

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7398 SENATE HEALTH EDUCATION & SOCIAL SERVICES

- ▼ Spending for employer-based health insurance premiums increased 164% in the past decade, from \$66 billion to \$174 billion.
- ▼ An increasing portion of every family's budget is going to pay for health care as shown by the 157% rise in out-of-pocket spending from 1980 to 1990 (excluding the cost of employee premium contributions), from \$63 billion to \$162 billion.
- ▼ State government spending for Medicaid increased 156% between 1980 and 1990, from \$10.7 billion to \$27.4 billion.
- ▼ Massachusetts (\$3,031), California (\$2,894), New York (\$2,818), Nevada (\$2,757) and Rhode Island (\$2,707) have the highest levels of per capita health spending in 1990. South Carolina (\$1,689), Idaho (\$1,726), Mississippi (\$1,751), Wyoming (\$1,756) and Utah (\$1,784) have the lowest levels of per capita health spending in 1990.
- ▼ In Arizona (160.7%), Alaska (157.2%), Florida (152.3%), New Mexico (152.2%) and Maine (150%) per capita health expenditures increased at least 150% from 1980 to 1990.

Although all states experienced health care spending increases well above the consumer price index, there is high variation in spending among states. This variation is generally explained by the following kinds of factors: demographics (especially the proportion of a state's population that is either women of child-bearing age, or older men and women); the numbers of uninsured persons in a state (uninsured persons consume about one-third less health care than insured persons); the environmental conditions in a state (these can cause deteriorating health); the number and type of health care facilities and providers in a state (this will cause individuals to travel into or out of a state to get health care); the practice patterns of providers in state (the use of hospital inpatient care and surgical procedures varies greatly among geographic areas), and historical levels of spending in a state.

THE 1980s: DECLINING ACCESS

Dramatic increases in health care spending have not resulted in more Americans having access to better care. Despite the high price tag of our health care system, millions of Americans are without any health insurance, public or private. The number of uninsured Americans has grown during the 1980s.² State-by-state data on

numbers of uninsured persons show variation in the growth or decline of uninsured persons. Reasons for this state variation are diverse. In some instances, an aging population means that a growing portion of the state's residents have become eligible for Medicare. The composition of a state's economy can also influence the number of uninsured, as particular industries are more or less likely to offer employer coverage. Other factors, such as a state's Medicaid eligibility level, income levels, and economic well-being, also influence the number of uninsured.

- ▼ Over 13% of Americans, almost 32 million, were uninsured on any given day in 1988.
- ▼ The number of uninsured Americans has increased 30%, from 24.5 million persons in 1980 to 31.8 million persons in 1988 (the most recent year for which published statistics are available).
- ▼ 28% of U.S. residents, 63 million people, lacked health insurance for at least a month during the 28 month period ending May 1987, according to the Census Bureau.
- ▼ New Mexico (22.8%), Arkansas (21.8%), Texas (21.4%), Florida (18.4%), Oklahoma (18%), Mississippi (17.9%), Arizona (17.7%), Nevada (17.3%), Louisiana (17.3%) and California (17.2%) had the highest percentages of uninsured persons as of 1988.
- ▼ Nevada (86.7%), Kentucky (68.9%), Florida (62%), Texas (59.5%) California (57.7%), Alaska (57.2%), and Oregon (52.6%) all saw the number of uninsured persons in the state increase by more than 50% from 1980 to 1988.

Who are these uninsured persons? Young adults are the most likely to lack insurance. Twenty-seven percent of persons 18-24 lack insurance.³ These are individuals who are likely to be in entry-level jobs and to be too old to qualify as dependents of other family members. Twenty-eight percent of the uninsured are children. Forty-two percent of the nation's uninsured live in the South.

Five out of eight uninsured persons are employed or are dependents of employed persons. Just over half of uninsured workers are employed by firms with less than 25 employees.

Why has the number of uninsured persons increased? One of the major reasons is a reduction in the number of individuals and their families covered by employment-

related insurance. In recent years there has been an increase in the number of persons employed in businesses that don't offer health insurance, or offer inadequate or unaffordable insurance.⁴

Health care inflation and competition in the small group insurance market have combined to make health insurance increasingly unaffordable for small businesses, their employees and their dependents. In order to hold premiums and benefit payments down and attract customers, insurers have been engaging in a number of practices that have had the effect of increasing the number of uninsured, or underinsured persons, who work in small businesses or are dependents of these workers. These practices include: denying coverage to certain, high-risk individuals within small groups; denying coverage to entire small groups considered to be high risk; and denying coverage for pre-existing conditions, such as diabetes or asthma.⁵

Analysis of the nonelderly population shows that an additional 13 percent of the nonelderly, 20 million persons, are underinsured -- at risk of spending more than 10 percent of their income on health care.⁶ Since the elderly spend an estimated 18% of their incomes on health care on average, including the elderly would add many millions to the number of underinsured.⁷

When small businesses do get insurance, the insurance companies establish the premiums based on "experience-rating" -- the practice of basing premiums solely on the experience of the specific group, rather than establishing a "community-rating" for the larger community as a whole. Premiums set on the basis of experience-rating, rather than community rating, are more unstable and rise quickly.

One of the ways employers have responded to escalating premiums is by charging employees a greater share of the premiums. The percentage of employees paying \$100 or more a month for family health insurance rose from 5 percent in 1986 to 16 percent in 1988. Average employee payments for individual coverage rose 32 percent between 1988 and 1989.⁸ These increased cost demands on employees result in employees, especially low-wage employees, declining health insurance because it is unaffordable.

A vicious cycle of higher costs and declining access was set in motion during the 1980s. Uninsured persons often forego cost effective preventive care and, when they seek care, do so at costly hospital emergency rooms instead of physicians' offices. To cover the cost of treating the uninsured, hospitals raise their rates to privately-insured patients and insurance premiums go up. Cost-shifting due to uncompensated care and the lack of insurance offered by some employers accounts for approximately

27% of employer health care costs. In the face of rising premiums, more employers chose not to offer coverage at all, ultimately increasing the costs of coverage for those who remain insured.

THE 1990s: A \$1.5 TRILLION ANNUAL HEALTH CARE BILL

The huge increase in outlays for health care during the 1980s pales in comparison to what this country will spend by the year 2000 should the status quo continue with our health care system. Absent fundamental change, consumers, employers and governments can expect a \$1.47 trillion annual health care bill by the year 2000.

- ▼ By 2000, health care spending will rise to \$5,515 per person, an increase of 443% from 1980.
- ▼ From 1980 to 2000, overall health care spending will be six and one-half times higher.
- ▼ Employers and employees will have to absorb a 529% increase from 1980 to 2000, from \$66 billion to \$412 billion for employer-based health coverage.
- ▼ Families will experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from \$63 billion to \$386 billion, not counting the employee share of health insurance premiums.
- ▼ By the year 2000, state governments can expect to see a 480% increase in Medicaid expenditures, from 1980 spending levels of \$11 billion to \$62 billion in 2000.
- ▼ In the 1980-2000 period, per capita spending will increase fastest in Arizona (493%), Alaska (485%), New Mexico (473.9%), Florida (473.7%), Maine (468.5%), North Dakota (467.6%) and Washington (466%).

Clearly, health care spending of the magnitude described above presents a crisis of affordability for every family, for the American economy, and for government. The data in this report illustrates the need for fundamental reform of our health care system. Unless the United States takes bold action now, all Americans will suffer a declining standard of health care and a declining standard of living as a result of the increasing burden of health care costs.

