ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7396 SENATE HEALTH EDUCATION & SOCIAL SERVICES

FINDINGS CONT.

2. The health care expenditures portion of the State of Alaska budget is the fastest growing component of the whole budget, 385.5 Million in FY 90, and at this pace will exceed 2.0 Billion in FY 95.

3. The number of uninsured residents in Alaska has increased at an alarming rate to a estimated 90,000 uninsured residents, representing 16.5% of the total population in Alaska.

4. The cost of providing health coverage for State employees and their dependents has been reduced and stabilized at $385.00 for FY 90 and 91. This compares favorably with the most recent survey of State's health care premiums that showed only one other state (Arizona) premiums were reduced, and three other State's premiums were held at the 1989 level[3].

5. The survey done by the Task Force revealed :

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[3]Survey of State employee health benefit plans 1990 Martin E Segal Company

DISCUSSION DRAFT

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

RECOMMENDATIONS

The Health Care Cost Containment Task Force has over the last nineteen months reviewed the rapidly increasing costs of health care in Alaska and have identified not one sole culprit but many contributing factors that collectively drive the health care economy in Alaska.

The Task Force has identified the following main contributing factors that should be focused on as a minimum starting point to bring health care expenditures in control for Alaska.

*Low occupancy rates at facilities
*Cost shifting from other programs
*Federal program cost shifting
*Inefficient delivery systems
*Uninsured / underinsured Alaska State residents
*Accessibility of care
*Mandated coverage costs
*Lack of involvement and education for end users
*Lack of current and meaningful data

After evaluating the many contributing factors , the following recommendations are designed to provide long term health care cost management for Alaska.

1.Establish a State Health Insurance Authority that would be responsible for:

A. Establishing and maintaining health care provider payment and utilization schedules taking into consideration geographic,availability, medical necessity and overall cost effectiveness (potentially using an established system as a foundation);

B. Establish a health care procurement and financing pool to maximize purchasing power for;

i State , local gov't and political subdivisions (Voluntary)
ii. Underinsured/uninsured for State residents
iii.Small employers plan

These Pools would be governed by a board and would provide health insurance on the most cost efficient basis.

C Collection and analysis of state health care utilization/cost data, to recognize trends and recommend solutions to the appropriate entity.

.2 Continued monitoring and certifying of facilities.expansion and substantial equipment purchases to assure need and eliminate duplication or unnecessary expense.

3.Promote health awareness, preventative medicine and quality health care for all state residents.

4. Provide health care for the underinsured/uninsured at an affordable premiums.

5. Continue to evaluate the effect of Federal program changes and maximize the use of Federal Funds.

EXHIBIT I

H.C.C.C. TASK FORCE CHART 1

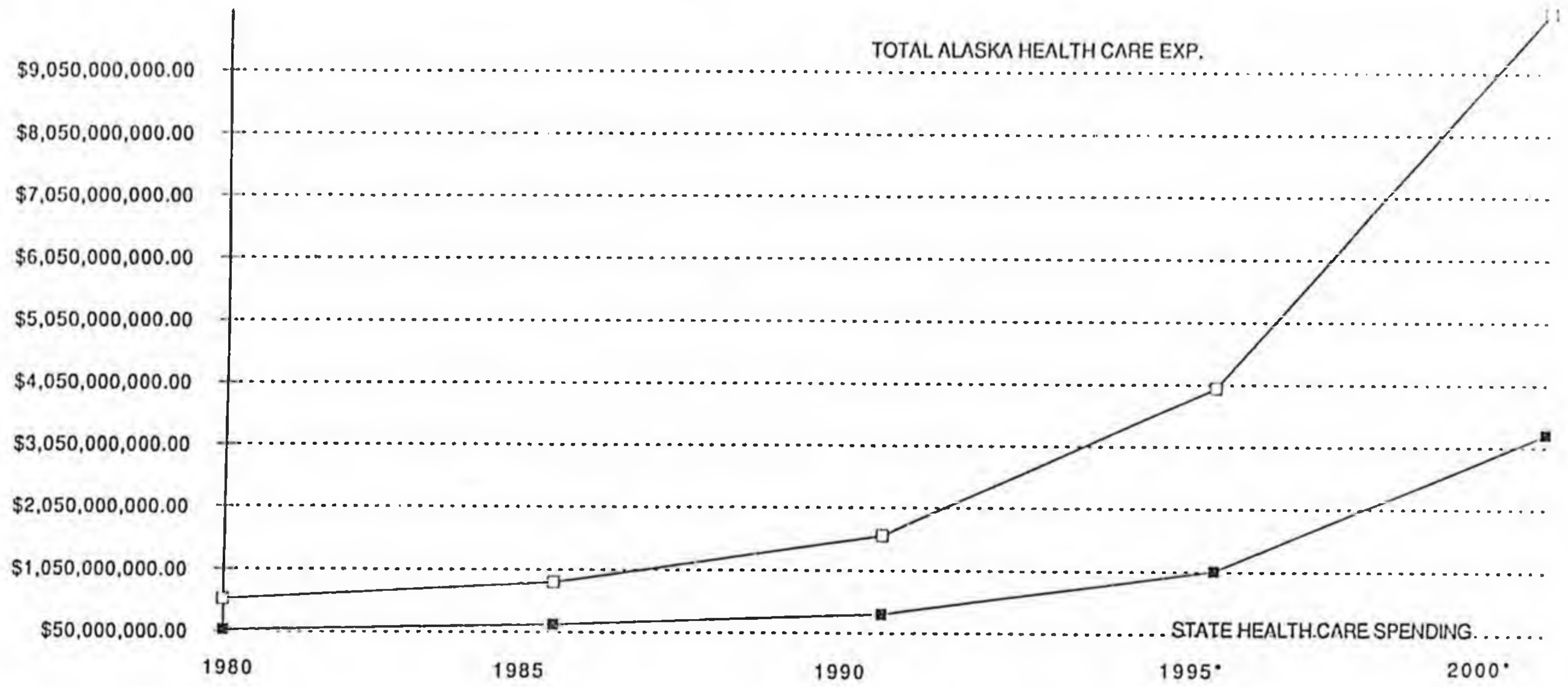
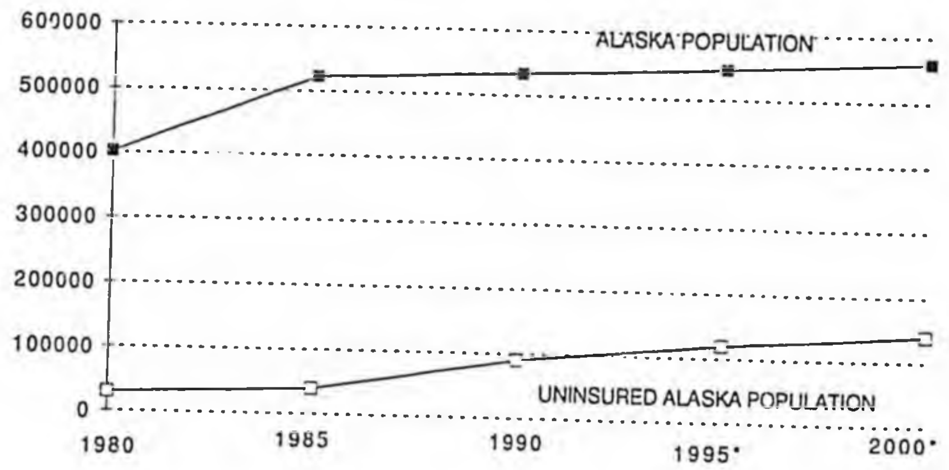
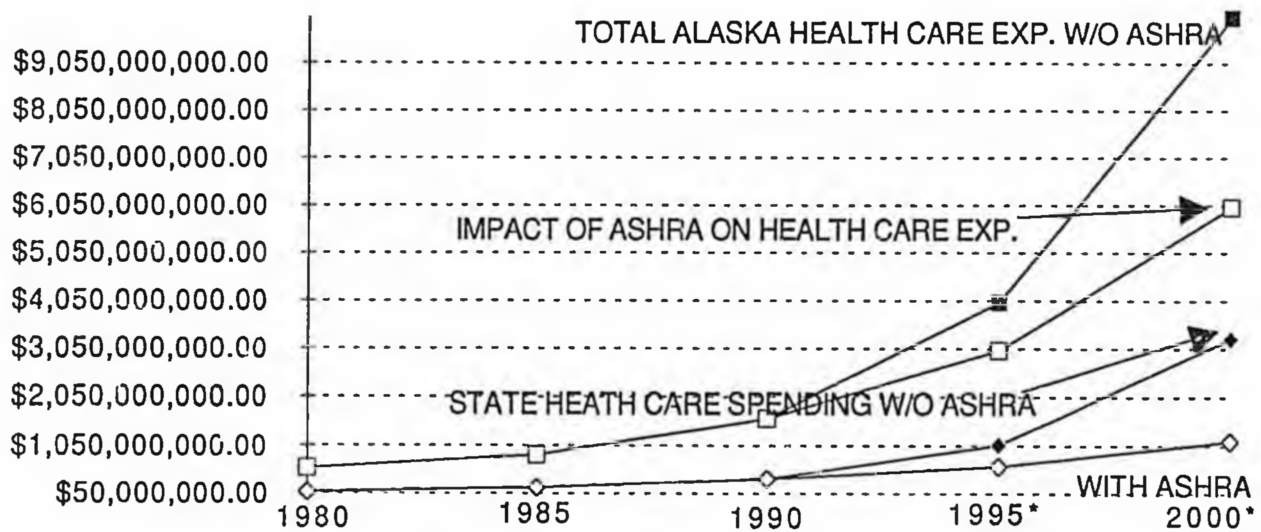


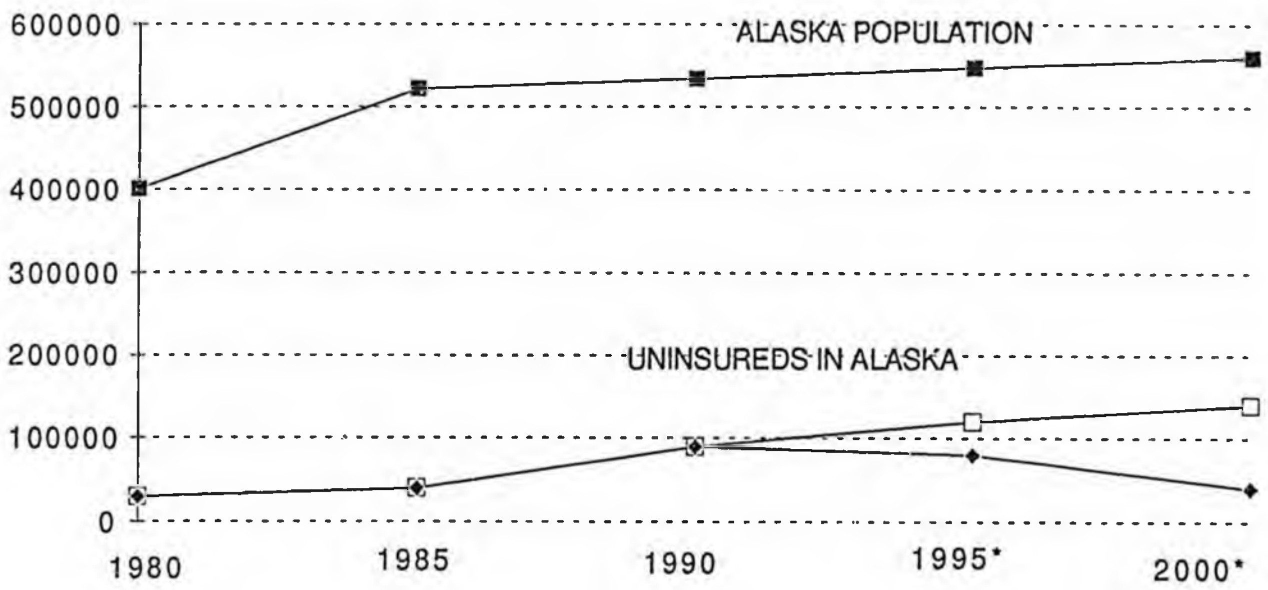
EXHIBIT II



ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA

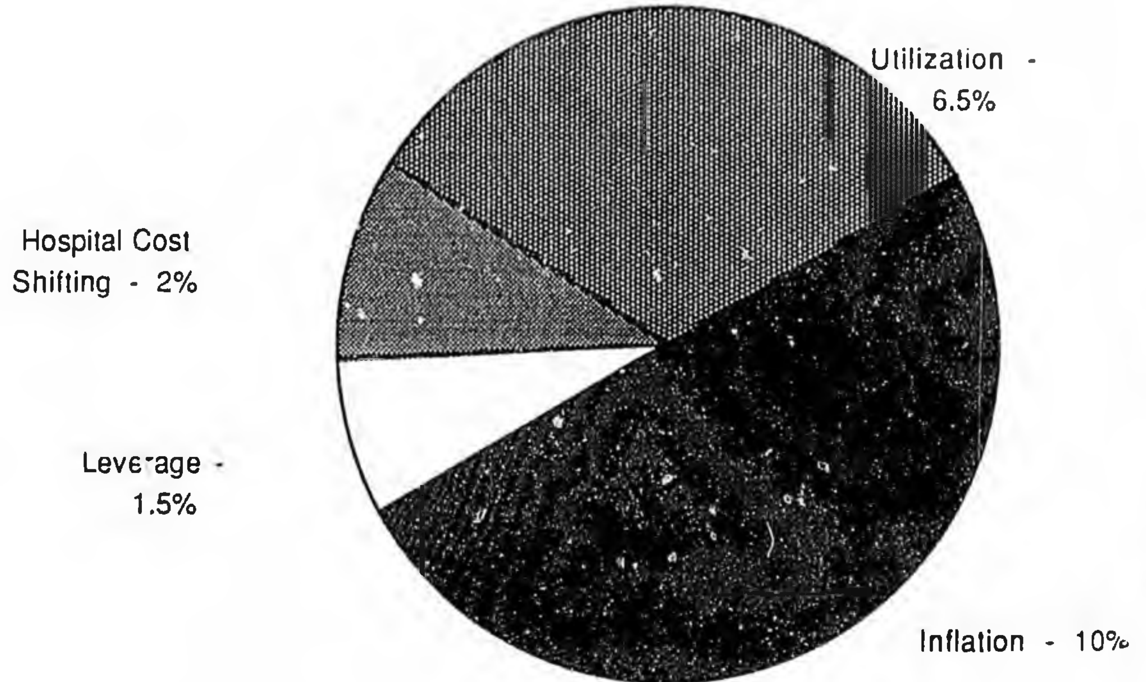


ESTIMATED IMPACT OF ASHRA ON THE UNINSURED IN ALASKA



AETNA

Indemnity Plan - With Healthline
Trend Components
(20% Annual)



Inflation:	Anticipated price increase for established medical services and commodities.
Hospital Cost Shifting:	Additional nonprice related increase in hospital charges to compensate for inadequate Government reimbursement for Medicare/Medicaid patients, lower negotiated rates for PPO's and HMO's, and no payment from the indigent.
Leverage:	Increased portion of medical costs paid by the employer due to the fixed nature of employee copayments.
Utilization:	Projected increase in utilization of services and commodities including the shift to new and more expensive methods of treatment.

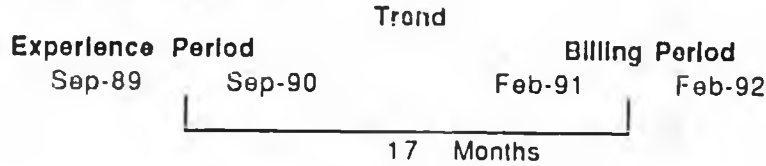
9/21/90

Exhibit J

STATE OF ALASKA

1991 TREND CALCULATION

I. MIDPOINT CALCULATION



II. ANNUAL TREND FACTORS

Coverage	Per Annum Trend %
Comprehensive Medical	20.0%
Comprehensive Dental	11.0%
Prescription Drug	30.0%
Basic Vision	3.0%

III. WEIGHTED TREND COMPONENTS

Actives & SBS I	Per Annum %	Claim %	Weighted Trend
Comprehensive Medical	20.0%	82.9%	16.6%
Comprehensive Dental	11.0%	13.9%	1.5%
Prescription Drug	30.0%	3.2%	1.0%
TOTAL WEIGHTED TREND			19.1%

Retiree D/V/A	Per Annum %	Claim %	Weighted Trend
Comprehensive Dental	11.0%	76.8%	8.4%
Basic Vision	3.0%	23.2%	0.7%
TOTAL WEIGHTED TREND			9.1%

IV. ADJUSTED TREND COMPONENTS

	Weighted Trend	X	Period	X	Loss Ratio	=	Adjusted Trend
Actives & SBS I	19.1%		17/12		75.5%		20.4%
SBS Option II	20.0%		17/12		61.3%		17.4%
Retiree Medical	20.0%		17/12		73.5%		20.8%
Retiree D/V/A	9.1%		17/12		77.0%		10.0%

9/21/90

Exhibit K

STATE OF ALASKA

SUMMARY OF RATES

	CURRENT RATES	EFFECTIVE February 1, 1991
I. ACTIVES		
Medical/Dental	$371.84	$371.84
Vision Service Plan	$12.70	To Be Determined
TOTAL	$384.54	
Employee Supplemental	$18.62	$18.62
Employee & Dependent Supplemental	$50.64	$50.64
II. SUPPLEMENTAL BENEFITS OPTION II		
Employee	$79.38	$79.38
Employee & Family	$194.40	$194.40
III. RETIREE MEDICAL		
Employee & Dependent	$243.98	$243.98
IV. RETIREE DENTAL/VISION /AUDIO		
Retiree	$27.65	$27.65
Retiree & Spouse	$55.30	$55.30
Retiree, Spouse & Child	$77.30	$77.30
Retiree & Child	$49.70	$49.70

LABOR AND COMMERCE
APRIL 15, 1991
SB 83
Prepared by Senator Duncan's Office

PRESENT
Senator Pearce, Chairman Labor and Commerce
Senator Duncan, Prime sponsor of SB 83
Staff from Senator Halford's office

Testimony on Line
Dr. Robert Critteden, Special Assistant to Governor Gardener State of Washington
Mr. John Colmers,Director of the Health Service Cost Review Commission, State of Maryland

Presentation by Dr. Critteden:

Today I would like to comment on three things. One is a little bit about the problems that we face in all states not just in Alaska or Washington. Second is to talk about the experience the State of Washington and lastly I would like to speak briefly to the special framework of SB 83.

