Association. He said, "In a country that now spends 35 cents of every [tax] dollar servicing its debt, we have to ask ourselves whether we can maintain our high standards of health care without any involvement from the private sector." O'Brien-Bell suggested that an infusion of private resources would allow the provinces to raise "sorely needed" revenues to finance the strong patient demand for service.

Canada's Struggle over Conflicting Imperatives

As I suggested at the outset, Canada's provincial health insurance plans face an increasing financial struggle because of the conflicting imperatives built into them at their creation. One source of tension is the moderation of support for the plans from the national government. As medical costs escalated in the 1970s, Ottawa concluded that it would have to abandon its practice of making an open-ended financial contribution to the plans. The original formula by which the provinces were encouraged to create their plans was based on an agreement that no matter how rapidly medical expenditures grew, Ottawa and the provinces would share the costs equally. This formula was incorporated into the Hospital Insurance and Diagnostic Services Act of 1957 and again in the Medical Care Act of 1971 -- the original federal laws on which the provincial plans were based.

Since 1977, through the enactment of the Federal–Provincial Fiscal Arrangements and Established Programs Act, the provincial governments have been placed at higher risk for increases in the cost of medical care. This change came about because the 1977 law linked the annual increase in the federal contribution to the provincial health insurance plans to the growth of the gross national product, leaving the provinces to absorb more of the health care costs when the aggregate outlays for health grew faster than the economy as a whole; health costs have increased more rapidly than the growth of Canada's economy in 8 of the past 13 years.

In 1986 and again in 1989, as Mulroney's government has sought to reduce an annual budget deficit of $30.5 billion (Canadian) on federal tax revenues of $112.4 billion, the Progressive Conservatives have altered the formula for the federal transfer of funds in ways that reduce the growth of Ottawa's contribution to the provincial plans (as well as to the costs of post-secondary education). Instead of a transfer formula based on the growth rate of a three-year running average of the gross national product, the formula is now based on this same prescription minus 3 percentage points of the gross national product. In the years 1987, 1988, and 1989, Canada's gross national product grew at rates of 9.4 percent, 9.2 percent, and 7.1 percent, respectively. The 3 percentage point reduction may seem small, but its cumulative effect on the provincial health budgets will amount to billions of dollars by the early 1990s.

To illustrate, data from Health and Welfare Canada show that Ottawa provided 44.6 percent of the total revenues of $14.1 billion expended by the provincial health insurance plans in fiscal 1979 and 1980. A decade later, Health and Welfare Canada estimates that the provincial plans will spend $39.2 billion in 1989 and 1990, only 36.7 percent of which will have been provided by the national government. In future years, officials in Ottawa anticipate that federal transfers, as a proportion of provincial health expenditures, will drop to percentages in the low 30s, although the precise projections are kept confidential. This trend, buried in the minutiae of federal–provincial transfer payments, has provoked little opposition from the provincial governments or the medical profession, although it is certain to intensify pressures on the health insurance plans.

One of the interesting aspects of Canadian health care is that the public is remarkably uninvolved in the ongoing struggles over resource allocation that pit the provincial governments against providers of care. An official of the Ontario Medical Association characterized this conflict as "tuxedo warfare," and with good reason. As political scientists would say, it engages the "elite" interest of government and medicine. Except for the occasional consumer who encounters an obstacle in obtaining access to care, the average citizen is not concerned about allocations of medical resources because government has insulated citizens time and again from worrying about the rising cost of care. Although Canadians pay the bill through general taxation (and in addition residents of Alberta and British Columbia pay legislated monthly premiums), the relation between the financing of care and the citizens to whom it is delivered is not tightly drawn, because pa-

tients do not pay at the point of service. Effective January 1, Ontario's provincial government abolished monthly premiums, which had been paid in roughly equal amounts by workers and employers, in favor of a payroll tax strictly on employers. In so doing it reinforced its policy that all possible obstacles to access should be removed. The income from premiums totaled about 13 percent of the current annual expenditure of $13.9 billion by the Ontario plan. One consequence of the overriding preference of policy makers to insulate consumers from paying for care directly is that the level of public support for the provincial plans remains very high. For example, a survey conducted in December 1987 for the Ontario Medical Association of attitudes toward the health care system in Ontario found that the vast majority of people (87 percent) were "very" (39 percent) or "somewhat" (48 percent) satisfied.

The outstanding recent example of government's commitment to safeguard unlimited access by patients to medical care came in 1984, when Parliament unanimously approved the Canada Health Act. In essence, this measure forced the provinces to ban the practice of extra billing by physicians (the charging of fees to patients in excess of those allowed by the provincial benefit schedule) and the practice of hospitals' charging fees directly to inpatients. Over the strong opposition of organized medicine, every province enacted legislation implementing the ban, because a failure to do so would have meant the loss of federal grants, dollar for dollar, in proportion to the amount of extra billing and user fees imposed on patients by providers. In Ontario, the provincial legislature's action provoked the longest strike by physicians in the nation's history — 25 days — and ruptured relations between the provincial government and the Ontario Medical Association, which characterized the new policy as a "mortal attack on our professional freedom." The passions stirred by the strike were not altogether matched by the actions of the province's physicians; most continued to treat their patients, as data compiled by the provincial plan show. The numbers of bills submitted to the plan by physicians during the strike (from June 12 through July 6, 1986), expressed as a percentage of the average billing for each day of the week from May 1 through July 31, were: Sunday, 93.5 percent; Monday, 69.0 percent; Tuesday, 76.1 percent; Wednesday, 82.0 percent; Thursday, 82.4 percent; Friday, 80.1 percent; and Saturday, 88.1 percent.

Constraining the Diffusion of Medical Technology

An important feature of Canada's approach to hospital budgeting is the separation of operating expenses and capital spending. Every year, Canada's 1243 hospitals (all but 9 of which are nonprofit institutions) must negotiate their annual operating budgets with the provincial government. They must apply separately for the approval and funding of new capital acquisitions. Thus, the provincial ministries have two major levers with which to control hospital growth. In some instances, hospitals raise private funds for new technological services through contributions from the community and philanthropic donors, but if an acquisition has not previously been approved by the government, the provincial plans often deny the necessary operating funds.

Through this process, the provincial plans have successfully contained the growth of hospital resources, including labor, supplies, and equipment. In three separate studies, Detsky and colleagues have documented the success of this strategy as applied by the Ontario Health Insurance Plan.[7-9] A central feature of the strategy, used by all the provincial plans, is to distribute forms of medical technology according to region in a fashion that compels physicians to judge carefully which patients would profit from their use. Virtually all the most sophisticated forms of technology are diffused in teaching hospitals only. One consequence of this effort to restrain the use of modern techniques is that such techniques are far less available in Canada than in the United States. For example, a recent study by Rublee showed that in comparison with the Federal Republic of Germany and the United States, Canada has appreciably slowed the diffusion of six major forms of technology: open-heart surgery, cardiac catheterization, organ transplantation, radiation therapy, extracorporeal shock-wave lithotripsy, and magnetic resonance imaging (MRI).[10] Key comparisons between Canada and the United States reveal that there are nearly eight times more MRI and radiation-therapy units per capita in the United States, more than six times as many lithotripsy centers, roughly three times as many cardiac catheterization and open-heart surgery units, and slightly more organ transplantation units. Rublee, a researcher affiliated with the AMA, conceded that "the differences in levels of major technology, in themselves, indicate little about the overall effectiveness, achievements, and weaknesses of the health care systems of any of the three countries studied."[10]

For the visitor to Canada, the growing conflict over the availability of technology is most readily seen in the newspaper articles and televised news accounts that report obstacles to the system's vaunted access to care, usually in a hospital setting. As the provincial plans restrain the use of technology, physicians increasingly face the difficult choice of providing care on the basis of medical need rather than rendering it to all who could benefit. Some forms of technology are more valuable than others, as is the case in all countries, but most have not been subjected to clinical trials. Recognizing the need for more information, in early December the federal, provincial, and territorial health ministers announced the creation of a Canadian Coordinating Office for Health Technology Assessment.