ENDNOTES

1. Katherine R. Levit, Mark S. Freeland and Daniel Waldo, "Health spending and ability to pay: Business, individuals and government," **Health Care Financing Review**, Spring 1989, p. 9.
2. The estimates in this report are based on the most recent data from the Census Bureau. These estimates, 31.8 million persons nationally, are lower than previous estimates of approximately 37 million uninsured persons because the Census Bureau now asks if uninsured persons are covered by insurance from someone not living in the household, e.g. a noncustodial parent.
3. Unless otherwise noted, data are the results of analysis by Lewin/ICF, Inc.
4. See **A Call for Action**, The Pepper Commission, The U.S. Bipartisan Commission on Comprehensive Health Care, Final Report, September 1990, p. 23-6.
5. These practices are described in "The Crisis in Health Insurance," **Consumer Reports**, August 1990, p. 533-7.
6. Jack Needleman, Judith Arnold, John Sheils and Lawrence S. Lewin, "The Health Care Financing System and the Uninsured," submitted to the Office of Research, Health Care Financing Administration, Department of Health and Human Services, April 4, 1990. The Joint Economic Committee estimates the number of the underinsured at 70 million. See **Medical Alert**, a staff report of the Subcommittee on Education and Health of the Joint Economic Committee, October 1989.
7. Committee Analysis, Select Committee on Aging, U.S. House of Representatives, October 26, 1988.
8. United States Department of Labor, Bureau of Labor Statistics, News, (Washington, D.C., USDL 90-160, March 30, 1990).

Table 1
PER CAPITA HEALTH SPENDING
1980 - 2000

STATE	1980	% Change		% Change Rank	% Change	
		1990	1980-1990		2000	1980-2000
ALABAMA	924	2,286	147.4%	13	5,201	462.8%
ALASKA	921	2,367	157.2%	2	5,390	485.5%
ARIZONA	848	2,211	160.7%	1	5,031	493.0%
ARKANSAS	844	1,944	130.4%	46	4,423	424.1%
CALIFORNIA	1,186	2,894	143.9%	17	6,584	454.9%
COLORADO	996	2,415	142.5%	20	5,496	451.8%
CONNECTICUT	1,148	2,699	135.2%	39	6,136	434.7%
DELAWARE	960	2,268	136.3%	36	5,160	437.6%
DISTRICT OF COLUMBIA	1,241	2,586	108.4%	51	5,882	374.1%
FLORIDA	962	2,427	152.3%	3	5,520	473.7%
GEORGIA	883	2,072	134.7%	40	4,714	434.0%
HAWAII	993	2,459	148.5%	9	5,619	465.6%
IDAHO	708	1,726	143.9%	18	3,928	455.0%
ILLINOIS	1,093	2,619	139.6%	29	5,953	444.6%
INDIANA	919	2,201	139.4%	30	5,004	444.3%
IOWA	993	2,351	136.6%	35	5,343	437.9%
KANSAS	1,057	2,548	141.1%	22	5,792	448.0%
KENTUCKY	806	1,875	132.5%	43	4,266	429.1%
LOUISIANA	940	2,185	132.4%	44	4,972	428.9%
MAINE	870	2,175	150.0%	5	4,945	468.5%
MARYLAND	1,041	2,436	134.1%	42	5,541	432.5%
MASSACHUSETTS	1,284	3,031	136.0%	38	6,890	436.5%
MICHIGAN	1,097	2,569	134.3%	41	5,840	432.5%
MINNESOTA	1,110	2,480	123.4%	49	5,641	408.1%
MISSISSIPPI	759	1,751	130.6%	45	3,984	424.6%
MISSOURI	1,033	2,568	148.6%	8	5,837	465.1%
MONTANA	859	2,059	139.7%	27	4,686	445.6%
NEBRASKA	1,016	2,452	141.4%	21	5,576	448.8%
NEVADA	1,109	2,757	148.5%	10	6,272	465.3%
NEW HAMPSHIRE	813	1,981	143.6%	19	4,505	453.8%
NEW JERSEY	930	2,224	139.2%	32	5,056	443.8%
NEW MEXICO	711	1,792	152.2%	4	4,078	473.9%
NEW YORK	1,257	2,818	124.2%	48	6,408	409.8%
NORTH CAROLINA	773	1,833	137.1%	34	4,170	439.5%
NORTH DAKOTA	1,066	2,661	149.7%	6	6,051	467.6%
OHIO	1,039	2,493	140.0%	26	5,667	445.6%
OKLAHOMA	906	2,139	136.2%	37	4,867	437.3%
OREGON	940	2,312	146.0%	15	5,260	459.8%
PENNSYLVANIA	1,021	2,536	148.3%	11	5,763	464.2%
RHODE ISLAND	1,184	2,707	128.6%	47	6,153	419.7%
SOUTH CAROLINA	706	1,689	139.2%	31	3,842	444.4%
SOUTH DAKOTA	952	2,322	144.0%	16	5,278	454.7%
TENNESSEE	952	2,262	137.7%	33	5,145	440.8%
TEXAS	915	2,192	139.7%	28	4,987	445.3%
UTAH	741	1,784	140.8%	23	4,062	448.0%
VERMONT	815	1,956	140.1%	25	4,448	445.9%
VIRGINIA	863	2,076	140.5%	24	4,724	447.2%
WASHINGTON	929	2,311	148.7%	7	5,258	466.0%
WEST VIRGINIA	843	2,088	147.6%	12	4,752	463.4%
WISCONSIN	1,097	2,449	123.2%	50	5,567	407.3%
WYOMING	714	1,756	146.1%	14	3,998	460.0%
TOTAL	\$1.016	\$2.425	138.7%		\$5.515	442.8%

SOURCE: Lewin/ICF estimates

Table 2

TOTAL HEALTH SPENDING

1980 - 2000

(in thousands of dollars)

STATE	1980	% Change		Rank	% Change	
		1990	1980-1990		2000	1980-2000
ALABAMA	3,598,838	9,522,402	164.6%	21	22,667,039	529.8%
ALASKA	370,082	1,242,929	235.9%	3	3,228,864	772.5%
ARIZONA	2,305,619	8,105,810	251.6%	1	23,306,832	910.9%
ARKANSAS	1,929,340	4,706,750	144.0%	37	11,097,073	475.2%
CALIFORNIA	28,080,581	84,754,469	201.8%	5	223,595,772	696.3%
COLORADO	2,878,913	8,045,268	179.5%	14	18,819,641	553.7%
CONNECTICUT	3,566,669	8,815,808	147.2%	32	20,996,403	488.7%
DELAWARE	570,197	1,547,100	171.3%	17	4,138,620	625.8%
DISTRICT OF COLUMBIA	791,551	1,559,131	97.0%	51	3,500,076	342.2%
FLORIDA	9,376,859	31,411,102	235.0%	4	90,060,126	860.5%
GEORGIA	4,822,254	13,669,245	183.5%	12	37,733,919	682.5%
HAWAII	958,674	2,797,343	191.8%	8	7,653,634	698.4%
IDAHO	668,050	1,748,435	161.7%	24	3,959,138	492.6%
ILLINOIS	12,489,958	30,597,883	145.0%	35	69,779,254	458.7%
INDIANA	5,047,369	12,362,662	144.9%	36	28,504,460	464.7%
IOWA	2,894,898	6,615,476	128.5%	49	13,620,316	370.5%
KANSAS	2,498,938	6,426,779	157.2%	26	14,677,643	487.4%
KENTUCKY	2,951,766	7,021,825	137.9%	45	15,737,895	433.2%
LOUISIANA	3,954,402	9,545,115	141.4%	42	20,590,574	420.7%
MAINE	978,536	2,687,926	174.7%	15	6,645,638	579.1%
MARYLAND	4,388,016	11,627,792	165.0%	20	31,074,629	608.2%
MASSACHUSETTS	7,367,870	17,947,477	143.6%	38	42,436,773	476.0%
MICHIGAN	10,158,071	23,874,781	135.0%	46	54,691,321	438.4%
MINNESOTA	4,525,259	10,857,061	139.9%	44	25,755,773	469.2%
MISSISSIPPI	1,914,580	4,638,528	142.3%	41	11,044,767	476.9%
MISSOURI	5,079,283	13,373,361	163.3%	23	31,946,064	528.9%
MONTANA	676,015	1,641,223	142.8%	39	3,486,657	415.8%
NEBRASKA	1,595,143	3,933,640	146.6%	33	8,580,707	437.9%
NEVADA	887,542	3,115,213	251.0%	2	8,837,119	895.7%
NEW HAMPSHIRE	749,188	2,258,658	201.5%	6	6,351,711	747.8%
NEW JERSEY	6,848,103	17,368,763	153.6%	27	42,383,428	518.9%
NEW MEXICO	925,932	2,757,688	197.8%	7	7,076,082	664.2%
NEW YORK	22,066,936	50,354,750	128.2%	50	115,121,894	421.7%
NORTH CAROLINA	4,546,873	12,259,381	169.6%	18	32,183,511	607.8%
NORTH DAKOTA	696,115	1,751,185	151.6%	30	3,606,280	418.1%
OHIO	11,215,407	27,193,403	142.5%	40	61,941,308	452.3%
OKLAHOMA	2,740,188	6,824,669	149.1%	31	14,232,334	419.4%
OREGON	2,474,037	6,523,595	163.7%	22	15,269,405	517.2%
PENNSYLVANIA	12,117,790	30,541,650	152.0%	29	69,555,852	474.0%
RHODE ISLAND	1,121,337	2,701,187	140.9%	43	6,448,659	475.1%
SOUTH CAROLINA	2,203,405	6,011,186	172.8%	16	15,222,478	590.9%
SOUTH DAKOTA	657,535	1,662,251	152.8%	28	3,773,731	473.9%
TENNESSEE	4,368,396	11,328,956	159.3%	25	27,908,735	538.9%
TEXAS	13,012,429	37,380,724	187.3%	10	88,910,873	583.3%
UTAH	1,082,735	3,085,385	185.0%	11	7,493,526	592.1%
VERMONT	416,395	1,117,014	168.3%	19	2,753,403	561.2%
VIRGINIA	4,615,580	12,931,845	180.2%	13	34,364,026	644.5%
WASHINGTON	3,838,548	11,084,596	188.8%	9	27,295,859	611.1%
WEST VIRGINIA	1,644,557	3,846,712	133.9%	47	7,844,814	377.0%
WISCONSIN	5,164,568	11,980,357	132.0%	48	26,967,967	422.2%
WYOMING	335,414	821,858	145.0%	34	1,634,546	387.3%
TOTAL	<u>\$230,166,741</u>	<u>\$605,978,347</u>	<u>163.3%</u>		<u>\$1,476,507,197</u>	<u>541.5%</u>