Briefly I think all states are having to face the same crisis with the health care system that you are. There is obviously a real cost crisis. We have major barriers to coverage, access, availability of different services, on the state side cost levels are major problems for state government as you know these include employee health care, medicaid, workman's compensation costs. In fact in our state health care costs are eroding a lot of other state priorities.

On the business side interestingly a lot of our businesses are finding erosion in their bottom line. For the large businesses it's now a minor to moderate issue. For our small businesses they are in a crisis as far as I can tell. They have come to us complaining and describing some fairly bad problems. Our labor sector folks and our employed people are extremely

affected at the present time the health benefits are being cut and in fact health benefits are cutting away any wage increases. As you might have heard the National Governor's Association has made health the number one issue this year and that's because this issue is pervasive throughout the country.

In Washington State I would like to comment really on the issue of cost and access. Beginning in about 1987 we took the access issue as our prime issue in the health arena. We put through a thing called the basic health plan which is a state subsidized health insurance program for low income working people. At that time we also put through a program that expands medicaid to cover women and children including special services. We call that our first steps program. Our second step was covering all children below poverty which we paid for with state only money.

After we finished putting all of those together we actually looked at the number of uninsured that we had and we found that in fact the number had increased. In fact our access problems were worse and we were no further ahead and in fact probably were further behind than when we started. The reason for this was the small businesses primarily the ones who are affected by the high cost of health care were slowly but surely decreasing their coverage of their own employees and particularly dependents because of health insurance.

Since that point we have changed our focus dramatically in the state and we still think that access is in the long run what we want to get out of the health care system. Actually what we really want out of the system is group health but access is one way to do that. But we also realize that to achieve that goal we need to create a system that can bring stability back to our health care system that can in fact control the costs that are right now making it unstable and eroding other state priorities. We believe also that we need to have the affected people sitting at the table when we do have some type of goal setting at the table and we feel that people have to make the trade off between what they want vs what they can pay for.

The problem with our current health care system is that we don't have a system and I think that the intent on our part is to move that way. We have put together a number of proposals in the last couple of years to move in that direction. One is we've taken our employee health and formed an authority which now is getting much more aggressive with its purchasing of health care. We have broadened that out to reforming all health care purchasing in the state and we have a proposal which is now in both the House and Senate budgets funding it and we will be moving forward very aggressively in reforming health care purchasing in our state. The third thing we have going on is we have a commission that is looking more broadly at ways we can develop a comprehensive system reform.

SB 83 is similar to a mechanism that has been discussed broadly by a number of people, having to do with bringing the purchasing power and the different elements together to form one integrated purchaser. After reading SB 83 I think it has a lot of similarities to other people's suggestions, it has elements to it that make a lot of sense. There are obviously concerns by a lot of people about whether or not you have some powerful control which would take away from the provider's availability to survive or they would be so disadvantaged. In fact in discussions in our own state with our different provider groups the issue is not whether something like this is going to happen but when.

I think in the long run with health care cost management there will be more and more concentration on ways of becoming better purchasers. The issue is whether the providers themselves can in fact join together on the other side and negotiate as a whole with a very strong entity and I think that that is the only fair thing to do. But I think that eventually we need to have a place where we can rationally allocate resources. I think that there are a lot of elements to this that make some sense.

I will say from my Governor's point of view we certainly take no position on your bill. I think that we are looking at something similar to this as well as other things so it's really a matter of us commenting on the fact that this is a proposal to answer some of the questions and one we are discussing in some general terms in our own state.

I would like to conclude with a couple of quick comments. One is that as far as developing a system up here every other country in this world has done it and I think that from our own broad perspectus we need to start looking at ways of creating a system of care as s opposed to a hodge podge which we have. Of interest to all other countries that have actually done it have better health status, they have helped their workers and are much more competitive than we are. This is an issue that we really have to face. Second issue is the constituencies in health care have changed. In the past we have always been on the advocates and the industry being the insurers and the providers to direct politically the health care policy and I think that now things are changing rapidly and we are finding that the labor, business and public purchaser's are becoming much more interested in health policy and having a larger role. I think they ought to be a central part in any solution that we put forth. That concludes my comments and I look forward to your resolution of this particular bill.

Senator Duncan

Regarding the basic health plan that you folks put together in the State of Washington and your expansion of medicaid etc. That is a subsidized program you have as far as your basic health plan?

Dr. Critteden:

Yes. It is definitely subsidized. The individual pays a premium but the total amount of the premium is about 17% of the total cost of the program so I think it is 83% subsidized.

Sen. Duncan:

Is that available to all individuals in the State, how do people access that plan?

Dr. Critteden:

It is not a statewide program but rather a demonstration program. We have it limited to 25,000 people and in about 6 or 7 communities. The demand far exceeds the supply. And in fact the providers are also very interested in providing when we have more supply available. But it is still preliminary.

Senator Duncan

After this was done and even after you provided access to 25,000 individuals you have still seen the number of uninsured residents of Washington increasing is that correct?

Dr. Critteden:

I would like to say that there is even more than that. We have covered the maximum medicaid expansions available and we have put in our own childrens only program in and after both of those we still found the number of uninsured increasing.

Sen Duncan:

The reason I understood you to say today on the teleconference here was because those who were being covered were dropping off dependents and others, why because of the rising cost or the increasing cost?

Dr. Critteden:

Yes. As far as we can tell that is what the small business people report as the reason they cannot continue coverage.

Sen Duncan:

You mentioned you have a purchasing authority that is being proposed or being put together is that correct?

Dr. Critteden:

It actually is in effect but it is limited to public employees, state employees at the present time. It is there and in fact a central part of our purchasing activity. But it is still limited only to state employees at the present time.

Sen Duncan:

This authority actually goes out and solicits and puts together a plan and solicits coverage from the insurance carriers in the state is that how that works?

Dr. Critteden:

It does it two ways. In the self insurer part half the public employees are covered by our own self insurer which we then have an internal management as well as contract outside for the rest subcontracting, P.P.O. arrangements and pharmacy issues. Half of the patients are covered through contracts with managed care providers, primarily health maintenance organizations.

Sen Duncan:

One final question. It kind of goes with what we have proposed in SB 83 you talked about how you think controlling cost is important and that there seems to be a direction a lot of folks are considering to move to bring purchasers together in one large group. You talked about the question about whether the providers can join together and negotiate for those rates and I think that's an important concept. Have you had any thought or suggestion as to how that might be structured? We have looked at that as we have discussed SB 83 and I think it's important that you have all parties at the table. The difficulty is to find who you should negotiate with for the providers, for the hospitals the doctors. Do you have any suggestions about how that might be structured?

Dr. Critteden:

I think it's a couple of issues. One is whether they can do it, there are those that are concerned with anti trust. Our lawyers are telling us that as long as it is for public good in other words it's stated in state statute that this is something that is for the public good that this is allowed then I don't think it's a problem. The second thing is who should represent them. I think that has to be determined by the providers themselves. The physicians have to determine whatever mechanism they want to and I think that has to be a mutually agreed upon thing. I guess I would probably go to the medical associations say and see if they could do a poll see if they can represent them if they can't legitimately represent then would have to think of another way of forming an organization. I would tend to think that your associations would be the place to start.

Sen Duncan

I have a copy of a news release from the National Governor's Association that was made in February of this year and one of the things they talked about NGA was coming out with their report in August of this year. The news release came out February 2nd 1991 from the office of public affairs of the NGA it says and I quote "the report will describe a series of incremental and discrete cost control strategies such as expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies such as a state level all payor system and global budgeting for the control of capital expansion." What we are talking about in SB 83 is trying to get to a state level all payor system. Do you have any further update on where NGA is on that thinking and is there any other information you can provide us at this time?

Dr. Critteden:

I think that I can tell you it sounds like the Governor's are going to be very pressured for putting together some sort of strong cost containment. I think there's some division exactly what the exact mechanism should look like. I'll say the majority are leaning toward the element you are talking about. There are a fair number of people who want to try a little more competitive model but also there is nobody who wants free competition..

Yes, I think we are moving ahead I think there will be recommendations with it. NGA comes out my bets are they are going to say this is the way, these are ways they can and one of the models will be similar to SB 83 an all payor sort of model. What we are asking for at this point is to have state's take a lead and start putting something in place so that we can derive our federal policy from that from the real experience. I think that's important. The second thing that the states are very clear about is that we can't wait for the federal government to act. I think we have to act now; I think we know what to do. In Washington we are going to have real problems in our next bi-annual budget we are squeaking by in this one with a fairly large cut in both education and in human services and particularly in health just because of the health budget. In the next two years from now we are going to be facing the worst problems. So we are not going to wait we are going to have to go ahead.

John Colmers, Director of Health Service Cost Review Commission in Maryland - Presentation

Asked specifically to testify on SB 83 and my comments are focused exclusively on describing the rate setting system in Maryland and how that system has functioned over the years. We have found ourselves the subject of considerably greater interest in the last 18 months or so than we have had in many years and I think the cycle that naturally occurs in political thought is swinging back in the direction of a more regulated approach to health care costs.

In Maryland our focus has been in the area of hospital expenses and the state recognized back in 1971 the importance of getting a handle on that element of health care expenditures. Hospitals represent roughly 40% of all personal health expenditures in the country and those figures are roughly equivalent in Maryland as well. In 1971 the cost for admission in a Maryland hospital was some 25-30% above the national average. By 1990 the cost for admission in a Maryland hospital was 8.1% below the national average. This has been accomplished by not in any one particular year achieving significant savings but by achieving savings of anywhere between 1% and 3 % each year. When you achieve results like that over a period of

time the savings can be quite substantial and there have been estimates made of what the cost in Maryiand would have been if we had gone up at the national average since 1976 that reach into the multiple billions of dollars and almost a billion dollars in 1990 dollars alone in that one particular year alone.

Now the rate setting system itself is fairly complex and although occasionally we hear complaints about its complexity the nature of the business that we regulate is complicated and the statute that we operate under has provided the rate setting system considerable flexibility in establishing the rates. It has been important over the years that in establishing those rates that considerable difference be made to the unique circumstances of individual hospitals. There are no flat formulas that are used to the exclusion of considering individual circumstances. There are substantial appeal rights available to providers. The rate setting commission decisions are appealable directly to the courts. There is no administrative appeal which has been a critical element of our system which has removed it from both the perception of and the actual fact of political influence. The decisions are appealable directly to the courts. We have not gone to court of appeals in Maryland which is the highest court in the state since 1985 so it has been relatively infrequent. The early years of the commission certainly we were in court more frequently with a number of test cases.

A critical feature of our rate setting system of course is the fact that it is an all payor system. We are the only all payor system in existence. The all payor system is brought about by the existence of what's known as the medicare waiver. A waiver is continued under provisions of the social security act section 18.14. b There are other sections in the social security act under which other states could apply for waiver status. That would be under section 18.86. c of the social security act.

The waiver is important for several reasons. First of all the waiver is what allows our system to be equitable. All payors are paying on the basis of the same rates there is no legitimized cost shifting that occurs within our rate setting system. The charges that are allocated to individual centers

ultimately are charged to patients are reflective of their costs. Do not include hidden costs or taxes in the form of cross subsidization that occurs in other jurisdictions.

The waiver is also important because it allows for our system to finance uncompensated care. In 1990 Maryland hospitals provided 275 million dollars in uncompensated care but that's the majority of which was recovered by hospitals through the rate setting system. Because of the waiver the medicare program is contributed to financing that uncompensated care.

The waiver is also important because it allows for a local control to hospital cost increases and that adds two important aspects. First of all, for institutions, it means that there is a single source that they can go to to address the financial means of their institutions. And unlike other institutions there are not the multiple payors you have to deal with; the federal medicare program, the state medicaid program, there is a single source to deal with issues associated with finance. And from the payors perspective that is also true. They do not have to deal with the 53 acute general hospitals within the state individually as much as they can deal on finance on broader financial issues with the committee, with that single agency. The payors are protected against the cross cost shifting that occurs as I mentioned earlier in other jurisdictions. I think the local control is also important from the sense that as I noted earlier there is considerable deference given to individual hospital requirements and if there is one thing that I have learned in the years that I have been at the Maryland system is that every hospital believes themselves to be unique and as a result it is important to be able to consider those characteristics. By having individuals who have a tie to the community, have a direct understanding of the conditions within the state; it's more likely to develop an equitable system than one that is developed on a national scale. It certainly will come as no surprise to you that we are very strong believers in state sponsored solutions to dealing with the problems with health care costs in particular hospital care. The role of the federal government is important in establishing general goals and guidelines and performance standards. Performance standards which we must meet in order to keep our waiver I

mights add. But by having that local control you can design the system to meet the unique characteristics of your institutions. I would be more than happy to spend more time talking about the nuts and bolts of the rate setting system. Let me pause right here and see if there are any questions on what I have just said so far.

Sen Duncan

First of all do you have a system? When you're setting the rates with the hospitals is that a negotiating system? How does that system work? Do you negotiate with them or do you just evaluate their cost based on certain criteria, certain components and set the rates and then they have the chance to appeal and that process works. Could you explain that?

Mr. Colmers

In essence there are two approaches that can be taken. One which is known as a full rate review and the other which is known as inflation adjustment system. The full rate review is a process by which a hospital's rates are set initially. All hospitals in Maryland have undergone at least one full rate review. That is a very complicated process that involves comparing the costs of the hospital under study with a peer group of institutions. There are formula's that are established but it is a matter that goes before the commission often involves considerable amount of negotiation in developing those rates. We conduct on average four or five full rate reviews a year. Some years we conduct none, some years we conduct more than four or five. Most hospitals have their rates set by a system that is known as the inflation adjustment system that is how they get their rates updated each year. That is much more formulistic and having less lee way involved. It has been developed as an accommodation to hospitals even though it is far less cumbersome and time consuming than a full rate application. It is also less risky for hospitals than a full rate application. Because under a full rate review the entire cost base of the institution is available for scrutiny. So the short answer is there really both methods, one that involves considerably more discussions and negotiations and lee way of course we are guided by precedent on how we do the full rate

reviews. The second is the inflation adjustment system which is much more formula driven. Neither of those systems are described in the statue itself but are contained in either regulatory language or in guidelines that have been developed by the commission.

Sen Duncan

My understanding or assumption then, each hospital has their own rates I assume, so when you are doing the full rate review it kind of involves negotiating you are dealing with one provider one hospital is that correct?

Mr. Colmers

We work one hospital at a time and we're comparing that hospital to peers, to similar institutions that's generally the standard of reasonableness. If someone else can do it for that cost the presumption is that you ought to be able to.

Sen Duncan

How does expansion and renovation work in your state, do you have a certificate of need process or does the rate setting process really replace certificate of need and that you determine whether or not the need is there and whether or not you will build increased expansion or renovation into the rates, is that how that works?

Mr. Colmers

There is a separate C.O.N. process here in Maryland and it is still in place for many projects. However, since 1989 there has been a change in statute here in Maryland that exempts any certificate of need project, regardless of the cost if the hospital agrees that they will take no more than a million and a half dollar in their rate over the life of the project in order to implement it. So that would mean that a major renovation project for example that had has an expected life of 30 years a million and a half dollars over 30 years is hardly anything at all and as a result many hospitals have decided to take

that route even though it means substantially no more money than they would have expected otherwise under the rate system they are willing to take that pledge rather than to go through the burdensome process of the C.O.N. Even if a hospital were to receive a certificate of need however that does not automatically guarantee that the hospital will be provided all the additional revenues that they requested they still have to deal with the rate setting commission separately.

Sen Duncan

Since this has begun in 1971 when you started rate setting have their been hospitals that have not been able to survive to operate under it do you prop up rates for certain hospitals so that they can continue if it's determined that there's a real need in that area of the state? How does that work?

Mr. Colmers:

I believe that there has been no hospital has failed in the Maryland system as a result of having inadequate rates. In terms of propping up institutions certainly there are hospitals within the state of Maryland that have greater needs than others. Whether it be because of their serving a very large poor population, whether it is because they have substantial amount of uncompensated care, whether the labor expenses in their area particularly higher than the norm. There is the possibility in our system for hospitals to make those cases so I don't believe a hospital has failed in Maryland because of the rate system.

There have been hospitals however who have either entered into bankruptcy or closed. There is an example of a hospital back in 1985 that filed for bankruptcy after it had been found to have overcharged as a result of a rate proceeding some 18 million dollars. The hospital filed in federal bankruptcy court right after the commission's decision in that rate case was upheld by court of appeals and the federal bankruptcy judge threw the hospital out of court saying that you can't go into bankruptcy to avoid the state rate setting function. As it turns out that hospital was sold to a national chain and it's part of the sales agreement there was a provision

established for the repayment of that 18 million dollars over a six year period and that's 3 million dollars a year. There is another hospital that is currently in bankruptcy in the state of Maryland located in western Maryland it is a result of a poor management decision. The hospital sold the facility to an entrepreneur and leased it back from that entrepreneur they still retained the license. They leased it back from the entrepreneur at an effective interest rate of 21%. The rate setting commission when the hospital came in for a full rate review said that type of arrangement is unreasonable and included in rates which we presume to be reasonable capital costs based on a reasonable assumption of interest and equity contribution over the life of the project. The difference between what was in rates and what the hospital received was close to a half a million dollars a year. Because of that management decision the hospital found that they had income that was not sufficient to cover expenses and they have called for protection under Chapter 11 of the federal bankruptcy code. Finally we have had hospitals that have merged or consolidated perhaps unlike the situation in Alaska.

There are many multiple hospital jurisdictions here in Maryland and we do have certainly excess hospital capacity. The rate setting system is structured to provide maximum encouragement to institutions to merge and consolidate and to remove that excess capacity.