The prime illustration of the problems provincial plans and providers are encountering in their efforts to match available resources with an effective system of triaging patients was provided by the case of Charles Coleman, a 63-year-old man who died shortly after a

heart operation in a Toronto hospital. Coleman's operation had been postponed 11 times. *Maclean's*, a Canadian weekly magazine, ran a cover story[11] about the case that provoked the Ontario Health Insurance Plan to investigate the cardiac-surgery program at St. Michael's Hospital in Toronto.

The three investigators identified various problems at St. Michael's and eight other Ontario teaching hospitals that offer adult cardiac-surgery programs for the province's 9 million citizens.[12] The team found a substantial increase in the length of the waiting lists and of the wait for cardiac surgery at St. Michael's; the number of patients waiting had increased from 38 in 1984 to 232 by 1989, and the wait had increased from two to three weeks to three to five months. These trends were consistent with conditions in other Toronto-area hospitals; in the same period, the total number of patients waiting increased from 356 in 1984 to 848 by 1989, and the length of the wait increased from two to three weeks to three to nine months. Although the waiting lists have grown, the number of cardiovascular surgical procedures performed at St. Michael's and some of the other hospitals began to decline in 1986. The number of cardiac surgeons performing operations has remained about the same.

A number of problems combined to lengthen the waiting lists and times and reduce the total number of cases that could be accommodated, the investigators found. An older patient population (the average age increased from 51 to 61 over the past decade) requiring longer hospitalizations was having cardiac operations and staying longer in the intensive care unit; a pronounced shortage of nurses trained in cardiac care forced a closure of beds in the cardiovascular ward, which in turn reduced the number of planned discharges from intensive care; and new methods of treating patients who have had heart attacks increased the number of patients requiring cardiac catheterization and ultimately cardiac surgery. Dr. Martin Barkin, the deputy minister of health, commented in an interview:

> We clearly did fall behind on cardiovascular surgery, and we're now quickly moving to bring that back up to standard. But that was not a deliberate withholding of funding because we wanted to have a queue there, it's because we couldn't respond fast enough to certain changes in practice patterns.[13]

Barkin's comment points up one aspect of a planned health care system. Although it has a greater capacity at first for rational allocation of resources, its strictly planned nature inhibits needed adjustments as circumstances change. Since the circumstances of Coleman's death triggered action, Ontario's health ministry has appointed a coordinator of cardiovascular services for the province, approved additional funding to expand the capacity of St. Michael's Hospital, and created Toronto's fourth cardiovascular-surgery unit as Sunnybrook Medical Centre — a project that had been planned for almost a decade. But these actions have not alleviated the problem totally. The head of St. Michael's cardiovascular division, Dr. Tom Salerno, put it simply in a recent telephone interview: "In reality, we are still going through a lot of hardship."

Because of the problems Canadians have had in gaining rapid access to some services (cardiac care, lithotripsy, radiotherapy, and renal dialysis), there has been an assumption, reinforced by news coverage, that patients in increasing numbers are turning for treatment to American medical facilities across the border. These reports were discussed last summer by the Pepper Commission in a meeting partly devoted to a review of Canadian health care. Representative Willis D. Gradison, Jr. (R-Ohio), asked the committee's staff members to investigate the reports. They surveyed 10 institutions — Buffalo General Hospital, the Cleveland Clinic, the Detroit Medical Center, Henry Ford Hospital, Johns Hopkins Medical Center, Massachusetts General Hospital, the Mayo Clinic, the Memorial Sloan-Kettering Cancer Center, the University of Rochester Medical Center, and the University of Washington Medical Center. Only two of the institutions provided evidence that they had treated a substantial number of Canadians. Buffalo General reported that 3 percent of its patients were Canadian and that 50 of the 100 patients receiving monthly lithotripsy treatments were doing so under a formal agreement with the province of Ontario. The University of Washington Medical Center reported that 125 of the 250 in vitro fertilization procedures it performed annually involved Canadians, who paid about $5,000 out of pocket for each procedure. On the basis of these findings, the commission's staff reported to Gradison on August 10 that there was "no evidence that substantial numbers of Canadians are seeking care at American medical centers." In the vast number of cases, Canadians normally travel only to medical institutions adjacent to the border for treatment, so the survey was somewhat skewed because of the inclusion of hospitals located farther away. More recently, patients in western Ontario who have needed cardiac surgery have been sent to St. John's Hospital in Detroit under an agreement initiated by physicians in Windsor, Ontario, and accepted by the provincial health insurance plan.

Supply and Incomes of Physicians

In 1986, I noted that most Western nations have a common problem of public policy: they are training more physicians than they seem prepared to accommodate, but few have decided how many physicians are enough.[14] That is certainly the case in Canada, where neither the federal nor the provincial government, organized medicine, nor the Association of Canadian Medical Colleges has adopted a definitive policy on the matter. In its most recent comment on the subject, in 1989, the Canadian Medical Association declared cautiously that it was "committed to working with governments, the medical profession, hospital associations and other parties" to strike "the best balance of physician resources to realize the objective of improving health status."[15]

The pool of Canadian physicians has grown faster than the population every year since 1965, and medicine remains an attractive profession despite the problems doctors encounter. The number of physicians leaving Canada each year, presumably to practice elsewhere, has decreased from 663 in 1978 to 386 in 1985; more stringent U.S. immigration policies may influence this trend. For each of the 1759 first-year positions filled by students in Canada's 16 medical schools in the academic year 1988–1989, there was an average of four applicants, as compared with a ratio of 1:1.6 in the United States. Eva Ryten, director of the Office of Research and Information Services of the Association of Canadian Medical Colleges, said in an interview: "On average, we have a more able applicant pool today than we had a decade ago. So medical schools are rejecting more highly qualified applicants now." There were 7124 medical school students (44.4 percent of whom were women) enrolled in Canadian universities in 1988–1989, as compared with 7492 in the peak year of 1982–1983. The total number of postdoctoral residency training positions in Canadian teaching hospitals has remained largely stable (7621 in 1989, as compared with 7633 in 1985 and 6870 in 1981), although more positions (an increase from 625 in 1981 to 1262 in 1989) are being funded by sources other than the health ministries (internal funds of the medical faculties, foreign governments, charitable foundations, and organizations established to combat a single disease), particularly in Ontario. This development saves the health ministries some money, but it does not alter the number of new doctors being produced.

As of December 1988, there were 49,706 active civilian physicians, excluding interns and residents, as compared with 35,432 a decade earlier and 25,656 in 1970. The population per practicing physician has declined over this period, from 837 in 1970 to 525 in December 1988; it ranges from a high of 766 people per physician in New Brunswick to a low of 490 in British Columbia and Quebec. In sharp contrast to the United States, where the number of primary care physicians is dwindling in proportion to the total supply, general and family practitioners represent 52.5 percent of all doctors in Canada; in most of Canada's urban areas, the demand for general practitioners is saturated. The medical specialties generally deemed to be in short supply are general surgery, psychiatry, medical and radiation oncology, and neonatology and the other pediatric subspecialties. In 1987, 16.8 percent of all practicing Canadian physicians were women. The rapidly increasing numbers of women will influence the availability of care, because in that same year male generalist physicians reported working 49.1 hours per week, and their female counterparts 38.6 hours. Male medical specialists reported working 50.1 hours per week in 1987, and their female counterparts 43.6 hours.