SOURCE: Levin/ICF estimates

Table 3a

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 ^{a/}
(Dollars in thousands)

STATE	OUT OF POCKET ^{b/}	EMPLOYEE SPONSORED	NON GROUP	OTHER PRIVATE	MEDICARE				TOTAL	PER CAPITA COST
					STATE	FEDERAL	MEDICARE	OTHER PUBLIC		
ALABAMA	1,117,579	756,469	186,631	44,044	77,669	193,143	551,715	651,587	3,598,838	824
ALASKA	88,940	121,467	7,206	6,155	13,720	13,720	17,773	101,013	370,082	921
ARIZONA	582,995	698,587	12,743	38,635	NA	NA	378,804	585,855	2,305,819	848
ARKANSAS	582,892	369,379	86,883	23,812	65,441	175,772	300,778	325,184	1,929,340	844
CALIFORNIA	6,111,415	7,281,598	710,178	370,271	1,401,953	1,401,953	4,164,000	6,639,211	28,089,581	1,100
COLORADO	695,272	933,532	74,885	43,390	87,470	99,272	302,454	642,638	2,878,913	998
CONNECTICUT	1,026,949	1,228,817	238,910	43,829	178,702	179,702	611,034	57,729	3,568,669	1,148
DELAWARE	168,160	139,750	28,468	5,787	23,279	23,279	87,529	88,949	570,197	950
DISTRICT OF COLUMBIA	168,707	123,705	28,275	8,661	86,588	86,588	148,818	142,410	791,551	1,241
FLORIDA	2,814,989	1,778,037	478,882	88,866	185,427	237,458	2,153,010	1,851,597	9,378,859	862
GEORGIA	1,499,191	1,132,191	231,268	54,378	157,967	317,264	614,894	813,100	4,822,254	883
HAWAII	217,889	277,774	24,639	12,659	49,435	49,435	92,413	234,429	958,674	993
IDaho	157,700	192,882	18,680	9,178	18,331	35,112	83,920	172,443	888,050	708
ILLINOIS	3,400,815	4,201,372	908,180	222,739	812,487	812,487	2,339,886	194,382	12,489,958	1,093
INDIANA	1,497,890	1,805,812	411,938	97,491	155,513	208,516	754,790	115,418	5,047,389	919
IOWA	817,145	979,140	238,551	51,420	132,750	133,838	488,428	85,821	2,894,898	993
KANSAS	674,088	798,112	204,462	42,970	88,389	111,000	443,405	130,491	2,498,938	1,057
KENTUCKY	945,732	738,292	181,148	31,588	87,004	208,798	397,782	373,522	2,951,788	808
LOUISIANA	1,198,552	880,116	198,340	40,451	133,052	293,670	470,571	741,550	3,954,402	940
MAINE	284,843	280,438	77,439	13,382	41,117	93,826	178,001	8,389	878,538	870
MARYLAND	1,286,977	1,149,042	211,012	48,508	164,234	164,234	688,873	687,138	4,308,018	1,041
MASSACHUSETTS	1,961,518	2,207,911	437,648	88,910	500,501	538,607	1,529,777	104,800	7,367,870	1,284
MICHIGAN	2,648,028	3,441,020	718,157	159,462	550,719	550,719	1,771,878	317,690	10,158,071	1,097
MINNESOTA	1,243,181	1,498,322	381,196	63,258	288,169	337,814	704,835	27,881	4,525,250	1,110
MISSISSIPPI	618,332	410,989	0	33,320	48,684	168,171	281,274	282,078	1,914,580	759
MISSOURI	1,482,558	1,652,437	438,857	98,288	120,224	183,065	1,008,024	89,831	5,078,283	1,033
MONTANA	158,707	182,422	19,088	9,501	22,871	41,158	73,442	188,847	878,015	859
NEBRASKA	469,733	532,375	134,464	30,893	47,389	84,430	260,572	55,287	1,595,143	1,018
NEVADA	202,680	261,305	22,759	12,294	23,073	23,073	112,798	229,561	887,542	1,109
NEW HAMPSHIRE	227,069	280,811	53,749	8,806	28,738	45,157	107,878	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,168	458,158	85,935	388,438	388,438	1,148,073	92,875	8,848,103	930
NEW MEXICO	228,563	248,079	25,581	14,411	22,378	49,875	91,184	247,833	925,032	711
NEW YORK	5,502,085	8,045,460	1,304,282	248,347	2,334,327	2,334,327	4,012,129	285,980	22,066,938	1,257
NORTH CAROLINA	1,443,086	1,108,169	227,200	52,419	133,382	278,833	578,892	729,155	4,548,873	773
NORTH DAKOTA	199,350	223,808	59,960	13,989	18,628	29,678	120,945	29,759	698,115	1,068
OHIO	3,218,538	4,009,817	854,293	190,723	373,505	458,355	1,818,967	191,410	11,215,407	1,039
OKLAHOMA	840,211	581,953	139,728	28,583	89,177	173,587	433,308	443,842	2,740,188	906
OREGON	558,453	705,573	88,503	33,498	81,525	102,339	319,288	804,859	2,474,037	940
PENNSYLVANIA	3,486,617	3,967,694	860,052	181,365	487,881	589,883	2,385,775	188,722	12,117,780	1,021
RHODE ISLAND	291,138	358,994	72,062	12,411	69,551	95,300	204,278	17,604	1,121,337	1,184
SOUTH CAROLINA	883,690	437,942	95,613	25,117	77,334	189,059	230,513	484,138	2,203,405	706
SOUTH DAKOTA	202,638	199,249	58,778	15,537	17,815	38,808	89,529	25,381	657,535	952
TENNESSEE	1,377,091	1,038,889	228,380	45,904	119,232	270,798	629,648	862,158	4,368,396	952
TEXAS	4,244,744	3,070,355	632,707	159,455	418,882	588,238	1,878,289	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	28,122	55,887	78,516	268,814	1,082,735	741
VERMONT	119,592	133,428	29,474	5,360	19,259	41,687	83,584	4,002	418,395	815
VIRGINIA	1,402,784	1,123,900	234,835	46,855	180,351	208,611	593,181	845,275	4,615,580	863
WASHINGTON	852,112	1,071,822	99,177	52,104	169,065	169,065	400,188	1,025,015	3,838,548	929
WEST VIRGINIA	551,141	398,291	89,965	18,220	34,764	71,711	252,528	229,937	1,644,557	843
WISCONSIN	1,349,249	1,765,318	391,282	78,756	298,468	408,588	822,555	52,372	5,184,568	1,097
WYOMING	78,091	108,783	9,384	4,878	7,420	7,400	32,597	87,905	335,414	714
TOTAL	\$63,149,884	\$65,626,952	\$12,948,686	\$3,123,818	\$10,897,188	\$13,147,308	\$37,248,701	\$24,228,100	\$230,166,741	\$1,016

^{a/} Includes personal health expenditures and administrative costs

^{b/} Does not include employee share of premiums for employer sponsored insurance. These payments are included in the 'Employer Sponsored' column.