So I would say that in summary we have not had to propp up hospitals. The legislation requires the commission to be concerned about the financial status of hospitals. The procedures that have been in place permit us to consider unique and individual circumstances. I don't think that we've ever had a case where a hospital has gone out of business because of the rates that have been set by the commission but we have had hospitals that have closed or have filed for protection under the bankruptcy laws.

Sen Pearce

First of all if you began this in 1971 how long did it take to get all of your hospitals on line and do the full rate reviews for all of them?

Mr. Colmers:

Statue was passed in 1971 and one of the most important features certainly back then was to get the commission a period of time before we actually had to go about setting rate. We began setting rates in 1974 and 1975. So it was about a three year period for start up. Now I would suspect that one would not need that long of period today. Much of the technology of how to go about setting rates has been dealt with by us and others but clearly you need some period of time to develop reporting mechanisms and the various rate setting systems for that particular jurisdiction.

Sen Pearce:

You spoke of under both the full rate review but also your inflation adjustment system that you actually negotiate with the hospitals, do you have a team that goes into an individual hospital in both cases and brings information back to a central place and provides some sort of a decision that goes then to the full commission for their decision who actually does the negotiating at what level does it happen?

Mr. Colmers

First of all if I gave the impression that the inflation adjustment system involved negotiation let me correct that. There is virtually no lee way in the inflation adjustment system at all it is all formula driven. A hospital either accepts what the inflation adjustment system provides or they can follow full rate review. They are protected by having that administrative route so that they can be denied the I.A.S. they don't have to take the I.A.S. and they still have the opportunity to follow full review.

In terms of negotiations the staff of the commission, we have 28 people, are budget is about 1.8 million dollars a year. We regulate an industry that's 3 and a half billion dollars in size in terms of gross revenue. When a hospital follows a full rate review there are generally two or three rate analysts on the staff who work in analyzing the information that has been submitted by the hospital and to conduct the standard comparisons that are used as part

of the review process. Once an initial recommendation has been prepared by that group I will review the material we will prepare a written recommendation that will go to the commission that will contain recommendations on each component of the hospitals application as well as a final revenue figure at the set of rates. If the hospital is in agreement with that fine, generally it involves a substantial amount of negotiation subsequent the hospital will go back and review our work papers, they will ask for a special consideration in one area or another.

There are probably two levels of negotiations that the team that I spoke of will handle much of the technical negotiation. Was this particular schedule filled out properly, were these the actual costs of the comparison group of hospitals, were they priced well within the proper manner. Questions of that nature will be handled by that group. The final negotiations generally involve myself or my deputy director. If we are unable to reach a conclusion, reach a negotiated settlement, obviously we go to the commission. That develops as a contested case in which the commission will establish a hearing process to review the testimony of the hospital and ultimately the record in that proceeding would be available to go to court for appeal by the hospital going forward.

Let me also say that in all since these involved contested cases and we have a single staff we do have assigned a staff member who does not attend staff meetings does not become part of a process of reviewing the rates of a particular hospital. To set up what is called a chinese wall between that member of the staff and one of the A.G.'s that has been assigned to us so that they can represent the commission in a public hearing on a contested case and the balance of the staff and the other A.G. assigned to us will represent the commission staff before the commission.

Sen Pearce

You said that most of your court tests happened early on what were the points that there was most contention on that you fought out in court?

Mr. Colmers

First and foremost was the first test cases had to do with testing the law itself whether we had the authority to do it, whether it was appropriate, what was meant by the terms peppered throughout the law. Are the terms reasonable, what is meant by reasonable, does it mean for example if there are competing quote reasonable rates for a hospital which one would prevail. And the courts decided that the commission could select among competing reasonable rates and if there was an adequate justification for their selection. It would be the commission's view that would prevail. Just because a hospital doesn't believe it's a reasonable rate doesn't mean that the commission wanted to accept that method. Some of the later court cases that tested this specific method that we have employed, how we are going about comparing hospitals, what are the criteria that are established to select hospitals that are comprable, how do you go about doing labor market adjustments, how do you account for differences in the types of cases that a hospital treats and so forth.

Finally there were a series of court cases that involved our jurisdiction over physician services. We had believed that in the initial years of the rate setting commission we have authority over setting rates for hospital based physicians. We went to the court of appeals twice on it, the first time we won, well partially won and it was remanded back to the commission. The next time we went to the court of appeals we lost jurisdiction over most of these hospital based physicians and that has been the case ever since. So there was a fair amount of activity that was involved in that.

But since 1985 the last case that went to the court of appeals in 1985 was a full rate application. It was in fact the full rate review of a hospital that I had mentioned earlier that filed for bankruptcy to try to escape the 18 million dollar over charging by the facility and that case tested virtually all of the rate setting methods that we have in place and the court of appeals came down in support of all of those procedures on point each and every one.

Sen Pearce

One of the things there's been a lot of comments about in the draft version of SB 83 are the kind of elusive components that the reimbursement systems and utilization standards components would be looked at in the setting views, you've got a list that says must include but are not limited to, do you have in your system for the full rate reviews, I know your inflation adjustment system is pretty much formula driven but for the full rate review do you have a list of things that you always take into account and then use kind of an open ended other things as necessary that the different hospitals can bring to you because they think they are unique?

Mr. Colmers

Well, again SB 83 as I read it, first of all in concept is quite different than the all payors system, but at least in the section that discusses reimbursement systems our statutes does not describe the procedures that we're supposed to take into account or in fact what are the characteristics we're supposed to be taking into account. Our statute in the section that talks about full authority for setting hospital rates is in fact very simple but does include language that ultimately has been tested in the court of appeals. The language which is there at section 19-216 of the health care article of Maryland requires that in reviewing the rates and in making any investigation that the commission considers necessary.

For purchasers first, that the total cost of all hospital services offered by or through a facility are reasonable. Two, that the aggregate rates of the facility are reasonably related to the aggregate costs of the facility and three that the rates are set equitably among all purchasers or costs of the purchasers without undo discrimination or preference. The commission is further given authority to be concerned with the financial condition of Maryland's hospitals that we permit a non profit facility to charge reasonable rates that will permit the facility to provide on a solvent basis efficient and effective services in the public interest. So throughout the year you have language that is balancing the needs of the facility with the needs of the payors and is mitigated by language such as reasonable and efficient and effective. It is not overly postscriptive in describing the rate setting mechanisms that are to be employed. And as I said at the outset these rate

setting mechanisms are extraordinarily complicated as I believe they need be. But it has been the language in the statute is the guide against which all of the rate setting mechanisms are ultimately tested in the courts. It was the courts view for example that the procedures that we use in the full rate review system were reasonable in evaluating the hospitals total costs that the rates that were produced would allow a hospital to operate efficiently and effectively on a solvent basis. So these balancing characteristics I think are critical in the statute and I did not see that in my review of the draft of SB 83 in terms of the balancing of those provisions. I think each one of the ones that I've talked about independently are important and I think collectively they work quite well together to balance the interests of both the purchasers and the providers.

Sen Pearce

I believe I understood you to say that there was a court case in which the commission lost the right to set rates for hospital based physicians and has there since that, obviously something made the commission feel that they had that right at the beginning is there, has there been discussion within the legislature or by the commission or by any group in Maryland of expanding to private physicians the cost setting?

Mr. Colmers

Yes, as a matter of fact for the last two legislative sessions there have been bills introduced in the general assembly to grant the commission authority over the rates of hospital paid physicians. Both years those bills have not received favorable report. Our commission certainly is in favor of looking at this issue. We think that for hospital based physicians given the nature of the work that they do given that individuals generally do not have any choice in selecting which hospital based physician that there ought to be at least an investigation to determine whether we ought to set the rates to that. That was a bill that was before the general assembly this year. Our commission supported that but for a variety of reasons not the least of which was the fiscal note attached to doing --- setting the bill did not

receive a favorable report. Maryland as many other states in the lower 48's are operating in a pretty tight budget.

DRAFT

State-Specific Estimates of the Size and Characteristics of the Uninsured Population

Submitted to:

The American Association for Retired Persons

Prepared by:

Lawrence Bartlett
and
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August, 1990

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CHAPTER ONE:
Background and Purpose of this Document

In recent years, increased public attention has focused on the problems this nation's uninsured population often face in obtaining access to needed health care services. At the federal level, this increased recognition of the problem has heightened the debate about the need for a national solution. However, it is at the state government level that many of the most significant public policy measures have been taken to address the problems of the uninsured.

One of the factors that has prompted state policymakers to act is the sheer size of the problem. Indeed, until recently, the estimate that 37 million Americans, or about 15% of the population, are without health insurance has been cited as evidence of the access problems that exist within our health care financing/delivery system.

This estimate of the number of uninsured persons was based upon data from the Current Population Survey (CPS), a national survey conducted each year by the U.S. Bureau of the Census. Data from the CPS had shown an increase in the number of uninsured nationwide from 1979 to 1984, with that number remaining fairly constant at approximately 37 million from 1984 to 1986. However, a recently published analysis of preliminary data from the 1988 CPS showed a significant drop in the estimated number of uninsured persons, from 37.4 million to 31.1 million, a decline of nearly 17%.

As will be discussed later in this document, a significant portion of this recent decline is likely to be due to changes in the way the CPS asked about health care coverage and in the manner in which the survey data are analyzed. For example, in addition to revisions of both the content and the sequence of questions used in earlier

surveys, several new coverage-related questions have been added to the new version of the CPS.

Such technical issues may explain much of the difference between the estimates of 37 million and 31 million uninsured nationwide. However, until these and other reasons for such differences are more widely understood, in many states the net effect of the new national CPS estimates will be, at best, to create considerable confusion and, at worst, to result in complete paralysis of access-related policy development. Such responses are likely to occur because many states that have developed proposals to expand coverage of the uninsured have based their analyses on state-specific estimates of the number of uninsured derived from pre-1988 CPS survey results.

This report seeks to reduce the confusion that may exist within many states and therefore enable policymakers to move forward in developing appropriate programs and policies that address the access problems that exist within their states. More specifically, the purposes of this study are the following:

- To reduce the confusion caused by the release of significantly different national estimates of the size and characteristics of the uninsured by explaining in easy-to-understand terms the possible reasons for such variations.

- To educate the target audience about the statistical reliability of estimates derived from surveys such as the CPS so that they will be better able to understand both current and future state-specific estimates of the uninsured that are derived from the CPS or similar survey.

- To provide persons at the state level--including state legislators and executive branch officials, AARP volunteers, and other concerned parties

with information on the size and characteristics of each state's uninsured population.

- To enable concerned parties from individual states to compare the size and characteristics of their uninsured populations with those of other states.

The material presented in this document can be divided into two major categories. In Chapter Two, the reader will find information about the general nature of the Current Population Survey, the questions in the survey that deal with health care coverage, and statistical issues concerning the accuracy and reliability of estimates derived from the CPS. While we have attempted to present this information in as simple a manner as possible, it is nonetheless somewhat technical in nature. Readers not immediately interested in this level of detail may wish to skip much of this material, although they should review the section dealing with the accuracy and reliability of estimates so that they will be aware of the limitations of certain state-specific estimates and understand the rationale behind certain of our analytic methods (e.g. combining two years of survey data for smaller states).

Chapter Three provides a narrative overview that discusses the national estimates of the size and characteristics of the uninsured population based upon data from the 1989 and 1988 CPS and highlights the extent of the variation that exists across states with respect to their uninsured populations. Information that should be of significant use to readers interested in learning more about the uninsured in their own state is contained in a series of tables that provide detailed information on the estimated number of uninsured people in each state and the age, poverty status, and employment characteristics of these persons. The tables are structured to allow easy comparisons both between national and state data and across states.

While it is beyond the scope of this document to provide a detailed state-by-state analysis of the demographic, economic, and public policy factors that result in a state having a relatively large or small uninsured population, what will become clear from the information presented in this report is the relationships that exist between age, poverty, and employment and being uninsured. The figures presented in this document may differ from figures that some states are now using to measure the size of their uninsured populations. Our hope is that such differences will prompt interested groups to assess the relative strengths and weaknesses of these estimates--including the methods used to collect the information and the time period to which the information applies--and to determine which set of figures best measures the situation in their state. Indeed, the overriding goal of this study is to generate greater interest among state policymakers and other individual parties in understanding the specific factors affecting the size of their state's uninsured population. It is hoped that the result of this enhanced understanding will be the development of more effective and appropriate strategies to address the access problem.

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
U.S. TOTAL	214,660	134,072	15,984	16,958	10,619	34,112	15.9
ALABAMA	3,478	2,069	202	311	134 •	695	20.0
ALASKA	453	212	27	63	58	90	19.7
ARIZONA	3,053	1,837	191	142	179	662	21.7
ARKANSAS	2,146	1,160	148	204	120	484	22.5
CALIFORNIA	24,907	13,740	1,780	2,615	1,399	5,080	20.4
COLORADO	2,802	1,731	231	183	202	428	15.3
CONNECTICUT	2,794	2,109	211	89	58 •	294	10.5
DELAWARE	589	409	29	42	40	64	10.9
DIST. OF COL.	507	294	36	47	18	101	20.0
FLORIDA	10,420	5,674	904	574	782	2,336	22.4
GEORGIA	5,564	3,286	395	421	316	1,049	18.9
HAWAII	920	549	60	47	145	111	12.1
IDAHO	879	511	114	47	39	159	18.1
ILLINOIS	10,094	6,838	695	891	313	1,219	12.1
INDIANA	4,849	3,404	373	190	211	617	12.7
IOWA	2,416	1,603	412	117	52	219	9.1
KANSAS	2,072	1,419	217	77	102	232	11.2
KENTUCKY	3,116	1,894	173	255	174	573	18.4
LOUISIANA	3,847	1,839	256	482	204	1,012	26.3
MAINE	1,038	669	82	100	50	121	11.6
MARYLAND	4,152	2,857	193	276	338	440	10.6
MASSACHUSETTS	5,164	3,651	377	388	178	510	9.9
MICHIGAN	8,205	5,532	553	948	316	719	8.8
MINNESOTA	3,908	2,498	523	349	66 •	451	11.5
MISSISSIPPI	2,282	1,126	186	273	138	516	22.6

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
MISSOURI	4,518	2,926	421	340	159	617	13.6
MONTANA	706	373	97	59	48	122	17.2
NEBRASKA	1,375	817	187	77	104	174	12.7
NEVADA	983	591	51	28	78	230	23.4
NEW HAMPSHIRE	968	716	63	17 *	38	126	13.0
NEW JERSEY	6,633	4,885	480	336	132	725	10.9
NEW MEXICO	1,331	588	111	134	123	361	27.2
NEW YORK	15,367	9,844	966	1,893	417	1,948	12.7
NORTH CAROLINA	5,576	3,594	406	266	350	843	15.1
NORTH DAKOTA	573	321	119	22	44	63	11.0
OHIO	9,717	6,777	590	884	313	995	10.2
OKLAHOMA	2,744	1,442	229	182	214	644	23.5
OREGON	2,427	1,601	142	152	87	425	17.5
PENNSYLVANIA	10,405	7,466	690	727	309	1,023	9.8
RHODE ISLAND	877	609	72	71	39	75	8.6
SOUTH CAROLINA	2,970	1,918	159	201	194	449	15.1
SOUTH DAKOTA	620	326	114	34	41	100	16.1
TENNESSEE	4,303	2,481	376	468	212	678	15.8
TEXAS	15,221	8,188	1,043	876	919	4,067	26.7
UTAH	1,519	1,058	117	79	54	203	13.3
VERMONT	480	318	48	31	18	60	12.6
VIRGINIA	5,312	3,309	348	283	552	737	13.9
WASHINGTON	4,193	2,709	311	262	356	522	12.4
WEST VIRGINIA	1,631	1,007	91	187	48	264	16.2
WISCONSIN	4,140	3,033	345	202	109	414	10.0
WYOMING	417	263	40	18	29	65	15.7

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

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For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

PRESS RELEASE

For the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 8.70% in Maryland last year, while the national average was 8.96%. Based on these figures, Marylanders saved an estimated $5.3 million in hospital costs in 1990.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1990 it was 8.11% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $1.1 billion in 1990 alone.

While hospital costs per admission rose 8.7%, hospital charges per admission rose 10.04%. Hospitals' uncompensated care rose in 1990 from approximately $246 million or 7.8% of revenue to $271.9 million or 7.7% of revenue. (See Chart 2).

TTY for The Deaf
Baltimore Area 383-7555
D.C. Metro Area 565-0451

Hospital profits decreased from $78.3 million in 1989 to $67.0 million in 1990. (See Chart 3). Nineteen hospitals (Memorial at Cumberland, Key Medical Center, Franklin Square, Frederick, GBMC, Good Samaritan, Harbor Medical Center, Holy Cross, Johns Hopkins, Johns Hopkins Oncology, Peninsula General, Physician Memorial, Sacred Heart, St. Agnes, St. Joseph's, Sinai, Suburban, University and Washington Adventist) had profits exceeding $2,000,000, while two hospitals (Homewood Medical Center and AMI Doctors Hospital) had losses exceeding $2 million. In total, 42 acute hospitals showed profits while 12 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Hospital profits fell slightly despite an increase in revenue per admission of 10.04% compared to an 8.24% increase in revenue per admission the previous year. Simultaneous with the release of this disclosure statement, the Commission released the second annual report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. The Commission modified the rate system last year by tying continued growth to the ability of the system to match the rate of growth in hospital costs nationally. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access. Our ability to continue this program will depend on the joint response of the Commission, the hospitals, and the payers to respond to the challenges of continued cost containment, particularly for

Medicare cases."

Net patient revenue increased by 11.53% as the combined result of a 1.00% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 84,695 or 1.8%.