There are various reasons that medicine remains, on balance, an attractive profession in Canada. One is that physicians are held in high esteem even though their public image has diminished a bit over the years. Another reason is that because the 16 medical schools are public, university-based institutions, they are subsidized heavily by the federal and provincial governments. In 1988–1989, medical students paid school fees ranging from approximately $750 a year in Quebec to $3,000 a year in British Columbia. Thus, very few Canadian medical students begin their professional careers heavily in debt, in contrast to students in the United States.

Another important reason for the continued appeal of medicine as a career is that despite the growing number of practicing doctors, physicians remain Canada's highest paid professionals, according to the reports of the Department of National Health and Welfare last October, based on taxation data from Revenue Canada. Expressed in U.S. dollars, the average net income of physicians was $84,700 in 1987, as compared with $70,800 for dentists, $63,500 for lawyers and notaries, and $49,300 for accountants. A decade ago, the corresponding figures were $41,500 for physicians, $35,500 for dentists, $34,200 for lawyers and notaries, and $29,400 for accountants. For the sake of comparison, I asked the Center for Health Policy Research of the AMA how U.S. physicians' incomes compared with those of other professional groups. Although no precisely comparable survey was available, the data showed that U.S. physicians in private practice earned an average net income of $132,300 in 1987. Dentists in independent private practice earned an average of $88,000 in the same year, according to the American Dental Association. The Bureau of Labor Statistics reported that lawyers working in the private sector had an average net income of $57,300, whereas those working in firms with two or more attorneys earned an average of $120,000.[16] The average income of men over the age of 25 working full-time who have had four years of college was $40,962.

Ontario's physicians are the highest-paid practitioners in Canada, on average. Table 1 compares their incomes with those of doctors in the United States, according to specialty. As the number of Canadian physicians has increased, the number of services they have provided to their patients has risen even more rapidly. This development has prompted 5 of Canada's 10 provinces — British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec — to incorporate some method of accounting for increases in the use of services into their negotiations with the provincial medical associations about fee schedules.[17]

On the other hand, physicians themselves are less concerned about the effect of their increasing numbers on the financial accounts of the provincial plans than about what they regard as governments' contradictory efforts to squeeze spending while promoting universal access. Concern over the current trends has been expressed by physicians in academic medicine and organized medicine, as well as by individual practitioners who do not participate in medical politics. Dr.

Table 1. Average Practice Expenses and Net Incomes of Self-Employed Physicians in Ontario and the United States in 1986, According to Specialty.*

Specialty	Ontario		United States	
	Expenses	Income	Expenses	Income
	thousands of U.S. dollars			
General practice	54.6	78.6	119.9†	84.3†
Family practice	54.9	74.7		
Internal medicine	57.3	121.9	110.5	118.6
Anesthesia	24.4	106.4	96.7	160.6
Psychiatry	35.0	91.0	46.7	98.3
Pediatrics	63.9	103.4	93.2	90.8
General surgery	63.3	109.7	112.3	152.8
Orthopedic surgery	68.4	130.4	210.3	212.8
Urology	28.2	136.1	125.5	136.6
Ophthalmology	90.6	116.4	152.3	163.5
Otolaryngology	80.2	132.5	159.6	154.2
Obstetrics and gynecology	75.7	114.9	149.5	144.5
Pathology	100.0	106.1	67.8	177.8

*The sources of these data are the Ontario Medical Association, which bases its data on information provided by Revenue Canada, and the American Medical Association's Socioeconomic Monitoring System. Income figures for Ontario are based on data for physicians whose income is derived solely from self-employment. U.S. physicians cited are nonfederal patient care practitioners.

†Figures for general practice and family practice are combined in the AMA data.

Frederick H. Lowy, a professor of psychiatry at the University of Toronto and former dean of its faculty of medicine, who recently chaired the Pharmaceutical Inquiry of Ontario, a commission established by the Ontario Ministry of Health to study the rapid rise in the cost of prescription drugs, summarized the sentiment in an interview:

> My physician colleagues are increasingly dissatisfied. Medical incomes are really quite good, that's not the central problem. It is more psychological. Physicians feel they are being increasingly conscripted by administrators and government. The cost containment methods allow government to negotiate from great strength. The playing field is quite unequal. There are significant restrictions on the availability of technology and hospital beds. Physicians are being asked to make unusual sacrifices compared to other segments of society.

A survey in 1989 of 608 physicians randomly selected from all parts of Ontario, conducted for the Ontario Medical Association, agreed with Lowy's view. When the physicians were asked whether they approved of the provincial government's handling of rising costs, 94 percent said they disapproved, and only 3 percent approved. Half the physicians polled said that they were finding it increasingly difficult to have patients admitted to hospitals; in Ontario, hospitals have an average occupancy rate of 90 percent.

Conclusion

In 1986, I reported that Canada's provincial health insurance plans resembled a pressure cooker building up steam on a hot stove.[18] Three and a half years later, the analogy holds, but the heat has been turned up. Canada's health care system is buffeted by conflicting forces — its strong commitment to universal access, of which Canadians are justifiably proud; the accelerating efforts of the provinces to control costs while they continue to expand the scope of covered benefits; and the increasing frustration of practicing physicians and hospital stewards who are caught in the middle. Until recently, these tensions have remained within manageable bounds throughout Canada, but whether that will continue, without a new accommodation, particularly if the national economy slows, is an open question. Most of the provinces have created blue-ribbon working groups in the past several years to seek solutions to identified problems, and these exercises have eased some of the tension temporarily. But it seems inevitable that Canada will eventually reopen the question of how care is financed. The provinces will jeopardize their capacity to support other social priorities if they continue to rely on tax revenues to finance unlimited access to most health services, and to produce more physicians than can be accommodated. At the same time, private investment could endanger the egalitarian nature of Canadian health care. Revising the current formulation of policy will require a more meaningful dialogue than exists at present among the federal and provincial governments, organized medicine, and other major stakeholders in the system. Without such dialogue, Canadians place at risk the future of their provincial health insurance plans, social enterprises that are admired throughout the Western world. The medical profession faces an additional challenge: to examine more rigorously the appropriateness and efficacy of the clinical care it renders.[19]