SOURCE: Lewin/ICF estimates

Table 3b

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 ^{a/}

(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYEE- SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID				TOTAL	PER CAPITA COST
					STATE	FEDERAL	MEDICARE	OTHER PUBLIC		
ALABAMA	2,814,760	2,012,389	416,532	101,765	163,013	425,482	1,932,843	1,655,817	9,522,402	2,286
ALASKA	329,687	427,212	29,864	24,057	80,300	80,360	80,357	231,034	1,242,829	2,387
ARIZONA	1,972,383	2,379,617	240,860	137,174	222,869	367,652	1,367,192	1,418,276	8,105,810	2,211
ARKANSAS	1,448,372	892,449	108,921	57,525	103,707	292,630	990,607	721,250	4,708,750	1,944
CALIFORNIA	20,379,570	25,840,378	2,335,173	1,471,282	3,574,078	3,574,078	14,853,732	12,928,177	84,754,469	2,694
COLORADO	2,097,807	2,670,571	203,730	139,260	304,439	304,439	969,270	1,295,747	8,045,268	2,415
CONNECTICUT	2,278,555	3,303,221	472,925	82,800	514,838	514,838	1,578,609	89,760	8,815,808	2,680
DELAWARE	454,368	385,103	70,128	14,539	86,058	86,058	291,765	218,899	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,178	50,202	11,191	182,518	182,518	344,880	228,817	1,559,131	2,586
FLORIDA	9,375,203	6,218,478	1,398,700	322,360	878,583	1,125,484	8,083,607	4,010,398	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,838	124,588	488,424	852,179	2,224,539	2,301,878	13,689,245	2,072
HAWAII	697,628	966,101	86,984	102,084	102,084	108,251	295,352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,198	14,179	48,179	109,063	238,416	305,267	1,748,435	1,726
ILLINOIS	8,208,898	10,348,102	1,808,853	26	1,231,833	1,231,833	8,719,023	519,434	30,597,883	2,619
INDIANA	3,382,637	3,988,394	810,531	26	481,451	813,488	2,204,733	447,133	12,382,682	2,201
IOWA	1,634,062	2,218,041	448,810	115,314	247,822	355,295	1,345,839	49,268	6,615,476	2,351
KANSAS	1,772,719	2,218,335	415,790	100,840	220,378	220,378	1,287,848	190,689	6,428,779	2,548
KENTUCKY	1,847,743	1,418,857	270,882	87,343	254,108	599,458	1,233,765	1,229,672	7,021,825	1,875
LOUISIANA	2,547,782	1,822,033	352,995	98,280	345,188	608,834	1,741,808	2,030,597	9,545,115	2,185
MAINE	689,728	882,374	149,985	29,998	128,835	284,450	480,731	82,124	2,687,928	2,175
MARYLAND	3,169,204	2,674,955	404,581	99,774	541,404	541,404	2,178,431	1,958,080	11,627,792	2,438
MASSACHUSETTS	4,443,742	6,173,324	740,868	195,223	1,238,474	1,239,474	3,827,313	280,008	17,947,477	3,031
MICHIGAN	6,085,418	7,977,976	1,391,031	372,097	1,001,888	1,318,780	5,159,240	570,371	23,874,781	2,569
MINNESOTA	3,032,352	4,004,588	872,128	180,038	859,001	758,225	1,408,019	144,050	10,857,081	2,480
MISSISSIPPI	1,319,923	849,242	177,033	51,154	111,948	408,809	827,081	895,339	4,638,528	1,751
MISSOURI	3,843,381	4,398,101	845,312	224,843	355,821	547,738	3,055,506	302,658	13,373,381	2,568
MONTANA	383,483	438,540	48,228	25,273	57,205	112,948	241,279	338,283	1,641,223	2,059
NEBRASKA	1,132,893	1,381,739	285,541	70,028	128,525	171,137	668,770	115,011	3,933,640	2,452
NEVADA	807,751	1,033,508	98,602	58,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,860	107,811	33,381	87,829	118,839	370,959	48,384	2,258,658	1,981
NEW JERSEY	4,545,827	6,011,019	741,459	200,122	1,042,327	1,042,327	3,501,694	283,989	17,368,763	2,224
NEW MEXICO	705,891	728,478	82,220	49,898	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,881	14,348,785	2,020,835	569,890	5,288,300	5,288,300	10,274,890	825,078	50,354,750	2,818
NORTH CAROLINA	3,808,151	2,855,434	587,968	130,692	378,718	850,088	1,957,921	1,712,411	12,259,381	1,833
NORTH DAKOTA	442,809	540,478	111,059	28,899	88,987	108,809	350,419	85,946	1,751,185	2,681
OHIO	6,966,974	8,754,357	1,645,871	428,028	1,244,280	1,738,605	5,855,967	557,522	27,193,403	2,493
OKLAHOMA	2,028,546	1,379,608	286,712	78,027	294,947	400,683	1,278,850	1,081,298	6,824,869	2,139
OREGON ^{1/}	1,657,140	2,007,536	207,895	110,855	171,045	274,849	888,919	1,108,958	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	385,577	1,248,011	1,835,583	7,748,007	375,838	30,541,650	2,538
RHODE ISLAND	704,348	853,513	135,007	30,385	173,508	223,809	531,828	48,987	2,701,187	2,707
SOUTH CAROLINA	1,809,718	1,401,609	269,581	63,523	100,028	428,154	889,188	891,428	6,011,188	1,689
SOUTH DAKOTA	469,323	532,487	108,789	30,842	51,119	107,733	320,442	43,718	1,682,251	2,322
TENNESSEE	3,284,049	2,385,882	493,952	110,504	341,451	804,357	2,185,968	1,742,697	11,328,958	2,282
TEXAS	11,992,115	8,477,215	1,555,824	465,330	1,145,085	1,320,848	6,584,259	5,840,450	37,380,724	2,192
UTAH	777,209	1,085,590	80,021	51,752	85,019	172,449	318,184	525,181	3,085,385	1,784
VERMONT	323,043	381,043	64,238	13,292	47,488	98,673	172,612	18,829	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,548	469,473	532,390	2,061,381	2,180,848	12,931,845	2,076
WASHINGTON	2,613,828	3,348,969	321,777	188,957	587,419	558,783	1,558,885	1,918,178	11,084,598	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	280,771	720,922	743,573	3,848,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	188,823	528,448	713,420	2,258,989	378,584	11,980,357	2,449
WYOMING	206,156	269,576	26,328	13,994	18,865	19,885	107,370	158,705	821,856	1,758
TOTAL	\$161,818,653	\$174,125,101	\$27,063,851	\$8,308,703	\$27,397,885	\$34,258,738	\$118,277,024	\$56,730,394	\$805,878,347	\$2,425

^{a/} Includes personal health expenditures and administrative costs.^{b/} Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ACF estimates.