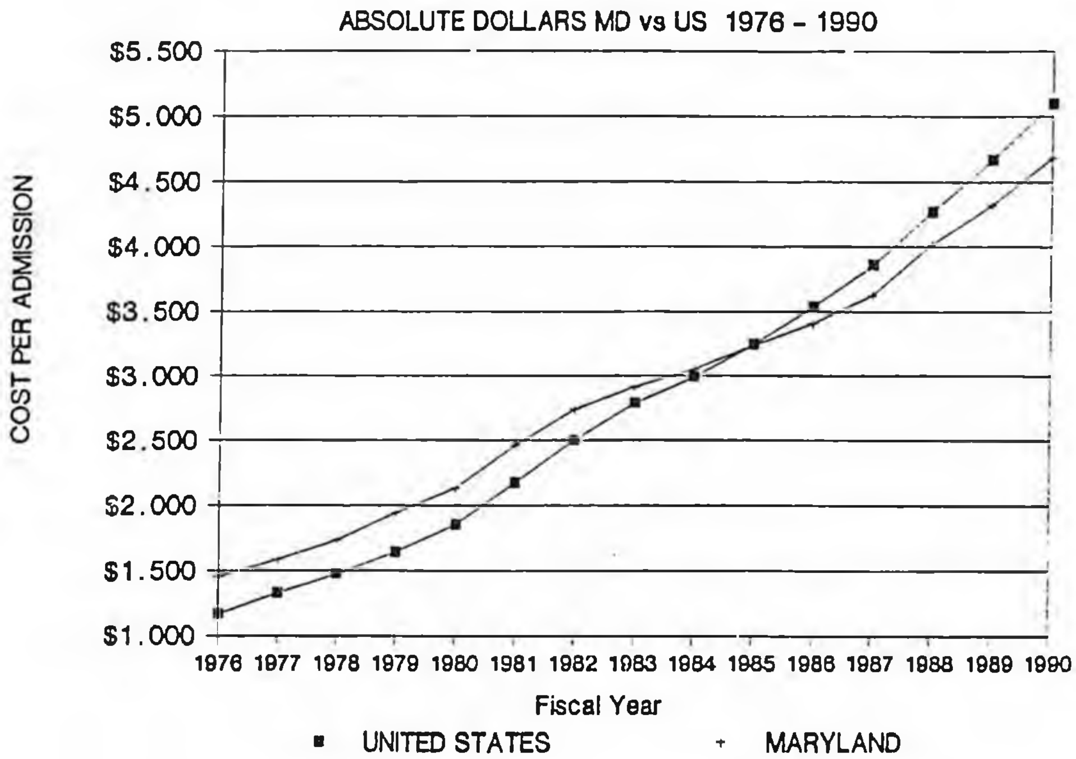
Hospital uncompensated care increased in absolute terms but decreased in relative terms in FY 1990. Total hospital uncompensated care rose to $271.9 million, an increase of 10.51% over the previous year. This represents 7.72% of gross patient revenue, a slight decrease from the 7.79% experienced the previous year.

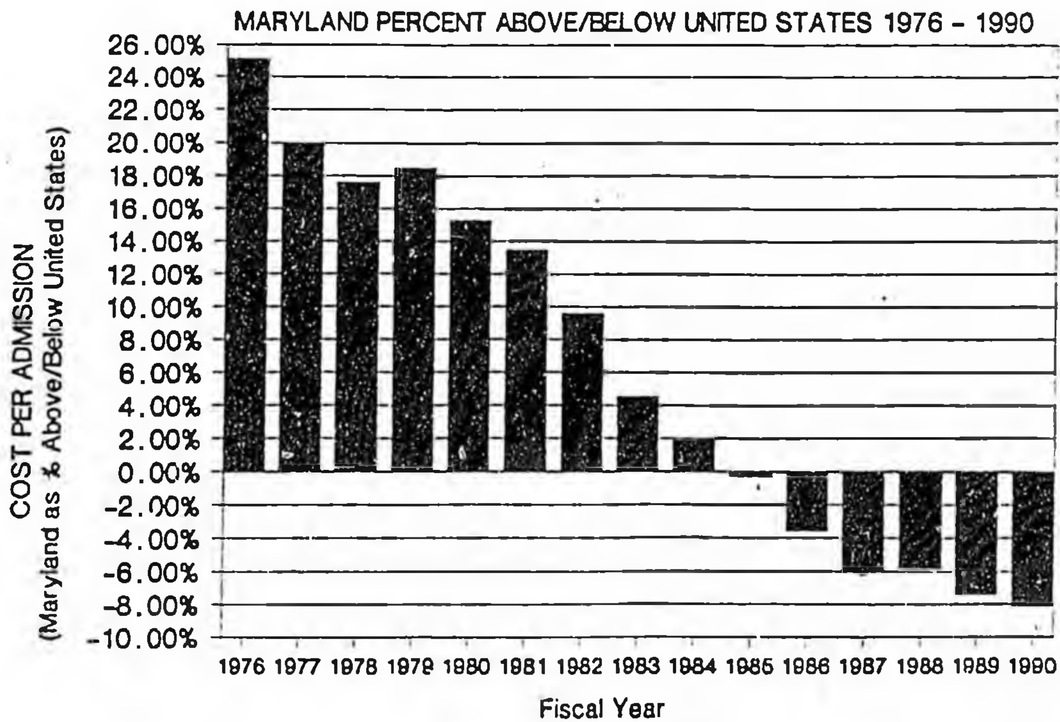
Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 8.11% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1

COMPARISON - COST PER ADMISSION

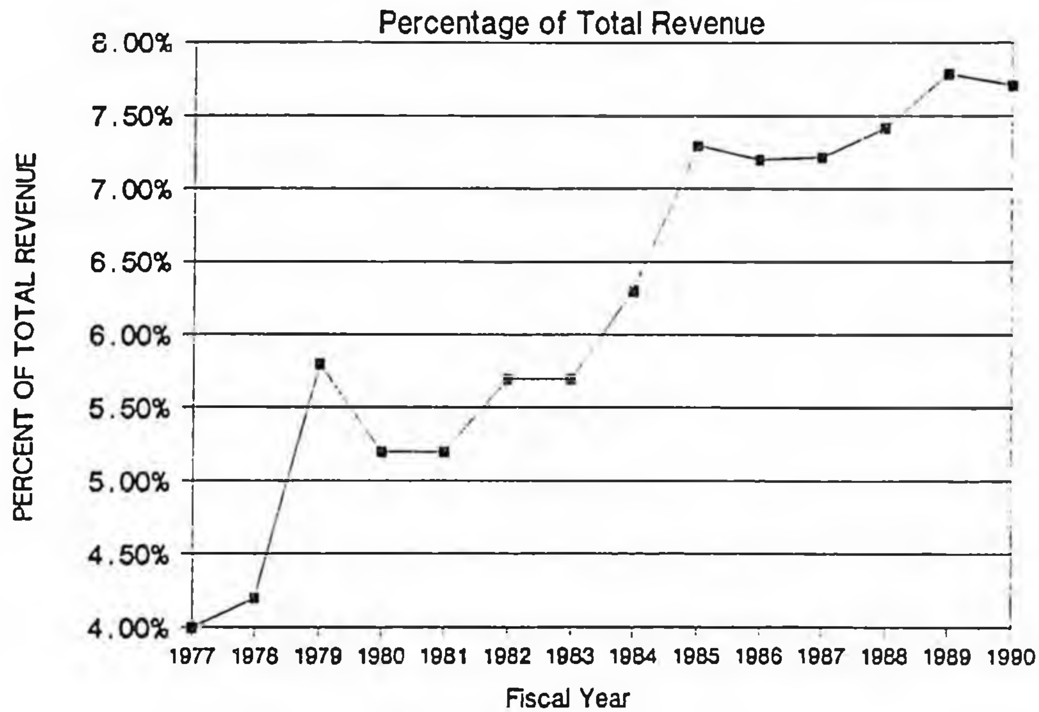


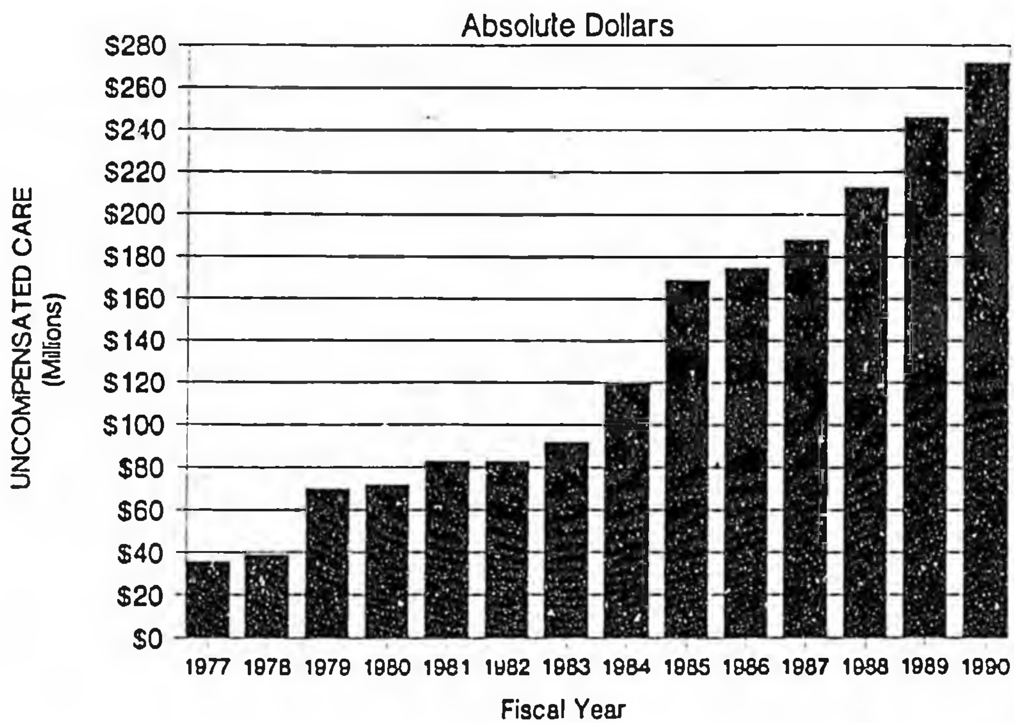


Source: HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1990

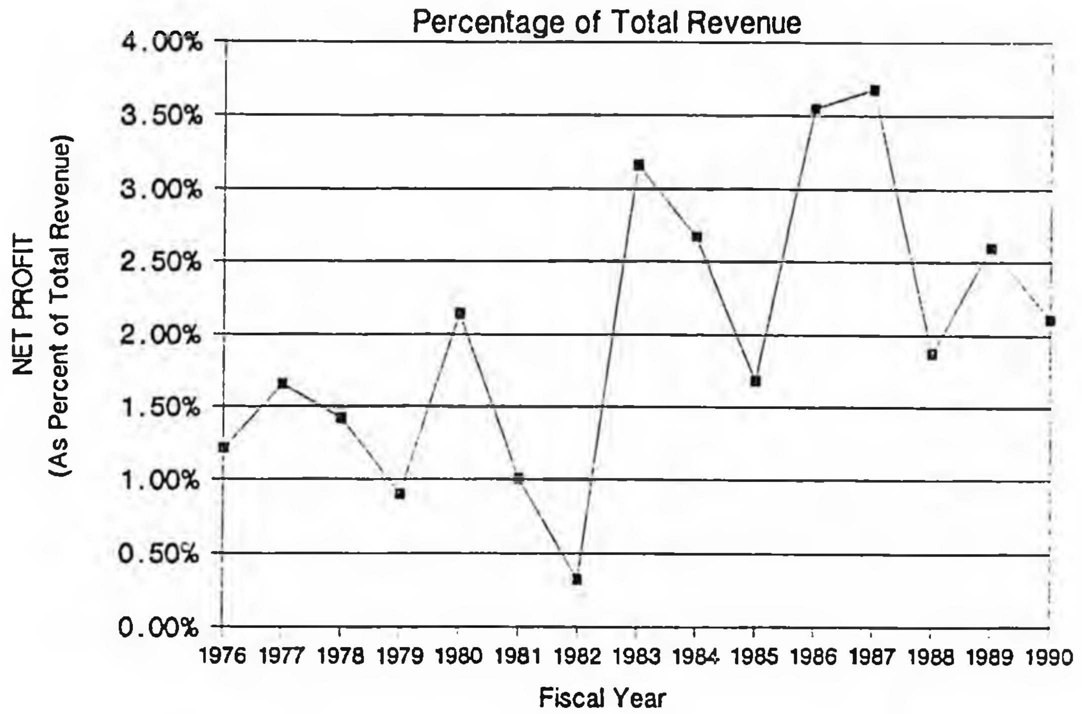


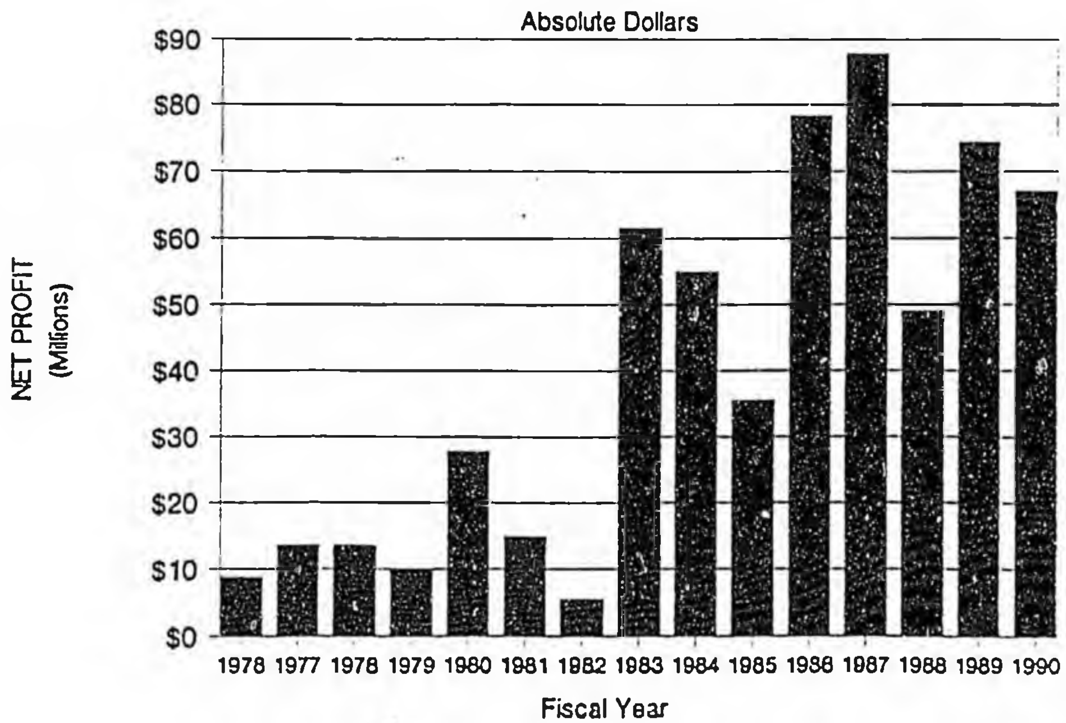


Source: HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1990





Source: HSCRC Annual Disclosure Reports

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*

For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

* * * * * * * * * * * *

DISCLOSURE OF

HOSPITAL FINANCIAL AND STATISTICAL DATA

Charles O. Fisher, Sr., Chairman of the Maryland Health Services Cost Review Commission (HSCRC), today released annual figures showing Maryland hospitals' performance during their last fiscal year.

In its annual disclosure of hospital costs, the Health Services Cost Review Commission revealed hospitals in Maryland held the increase in cost per equivalent admission (EIPA) to 8.7%. The estimated national rate of increase in 1990, according to statistics produced by the American Hospital Association, was 8.96%. Viewed from this perspective, this comparatively good performance yielded savings totalling $5.3 million.

This is the fifteenth year in a row that the Health Services Cost Review Commission's disclosure report has demonstrated that the percentage increase in hospital costs in Maryland has been lower than the rest of the nation. Last year's disclosure report indicated that the hospital cost increase per admission in Maryland was approximately one and two thirds percentage points less than the national average.

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The Health Services Cost Review Commission was the first hospital rate review agency in the United States established to regulate rates for all those who purchase hospital care. The Commission began regulating hospitals in 1974 and has since assisted Maryland hospitals in remaining well below the national level of hospital cost increases. Had cost per admission since Fiscal Year 1975 risen at the national rate, Fiscal Year 1990 expenditures would have been $4,250,241,000 or $1.1 billion more in 1990 alone. This is a cumulative savings of approximately 34%.

Equivalent Inpatient Admissions (EIPA) is a statistic formulated by the Health Services Cost Review Commission which equals inpatient admissions plus an adjustment to include outpatient visits. Equivalent Inpatient Days (EIPD) makes a similar adjustment in a per day basis.

An examination of the new financial disclosure reveals the following for Maryland acute hospitals:

1) The average cost per EIPA (equivalent admission) increased 8.7% from $4,115 in 1989 to $4,473 in 1990.

2) The average cost per EIPD in Maryland increased 8.97% from $618 in 1989 to $673 in 1990.

3) The average charge per admission increased 10.04% from $4,587 in 1989 to $5,048 in 1990.

4) Total net profits in decreased 14% from $78,323,400 in 1989 to $67,012,300 in 1990.

5) Total net patient revenue rose from $2,765,000,000 in 1989 to $3,083,861,800 in 1990 an increase of 11.53%.

Another unique feature of the Maryland hospital payment system is the coverage of the reasonable cost of providing care to those who can not pay -- i.e., uncompensated care. In 1990, Maryland hospitals incurred approximately 7.7 cents of uncompensated care for every dollar of total operating cost. More than 88% of the statewide uncompensated care expenditure of $272 million originated in the state's metropolitan areas.

The Maryland Health Services Cost Review Commission (HSCRC) was established by the General Assembly in 1971. It is an independent Commission functioning within the Department of Health and Mental Hygiene. It consists of seven members interested in health care problems and appointed by the Governor. The Commission's rate review authority includes assuring the public that (a) a hospital's total costs are reasonable; (b) a hospital's aggregate rates are reasonably related to its aggregate costs, and (c) rates are set equitably among all purchasers of care.

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For further information call:	*	For release 1:30 p.m.
John M. Colmers	*	February 7, 1990

PRESS RELEASE

For the fourteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 7.44% in Maryland last year, while the national average was 9.29%. Based on these figures, Marylanders saved an estimated $49 million in hospital costs in 1989. Mr. Fisher congratulated Maryland's hospitals for this excellent relative performance in holding down the rate of increase in the cost of hospital care.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1989 it was 7.37% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $976 million in 1989 alone.