References

1. Evans RG. "We'll take care of it for you" health care in the Canadian community. Daedalus 1988; 117(4):155-89.
2. Iglehart JK. The United States looks at Canadian health care. N Engl J Med 1989; 321:1767-72.
3. Doherty K. Is the Canadian system as good as it looks for employers? Bus Health 1989; 7(7):31-4.
4. Evans RG, Lomas J, Barer ML, et al. Controlling health expenditures — the Canadian reality. N Engl J Med 1989; 320:571-7.
5. Wilkins R, Adams O, Brancker A. Changes in mortality by income in urban Canada from 1971 to 1986: findings of a joint study undertaken by the Policy, Communications and Information branch, Health and Welfare Canada, and the Canadian Centre for Health Information, Statistics Canada, 1989.
6. Greenhouse S. Sweden's social democrats veer toward free market and lower taxes. New York Times. October 27, 1989:A3.
7. Detsky AS, Stacey SR, Bombardier C. The effectiveness of a regulatory strategy in containing hospital costs: the Ontario experience, 1967-1981. N Engl J Med 1983; 309:151-9.
8. Detsky AS, Abrams HB, Ladha L, Stacey SR. Global budgeting and the teaching hospital in Ontario. Med Care 1986; 24(1):89-94.
9. Detsky AS, O'Rourke K, Naylor CD, Stacey SR, Kitchens JM. Containing Ontario's hospital costs under universal insurance in the 1980s: what was the record? Can Med Assoc J (in press).
10. Rublee DA. Medical technology in Canada, Germany, and the United States. Health Aff (Millwood) 1989; 8(3):178-81.
11. The crisis in health care: sick to death. Maclean's. February 13, 1989:32-5.
12. Kaminski VL, Sibbald WJ, Davis EM. Investigation of cardiac surgery at St. Michael's Hospital, Toronto, Ontario: final report, 1989.
13. Kosterlitz J. Taking care of Canada. Natl J 1989; 21(28):1792-7.
14. Iglehart JK. Canada's health care system: addressing the problem of physician supply. N Engl J Med 1986; 315:1623-8.
15. Canadian physician resources: report of the Canadian Medical Association committee on physician resources, August 21, 1989.
16. The 1989 survey of law firm economics. Ardmore, Pa.: Altman and Weil Management Consultants, 1989.
17. Lomas J, Fooks C, Rice T, Labelle RJ. Paying physicians in Canada. Health Aff (Millwood) 1989; 8(1):80-102.
18. Iglehart JK. Canada's health care system. N Engl J Med 1986; 315:202-8.
19. Linton AL, Peachey DK. Utilization management: a medical responsibility. Can Med Assoc J 1989; 141:283-6.

Alaska State Medical Association

4107 Laurel Street   Anchorage, Alaska 99508   (907) 562-2662   (Fax) 561-2063

Dr. John Kitzhaber, an Oregon physician and current president of the Oregon State Senate offers a clear and cogent presentation on the issue of uncompensated care in America. I have taken the liberty of paraphrasing his comments and urge you to read them thoroughly. It speaks to an issue that we in the health industry are just now beginning to understand, and it points out the need for greater dialogue between provider and legislator in order to address a critical social problem.

Let me begin by stating to you that unequivocally the most serious threat facing the health industry today is uncompensated care. If left unresolved, it will erode the health of our society and in turn will lead to an erosion of the clinical autonomy of physicians and other providers. It will also undermine some of the very principles on which our health care system has been built and will lead to increased regulation of the practice of medicine and probably to a government controlled health care delivery system.

To understand the threat and challenge it poses, we must first consider the evolution of our American health care system. Our health care system was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer. We were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered and the cost was merely shifted to someone who could pay through an incremental increase in their bill or in their insurance premium.

This policy was no accident, but was the result of conscious decisions in both the public and private sector. In the public sector, we enacted Medicare and Medicaid in 1986 extending coverage to the poor and the elderly. At the same time, we had a rapid expansion of private policies funded primarily through employment. This rapid growth of third-party insurance coverage led to the belief that health care for the poor in this country was free, when in fact it being subsidized primarily by the government and by the business community. We created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they wanted or needed. Physicians could practice pure medicine, viewing their patients primarily from their health needs without concerning themselves over income. But this system also led to, and encouraged utilization. It led to the deeply held social belief in this country that health care is a right. That resulted, understandably, in a dramatic increase in

expenditures. The amount we spent on health care grew from $75 billion in 1980 to nearly $500 billion in 1988 and it still continues to grow. An more telling, is the growth of health care expenditure as a percent of the Gross National Product. We spent 7.4 cents on the dollar in 1970 and we spend about 12 cents today. If this rate continues, by the turn of the century we will be spending 20 percent of the Gross National Product on health care, and by about 2020, we will be spending 40 cents out of every dollar on health care.

This, of course, will not happen. It makes a great deal of sense in terms of a social policy, but makes little sense in terms of an economic policy. No single set of expenditures can grow at a rate faster than the growth of the Gross National Product.

The prosperity we have enjoyed in the lst 20 years has allowed us to absorb these rapid increases and has masked the underlying fallacy of the way we finance health care in this country. A number of factors occurred that have brought our ideal health care system into collision with economic realities. New medical technologies were being developed and being used because there was no financial restraint on the system, and at a tremendous cost. Secondly, the population was aging. There has been a significant increase in the elderly as a percent of the population, and they use more health care services. They have a larger incidence of chronic diseases, both of which increase the financial strain on the system. These factors brought the people who had been traditionally subsidizing the cost of health care for the poor, the business community and the government, to a position where they had to reevaluate their willingness to continue to do that. The economic stagnation that we experienced at the beginning of this decade could no longer absorb the rapid increases in the cost of health care. Our annual productivity growth was 3% a year in the sixties and seventies, but fell to half a percent a year by 1979, and was actually negative in the early eighties.

Our federal budget deficit increased from about $73 to $211 billion in five years. We liquidated all our foreign assets and became the largest debtor nation in the world. The government in the first part of this decade recognized that they could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit or making deep cuts in other domestic programs. At the same time, this country entered the world market. We began recognizing [illegible] were not competing just among ourselves like the auto industry once [illegible], but were competing with mainland China, West Germany, Japan, etc. They realized that cutting costs, particularly labor-related costs, had to be done in order to remain competitive with cheap labor industries abroad. They couldn't pass the cost of health care on to their consumers and still remain competitive; particularly when American business has to carry the cost of health care on the books as necessary expense and are competing with countries that do not carry health care as a cost, because they have nationalized health care programs.

The business community now became interested in cost containment in order to remain competitive. The government became interested in cost containment to balance the budget. The object of business and government was simply to reduce the exposure to the cost shift, and to reduce their funding and subsidy of the cost to care for the poor. The subsidy was not taken out of the system, it was merely shifted on to individuals and

providers. How did they do it?

In 1983, the federal government enacted the DR'G's, which is a prospective reimbursement system that shifted economic risk on to providers. They began requiring first-day hospital deductible for Medicare, increases in the Part B monthly Medicare premium. This shifted costs on to the individuals. With Medicaid, the program for the poor, they cut their match rate and shifted that to the states. The first thing the states did was cut provider reimbursement rates, so that now we get 45 to 50 cents on the dollar for taking care of someone on welfare. That pushed costs and responsibility to the individuals. We have had 800,000 women and children squeezed off Medicaid in the last ten years. That program, which used to cover 65 percent of the poor, now covers less than 38 percent of the poor.

The private sector reacted exactly in the same way with an increased involvement in HMO's, PPO's, and other prospective managed care plans that put the providers at risk. They increased co-payments and deductible for their employees then shifted costs on to individuals. The important thing to remember is that cost containment reflected absolutely no social policy beyond cutting costs for the government and the business community. There was recognition that the amount of health care that could be spent on the poor was limited. There was no consideration of the implications of those decisions on access to health care. They reduced the funding in the system, but didn't reduce what the public expected from the system.

Today we find ourselves in a situation of transition. We are still ostensibly committed to the principle of universal access; but now the system is driven by economic factors, not by the social factors that drove it in the Sixties and Seventies. Providers are now at economic risk, and we are losing our ability to cost shift.

Our ability to deliver on the concept of universal access has depended on cost shifting and the willingness of business and government to subsidize the cost of care for the poor. But what we are seeing today, while we are still supposedly committed to universal access, is a progressive shifting of the responsibility to pick up that cost. Remember that between 1965 and 1980 that subsidy was borne by government and business which spread it out over taxpayers in general. So society was paying for the social responsibility to have universal access in this country.

Because of the cost containment measures that have occurred, the subsidy has now been shifted to providers. Physicians have far less ability to absorb this shift and what formerly was subsidized care for the poor is now showing up as uncompensated care. As physicians reach a point where they can't absorb additional uncompensated care and still pay the bills, they push the costs on to individuals. So today, if you don't have insurance coverage or money, you are increasingly likely to lose access to the health car system - either because the provider won't take in any additional indigent patients, or you delay treatment because you are afraid you can't afford it.