Table 3c

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 ^{a/}
(Dollars in thousands)

STATE	OUT OF POCKET ^{b/}	EMPLOYER SPONSORED ¹	NON-GROUP	OTHER PRIVATE	MEDICAID				TOTAL	PER CAPITA COST
					STATE	FEDERAL	MEDICARE	OTHER PUBLIC		
ALABAMA	6,587,653	4,700,531	078,803	267,896	367,825	880,063	5,375,234	3,424,954	22,667,039	5,201
ALASKA	865,699	1,121,008	78,581	71,054	152,808	152,808	250,751	536,159	3,228,804	5,370
ARIZONA	5,810,602	8,764,390	686,598	438,907	810,878	1,008,299	4,621,731	3,585,831	23,308,882	5,031
ARKANSAS	3,349,188	2,080,831	460,622	149,517	231,240	652,384	2,720,302	1,472,984	11,097,073	4,423
CALIFORNIA	53,007,530	68,844,841	8,086,483	4,304,439	8,982,640	8,982,640	45,912,880	29,714,318	223,599,772	6,584
COLORADO	4,691,263	6,222,417	616,190	365,225	684,300	684,300	2,685,710	2,670,100	18,810,641	5,498
CONNECTICUT	5,271,870	7,637,348	1,003,744	241,508	1,140,850	1,148,858	4,340,830	203,993	20,994,403	6,138
DELAWARE	1,195,017	959,790	184,820	43,011	107,503	187,503	811,917	509,052	4,131,820	5,180
DISTRICT OF COLUMBIA	704,048	529,771	111,189	27,784	388,391	388,391	804,558	445,985	3,500,078	5,882
FLORIDA	28,031,662	17,254,594	3,888,487	1,008,793	2,351,978	3,012,935	28,673,673	9,842,004	90,060,128	5,520
GEORGIA	10,652,590	8,320,811	1,585,419	383,829	1,281,795	2,513,120	7,237,055	5,589,541	37,733,018	4,714
HAWAII	1,910,550	2,643,972	260,159	147,929	289,540	289,540	861,238	1,173,704	7,853,034	5,819
IDAHO	893,703	1,184,244	120,221	71,820	104,758	237,141	838,885	608,459	3,959,138	3,828
ILLINOIS	18,024,980	22,707,029	3,975,387	1,315,734	2,807,418	2,807,418	17,533,255	1,008,052	89,778,254	5,953
INDIANA	7,587,956	8,940,008	1,035,488	576,081	1,041,238	1,759,288	5,877,353	888,481	28,504,480	5,004
IOWA	3,643,891	4,405,316	893,581	257,688	474,894	606,588	3,177,848	86,542	13,620,310	5,343
KANSAS	3,918,823	4,897,773	920,558	250,103	489,432	489,432	3,381,372	372,350	14,877,843	5,792
KENTUCKY	4,324,250	3,147,873	602,648	180,189	543,908	1,283,120	3,255,128	2,412,801	15,737,895	4,288
LOUISIANA	5,458,388	3,899,393	757,558	231,930	712,733	1,258,687	4,432,487	3,643,422	20,580,574	4,972
MAINE	1,663,097	2,126,142	362,405	81,089	299,039	681,285	1,320,211	132,350	6,845,838	4,945
MARYLAND	8,357,708	7,049,413	1,227,079	295,958	1,378,538	1,378,538	8,827,112	4,583,888	31,074,829	5,541
MASSACHUSETTS	10,178,490	14,127,420	1,718,518	502,888	2,738,599	2,738,599	8,871,559	568,719	42,438,773	6,890
MICHIGAN	13,452,128	17,623,528	3,081,357	925,189	2,135,251	2,808,318	13,553,224	1,114,322	54,691,321	5,840
MINNESOTA	7,051,420	9,305,816	1,568,223	470,911	1,478,030	1,895,420	3,891,005	296,049	25,755,773	5,841
MISSISSIPPI	3,116,442	2,003,742	418,860	135,852	254,833	828,041	2,320,879	1,868,319	11,044,787	3,984
MISSOURI	8,368,582	10,095,144	1,945,872	580,908	787,988	1,212,968	8,340,413	814,402	31,948,004	5,837
MONTANA	813,087	929,192	98,218	80,273	118,938	230,888	607,947	830,119	3,488,657	4,688
NEBRASKA	2,403,868	2,887,401	607,149	187,138	282,930	350,103	1,888,381	215,883	8,580,707	3,578
NEVADA	2,264,610	2,895,540	277,018	179,189	193,513	193,513	1,827,012	1,206,717	8,837,119	6,272
NEW HAMPSHIRE	1,867,768	2,188,757	295,910	102,842	257,810	314,084	1,207,487	117,076	6,351,711	4,505
NEW JERSEY	10,737,775	14,188,913	1,755,005	531,709	2,373,749	2,373,749	8,828,803	592,888	42,383,428	5,058
NEW MEXICO	1,814,472	1,871,107	211,785	144,284	216,800	480,780	1,053,827	1,283,288	7,078,882	4,078
NEW YORK	28,052,821	31,813,339	4,493,114	1,422,407	11,313,588	11,313,588	27,084,850	1,818,092	115,121,894	6,408
NORTH CAROLINA	9,878,128	7,405,800	1,477,120	381,518	847,818	2,127,070	6,038,653	3,927,803	32,183,511	4,170
NORTH DAKOTA	885,467	1,080,024	222,543	60,052	187,683	205,918	832,722	151,892	3,866,280	6,051
OHIO	15,318,195	19,232,288	3,825,387	1,080,889	2,637,287	3,887,115	15,298,854	1,083,233	81,941,308	5,887
OKLAHOMA	4,165,518	2,833,788	590,559	175,778	584,502	794,040	3,123,838	1,884,314	14,232,334	4,887
OREGON	3,848,838	4,657,015	487,808	289,452	384,153	814,885	2,722,582	2,271,082	15,289,405	5,260
PENNSYLVANIA	17,430,559	20,877,038	3,490,750	898,713	2,823,883	3,438,893	20,075,888	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,380	499,056	1,482,811	100,253	6,448,658	6,133
SOUTH CAROLINA	4,553,474	3,524,182	679,663	179,781	388,200	1,033,778	2,858,713	2,204,878	15,222,478	3,842
SOUTH DAKOTA	1,032,399	1,170,535	235,401	75,818	188,414	228,484	837,887	84,893	3,773,731	5,278
TENNESSEE	7,962,737	5,732,759	1,200,188	301,378	708,187	1,880,317	8,288,723	3,734,459	27,808,735	5,145
TEXAS	28,125,731	19,868,305	3,658,095	1,227,572	2,589,258	2,988,233	18,351,490	12,106,189	88,910,873	4,987
UTAH	1,889,913	2,682,268	194,991	141,549	152,431	404,292	819,418	1,128,663	7,493,528	4,082
VERMONT	777,894	918,691	154,985	35,992	110,215	224,378	493,830	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	380,799	1,192,047	1,351,801	6,451,550	5,029,568	34,364,028	4,724
WASHINGTON	6,498,052	8,197,810	790,328	520,941	1,340,850	4,340,850	4,540,841	4,155,188	27,295,859	5,258
WEST VIRGINIA	2,216,108	1,441,469	344,513	78,170	201,945	507,382	1,728,884	1,328,244	7,844,814	4,752
WISCONSIN	6,803,691	8,888,593	1,853,258	409,690	1,109,502	1,503,550	5,868,345	733,339	29,987,987	5,587
WYOMING	409,029	534,489	52,348	31,230	37,999	37,999	253,161	278,293	1,534,548	3,998
TOTAL	\$385,931,868	\$412,369,109	\$63,755,912	\$22,248,107	\$62,147,543	\$77,768,648	\$328,079,858	\$124,210,355	\$1,478,507,197	\$5,515

^{a/} Includes personal health expenditures and administrative costs.^{b/} Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates

Table 4

ESTIMATED NUMBER OF UNINSURED PERSONS

STATE	1980			1988			PERCENT CHANGE
	NUMBER a/	% OF STATE POP	RANK b/	NUMBER c/	% OF STATE POP	RANK b/	
ALABAMA	560,052	14.4%	9	615,680	15.1%	15	9.9%
ALASKA	54,655	13.6%	11	85,903	15.8%	13	57.2%
ARIZONA	449,151	16.5%	2	608,444	17.7%	7	35.5%
ARKANSAS	372,852	16.3%	3	519,163	21.8%	2	39.2%
CALIFORNIA	3,004,160	12.7%	14	4,737,675	17.2%	10	57.7%
COLORADO	371,701	12.9%	13	428,555	13.0%	22	15.3%
CONNECTICUT	193,401	6.2%	50	186,011	5.8%	51	-3.8%
DELAWARE	53,621	9.0%	36	65,178	10.2%	34	21.6%
DISTRICT OF COLUMBIA	97,916	15.3%	6	97,659	15.7%	14	-0.3%
FLORIDA	1,358,123	13.9%	10	2,199,960	18.4%	4	62.0%
GEORGIA	672,080	12.3%	17	788,513	12.6%	25	17.3%
HAWAII	78,539	8.1%	43	87,669	8.1%	42	11.6%
IDAHO	115,174	12.2%	18	165,419	16.4%	11	43.6%
ILLINOIS	1,078,105	9.4%	32	1,164,471	10.1%	35	8.0%
INDIANA	538,413	9.8%	30	751,116	13.6%	21	39.5%
IOWA	244,302	8.4%	41	222,017	7.9%	44	-9.1%
KANSAS	172,575	7.3%	48	257,374	10.4%	33	49.1%
KENTUCKY	328,638	9.0%	37	555,113	14.9%	16	68.9%
LOUISIANA	522,790	12.4%	16	778,919	17.3%	9	49.0%
MAINE	127,156	11.3%	22	92,123	7.8%	45	-27.6%
MARYLAND	382,164	9.1%	35	430,254	9.5%	38	12.6%
MASSACHUSETTS	493,906	8.6%	39	424,868	7.3%	48	-14.0%
MICHIGAN	604,488	6.5%	49	756,414	8.2%	41	25.1%
MINNESOTA	350,485	8.6%	40	282,003	6.6%	50	-19.5%
MISSISSIPPI	378,740	15.0%	8	472,365	17.9%	6	24.7%
MISSOURI	511,424	10.4%	26	533,342	10.5%	32	4.3%
MONTANA	120,046	15.3%	7	129,258	15.9%	12	7.7%
NEBRASKA	147,733	9.4%	33	168,268	10.5%	31	13.9%
NEVADA	92,188	11.5%	20	172,097	17.3%	8	86.7%
NEW HAMPSHIRE	70,854	7.7%	46	105,263	9.9%	36	48.5%
NEW JERSEY	688,699	9.4%	34	538,403	8.3%	40	-7.3%
NEW MEXICO	245,114	18.8%	1	345,509	22.8%	1	41.0%
NEW YORK	1,656,634	9.4%	31	2,049,755	11.5%	28	23.7%
NORTH CAROLINA	668,728	11.4%	21	883,308	13.8%	20	32.1%
NORTH DAKOTA	52,615	8.1%	45	50,447	7.5%	47	-4.1%
OHIO	872,119	8.1%	44	1,031,230	9.6%	37	18.2%
OKLAHOMA	399,994	13.2%	12	592,995	18.0%	5	48.3%
OREGON	260,217	9.9%	29	397,160	14.6%	18	52.6%
PENNSYLVANIA	981,113	8.3%	42	949,608	8.0%	43	-3.2%
RHODE ISLAND	72,422	7.6%	47	71,051	7.2%	49	-1.9%
SOUTH CAROLINA	493,006	15.8%	5	406,552	11.9%	26	-17.5%
SOUTH DAKOTA	86,842	12.6%	15	104,051	14.7%	17	19.8%
TENNESSEE	536,142	11.7%	19	687,400	14.2%	19	28.2%
TEXAS	2,270,337	16.0%	4	3,621,720	21.4%	3	59.5%
UTAH	146,561	10.0%	28	198,706	11.7%	27	35.6%
VERMONT	52,373	10.2%	27	50,256	9.2%	39	-4.0%
VIRGINIA	473,667	8.9%	38	637,029	10.8%	30	34.5%
WASHINGTON	457,440	11.1%	24	579,781	12.8%	24	26.7%
WEST VIRGINIA	217,640	11.2%	23	245,160	12.9%	23	12.6%
WISCONSIN	273,431	5.8%	51	361,781	7.6%	45	32.3%
WYOMING	50,687	10.8%	25	54,968	10.9%	29	8.4%
TOTAL	24,501,212	10.8%		31,837,904	13.1%		29.9%

a/ Based upon March 1980 Current Population Surveys (CPS) estimates adjusted to reflect changes in survey design implemented in the March 1988 CPS.

b/ Based upon percent uninsured.

c/ Based upon March 1988 CPS data.

SOURCE: Lewin/ICF estimates.

TECHNICAL APPENDIX

*Methodology Used to Project State
Health Expenditures in 2000*

By:

Lewin/ICF

a division of Health & Sciences International, Inc.

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 1986 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:

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- **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.

These steps were performed separately to develop estimates for 1980 and 1987.

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.

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ADDITIONAL TABLES

*Sources of Payment for
Personal Health Expenditures
1980, 1990, 2000*

Percentage Distribution

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 a/

STATE	OUT OF POCKET b/	EMPLOYER				MEDICARE				TOTAL
		SPONSORED	NON-GROUP	OTHER PRIVATE	STATE	FEDERAL	MEDICARE	OTHER PUBLIC		
ALABAMA	31.0 %	21.0 %	5.2 %	1.2 %	2.2 %	5.4 %	15.3 %	16.1 %	100.0 %	
ALASKA	24.0	32.8	2.0	1.7	3.7	3.7	4.8	27.3	100.0	
ARIZONA	25.3	30.3	3.2	1.0	0.0	0.0	14.3	25.4	100.0	
ARKANSAS	30.2	19.1	4.5	1.2	3.4	9.1	15.8	18.9	100.0	
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.8	23.4	100.0	
COLORADO	24.2	32.4	2.8	1.5	3.0	3.4	10.5	22.3	100.0	
CONNECTICUT	28.8	34.5	8.7	1.2	5.0	5.0	17.1	1.0	100.0	
DELAWARE	28.5	24.0	5.0	1.0	4.1	4.1	15.4	17.0	100.0	
DISTRICT OF COLUMBIA	21.3	15.9	3.8	0.8	10.0	10.0	18.8	18.0	100.0	
FLORIDA	30.0	10.0	5.1	1.0	1.8	2.5	23.0	17.6	100.0	
GEORGIA	31.1	23.5	4.8	1.1	3.3	6.8	12.8	16.9	100.0	
HAWAII	22.7	28.0	2.8	1.3	5.2	5.2	0.8	24.5	100.0	
IDAHO	23.8	28.8	2.8	1.4	2.7	5.3	9.8	25.8	100.0	
ILLINOIS	27.2	33.8	7.3	1.8	4.9	4.6	18.7	1.8	100.0	
INDIANA	20.7	35.8	0.2	1.9	3.1	4.1	15.0	2.3	100.0	
IOWA	28.2	33.8	8.2	1.8	3.5	4.8	18.8	3.0	100.0	
KANSAS	27.0	31.9	8.2	1.7	3.9	4.4	17.7	5.2	100.0	
KENTUCKY	32.0	25.0	5.5	1.1	3.3	7.0	13.5	12.7	100.0	
LOUISIANA	30.3	22.3	5.0	1.0	3.4	7.4	11.9	18.8	100.0	
MAINE	29.1	28.7	7.8	1.4	4.2	0.8	18.3	0.8	100.0	
MARYLAND	28.3	28.2	4.8	1.1	3.7	3.7	15.9	15.2	100.0	
MASSACHUSETTS	26.6	30.0	5.9	1.2	8.8	7.3	20.8	1.4	100.0	
MICHIGAN	28.1	33.8	7.1	1.8	5.4	5.4	17.4	3.1	100.0	
MINNESOTA	27.5	33.1	8.0	1.8	5.9	7.5	15.8	0.8	100.0	
MISSISSIPPI	32.3	21.5	0.0	1.2	2.5	8.8	14.7	13.7	100.0	
MISSOURI	29.2	32.5	8.8	1.9	2.4	3.8	19.8	2.0	100.0	
MONTANA	23.5	27.0	2.8	1.4	3.4	8.1	10.9	25.0	100.0	
NEBRASKA	20.4	33.4	8.4	1.8	3.0	4.0	18.3	3.5	100.0	
NEVADA	22.8	29.4	2.8	1.4	2.8	2.8	12.7	25.9	100.0	
NEW HAMPSHIRE	30.3	34.8	7.2	1.3	3.8	8.0	14.4	2.1	100.0	
NEW JERSEY	27.8	34.8	8.7	1.3	5.7	5.7	18.7	1.4	100.0	
NEW MEXICO	24.7	28.8	2.8	1.8	2.4	5.4	9.8	28.8	100.0	
NEW YORK	24.9	27.4	5.9	1.1	10.8	10.8	18.2	1.3	100.0	
NORTH CAROLINA	31.7	24.5	5.0	1.2	2.9	8.1	12.7	18.0	100.0	
NORTH DAKOTA	28.8	32.2	8.8	2.0	2.7	4.3	17.4	4.3	100.0	
OHIO	28.7	35.8	8.5	1.7	3.3	4.1	18.2	1.7	100.0	
OKLAHOMA	30.7	21.2	5.1	1.0	3.8	8.3	15.8	18.2	100.0	
OREGON	22.8	28.5	2.8	1.4	3.3	4.1	12.9	24.4	100.0	
PENNSYLVANIA	28.8	32.7	7.1	1.3	4.0	4.9	19.7	1.4	100.0	
RHODE ISLAND	28.0	32.0	8.4	1.1	8.2	8.5	18.2	1.8	100.0	
SOUTH CAROLINA	30.1	19.9	4.3	1.1	3.5	8.8	10.5	22.0	100.0	
SOUTH DAKOTA	30.8	30.3	8.9	2.4	2.7	5.9	15.1	3.9	100.0	
TENNESSEE	31.5	23.7	5.2	1.1	2.7	8.2	14.4	15.2	100.0	
TEXAS	32.8	23.8	4.9	1.2	3.2	4.5	14.4	15.5	100.0	
UTAH	24.2	32.1	2.7	1.4	2.4	5.1	7.3	24.8	100.0	
VERMONT	28.7	32.0	7.1	1.3	4.8	10.0	15.3	1.0	100.0	
VIRGINIA	30.4	24.4	5.1	1.0	3.5	4.5	12.9	18.3	100.0	
WASHINGTON	22.2	27.9	2.8	1.4	4.4	4.4	10.4	28.7	100.0	
WEST VIRGINIA	33.5	24.1	5.5	1.1	2.1	4.4	15.4	14.0	100.0	
WISCONSIN	28.1	34.2	7.8	1.5	5.7	7.9	15.9	1.0	100.0	
WYOMING	23.3	32.4	2.5	1.5	2.2	2.2	9.7	28.2	100.0	
TOTAL	27.4 %	28.5 %	5.8 %	1.4 %	4.8 %	5.7 %	18.2 %	10.5 %	100.0 %	