TTY for The Deaf:
Baltimore Area 383-7555
D.C. Metro Area 565-0451

While hospital costs per admission rose 7.44%, hospital charges per admission rose 8.24%. Hospitals' uncompensated care rose in 1989 from approximately $213.6 million or 7.4% of revenue to $246.0 million or 7.8% of revenue. (See Chart 2).

Hospital profits increased from $49 million in 1988 to $74.4 million in 1989. (See Chart 3). Sixteen hospitals (Anne Arundel, Key Medical Center, Franklin Square, Frederick, Good Samaritan, Harbor Medical Center, Johns Hopkins, Liberty Medical Center, Mercy, North Arundel, Sacred Heart, St. Joseph's, Suburban, Union Memorial, University and Washington County) had profits exceeding $2,000,000, while five hospitals, (Bon Secours, AMI Doctors, Prince George's General, St. Agnes and University - MIEMSS) had losses exceeding $2 million. In total, 45 acute hospitals showed profits while 10 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Overall hospital profits increased during the past year while, at the same time, hospital costs in Maryland continued to increase at levels below that of hospitals nationally. Simultaneous with the release of this disclosure statement, the Commission released the first report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher congratulated hospitals on their performance and renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access."

Net patient revenue increased by 9.20% as the combined result of a 1.29% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 30,315 or .7%.

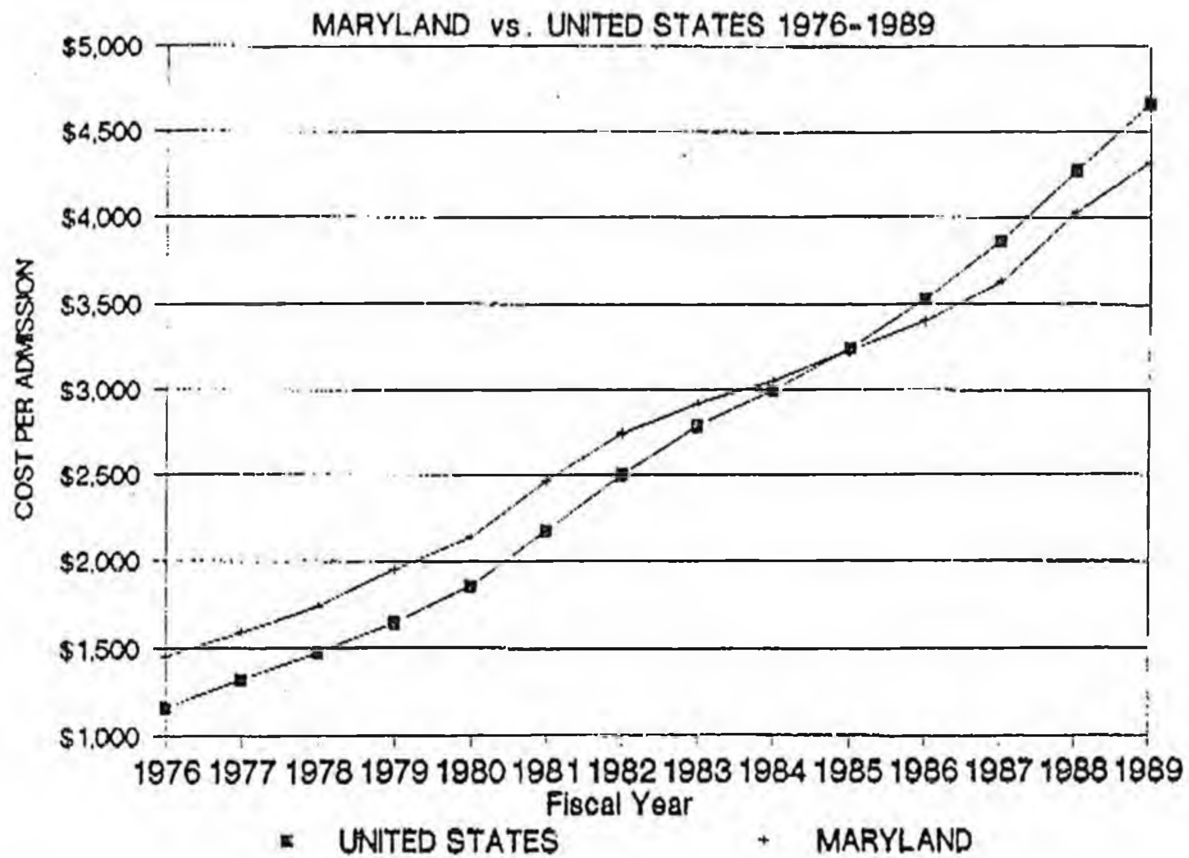
Hospital uncompensated care increased both in relative and absolute terms in FY 1989. Total hospital uncompensated care rose to $246 million, an increase of 13.61% over the previous year. This represents 7.79% of gross patient revenue, an increase from the 7.42% experienced the previous year, thereby continuing the increase in the percent of uncompensated care reported last year.

Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 7.37% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1

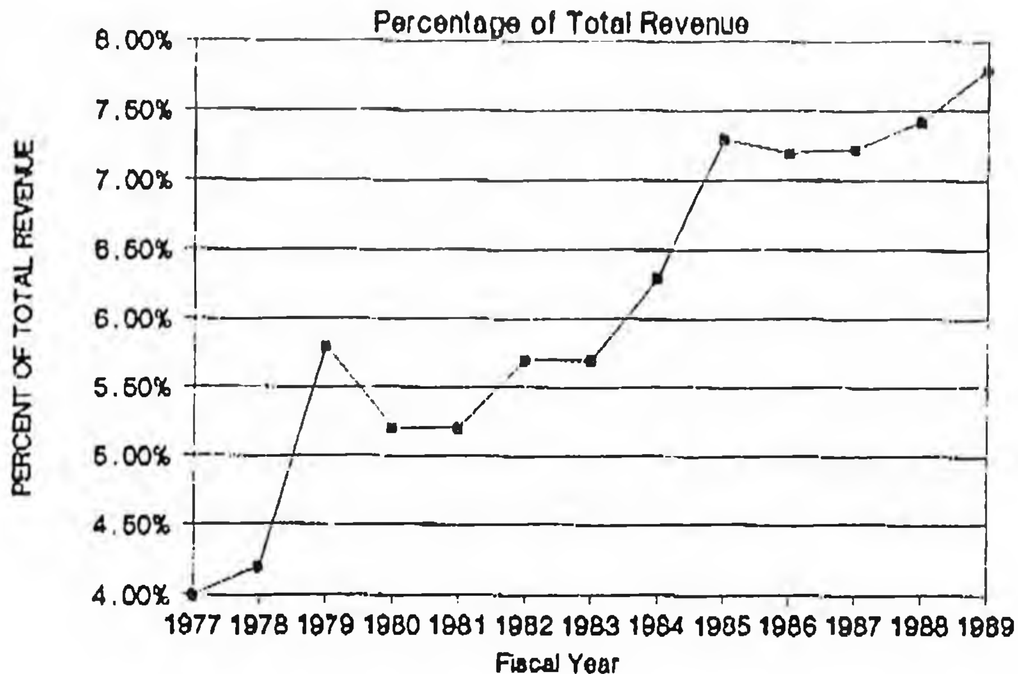
COMPARISON - COST PER ADMISSION

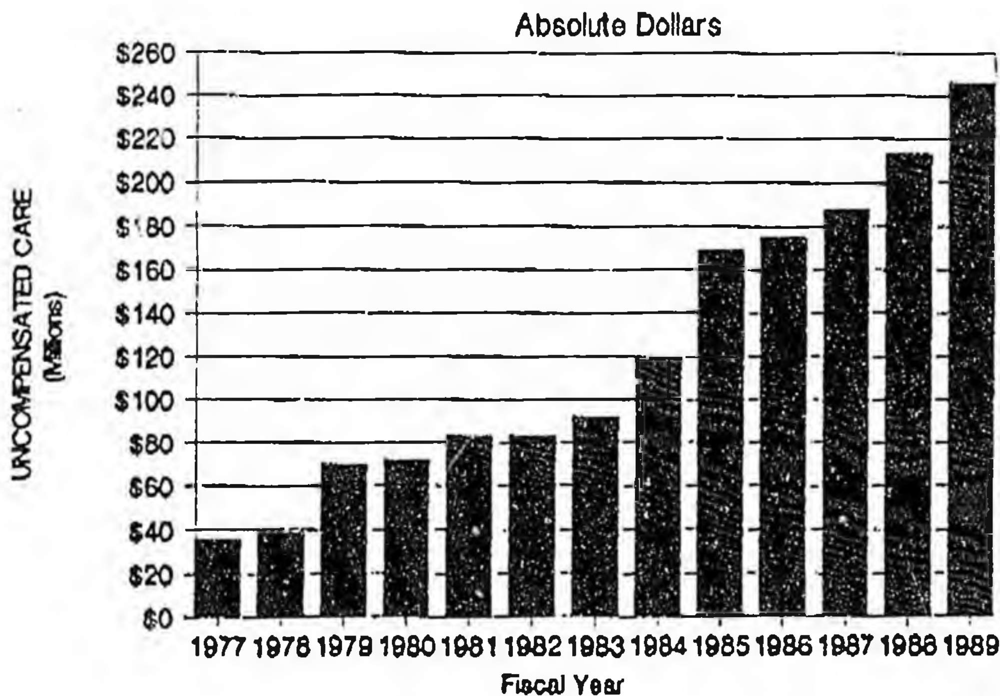


Source: HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1989

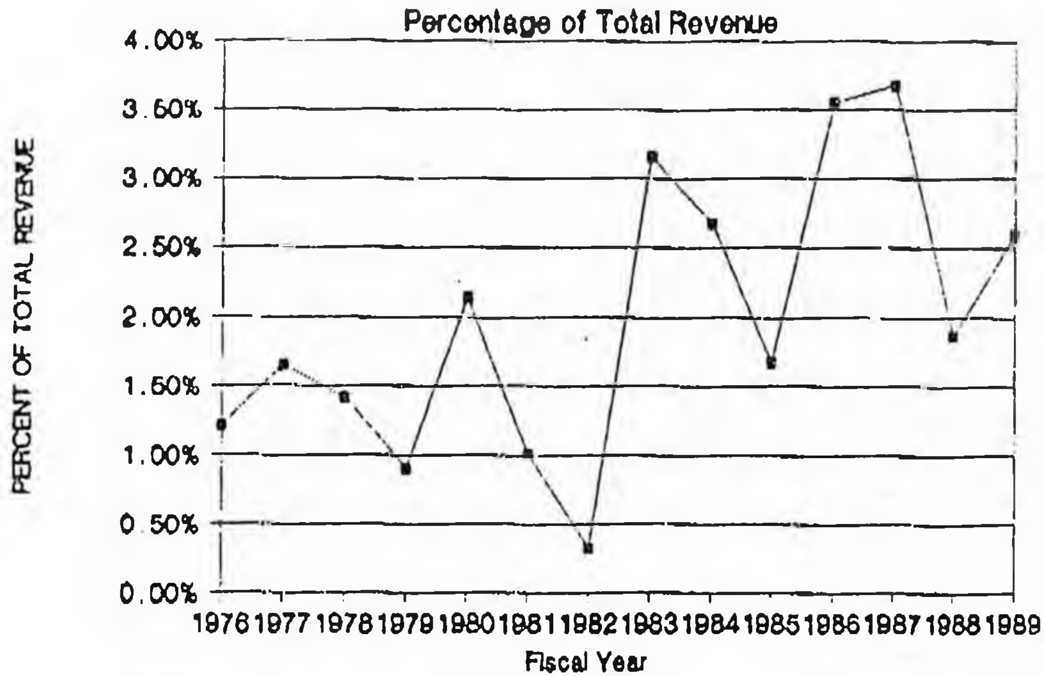


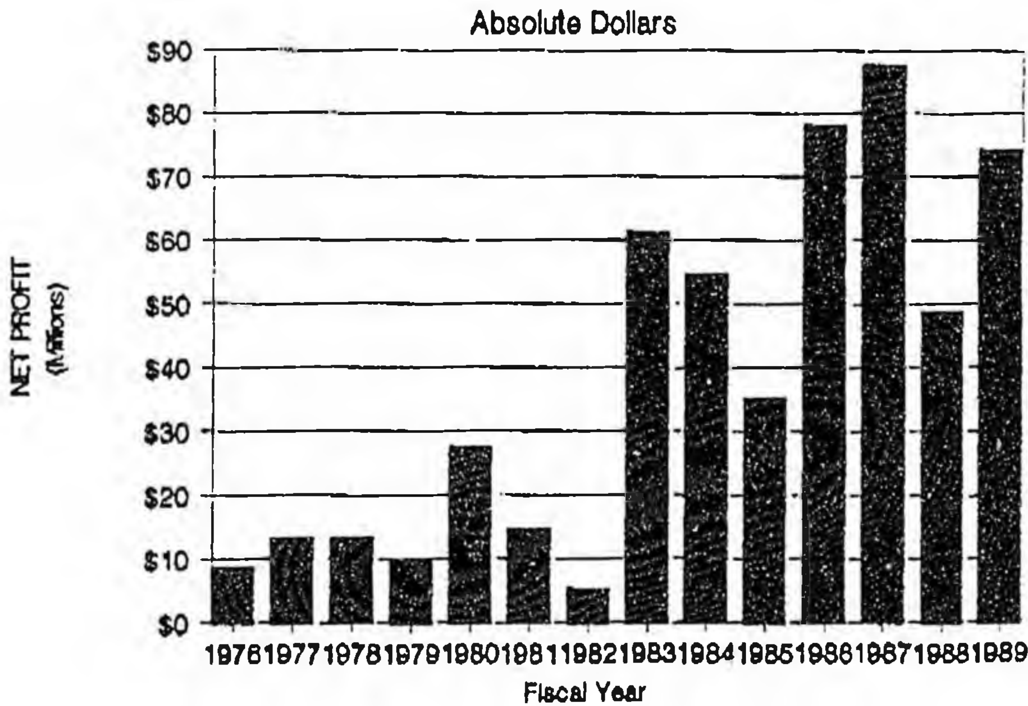


Source: HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1989





Source: HSCRC Annual Disclosure Reports

HEALTH SERVICES COST REVIEW COMMISSION

I. BACKGROUND

In 1971, the Maryland General Assembly reacted to the skyrocketing increase in hospital costs by creating the Health Services Cost Review Commission (the "HSCRC"), the first hospital rate setting agency in the country. Before 1971, hospitals in Maryland were reimbursed on the basis of "reasonable costs" incurred. This open ended financing system guaranteed funds for hospitals, but imposed no constraints on efficiency. With the creation of the HSCRC, hospitals were to be reimbursed based on the reasonableness of the relationship between costs and services, as determined by the HSCRC. HSCRC's rate setting methodology establishes standards of reasonableness that promote efficient use of resources.

In 1974, after three years of development, the HSCRC began performing rate reviews. At the same time, the HSCRC began negotiating with the Department of Health and Human Services for a demonstration project grant which would include a "waiver" of Medicare and Medicaid reimbursement principles in favor of HSCRC rate setting methodology. The waiver was considered essential in order to achieve the goal of equitable pricing for all payor groups. Finally, after three years of negotiations, the waiver was granted effective July 1, 1977. As a result, Maryland became one of the first two states to establish an all-payor system. Today, Maryland stands alone as the one state in the country that maintains the equity in pricing attributable to an all-payor system.

This equity in pricing has achieved dramatic results. In February of 1991, the HSCRC released its annual Disclosure Statement revealing that for the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average. Specifically, the cost per admission in Maryland rose 8.70%, while the national average was 8.96%. It is noteworthy that in 1976, the cost of an admission to a Maryland hospital was

more than 25% above the national average. As a result of hospitals responding to the incentives of the Maryland rate setting system, the cost per admission to a Maryland hospital in 1990 was 8.11% below the national average.

II. RATE REVIEW METHODOLOGY

The Maryland rate setting system uses a quasi-public utility approach to hospital rate regulation, in which rates are set and then adjusted for such items as inflation, volume changes, and pass-through costs. Hospital rate setting in Maryland currently consists of four systems: (a) Rate Review; (b) Inflation Adjustment; (c) the Guaranteed Inpatient Review System; and (d) the Screening System.

A. Rate Review

In reviewing a hospital's request for permanent rates, the HSCRC applies a standard of reasonableness based on the experience of similar hospitals. A rate review system is used to develop an initial set of rates approved for units of service in the various revenue producing departments. Under this system, all hospitals are required to annually submit data on base and budgeted years, using a uniform accounting and reporting system. The total approved revenues are based on four component parts: direct and allocated indirect departmental expenses, other financial considerations (inclusion of provisions for reasonable uncompensated care and working capital), a payor differential, and a capital facilities allowance for buildings and equipment. All in all, Maryland's rate review system provides an equity among classes of patients that far surpasses the pluralistic payment approach of non-regulated states.

B. Inflation Adjustment

The Inflation Adjustment System was instituted to allow hospitals reasonable rate increases while avoiding the administrative burden of full rate review. It considers inflation adjustments, volume adjustments, changes in payor and case mixes, and certain limited pass-

through costs.

Inflation adjustments are made for: 1) salaries and fringe benefits and 2) food, supplies, utilities, and other expenses. The inflation adjustment compensates the hospital for the past year if actual inflation was greater than the projected rate. (Conversely, if the actual rate is lower than the projected rate, then a deduction will be made in the budget year rate.) Second, if a correction needs to be made, a price leveling adjustment brings the rates to the level where they would have been if the inflation rate had been projected accurately. Finally, the provision for future inflation is established at a level equal to the most recent changes in inflation.

Volume for the budget year is established at a level equal to the actual volume for the current year. Different fixed-variable cost proportions have been established for the routine and ancillary areas as well as for different magnitudes of volume changes.

Pass-through costs are limited to: 1) changes in the Federal minimum wage law to the extent that they exceed wage and salary allowances, 2) actuarially-supported pension cost increases (only to the extent that such increases were above the allowed increase for inflation), and 3) incremental costs resulting from compliance with requirements mandated by the Commission.