This has changed how we finance health care in this country. Our health care system now has a bifurcated financing mechanism. On one side

is the public system, which is Medicare and Medicaid; and on the other side is the private system which is mostly employment based policies and some individual policies. There has always been a little gap in between where some people slip through the cracks. But as long as government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and has really contained only society's truly downtrodden.

Today as those two-third party payers are trying to escape from the subsidy, we've seen a reduction in government expenditures, co-payments and deductible in Medicare and increases for Medicaid eligibility, so people spill of the public side into that gap. As competition in the world market increases, we shift from a manufacturing to a service based economy with large numbers of low paid, non-unionized workers without health insurance coverage, and as premium rates continue to climb, people spill off the private side into that gap. Today that gap is no longer narrow, it has 37 to 40 million Americans in it. They are no longer just society's downtrodden. Seventy percent of those people are working full time or part time or are dependents of someone who is working. But it's those in that gap that are generating 75 percent of the uncompensated care. Why should we be concerned about this? Because there are some serious consequences in the shifting of responsibility to pay for the care of the poor, and there are some social and professional consequences that affect providers.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. Since market systems were not designed to foster social responsibility, it shouldn't be surprising that no one is competing for the poor. Public health clinics are closing and we are seeing patient dumping from hospital to hospital, physician to hospital and between physicians. There are treatment delays and a growing number of people in the gap.

That leads to the second consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two-thirds of those mothers do not receive adequate prenatal care. Forty percent of the poor in America are children and only one-third of them are covered by Medicaid, the other two-thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in pertussis and pediatric nutritional problems. There is case after case of people actually dying because of lack of access to the system. People are dying from strokes because they couldn't get in to get their blood pressure medication refilled. People are dying of heart failure and having MI's because of lack of routine checkups. People are dying of perforated ulcers because of treatment delays.

The third consequence is that we are mortgaging our own future. Remember, that 40 percent of the poor in this country are children, and two-thirds of them are in the gap. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we're expecting to fuel the economy and pay for

a growing retired population. How are we going to do that in the face of $170 billion owed to foreign governments and nearly a three trillion dollar national debt; a ten trillion dollars unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security and federal pensions, most of which are automatically indexed and have no income eligibility requirements. What we're asking these people to do is be more productive than any other generation. We are asking them to do something that we have all refused to do, and that is recognize that increases in personal consumption have to be balanced with increases in productivity.

In the last ten years, American workers have averaged a $3200 increase per capita in personal consumption and only $950 of that has been paid for by increases in what each one produces. The remaining $2200 has been paid for by cuts in domestic spending and investment and by foreign debt. We are asking this group of people to be more productive than anyone in the history of this country, and probably take a reduction in their standard of living. Having asked them that, we are crippling them going in by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is health and well educated. This is a very, very serious implication.

There are also some disturbing professional implications. The first is the growing problem of uncompensated care that is catching physicians and providers between what society expects from our health care system, and economic realities. When the government and the business community move to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals, and they could do so without publicly or explicitly abandoning the idea of universal access, because they shifted that subsidy on to the providers. But when physicians move to limit their exposure to this for exactly the same reasons, they have to deny access to individuals. When a physician reaches a point where he or she cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring. That puts physicians in direct conflict not only their professional ethics, but with social expectations for the health care system. It casts them in a very unfavorable light as many people still view physicians as they were in the halcyon days of the 1960's or 1970's, when the economy was booming and incomes were rising. Most physicians do not understand the relationship between cost shifting and subsidizing care for the poor, and they don't understand the implications of taking cost shifting away from providers. The thought that a wealthy profession would be denying access to the poor is unacceptable to them. It puts them in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react and they are going to say: If physicians are not going to take care of the poor voluntarily, we are going to force you to do that. There are a lot of ways that are designed to force physicians to assume the responsibility for taking care of the poor, but they ignore the fact that society, while paying lip serve to universal access, has

made a decision to limit the amount of money that they're going to spend on it. When someone convinces corporate America that a government sponsored health care program will put them in a better position in terms of competition in the world market; then we will be looking at a nationalized health care program. But in the short run, we are looking at increased regulation, reduction, and erosion in physician clinical autonomy.

What can we do about this problem? To solve this crisis in uncompensated care, we have got to start by accepting three very hard realities. The first reality is that resources are limited and that's a difficult reality. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars. As we said, we have a national debt approaching three trillion dollars that must be reduced. We have a huge defense budget that has been traditionally hard to pare down, and we spend $450 billion a year on Medicare, Social Security and other federal pensions. At the same time, we are cutting aid to education, we are also cutting investments in road, sewers, and infrastructure; and civilian research and development. All of those things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut, but at the same time, we want to reduce government spending. We want good road and schools, safe streets, criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, clean water; and we want to do all that, of course, with lower taxes and higher wages.

Obviously that doesn't work. There is a finite amount of money that this country can invest in health care versus the other things we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality. The rich are always going to have access to more health care than the poor. That's all right if what the poor get is adequate and if they're all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis of income, not necessarily on need or merit. We readily accept that in most instances. We don't expect public housing to look like the Ritz and we don't expect food stamps to be redeemed in very expensive restaurants. But because of our system, our concept of universal access, we take for granted that the poor should have access to all the health care services that are available to the rich.

This is the only part of our system that operates on this open-ended economic principle. What we've done is reject a multi-tiered system based on income. But actually we already have that kind of a system in place. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available near home. They have had consultations and elective surgeries that the poor have not had access to. We would all agree that everyone should have a right to prenatal care. You may argue whether or not the public should pay for a face lift electively for everybody on welfare, but it becomes much more difficult when you are trying to balance a transplant versus prenatal care.

What we need is a better defir·'ion of adequate health care to address that question. If we know resources are limited, if we know people with high incomes can buy more health care than people of lower incomes, and if we know that society can't buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get, that means the definition of adequate health care.

That brings us to the last reality, the inevitability of rationing. T s is very difficult for physicians and providers to come to terms with. But when you define adequate health care, you also define what's more than adequate. That lads to the basis for explicit rationing of health care. I suggest that rationing already exists in our system. We ration by income and transportation barriers. But more importantly, we ration through a lack of any policy to guide how we spend our health care dollars. We ration inadvertently by legislative decision. If we have a limited amount of money in the health care budget and you spend it on one thing, it`s not available to be spent on something else.

Consider how we are doing this today. We spend almost $2000 per capita on health care in America. That is more than any other country in the world and yet our wellness as measured by morbidity and mortality statistics is not significantly higher than in England, which spends half as much, or even Singapore which spends a fourth as much. Why is that? Because we have no policy to guide how we spend our health care dollars. We are spending huge sums on some and none on others. We spend more per capita than any country in the world, yet 37 million Americans have no coverage and many of them are losing access to the system. We spend three billion dollars a year on neonatal intensive care while we're denying prenatal care to hundreds of thousands. We spend $50 billion a year on people in the last six months of their lives, while we are closing pediatric clinics. That's like having someone in charge of a truck fleet for your corporation who adopts a policy that he won't change the oil in the trucks until the blocks melt. You certainly wouldn't hire that guy to work for you. But that's exactly how we spend health care dollars in this country. We don't spend it on prenatal care, we spend it on neonatal intensive care. We don't treat hypertension, we treat people who have stroked out. We are rationing by default. It's guided by no social policy and it's not equitable. We are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly as opposed to explicitly is because we don`t want to come to grips with our own limits.