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 a/

STATE	OUT OF POCKET b/	EMPLOYER- SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	29.8 %	21.1 %	4.4 %	1.1 %	1.7 %	4.6 %	20.3 %	17.4 %	100.0 %
ALASKA	28.5	34.4	2.4	1.9	4.9	4.9	8.5	18.8	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	18.8	17.5	100.0
ARKANSAS	30.8	19.0	4.2	1.2	2.2	8.2	21.0	15.3	100.0
CALIFORNIA	24.0	30.3	2.8	1.7	4.2	4.2	17.5	18.3	100.0
COLORADO	28.1	33.2	3.3	1.7	3.8	3.9	12.0	18.1	100.0
CONNECTICUT	25.8	37.8	4.9	1.1	5.8	5.8	17.9	1.1	100.0
DELAWARE	29.4	23.8	4.5	0.9	4.3	4.3	18.8	14.2	100.0
DISTRICT OF COLUMBIA	20.5	15.4	3.2	0.7	11.7	11.7	22.1	14.7	100.0
FLORIDA	20.8	19.8	4.4	1.0	2.8	3.8	25.7	12.8	100.0
GEORGIA	28.0	22.3	4.2	0.9	3.6	7.0	16.3	18.8	100.0
HAWAII	24.9	34.5	3.5	1.7	3.8	3.8	10.8	17.3	100.0
IDAHO	25.2	30.1	3.0	1.8	2.8	8.2	13.8	17.5	100.0
ILLINOIS	28.8	33.8	5.9	1.7	4.0	4.0	22.0	1.7	100.0
INDIANA	27.4	32.3	8.8	1.8	3.9	8.8	17.8	3.8	100.0
IOWA	27.7	33.5	8.8	1.7	3.7	5.4	20.3	0.7	100.0
KANSAS	27.8	34.5	8.5	1.8	3.4	3.4	20.0	3.0	100.0
KENTUCKY	27.7	28.2	3.9	1.0	3.8	8.5	17.8	17.5	100.0
LOUISIANA	28.7	19.1	3.7	1.0	3.8	8.4	18.2	21.3	100.0
MAINE	25.7	32.8	8.8	1.1	4.8	10.8	17.1	2.3	100.0
MARYLAND	27.3	23.0	4.0	0.9	4.7	4.7	18.7	15.8	100.0
MASSACHUSETTS	24.8	34.4	4.2	1.1	8.9	8.9	20.2	1.8	100.0
MICHIGAN	25.5	33.4	8.8	1.8	4.2	5.5	21.8	2.4	100.0
MINNESOTA	27.9	38.9	8.2	1.7	8.1	7.0	13.0	1.3	100.0
MISSISSIPPI	28.5	18.3	3.8	1.1	2.4	8.8	17.8	19.3	100.0
MISSOURI	27.2	32.9	8.3	1.7	2.7	4.1	22.8	2.3	100.0
MONTANA	23.4	28.7	2.8	1.5	2.5	8.8	14.7	20.5	100.0
NEBRASKA	28.8	34.8	7.3	1.8	3.3	4.4	17.0	2.9	100.0
NEVADA	25.9	33.2	3.2	1.8	2.3	2.3	15.7	15.8	100.0
NEW HAMPSHIRE	30.2	35.4	4.8	1.5	4.3	5.3	18.4	2.1	100.0
NEW JERSEY	28.2	34.8	4.3	1.2	8.0	8.0	20.2	1.8	100.0
NEW MEXICO	25.8	28.4	3.0	1.8	3.2	7.0	12.5	20.5	100.0
NEW YORK	23.3	28.5	4.0	1.1	10.5	10.5	20.4	1.8	100.0
NORTH CAROLINA	31.0	23.3	4.8	1.1	3.1	8.9	18.0	14.0	100.0
NORTH DAKOTA	25.3	30.9	8.3	1.5	5.0	8.1	20.0	4.9	100.0
OHIO	25.8	32.2	8.1	1.8	4.8	8.4	21.5	2.1	100.0
OKLAHOMA	28.7	20.2	4.2	1.1	4.3	8.9	18.7	15.8	100.0
OREGON	25.4	30.8	3.2	1.7	2.8	4.2	15.1	17.0	100.0
PENNSYLVANIA	28.2	31.4	5.2	1.2	4.1	5.4	25.4	1.2	100.0
RHODE ISLAND	28.1	31.8	5.0	1.1	8.4	8.3	19.7	1.8	100.0
SOUTH CAROLINA	30.1	23.3	4.5	1.1	2.7	7.1	14.8	18.5	100.0
SOUTH DAKOTA	28.2	32.0	8.4	1.8	3.1	8.5	19.3	2.8	100.0
TENNESSEE	28.0	20.9	4.4	1.0	3.0	7.1	18.3	15.4	100.0
TEXAS	32.1	22.7	4.2	1.2	3.1	3.5	17.8	15.8	100.0
UTAH	25.2	35.5	2.8	1.7	2.1	5.8	10.3	17.0	100.0
VERMONT	28.9	34.1	5.8	1.2	4.3	8.7	15.5	1.7	100.0
VIRGINIA	30.1	24.1	4.4	1.0	3.8	4.1	15.9	18.7	100.0
WASHINGTON	23.8	30.2	2.9	1.7	5.1	5.1	14.1	17.3	100.0
WEST VIRGINIA	28.5	18.8	4.4	0.9	2.7	8.8	18.7	19.3	100.0
WISCONSIN	28.0	34.0	8.3	1.4	4.4	8.0	18.9	3.2	100.0
WYOMING	25.1	32.8	3.2	1.7	2.4	2.4	13.1	19.3	100.0
TOTAL	28.7 %	28.7 %	4.5 %	1.4 %	4.5 %	5.7 %	19.2 %	8.4 %	100.0 %