C. Guaranteed Inpatient Review System

The Commission instituted the Guaranteed Inpatient Revenue (GIR) System because of concern that the original system, based on rates per units of service, was leading to increased volume and overuse of hospital services. The GIR system seeks to control the volume of ancillaries and lengths of stay. It guarantees payment for each case treated by the hospital. The GIR system determines the average charge for each diagnosis for each type of payor. The average charge is adjusted for inflation and a minimum 1 percent factor for growth and technology. The total GIR payment is the product of discharges (by diagnosis

and payor) and adjusted charges. At year end, the GIR payment is compared to the revenue from the Commission-approved rates charged by the hospital during the year. If the revenue from rates is less than the GIR payment, the hospital will receive the fixed cost portion of the savings. However, if the revenues exceed the GIR payment, the Commission will recoup the additional funds from the hospital in the following year.

D. Screening System

The Screening System is based on a comparison of hospitals' average charge per admission after a series of adjustments for cost factors which are either beyond management control (such as labor market differences) or which the Commission chooses to finance (such as bad debt and charity expenses). This system, introduced in 1982, was designed to identify those hospitals appropriate for targeting for HSCRC rate review efforts. The Screening System also identifies those hospitals eligible for the Inflation Adjustment System. Until 1986, the comparison of hospitals' average charge per admission was done within five groups, and the cutoff point was mean plus twice the inflation factor for the particular year. Then a statewide comparison was adopted with additional regression analysis-based adjustments to each hospital's charge per admission for indirect teaching costs and the presumed cost of treating low income patients. These regression-based adjustments are similar to those used for the Medicare Prospective Payment System.

III. UNCOMPENSATED CARE METHODOLOGY

The Uncompensated Care Methodology has been developed in order for hospitals to recover their reasonable full financial requirements. As with all other components of the Commission's rate setting system, the uncompensated care provision is subject to a reasonableness standard. Since 1983, the reasonableness standard has been based upon a regression analysis conducted annually by the Commission. This regression analysis produces

a predicted level of uncompensated care which serves as the upper limit in the provision of rates. For each year since 1983, one of the variables that has been used in the analysis has been the percentage of revenue attributed to Medicaid patients. The actual level of uncompensated care included in rates is based upon an analysis of the predicted amount, the actual amount incurred by the hospital, and the amount in rates, as well as the relative profits of the institution and its relative standing in charge per admission. The most recent update to the policy was adopted by the Commission at its June, 1990 public meeting. This particular regression analysis found that the variables significant in explaining the variation in uncompensated care among the hospitals in the State included: the percentage of Medicaid and SSI revenue; the percentage of inpatient revenue from commercial insurance patients; the percentage of revenue from patients residing in either Baltimore City or the District of Columbia; and, the percentage of revenue from non-Medicare patients admitted through the emergency room.

IV. CONCLUSION

Despite its longstanding success, the HSCRC is well aware that hospitals are facing increasing pressures that lead to increased costs. Therefore, the HSCRC is committed to continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payors. The Commission is also committed to continuation of the cooperative spirit that has existed between the agency and the State and Federal governments, which has made it possible for Maryland to consistently take the lead on health care cost containment issues.

NATIONAL GOVERNORS' ASSOCIATION

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Backgrounder

OFFICE OF PUBLIC AFFAIRS
February 2, 1991 (12-91)
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HEALTH CARE REFORM: Rx FOR A HEALTHY AMERICA

WASHINGTON, D.C. -- The nation's Governors have made health care reform their number one priority this year for several reasons:

- Health care costs have risen so dramatically that states -- who finance health care for the needy, directly provide services through public health and other programs, and pay for health benefits as employers -- find it increasingly difficult to fund other critical state priorities.

- Despite the expenditure of ever-increasing amounts of money, access to health care services is limited and may become increasingly limited.

- The shifting of costs and responsibilities from one payor to another in the system is exacerbating the problems of both cost and access and is contributing to an inefficient system.

- The current health care system is not structured to encourage the delivery of preventive health care services, which Governors increasingly understand is critical to a healthy and productive citizenry.

Health care in the United States is nearing a state of crisis. In 1983, the United States spent $357 billion, or 10.5 percent of the gross national product (GNP) on health care. By 1989, those figures had climbed to more than $599 billion, or 11.5 percent of GNP -- that's $2,400 for every man, woman, and child in the country. Left unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of the GNP, by the year 2000.

Yet, millions of Americans have limited or no access to the health care services they need. Based on insurance statistics alone, the figures are appalling. Approximately 31 million people are uninsured annually, and 37 million are uninsured in any given month. Governors, who are responsible for the health and welfare of their citizens, understand clearly that having health insurance or Medicaid coverage does not ensure access to services, particularly for poor and rural citizens.

-more-

Because there are so many other factors that make a difference in whether people actually have access to health care services, Governors must address the following kinds of issues: adequately funding public health efforts; meeting the transportation needs of poor and rural citizens; coordinating the outreach efforts that result in people using health care services more effectively; and screening and licensing health care personnel and facilities.

Employers, the traditional source of insurance coverage for workers and their families, are experiencing double-digit increases in their employee health insurance premiums. Their responses have ranged from dropping coverage for their workers' dependents to decreasing coverage for their employees. For most small businesses, increasingly expensive health insurance is simply beyond their financial reach.

Governors are employers too. In fact, in some states, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer.

<u>Where Does Medicaid Fit?</u>

While the Governors are taking an expansive view of health care reform in their initiative, "Rx for a Healthy America," it is clear that the genesis of their interest is their concern and frustration with the current direction of the Medicaid program.

Since its inception in 1965 as a program designed to provide health care services to women and children eligible for Aid to Families with Dependent Children (AFDC) and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI), Medicaid has grown to include a wide variety of special populations and services. This growth has created problems both in the states' ability to fund and effectively administer the program.

For instance, in 1980, Medicaid spending accounted for 9 percent of a state's budget; in 1990, it accounted for nearly 14 percent of all state spending. Further, the rapid expansion of mandated populations and federal micro-management of services has created an administrative nightmare.

The NGA Task Force on Health will consider and discuss a variety of conceptual options for restructuring the Medicaid program when it meets in Washington, D.C., on February 3, 1991. Although Medicaid is but one piece of a larger puzzle, it is a very large piece.

Wide-reaching and thoughtful discussion about Medicaid could lead to the creative use of its resources.

-more-

What Are the Governors Doing?

To provide the larger context for Medicaid and the other critical and interlocking issues in health care, National Governors' Association Chairman Booth Gardner of Washington established the Task Force on Health. The task force is working on two products that will be completed by August 1991: a report on state options in health care reform and a policy on health care.

Task Force Report. The task force report will detail state options to both increase access to health care and control costs throughout the health care system. The options in the report will both identify incremental steps states have already taken successfully and describe comprehensive ways states can restructure their health care financing and delivery.

The report will guide states in reorienting their health care systems to emphasize preventive and primary care. It also will discuss how to overcome the barriers to the provision of preventive and primary care; barriers that riddle the current structure of the health care system.

The report will outline steps Governors can take to help the working uninsured. Constructive guidance will be offered to Governors interested in working with their business community to help small businesses obtain affordable health insurance for their employees. It will offer suggestions to help stabilize the insurance situation for businesses that now provide health insurance coverage but are finding it increasingly difficult to do so.

A variety of options for expanding access to health care for the non-working population will also be covered. The options will range from expanded use of Medicaid and Medicare to the development of a totally new publicly funded health insurance program for non-working people.

Because the Governors know that without significant new cost controls, the goal of increasing access to care will never be realized, the report will contain a wide range of options for cost containment.

The report will describe a series of incremental and discrete cost control strategies, such as the expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies, such as a state-level all-payor system and global budgeting for the control of capital expansion.*

* All-Payor System: A system in which association of purchasers come together to negotiate payment with an association of providers.

Global Budgeting: The idea of defining limits on the total amount of health care expenditures. Allocations are then made within that amount.

Managed Care: The concept of managing the access to health care, the utilization of services, and the cost of care.

Finally, although the focus of the report will clearly be on state action, the report will contain suggestions for federal action that would help the states implement the strategies.

Policy on the Federal Role. To complement the report, the task force will develop a policy for consideration during their annual meeting in August 1991. The policy will focus on the key issues that would require federal action to restructure the health care system. The policy will focus on recommendations on the future of the Medicaid program, changes in insurance practices, and small market reforms to enhance increased access to health insurance.

How Are the Governors Reaching Out?

The Governors began the process of reaching out to a wide variety of people when they hosted a national conference on health care reform in September 1990. During the two-day conference, some of the best health policy analysts and experts in the country participated in roundtable discussions. The participants and Governors explored issues ranging from ensuring the delivery of quality care to helping business find affordable, stable insurance policies; from insurance practice reforms to the individual's responsibility for health care. That conference gave the task force valuable information and insight with which to begin its work.

As the report is developed, Governors will seek extensive feedback and "reality-testing" from the wider community. This spring, Governors will hold a series of regional meetings to elicit comments on drafts of the report from business, labor, the insurance industry, and the provider community.

Further, the Governors will host a working meeting of state health policy analysts and health and human service executives to invite review and comment on the report as it moves to its final form. By involving the widest variety of interested people, Governors believe the strategies in the report will be tested for "workability" and will have benefitted from the best thinking of those involved in the health care system.

What Happens Beyond the Task Force?

Although the formal work of the task force will conclude in August 1991, the issue of health care reform will remain a high priority for the nation's Governors. As the Governors begin to implement the recommendations contained in the report, policymakers at all levels of government will have the opportunity to learn more about what works and what does not.

The Governors want to have the participation and cooperation of their federal partners in fashioning innovative approaches to health care reform. As the Governors and their federal partners evaluate these approaches, there will be opportunities to develop an informed national consensus about how best to move the nation's health care system toward a day when access to health care can be ensured for everyone at prices all can afford.

To The Rescue

Toward Solving America's Health Cost Crisis

A report by
Families USA Foundation

in cooperation with
Citizen Action

November 1990

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

<u>*EXECUTIVE SUMMARY*</u>

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill in the year 2000. This is a bill none of us can afford. The United States health care system can be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

By taking action now to control provider rates, reduce unnecessary procedures, and eliminate insurance administrative waste, the United States could reduce the health care bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

The data in this report demonstrates that both universal access and cost containment are achievable goals. Three specific and straight-forward steps would produce the following savings and benefits:

- *Insurance administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high cost of private insurance administration. This does not include additional savings that physicians and hospitals may realize under a simplified insurance administration system.*

- *By holding health expenditures to a 6.6% annual rate of growth (still above general inflation, but 2% below projected health care inflation), $245.7 billion can be saved in 2000. The Medicare program is already committed to achieving this level of savings through rate and volume controls. It is time to make a national commitment to apply the 2% solution system-wide.*

- *The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion. This cost is far less than the savings described above.*

Tables at the end of this report present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill by the year 2000. This is a bill none of us can afford to pay without seriously jeopardizing our standard of living, access to care and our economy. The United States health care system needs to be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

This report presents data, on a state-by-state and national basis, about specific steps this country could take to achieve lower health care costs, universal access and improved quality of care for all Americans. By taking action now to control provider rates and reduce insurance administrative waste, the United States could reduce this bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

In the face of rising health costs and declining access, public dissatisfaction with the American health care system has been increasing. Most Americans (89%) see the need for fundamental change in the direction and structure of the U.S. health care system. Only 10% agree with the statement that "on the whole, the health care system works pretty well." Americans are significantly less satisfied with their health care system and physician care than either the Canadians or British.[1]

Economist Uwe Reinhardt has observed that this public disenchantment with the health care system reflects serious misgivings over the way American health care is financed. The American health insurance system lacks the security, portability and administrative simplicity desired by American citizens.[2] The approaches to health care reform described in this report address the sources of this public dissatisfaction.

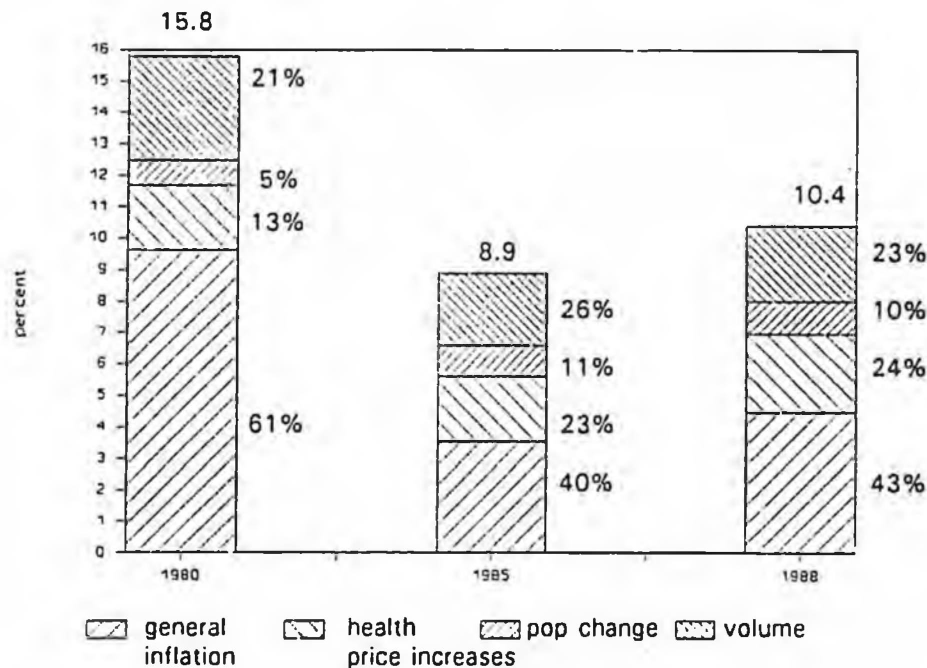
CAUSES OF EXCESSIVE HEALTH CARE INFLATION

Health care spending has increased at more than twice the rate of general inflation during the last decade and, absent reform, this trend is expected to continue during the 1990s. An analysis of the components of health care inflation reveals areas that can be controlled without affecting quality.

Health care inflation is usually broken down into four components: general price inflation; medical price inflation; population changes; and intensity, or the volume of services provided. Although the United States has an aging population, changing demographics account for a relatively minor portion of increased health care spending -- 1% of the 11.7% annual compound rate of growth between 1975-87.[3] The fact that as Americans grow older they need more health care is not the major contributor to spiraling health costs. This factor accounts for one-tenth of rising costs.

A major factor driving up health care costs is the amount health care prices have increased above the general rate of inflation -- that is, the amount that health care providers have increased their prices for services by more than the rate of general inflation. These excess

price increases accounted for 2.2% of the 11.7% rate of growth between 1975-87.[4] These excessive health care price increases account for <u>one-fifth</u> of rising health costs. Such price increases are encouraged by the fee-for-service reimbursement system that is prevalent in the United States. Under many insurance plans, providers are paid more the more they increase their fees. The last decade has been marked by sustained increases in real net physician income. Physician incomes have increased an average of 7.1% from 1981-88 compared to average earnings increases of 4.1%.[5] Health care chief executives were the nation's highest paid CEOs in 1989.[6]



Source: Health Care Financing Administration

The American fee-for-service system rewards physicians more for performing surgery and other procedures, than for time spent counseling, diagnosing and examining patients. The financial incentives inherent in this type of payment system contribute to the second major factor which drives up health care spending -- the increasing quantity, or volume and intensity, of services provided to each person. Volume and intensity growth accounted for 2.3% of the 11.7% growth rate, or <u>one-fifth</u> of health care inflation.[7]

This increase in the amount and type of medical procedures is especially worrisome since there is overwhelming evidence that a significant proportion of the American health care dollar is spent on unnecessary tests and procedures, endangering health and quality of care. Recent research has found that 32% of carotid endarterectomies, 17% of coronary angiographies, and 17% of upper gastrointestinal endoscopies are inappropriate. The General

Accounting Office found that inappropriate use of surgical procedures ranged from 14% to 32%. Many common procedures, such as Caesarean section deliveries and coronary artery bypass surgery, are often used without producing any medical benefit for the patient.[8]

The cost-containment strategies described below are designed to reduce the size of the two most troublesome components of health care inflation: excess health price increases and increases in the volume and intensity of health care services provided. The other two components -- economy-wide inflation and increases in the population -- are determined outside of the health care system.

Although both public and private health care plans have initiated a variety of cost containment efforts in the last decade, these piecemeal approaches have failed to control costs system-wide. The fragmented nature of our multiple-payer approach has been a major barrier to effective cost containment. All too often one payer's success at controlling use and charges has resulted in another payer's loss, as providers just shift costs to those with less bargaining power in the health care marketplace. Private employers are paying an estimated $31 billion, or 27% of their health care costs, for uninsurance, underinsurance or underpayments by other sectors of our society.[9] The lack of uniform cost and quality data and standards is also an impediment to controlling system-wide costs.

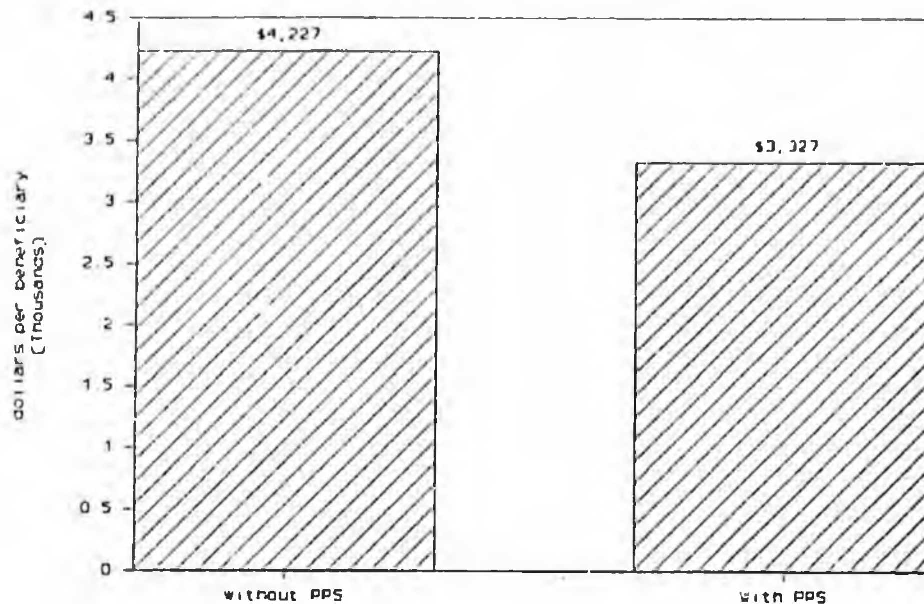
CONTROLLING HEALTH CARE EXPENDITURES

THE 2% SOLUTION -- MAKING A NATIONAL COMMITMENT

The Medicare program, which accounts for almost one-fifth of our national health spending, has developed successful methodologies for holding down costs. These methodologies would have a far greater impact if they could be applied system-wide. Without mechanisms for controlling costs system-wide, providers have the ability to shift costs to other payers. Other industrialized countries and some states have also adopted strategies that have held down costs.