To solve this problem of uncompensated care with of the ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system that is based on the three realities that we've just discussed: limited resources, acceptance of th fact that the rich will always be able to buy more health care than the poor, and that we`re going to have to ration. We have to recommit ourselves to universal access, but not universal access for everyone to everything. Universal access for everyone to an adequate level of health care. This will put our system back on a sound economic foundation, and means we are going to have a three tiered system of delivery in this country. We already have a non-defined sort of implicit multi-tiered system. But this would mean a

government sponsored tier for the poor. It would mean a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services. It's at that bottom tier that we have to come to grips with rationing.

The government has a responsibility to pay for the poor, not for the elderly. The government should pay for the poor regardless of age and there is no reason Lee Iacocca needs Medicare. We should put an income eligibility requirement on it.

It's the bottom tier that we have to come to grips with rationing. It's this tier that we have to set the socially acceptable minimum level of health care for this country, and how do we get there? I suspect there are three elements to resolving this. We must have a clear social policy and we need to define adequate health. Then we need a universal insurance system to insure that people get access to that care. The social policy we had in the Sixties, Seventies, and Eighties, was universal access. One of the reasons we are in trouble today is because we were able to cover everybody for almost everything. But unless you define what it is you're covering people for, you still have an open-ended system that we can't afford. Politically it's far more difficult to deal with the question of adequate health care than to design and politically adopt a posi ion to deal with the universal insurance coverage question.

We must have a clear social policy because we need a framework to guide how we spend those health care dollars in a way that is efficient and equitable. We must make an attempt to recognize our limits and adopt such a policy. Should we discontinue funding for heart, bone marrow and liver transplants for people on welfare or should we take that money and extend it out to buy preventive and prenatal services for a far larger group of people who have been in the gap? The question is not whether transplants have merit. The question is not whether, in the short run, we could find some additional money to buy a few more transplants for people on public assistance. The issue is, does it make more sense and is it a better use of public dollars if we we're going to spend more on health care to buy high tech services for a group of people who already had access to virtually everything in the private sector; or should we extend services to a larger number of people who currently do not have access to any health care whatsoever. Should universal access to adequate health care be the first priority for spending additional dollars?

Once we get a definition of adequate health care and array our health care services on a priority basis, we are changing, in a very fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus. It goes like this: You have one heart and three potential recipients. Do you give that heart to the 17-year-old unwed mother of three on welfare or do you give it to a 40-year-old corporate executive? This raises the kind of imponderable ethical and moral question that society, almost by definition, can't resolve on an individual basis. But when you develop a definition of adequate, and array your health care services in a priority order, you shift that debate from the individual focus to a social focus. You are no longer debating which service should be given or denied to which individual, you are debating which priority funding should be given to

each service, given the reality of limited resources. Society has made the decision to limit the amount of money it's spending on health care. Society needs to make the decisions on how to spend that money. That takes physicians out of the squeeze and they can now continue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. A group of dedicated providers and health experts should break down every dollar spent on health care. A list should be made of the number of people getting the service and the cost; the number of people not getting the service and the economic as well as health implications of not giving them that service; and the cost to extend the service to cover everybody in giving them that service; and then the cost to extend the service to cover everybody in the unmet need population. Arrange this list in a tentative priority order and begin presenting it at town hall meetings where citizens are actually getting involved in working through the trade-offs and choices that are necessary to set up a priority list of health care choices. Bring this information together and generate a final list that will be submitted to the legislature. Once the health care resources are arrayed in that kind of a list, you ;have to integrate it with the budget process. You must, then, require that the funding go to the first item on your priority list for everyone in the population for whom the state has responsibility. You go down and fund the second, third, etc., until you run out of money.

What that does is, put accountability in the system. If our state legislature decided to cut $20 million out of our health care budget, it would not be an abstract accounting exercise. It would mean the deletion of very specific services for very specific individuals off the bottom of the priority list and then the debate becomes far more focused. If you want to come in and refund the transplant program, it's very clear that you either have to knock something else off your priority list - you have to make a choice, a clinical choice and a political choice between those two health services, or you have to rob another program, or raise more money.

The final point with this type of system is that, if it's done on the basis of sound clinical grounds, you can actually save money in the system. A study done in California suggested that the cost of treating a low birth weight infant was $28,000 up to six figures. The study suggested that if you provided that care to all the indigent women who needed it, you could save $22 million a year in your health care system. That's money that can be used to add services on your priority list. It could be used to raise provider reimbursement levels to a reasonable point where people are not trying to avoid dealing with that population.

What is the role of physicians in resolving this problem? The most significant role they plan is to come to grips with their own limits. They have got to recognize that health care resources in America are in fact limited. How can we expect the public to accept the limits or expect state legislatures to recognize the limits if physicians are not willing to recognize them themselves. We are inviting all of the ominous

consequences that uncompensated care is bringing our way. We have to do that as a first item and express that publicly, physicians must discuss it with each other and with their patients.

Secondly, professional organizations need to adopt a policy, a statement on how to expend limited health care dollars. Something that says the first priority is to extend the basic level of health care coverage, and then we can fight about the budget. But to do that, we have to get involved in the definition of "adequate". Physicians are really the only group in this country that have the qualifications to provide sound clinical input to the state legislature. We need to say, yes, we are going to have to ration health care in this country. It's inappropriate and unethical for physicians to do it, society needs to do it. If the legislature is going to ration health care, then offer a list of clinically wise priorities. This makes sense in terms of marginal costs and marginal benefits. We have to provide that input and then support the legislative decisions that make responsible resource allocation decisions. We have to do that publicly, in our community and at the legislative level.

Uncompensated care requires a partnership solution between public policy makers at the state legislative level and leadership in the medical community. If left unresolved, the problem of uncompensated care is going to result in an erosion in our social commitment to universal access, a deterioration of health for a growing number of Americans with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system. This will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We cannot accept this outcome as in the final analysis, physicians are patient advocates.

I hope this will assist your understanding concerning the health care industries dilemma and crystallize societies dilemma as well.

Sincerely,

Ray Schalow
Executive Director

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

HOSPITAL COST CONTAINMENT

A LEGISLATOR'S GUIDE

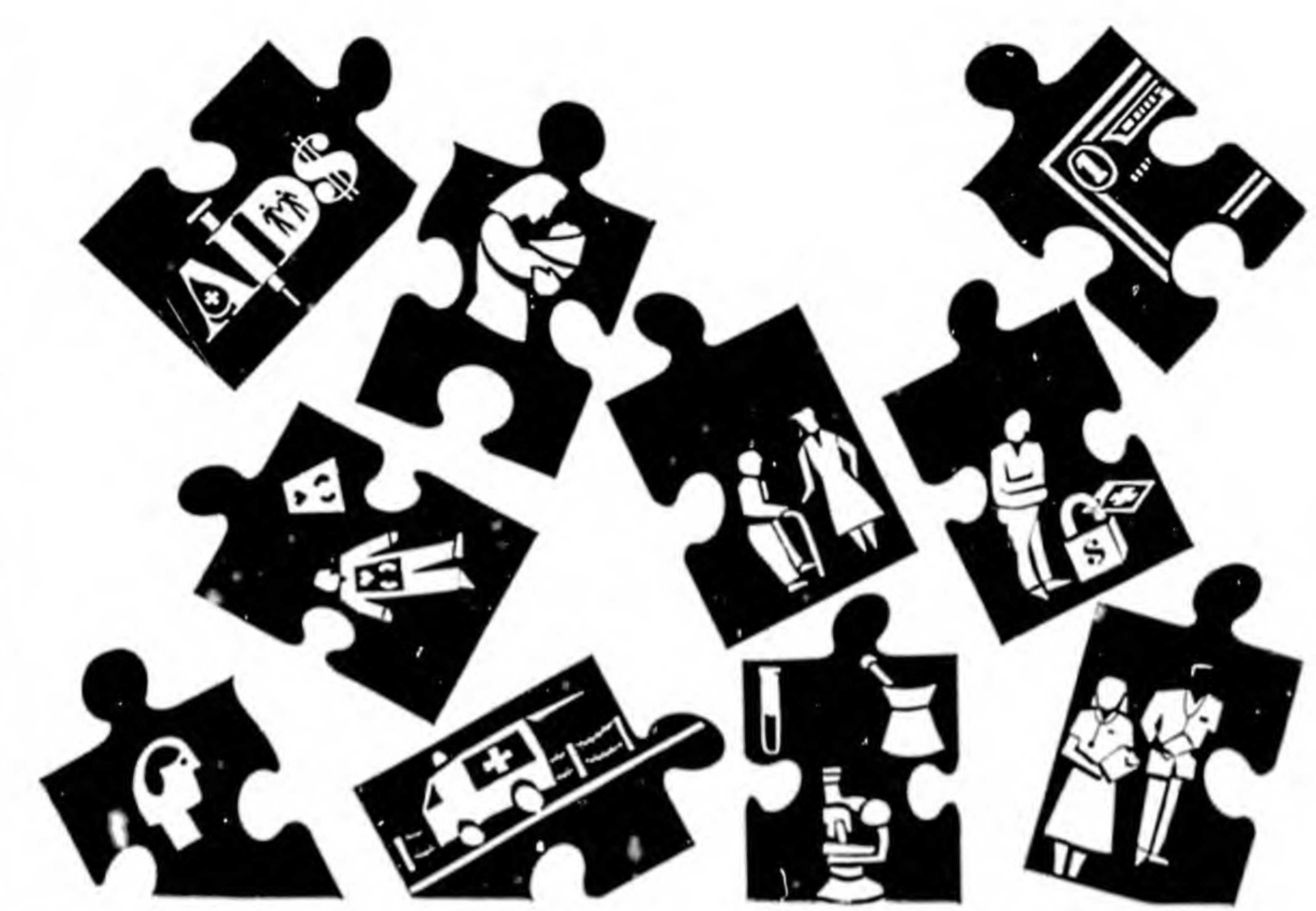
National Conference of State Legislatures

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

1988 Health Care Legislation

Health and Mental Health Program

National Conference of State Legislatures



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

Medical Indigency and Uncompensated Health Care Costs

National Conference of State Legislatures

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

Health Access America

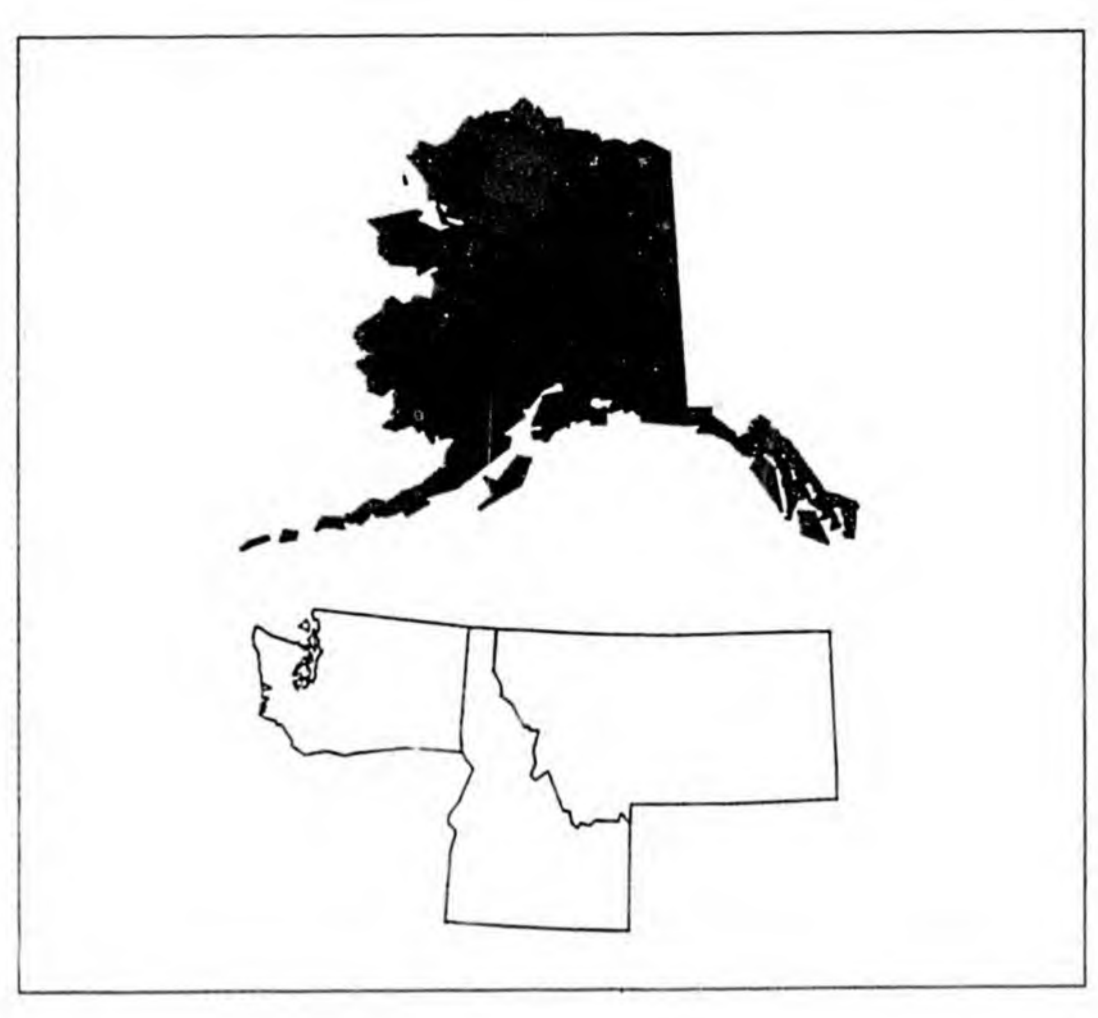
The AMA proposal to improve access to affordable, quality health care

American Medical Association

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

UNIVERSITY OF WASHINGTON

School of Medicine
in
ALASKA



Health Care Costs Containment

HOUSE HESS COMMITTEE

1) CALL MEETING TO ORDER

2) NOTE MONTH/DAY/YEAR Monday, March 20, 1989

3) NOTE TIME:

4) NOTE MEMBERS PRESENT AND EXCUSED

   (For the record, note any late arrivals to the meeting)

5) REMIND PARTICIPANTS TO SIGN WITNESS REGISTER

6) COMMITTEE CALENDAR:

   SB 166: Medicaid Payments to Health Facilities

   Containing the Costs of Health Care in Alaska

7) INTRODUCE WITNESSES

   For the record, ask witnesses to state their name, title and the name of the firm or agency they represent.

   Ask witnesses with written testimony to submit it to the committee secretary.