The Medicare program is putting into place a new system for paying physicians. This new system addresses many of the problems identified above. A new physician fee schedule will increase reimbursement for primary care services and reduce fees for over-valued procedures. At the same time, Medicare will use a volume performance standard, or VPS, to protect Medicare against physicians performing more services to make up for any fee reductions. The new legislation assumes that Medicare physician costs will be reduced 2% annually beginning in 1993, below what they would have been without any volume controls. The VPS is modelled after the concept of expenditure targets used in several Canadian provinces.

Prospective Payment System Savings
1991 costs per beneficiary



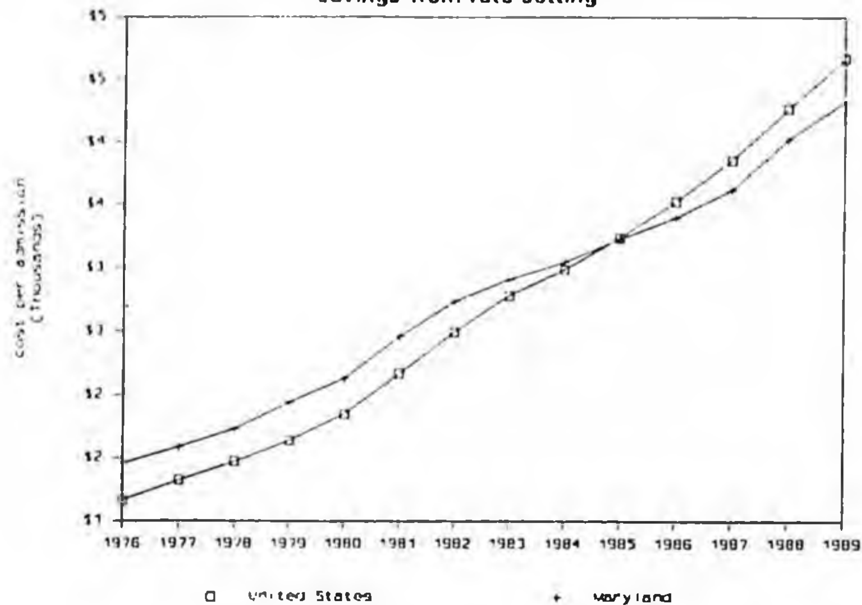
Source: Committee on Ways & Means, *1990 Green Book*, p. 238

Since 1984, Medicare has been paying hospitals a set dollar amount per admission based on diagnosis and adjusted for geographic variations in labor costs. This prospective payment system (PPS) will save Medicare $30 billion in 1991 alone. As the graph illustrates, Medicare's prospective payment system for hospitals has saved the program 21% on hospital costs per beneficiary.[10] The Health Care Financing Administration has estimated that increases in hospital costs could be reduced 2% nationally through practice pattern changes (primarily reduced length of stay).[11]

Several states have controlled hospital costs by establishing rates for all payers, public and private, large and small. The rate of increase in individual hospital expenses was reduced 4% in these states. Hospital charges per admission were 3.8% lower in the experimental states compared to other states.[12] As of 1988, Maryland's cost per admission rose 7.5%, as compared with a national rate of increase of 9.1%. This difference saved residents of Maryland $38 million in 1988 alone. If costs per admission in Maryland had risen at the national rate since 1976, when Maryland began its rate-setting system, Marylanders would have paid an additional $845 million for hospital costs between 1976 and 1988.[13]

Maryland vs. United States 1976-1988

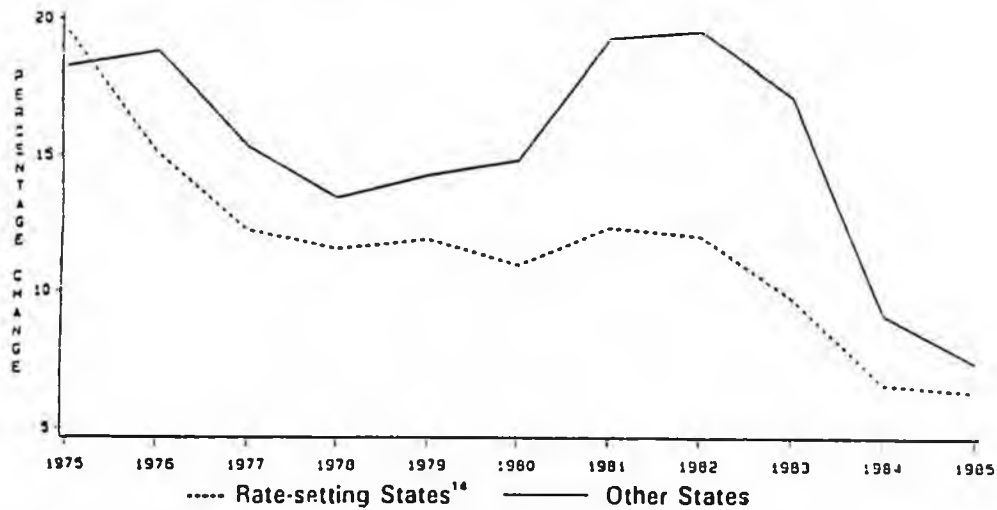
savings from rate-setting



Source: Maryland Health Services Cost Review Commission, FY 1989 Report

Rate-Setting States vs. United States

Change in Gross Inpatient Revenue per Admission



Source: Johns Hopkins Center for Hospital Finance and Management

The development by the Medicare program of new methodologies to set physician fees fairly and to control the volume of physician services means that states now have the tools to control all health expenditures within the state.

Reducing health expenditures by 2% annually is a realistic and modest goal. Using rate control authority to reduce anticipated medical inflation by just 2% per year would produce

enormous savings by the year 2000. This expenditure control approach would still allow an annual medical inflation rate of 6.6%, well above projected general inflation of just over 4%, and produce savings of $245.7 billion in 2000.

Establishment of system-wide rate controls for providers would go far to get at the two causes of health care inflation identified above -- excess price and volume increases -- and would effectively contain costs. Unified payment rates would also eliminate the destructive cost-shifting and high administrative burden imposed by our current fragmented health care system. Such an approach would draw on the proven cost containment successes of otner countries and on our own Medicare and state-based approaches.

ACHIEVING THE SAVINGS

There are a wide variety of ways this nation can achieve this annual 2% savings without reducing quality of care. Holding down the rates of increase in providers' income is one way. Other ways involve using our national resources in a more rational manner.

The development and use of **practice guidelines** for care is one way to reduce unnecessary care and the high costs associated with it. Studies consistently find striking variations in practice patterns in different geographic regions. These variations are not explained by differences in the population. Rather, practice styles of physicians account for the differences, not patient needs or superior care. Research has shown that once physicians do learn about the results of appropriateness studies and variations in use of procedures, their practice patterns change. The elimination of unnecessary procedures not only saves money, but improves quality of care for all Americans. The National Leadership Commission on Health Care estimated that practice pattern changes could reduce health expenditures by up to $22 billion annually.[15]

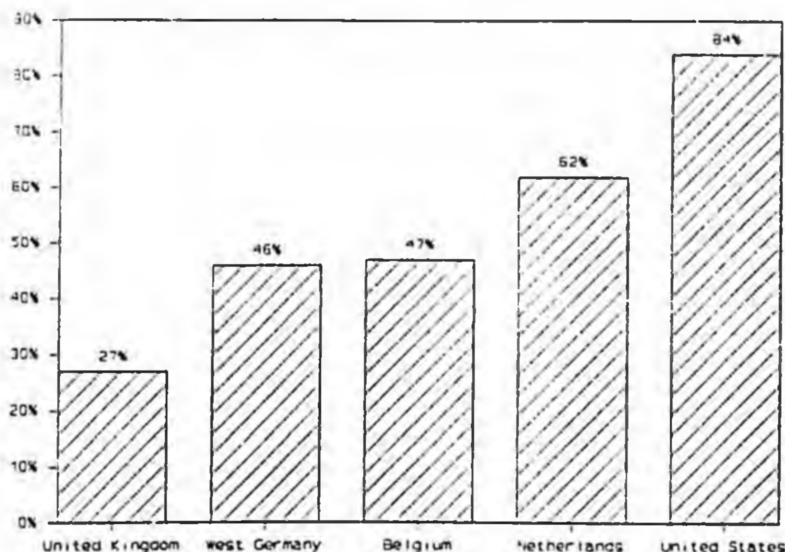
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes. Technology assessment could both save costs and improve quality. Similarly, capital spending review and budgets for both inpatient and outpatient services would eliminate incentives for wasteful and duplicative capital spending. Excess hospital beds are costing the United States at least $3.1 billion in 1990.[16] Furthermore, quality is improved when providers perform procedures frequently. Studies have found that a greater concentration of surgery in fewer hospitals tended to lower mortality rates.[17]

Other countries, including Canada, have used their rate-setting and budget authority to directly address the tough questions of a **fair net income for physicians and the appropriate supply of physicians.** In Canada physician incomes are four to five times the average industrial wage, as compared with five to six times the average industrial wage in the United States. In contrast to the United States, income differentials between primary care

and specialties are relatively small in Canada.[18] In the United States, the number of primary care physicians is decreasing relative to other physicians. In Canada, primary care physicians account for 52.5% of all physicians.[19]

Other Western countries have successfully increased the percentage of primary care physicians relative to specialists. As of 1980, the percentage of active physicians who were specialists varied among industrialized countries as follows: United Kingdom - 27%; West Germany - 46%; Belgium - 47%; Netherlands - 62%; United States - 84%.[20]

Specialists by Country
percent of physicians, 1980



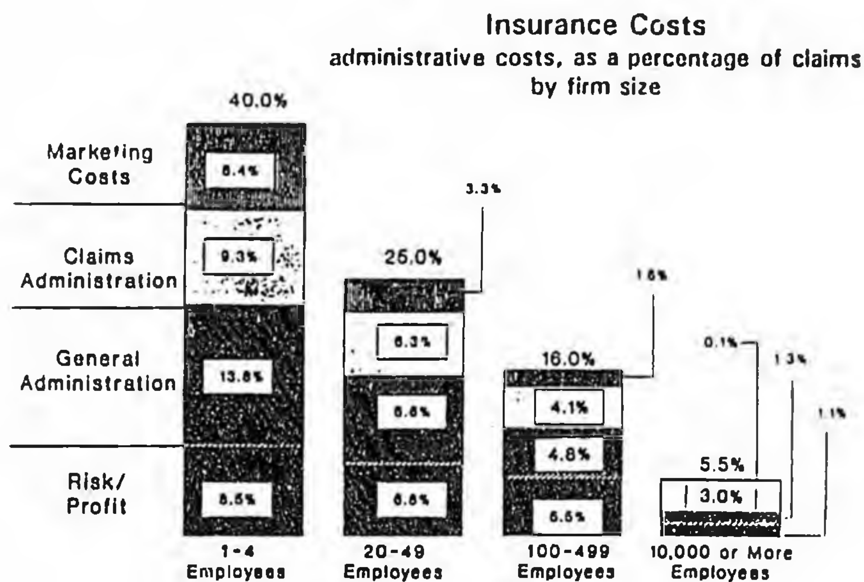
Source: *Journal of the American Medical Association*

INSURANCE ADMINISTRATIVE SAVINGS

The United States health care system has the highest proportion of administrative costs in the world. Our pluralistic health insurance system, with over 1,500 different insurance companies and several public programs, spawns diverse and duplicative payment rules, differing rates, dozens of separate utilization review systems, complex and costly eligibility determinations, high marketing costs and profits. Americans, in effect, pay what one economist has described as a "plurality tax" on all health services.[21]

The high administrative costs of the private insurance industry are disproportionately borne by small business and individuals who must purchase coverage on their own. The costs of marketing, insurance company profits, medical underwriting, and commissions fall most heavily on those groups with the least market power. For every dollar of health care costs paid by groups of 1-4 individuals, 40 cents goes for administrative costs under our private

insurance system. Groups of 20-49 incur 25 cents in administrative costs for every dollar spent. Even groups of 100-500 pay administrative costs of 16 cents for every dollar spent.[22]



Source: Hay/Huggins, Inc.

By 2000 the United States could save $52.8 billion annually in insurance administration costs by eliminating this plurality tax and utilizing a single, public administrative system. These savings are calculated by reducing health insurance administrative costs to those of the Medicare and Medicaid programs (2.7%).

Simplifying insurance administration in the U.S. may also allow physicians and hospitals to save on overhead costs associated with billing. Such savings are not included in the above estimates. The **provider administrative and billing overhead costs** associated with the American multiple-payer system are higher than any other country. In the United States, 18% of hospital spending is for administration and billing and 45% of gross physician income is for professional expenses, much of it for billing. Under Canada's single-payor system, only 8% of hospital costs are for administration and billing, and 36% of physician costs for professional expenses. According to one estimate, adopting a Canadian-style, single-payor health insurance system in the United States could have saved $22.5 billion in hospital, physician and nursing home expenses in 1983.[23] Reducing these costs incurred by American hospitals, doctors and other providers is another way to reduce provider rates without reducing provider income or quality of care. Administrative simplification would also address the dissatisfaction with complex and overlapping bureaucracy increasingly expressed by patients and providers.

UNIVERSAL COVERAGE

Savings from either of the reforms presented in this report -- 2% rate reductions and/or 12% administrative savings -- are more than enough to fund coverage for the uninsured.

A fundamental aspect of any health care reform must be the provision of universal access. Without universal access, Americans will continue to incur unnecessary costs due to delayed care, lack of cost-effective preventive care for children and pre-natal care for women, and untreated chronic illnesses which become more serious and costly. If everyone is insured, the risks can be spread evenly across the population.

Universal access will also help to ensure an adequate supply and distribution of health care providers. The financial burden of hospital uncompensated care is forcing hospitals to eliminate services that attract uninsured patients -- such as emergency and trauma centers. This curtails access for insured patients and forces everyone to travel further for emergency care. In geographic areas with large proportions of uninsured people, providers find that losses from uninsured patients cannot be recovered from the shrinking base of insured people and that continued provision of service to the entire community is not financially viable.[24]

The costs of providing coverage for the uninsured in the year 2000 will be $24.3 billion. This cost is based on a basic benefit package of hospital, physician services, diagnostic tests, limited mental health preventive services and prescription drug coverage. Since the uninsured use approximately one-third less health care than insured persons, this estimate shows the cost of the increase in the use of services. This estimate does not include any savings that would be generated by ensuring cost-effective preventive care and on-going treatment of chronic illnesses.

CONCLUSION

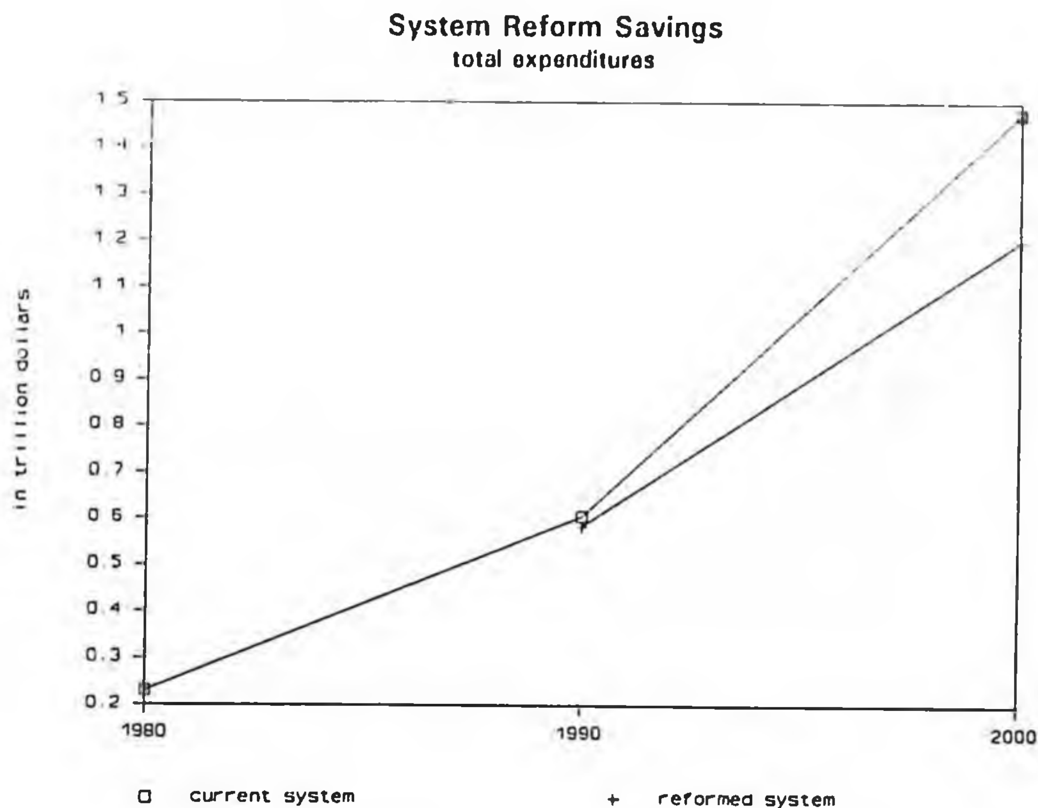
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

- The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion.

- By holding provider fees and rates to a 6.6% annual rate of per capita growth (about one and one-half times general inflation) $245.7 billion can be saved by the year 2000. This can be accomplished by expanding reforms in the Medicare program to our entire health care system.