8) UPCOMING COMMITTEE MEETING SCHEDULE: See attached

9) ANNOUNCE TIME OF ADJOURNMENT

Presentors for the Health Association of Alaska:

Jim Gingerich (Fairbanks Memorial Hospital) - acute care

Dennis Murray (Heritage Place -a nursing home in Soldotna) - long term care

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

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

HOUSE HESS COMMITTEE

Committee Schedule
March 20 - March 24, 1989

(*indicates first public hearing)

HOUSE HESS	Capitol Rm. 106 465-3759 or 60	8:30 a.m. T - W - Th - F

~~Monday, March 20, 1989 8:00 a.m.~~

~~SB 166: Medicaid payments to health facilities~~

~~Containing the Costs of Health Care in Alaska~~

Tuesday, March 21, 1989

Containing the Costs of Health Care in Alaska (Cont'd)

Wednesday, February 22, 1989

Yukon Legislative Assembly Presentation

Report on Disease Outbreaks in Rural Alaska

HB 126: Anabolic steroids as controlled substance

Thursday, March 23, 1989

NO MEETING

Friday, March 24, 1989

NO MEETING

Blue Cross pullout hits home for Redwood City employees

By Shannon Rasmussen
Times Tribune staff

Now that the news has sunk in that Blue Cross of California is canceling its health insurance coverage, Redwood City employees are scrambling to find a comparable plan.

With only about two months before the cancellation becomes effective, city union representatives already have suggested one plan they believe would provide a stable and long-term benefit.

"To us it's extremely serious that Blue Cross is canceling," said Joe Brenner, who represents Local 715 of the Service Employees International Union. "We're absolutely committed to find the best alternative."

Last week, the City Council's Personnel Commission began to look at the request of various city union representatives to contract with the Public Employees Retirement System plan, which offers about 15 different health coverage plans under its umbrella.

However, at issue with the PERS plan is the cost that the city may incur. The plan would require the city to contribute as much money to its retirees' health plans as to its active employees' plans, according to officials.

Currently, retirees who were hired before 1983 and who participate in the city's health coverage plans receive $270 per month toward health coverage — equal to the city's monthly contribution to plans for active employees.

But the city does not pick up insurance costs for employees hired after 1983 who retire.

In some cases, such as the city's Kaiser plan, the $270 buys the maximum coverage of $232.91 per month for an employee with two or more dependents.

Another consideration is that PERS may raise its monthly premium rate to more than $400 for a family, said Jim Irizarry, director of human resources.

"We're trying to work with our employee organizations," Irizarry said. "We're sympathetic to this crisis."

Employees currently may choose to join health plans under Bay Pacific, Kaiser and the Association of Bay Area Governments.

For city employee Molly Spore-Alhadef, PERS would be an answer to the problems she faces.

Her husband sees a number of specialists, many who aren't covered under her current Association of Bay Area Governments health plan.

She was with Blue Cross for 10 years, until a year ago when the rates became too costly.

Alhadef recently had considered returning to Blue Cross, but now does not have that choice. Now she says PERS is her best bet.

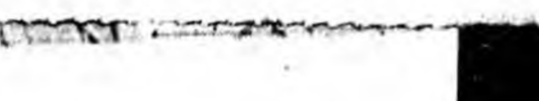
"We are stuck," she said. "For those of us affected this is a big crisis. Health care is such a personal thing."

When Blue Cross could not get 50 percent of the city's employees to participate in its plans, it notified the city it would withdraw effective May 1.

Christine Sullivan, public relations specialist with Blue Cross, said it is standard practice within the insurance industr 'o cancel when membership falls below 50 percent. The reason, she said, is that a larger client pool spreads the risk and ensures a balance between premium costs and claims costs.

Several Peninsula cities and

Please see PULLOUT, A-4



PULLOUT

Continued from A-3

school districts who have Blue Cross coverage reported they have received no indication they may face a similar situation.

In Menlo Park, however, a city official said the city did not renew its coverage with Blue Cross last year because of the increase in premiums and because not enough people were participating.

Sandy Salerno, finance director in Belmont, said in July the city joined the PERS plan rather than stick with Blue Cross partly because of imposed rate increases.

Redwood City's cancellation followed an initial notice that the company would raise its rates between 52 percent and 57 percent for its Fee for Service and Prudent Buyer plans.

The increase would have resulted in a monthly charge to the city's Blue Cross customers of between $392 to $502 per month, depending on the type of coverage.

As of last month, 108 of the city's 456 employees were enrolled in Blue Cross. Of 172 retirees, 66 were enrolled in the plan.

On the Peninsula and across the nation, municipalities have been hit with rate increases as the cost of health care escalates, said Armand Bengle, vice president of Alexander & Alexander Consulting Group, an employee benefits consulting firm in San Francisco.

Many municipalities, such as Redwood City, contribute a set amount per month toward employees' premiums, which also may affect which plan an employee chooses, Bengle explained.

If a company cannot get 50 percent participation, the costs are spread among a smaller number of people and at a greater risk to the company, Bengle said.

Based on other reports and trends, health care officials speculate that health insurance premiums will continue to jump nationwide.

Redwood City anticipates that its overall health insurance costs could double in the next five years, causing officials to be extra cautious.

That increase could mean spending $3.4 million per year for employees and another $700,000 per year for retirees in Redwood City.

Prior to the cancellation, Blue Cross had presented a proposal to Redwood City requiring the city to replace its Bay Pacific health plan with Blue Cross' California Care Health Maintenance Organization.

But city employee representatives were not interested in that proposal, and the city cannot require employees to join one plan over another, Irizarry said.

CRITICAL OBJECTIVES
FACING 1989 ALASKA LEGISLATURE

OBJECTIVE	ACTION
1. MODERATE COST EXPANSION OF STATE EMPLOYEE BENEFIT PROGRAM.	
2. PROVIDE FINANCIAL ACCESS TO SERVICES TO PEOPLE WHO CAN NO LONGER AFFORD HEALTH INSURANCE.	
3. PAY FAIR AND REASONABLE PRICES FOR MEDICAID SERVICES.	
4. KEEP AND BUILD A STRONGER LOCAL HEALTH CARE STRUCTURE IN EACH ALASKAN COMMUNITY.	
5. CREATE A LOCALLY OWNED STRUCTURE TO MANAGE AND GOVERN HEALTH CARE APPROPRIATE TO ALASKA.	

COMMUNITY CORPORATION

PRIVATE
(YEARS 1 - 3)

SMALL EMPLOYERS
LARGE EMPLOYERS
. SCHOOLS
. BOROUGH
. HOSPITAL
. CHAMPUS/
FEDERAL EMPLOYEES
INDIVIDUALS
. INDIVIDUAL POLICY
. BASIC CARE POLICY

PUBLIC
(YEARS 2 - 5)

MEDICARE
MEDICAID
LABOR & INDUSTRIES
HIGH RISK
UNCOMPENSATED ASSISTANCE

OTHER

LONG-TERM CARE
DENTAL
PUBLIC HEALTH ISSUES

STATE OF ALASKA

WHAT CAN BE DONE TO KEEP BENEFITS AND REDUCE COSTS?

YEAR 1

- IMPLEMENT UTILIZATION REVIEW, INCLUDING DEDUCTIBLE FOR PREAUTHORIZATION
- FOCUS ON INPATIENT AND ALCOHOL, SUBSTANCE AND MENTAL HEALTH
- ANALYZE DATA TO TARGET REVIEW
- DEVELOP EMPLOYEE ASSISTANCE PROGRAM
- EDUCATE EMPLOYEE - NEWSLETTER
- PILOT - OPTIONAL INSURANCE PROGRAM

YEAR 2

- GENERAL BENEFIT MODIFICATIONS
- NEW BASIC PLAN OFFERED AS AN OPTION
- BUY CARE FROM LESS COSTLY PROVIDERS
- FEE SCHEDULE FOR DENTISTS/PHYSICIANS

PRINCIPLES

- Start immediately with the possible
- Understand your data and develop short-term and long-term plan
- Move incrementally
- Offer choices and reward employees for prudent decisions
- Buy strategically - not year to year