♦ Administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high costs of private insurance administration. Additional savings may be possible from reduced provider overhead costs associated with billing.

The following tables present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.



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9. Lewin/ICF estimate using the Health Benefits Simulation Model.

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13. Maryland Health Services Cost Review Commission, Fiscal Year 1989 Report.

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COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES
BY STATE UNDER ALTERNATIVE POLICIES IN 2000
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	22,687,039	389,069	(3,805,249)	(629,995)	18,620,864	(4,046,175)
ALASKA	3,228,864	52,890	(534,023)	(134,508)	2,613,223	(515,640)
ARIZONA	23,306,882	313,035	(3,866,095)	(835,211)	18,918,612	(4,388,270)
ARKANSAS	11,097,073	193,713	(1,867,838)	(282,744)	9,140,204	(1,956,868)
CALIFORNIA	223,595,772	3,283,773	(37,113,065)	(8,154,865)	181,611,615	(41,984,157)
COLORADO	18,819,641	328,250	(3,119,607)	(762,585)	15,265,699	(3,553,942)
CONNECTICUT	20,996,403	354,138	(3,463,197)	(940,296)	16,947,048	(4,049,355)
DELAWARE	4,138,620	60,393	(691,154)	(125,720)	3,382,140	(756,480)
DISTRICT OF COLUMBIA	3,500,076	67,223	(593,286)	(70,790)	2,903,224	(596,852)
FLORIDA	90,060,126	1,210,959	(15,089,001)	(2,344,533)	73,837,551	(16,222,576)
GEORGIA	37,733,919	538,227	(6,309,527)	(1,087,148)	30,875,471	(6,858,448)
HAWAII	7,653,634	109,434	(1,262,304)	(323,721)	6,177,043	(1,476,590)
IDAHO	3,959,138	71,591	(659,214)	(145,671)	3,225,845	(733,294)
ILLINOIS	69,779,254	1,240,749	(11,547,728)	(2,963,833)	56,508,442	(13,270,812)
INDIANA	28,504,460	497,770	(4,717,173)	(1,201,718)	23,083,339	(5,421,122)
IOWA	13,620,316	271,924	(2,257,420)	(588,209)	11,046,611	(2,573,704)
KANSAS	14,677,643	257,370	(2,425,163)	(642,393)	11,867,457	(2,810,186)
KENTUCKY	15,737,896	291,848	(2,649,529)	(414,825)	12,965,388	(2,772,507)
LOUISIANA	20,590,574	410,813	(3,475,688)	(517,528)	17,008,171	(3,582,403)
MAINE	6,645,638	105,620	(1,099,393)	(272,017)	5,379,847	(1,265,790)
MARYLAND	31,074,629	458,792	(5,196,582)	(907,527)	25,429,311	(5,645,318)
MASSACHUSETTS	42,436,773	725,588	(7,030,106)	(1,730,655)	34,401,601	(8,035,173)
MICHIGAN	54,691,321	967,289	(9,055,599)	(2,289,721)	44,313,290	(10,378,031)
MINNESOTA	25,755,773	429,535	(4,239,365)	(1,200,744)	20,745,199	(5,010,574)
MISSISSIPPI	11,044,767	193,386	(1,860,928)	(270,833)	9,106,391	(1,938,375)
MISSOURI	31,946,064	536,740	(5,284,951)	(1,336,112)	25,861,740	(6,084,324)
MONTANA	3,486,657	69,350	(583,844)	(115,140)	2,857,023	(629,634)
NEBRASKA	8,580,707	159,869	(1,417,323)	(387,626)	6,935,627	(1,645,080)
NEVADA	8,837,119	112,469	(1,458,356)	(354,811)	7,136,421	(1,700,698)
NEW HAMPSHIRE	6,351,711	85,896	(1,045,852)	(273,909)	5,117,846	(1,233,865)
NEW JERSEY	42,383,428	701,136	(7,014,626)	(1,744,086)	34,325,852	(8,057,576)
NEW MEXICO	7,076,082	112,592	(1,179,766)	(235,763)	5,773,146	(1,302,936)
NEW YORK	115,121,894	2,064,813	(19,206,482)	(3,993,908)	93,986,317	(21,135,578)
NORTH CAROLINA	32,183,511	489,202	(5,377,481)	(980,695)	26,314,536	(5,868,975)
NORTH DAKOTA	3,606,280	73,636	(599,931)	(144,244)	2,935,741	(670,539)
OHIO	61,941,308	1,100,776	(10,267,317)	(2,531,973)	50,242,794	(11,698,514)
OKLAHOMA	14,232,334	293,934	(2,400,143)	(381,102)	11,745,023	(2,437,311)
OREGON	15,269,405	258,617	(2,537,250)	(574,818)	12,415,954	(2,853,451)
PENNSYLVANIA	69,555,852	1,237,755	(11,558,415)	(2,674,454)	56,560,738	(12,995,113)
RHODE ISLAND	6,448,659	109,254	(1,070,219)	(250,613)	5,237,081	(1,211,578)
SOUTH CAROLINA	15,222,478	239,954	(2,544,917)	(464,043)	12,453,472	(2,769,006)
SOUTH DAKOTA	3,773,731	67,320	(625,132)	(156,856)	3,059,063	(714,667)
TENNESSEE	27,908,735	456,767	(4,683,098)	(765,810)	22,916,594	(4,992,141)
TEXAS	88,910,873	1,544,835	(14,903,[illegible]74)	(2,620,198)	72,931,636	(15,979,237)
UTAH	7,493,528	123,948	(1,238,664)	(317,448)	6,061,362	(1,432,164)
VERMONT	2,[illegible]3,403	43,861	(454,743)	(117,254)	2,225,268	(528,135)
VIRGINIA	34,364,026	507,109	(5,735,435)	(1,069,528)	28,066,172	(6,297,854)
WASHINGTON	27,295,859	429,823	(4,533,675)	(1,006,614)	22,185,394	(5,110,465)
WEST VIRGINIA	7,844,814	165,857	(1,325,762)	(197,336)	6,487,573	(1,357,240)
WISCONSIN	26,967,967	480,209	(4,460,714)	(1,159,098)	21,828,364	(5,139,603)
WYOMING	1,634,548	36,516	(272,443)	(65,427)	1,333,192	(301,354)
TOTAL	$1,478,507,197	$24,325,619	($245,708,644)	($52,756,656)	$1,202,367,516	(274,139,681)

a/ Savings computed on the basis of total health spending under Universal Access
SOURCE: Lewin/ICF estimates

COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES BY STATE UNDER ALTERNATIVE POLICIES IN 1990

(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	9,522,402	194,638	(178,794)	(267,894)	9,270,352	(252,050)
ALASKA	1,242,929	26,459	(23,357)	(50,932)	1,195,100	(47,830)
ARIZONA	8,105,810	156,601	(152,028)	(291,921)	7,818,461	(287,348)
ARKANSAS	4,706,750	96,908	(88,387)	(121,620)	4,593,652	(113,099)
CALIFORNIA	84,754,469	1,642,760	(1,589,709)	(3,117,188)	81,690,332	(3,064,137)
COLORADO	8,045,268	164,212	(151,054)	(325,362)	7,733,064	(312,204)
CONNECTICUT	8,815,608	177,163	(165,471)	(405,325)	8,422,175	(393,633)
DELAWARE	1,547,100	30,213	(29,023)	(47,620)	1,500,670	(46,430)
DISTRICT OF COLUMBIA	1,559,131	33,630	(29,307)	(31,931)	1,531,523	(27,608)
FLORIDA	31,411,102	605,802	(589,111)	(840,263)	30,587,530	(823,572)
GEORGIA	13,669,245	269,257	(256,468)	(395,572)	13,286,461	(382,784)
HAWAII	2,797,343	54,746	(52,478)	(117,620)	2,681,991	(115,352)
IDAHO	1,748,435	35,815	(32,830)	(64,245)	1,687,175	(61,260)
ILLINOIS	30,597,883	620,704	(574,422)	(1,343,072)	29,301,094	(1,296,789)
INDIANA	12,362,662	249,017	(232,055)	(532,810)	11,846,815	(515,847)
IOWA	6,615,476	136,034	(124,228)	(294,609)	6,332,683	(282,794)
KANSAS	6,426,779	128,754	(120,622)	(289,497)	6,145,414	(281,365)
KENTUCKY	7,021,825	146,002	(131,888)	(186,001)	6,849,938	(171,888)
LOUISIANA	9,545,115	205,516	(179,412)	(240,437)	9,330,783	(214,332)
MAINE	2,687,926	52,838	(50,430)	(112,449)	2,577,885	(110,041)
MARYLAND	11,627,792	229,518	(218,175)	(342,905)	11,296,230	(331,562)
MASSACHUSETTS	17,947,477	362,987	(336,913)	(753,437)	17,220,115	(727,362)
MICHIGAN	23,874,781	483,902	(448,200)	(1,031,175)	22,879,307	(995,473)
MINNESOTA	10,857,061	214,882	(203,724)	(514,127)	10,354,092	(502,969)
MISSISSIPPI	4,638,528	96,744	(87,129)	(114,055)	4,534,088	(104,439)
MISSOURI	13,373,361	268,513	(251,010)	(578,860)	12,812,003	(561,358)
MONTANA	1,641,223	34,694	(30,837)	(53,992)	1,591,087	(50,136)
NEBRASKA	3,933,640	79,977	(73,851)	(181,791)	3,757,975	(175,664)
NEVADA	3,115,213	56,264	(56,355)	(125,858)	2,987,264	(127,949)
NEW HAMPSHIRE	2,258,658	42,971	(42,350)	(99,597)	2,159,682	(98,976)
NEW JERSEY	17,368,763	350,755	(326,039)	(735,990)	16,657,489	(711,274)
NEW MEXICO	2,757,688	56,326	(51,778)	(91,096)	2,671,140	(86,547)
NEW YORK	50,354,750	1,032,956	(945,534)	(1,792,954)	48,649,219	(1,705,532)
NORTH CAROLINA	12,259,381	244,731	(230,076)	(376,230)	11,897,807	(361,574)
NORTH DAKOTA	1,751,185	36,838	(32,900)	(71,797)	1,683,326	(67,859)
OHIO	27,193,403	550,681	(510,491)	(1,146,344)	26,087,249	(1,106,154)
OKLAHOMA	6,824,669	147,045	(128,280)	(184,441)	6,658,993	(165,676)
OREGON	6,523,595	129,377	(122,415)	(246,256)	6,284,301	(239,294)
PENNSYLVANIA	30,541,650	619,207	(573,360)	(1,221,936)	29,365,561	(1,176,089)
RHODE ISLAND	2,701,187	54,656	(50,706)	(107,859)	2,597,276	(103,911)
SOUTH CAROLINA	6,011,186	120,041	(112,815)	(183,631)	5,834,781	(176,405)
SOUTH DAKOTA	1,662,251	33,678	(31,205)	(70,916)	1,593,808	(68,443)
TENNESSEE	11,328,956	228,505	(212,657)	(314,445)	11,030,359	(298,597)
TEXAS	37,380,724	772,828	(702,025)	(1,111,317)	36,340,210	(1,040,514)
UTAH	3,085,385	62,007	(57,912)	(129,926)	2,969,554	(125,831)
VERMONT	1,117,014	21,942	(20,957)	(48,544)	1,069,456	(47,558)
VIRGINIA	12,931,845	253,690	(242,614)	(404,510)	12,538,410	(393,434)
WASHINGTON	11,084,596	215,026	(207,913)	(408,369)	10,683,339	(401,257)
WEST VIRGINIA	3,846,712	82,973	(72,306)	(97,342)	3,760,037	(86,675)
WISCONSIN	11,980,357	240,232	(224,859)	(528,175)	11,467,555	(512,802)
WYOMING	821,858	18,268	(15,458)	(32,805)	791,862	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(22,177,039)	584,596,673	(21,381,674)

a/ Savings computed on the basis of total health spending under Universal Access

SOURCE: Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

In this analysis we developed estimates of total health expenditures in each state by source of payment in 1980 and 1987. We also developed projections of future health expenditures by state in selected years under current policy and alternative health care financing scenarios. This appendix describes the methods used to develop these estimates.

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1987 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

- Direct payments by households.
- Employer health insurance payments.
- Payments by other private sources.
- Medicare payments.
- State Medicaid expenditures.
- Federal Medicaid expenditures.
- Payments by other public sources.

State-level data on Medicare and Medicaid spending were obtained from the Health Care Financing Administration (HCFA). However, information on other health care expenditures by state and local governments is largely unavailable from existing data sources. Data on health spending by households and employers are also unavailable at the state level.

Due to the lack of state-level health expenditures data, we estimated state spending using techniques that reflect the unique socio-economic composition of the population in each state. We developed these estimates for 1980 and 1987 using the following three steps:

- **Develop First Stage estimates.** We estimated total expenditures by source of payment based upon the socio-economic composition of the population in each state. The Lewin/ICF Health Benefits Simulation Model (HBSM) was used to estimate per-capita health spending for each source of payment by age, income, geographic region, and health insurance status. Using these per capita health spending estimates, we estimated total health spending in each state based upon state-level data on the distribution of persons by age, income, and insured status as reported in the Current Population Survey (CPS) for 1980 and 1987.

- **Adjust First Stage Estimates to Replicate Known Totals By State.** We then adjusted the first stage estimates to reflect the following known control totals for 1980 and 1987:

  -- Medicare spending by state.
  -- Federal Medicaid spending by state.
  -- State Medicaid spending.

  In addition, we adjusted total health spending to reflect HCFA estimates of relative differences in per-capita health spending by state in 1982.

- **Adjust Second Stage Estimates to Replicate HCFA Estimates of National Health Spending by Source of Payment.** The state-level health spending estimates developed in the second stage were adjusted to replicate HCFA estimates of national health spending by source of payment.

B. PROJECTIONS OF HEALTH SPENDING IN FUTURE YEARS UNDER ALTERNATIVE SCENARIOS

In the second task we developed projections of total health spending in each state under alternative health care financing strategies. Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

We then developed estimates of total health spending by state under three policy scenarios. These policy scenarios are described below.

Scenario #1

In the first scenario we developed estimates of national health spending under a universal health plan that emphasized a pluralistic health insurance system. We assumed

that, under this scenario, all individuals would be covered under a benefits package similar to that recommended by the Pepper Commission with the exception that prescription drugs would be covered.

Under this scenario, we estimate that there will be an initial increase in health spending in 1990 as previously uninsured persons become covered under a health plan. The increase in health spending was allocated across states in proportion to the number of uninsured in each state. (Estimates of uninsured persons by state are also provided as part of this study.) For purposes of estimating the administrative costs of insurance under this scenario, we assumed that 1) all workers and dependents would become covered under private employer health insurance where administrative costs average about 15 percent of benefit payments, and 2) all non-workers would become covered under a public plan where administrative costs average about three percent of benefit payments.

Scenario #2

In the second scenario we assumed that all persons in the United States would become covered under a unitary payer system. We assumed that the unitary plan would have patient cost sharing similar to that under the Pepper Commission proposal ($250 deductible for a single person, $500 per family, 20% copayments for hospital, physician and lab services, with an out-of-pocket limit of $3,000 per individual or family). Under this scenario, we estimated the savings due to reduced insurance administrative overhead charges under a unitary payer system.

We assumed that the shift to the unitary payer would result in substantial savings in administrative costs due to the elimination of insurer profits and marketing costs and the simplification of claims processing and other general administrative functions. We estimated these administrative savings by assuming that persons who were privately insured in Scenario #1 would be shifted to a unitary payer where administrative overhead

charges are assumed to be the same as in the current Medicare program. For privately insured persons we assumed that this would reduce administrative charges from 15 percent of benefit payments to less than 3 percent.

Scenario #3

We also estimated total health spending in 1990 and 2000 assuming cost controls were implemented. HCFA estimates that per capita health spending will increase by about 8.6 percent per year through 2000. To illustrate the potential impact of cost controls, we estimated health expenditures in 2000 assuming the growth in spending is reduced to 6.6 percent annually.

The purpose of these estimates is to show the potential savings that could be achieved by slowing the projected rate of growth in health spending. These estimates are intended to be illustrative and should not be interpreted as estimates of the savings arising under any particular cost containment program.

EMERGENCY!

Rising Health Costs in America 1980 - 1990 - 2000

A Families USA Foundation Report

in Cooperation with

Citizen Action

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
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October 1990

Health care costs in the United States have risen dramatically, far outpacing economic growth, general inflation, and families' incomes. These spiraling health costs are creating an emergency -- a crisis of affordability for consumers, government, labor, and business. Families are paying more in premiums, deductibles and co-payments while often seeing their benefits shrink. Employers faced with double digit premium increases now find that health care costs consume nearly 94% of net profits.[1] Rising costs have also resulted in a growing number of Americans without adequate health coverage, or none at all.

This report examines the magnitude of the health care cost crisis by providing data on health spending and the uninsured during the 1980s and projections of what the United States will be spending by the end of the 1990s should the status quo continue in our health care system. Information on health care costs and numbers of uninsured are provided on a state-by-state and national basis. This is the first time state-based data on health care expenditures has been available since 1982, when the Health Care Financing Administration stopped providing it.

The magnitude of health care cost increases over the 1980s indicates why there is serious interest in health care reform. This interest has been increasing among both state and federal legislators.

THE 1980s: RISING COSTS

During the last decade, health care costs have risen at rates far exceeding the consumer price index. Between 1980 and 1989 the average annual increase in the consumer price index was 4.7%. Health care spending increases averaged 10.4% during this same period. An increasing portion of every family budget has been going to pay for health care since skyrocketing health costs have dwarfed wage increases. Annual earnings increased 4% per year, on average, since 1980.

National health care spending more than doubled between 1980 and 1990, jumping from $230 billion to $606 billion. American consumers pay directly for over 25% of this huge health care bill through out-of-pocket payments. Although many public and private health plans have responded to these cost increases with a variety of cost control initiatives, these efforts have been piecemeal and have not succeeded in holding down system-wide costs.

- Per capita spending increased 139% from 1980 to 1990, rising from $1,016 to $2,425 per person in 1990.

- From 1980 to 1990 overall health care spending in the United States more than doubled, increasing by 163%, from $230 billion to $606 billion.