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 a/

STATE	OUT OF POCKET b/	EMPLOYER- SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	20.1 %	20.0 %	4.3 %	1.2 %	1.0 %	4.2 %	23.7 %	15.1 %	100.0 %
ALASKA	28.8	34.7	2.4	2.2	4.7	4.7	7.6	16.6	100.0
ARIZONA	24.1	29.0	2.9	1.9	2.6	4.3	19.8	15.3	100.0
ARKANSAS	30.2	18.6	4.2	1.3	2.1	5.9	24.5	13.3	100.0
CALIFORNIA	23.7	29.8	2.7	1.9	4.0	4.0	20.5	13.3	100.0
COLORADO	20.0	33.1	3.3	1.9	3.8	3.6	14.3	14.2	100.0
CONNECTICUT	25.1	38.4	4.8	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	28.9	23.2	4.5	1.0	4.0	4.0	22.0	12.3	100.0
DISTRICT OF COLUMBIA	20.1	15.1	3.2	0.8	11.1	11.1	25.6	12.7	100.0
FLORIDA	28.9	19.2	4.3	1.1	2.6	3.3	29.8	10.9	100.0
GEORGIA	28.8	22.1	4.1	1.0	3.4	6.7	18.2	14.6	100.0
HAWAII	25.0	34.5	3.5	1.9	3.5	3.7	12.6	15.3	100.0
IDAHO	25.1	29.9	3.0	1.8	2.6	6.0	16.1	15.4	100.0
ILLINOIS	25.8	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	26.6	31.4	6.4	2.0	3.7	6.2	20.6	3.1	100.0
IOWA	20.8	32.3	6.6	1.9	3.5	5.0	23.3	6.6	100.0
KANSAS	20.7	33.4	6.3	1.7	3.2	3.2	23.0	2.5	100.0
KENTUCKY	27.5	20.0	3.8	1.1	3.5	6.2	20.7	15.3	100.0
LOUISIANA	28.5	18.9	3.7	1.1	3.5	6.1	21.5	18.7	100.0
MAINE	25.0	32.0	5.5	1.2	4.5	10.0	19.9	2.0	100.0
MARYLAND	26.9	22.7	4.0	1.0	4.4	4.4	22.0	14.7	100.0
MASSACHUSETTS	24.0	33.3	4.0	1.2	6.4	6.4	23.3	1.3	100.0
MICHIGAN	24.6	32.2	5.8	1.7	3.0	5.1	24.8	2.0	100.0
MINNESOTA	27.4	36.1	6.1	1.6	5.7	6.6	15.1	1.1	100.0
MISSISSIPPI	26.2	18.1	3.8	1.2	2.3	6.4	21.0	16.9	100.0
MISSOURI	26.2	31.6	6.1	1.8	2.5	3.6	26.1	1.9	100.0
MONTANA	23.3	26.6	2.8	1.7	3.4	6.6	17.4	18.1	100.0
NEBRASKA	26.0	33.7	7.1	1.9	3.1	4.1	19.7	2.5	100.0
NEVADA	25.8	32.8	3.1	2.0	2.2	2.2	18.4	13.7	100.0
NEW HAMPSHIRE	29.4	34.5	4.7	1.6	4.1	4.9	19.0	1.8	100.0
NEW JERSEY	25.3	33.5	4.1	1.3	5.6	5.6	23.2	1.4	100.0
NEW MEXICO	25.8	28.4	3.0	2.0	3.1	6.6	16.9	16.1	100.0
NEW YORK	22.6	27.6	3.9	1.2	9.6	9.6	23.5	1.4	100.0
NORTH CAROLINA	30.7	23.0	4.6	1.2	2.9	6.6	18.6	12.2	100.0
NORTH DAKOTA	24.6	29.9	6.2	1.7	4.6	5.7	23.1	4.2	100.0
OHIO	24.7	31.0	5.9	1.7	4.3	6.0	24.7	1.7	100.0
OKLAHOMA	29.3	19.9	4.1	1.2	4.1	5.6	21.9	13.6	100.0
OREGON	25.2	30.5	3.2	1.8	2.5	4.0	17.8	14.6	100.0
PENNSYLVANIA	25.1	30.0	5.0	1.3	3.6	4.9	26.9	1.0	100.0
RHODE ISLAND	25.3	30.6	4.9	1.2	6.0	7.7	22.7	1.6	100.0
SOUTH CAROLINA	29.9	23.2	4.5	1.2	2.6	6.6	17.3	14.5	100.0
SOUTH DAKOTA	27.4	31.0	6.2	2.0	2.9	6.1	22.2	2.3	100.0
TENNESSEE	26.5	20.5	4.3	1.1	2.9	6.7	22.6	13.4	100.0
TEXAS	31.6	22.3	4.1	1.4	2.9	3.4	20.6	13.6	100.0
UTAH	25.2	35.5	2.6	1.8	2.0	5.4	12.3	15.1	100.0
VERMONT	28.2	33.3	5.6	1.3	4.0	6.1	17.9	1.4	100.0
VIRGINIA	29.8	23.9	4.4	1.1	3.5	3.9	18.8	14.6	100.0
WASHINGTON	23.5	30.0	2.9	1.9	4.9	4.9	16.6	15.2	100.0
WEST VIRGINIA	28.2	18.4	4.4	1.0	2.0	6.5	22.0	16.9	100.0
WISCONSIN	25.2	33.0	6.1	1.5	4.1	5.8	21.8	2.7	100.0
WYOMING	25.0	32.7	3.2	1.9	2.3	2.3	15.5	17.0	100.0
TOTAL	28.1 %	27.9 %	4.3 %	1.5 %	4.2 %	5.3 %	22.2 %	6.4 %	100.0 %

a/ Includes personal health expenditures and administrative costs

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: Lewin/ICF estimates.



STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
TASK FORCE REPORT
TO
THE SEVENTEENTH LEGISLATURE

RELATING TO THE ACCESS, QUALITY, DELIVERY AND
FINANCING OF
HEALTH CARE FOR ALL ALASKA RESIDENTS

WITH
SUMMARY OF FINDINGS AND RECOMMENDATIONS

FEBRUARY 1991

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
TASK FORCE

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STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

REPORT TO THE SEVENTEENTH LEGISLATURE

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EXECUTIVE SUMMARY

The purpose of this section of this report is to give an overall perspective of the problems facing Alaska with rapidly rising health care costs and illustrate Task Force recommendations that provide solutions to assure affordable quality health care access to all Alaska residents.

OVERVIEW

Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods and services. **In 1990, total Alaska health care expenditures are estimated to be in excess of \$1.5 billion up from \$480 million in 1979. Without a plan for a long term health care delivery system, quality assurance, and financing management, total health care expenditures in Alaska will exceed \$10.0 billion by the year 2000 of which the state governments portion will be \$3.0 billion. (see exhibit one on page 10)**

Health care expenditures in Alaska have been rising at a rate of over 20% each of the last five years. These trends are not unique to Alaska alone. Health care expenditures in the U.S. exceeded \$606 billion in 1989 and consumed twelve percent of our Gross National Product. Nationally, the Federal Government and virtually all other states are seeking ways to reduce these expenditures or slow the health care inflation rate to be in line with the market basket Consumer Price Index.

These rapidly rising costs further exacerbate the uninsured population in Alaska, **recent estimates indicate that more than 90,000 Alaska residents are uninsured. At this rate twenty-five percent of Alaskas' population will be uninsured by the year 2000¹(see exhibit two on page 11).** These increase in costs have substantially driven up health insurance premiums for all employers, making it very difficult if not impossible, to continue to provide or offer coverage.

¹ Families U.S.A. Foundation

The Health Care Cost Containment Task Force initially was charged with the task of investigating, analyzing and recommending ways to reduce or stabilize the health insurance costs for State of Alaska employees, retirees and their dependents

With these recommendations implemented, the monthly premium cost was reduced and stabilized at \$385.00 until January 31, 1992, resulting in net savings in excess of \$20 million for FY 90 & 91².

The Task Forces' charge was expanded early last session to include reviewing the delivery, quality, access and financing of health care for all Alaska residents.

The Task Force, in its expanded role, has investigated the problem of rapidly increasing health care costs in Alaska through public testimony, surveys, research (statewide and nationally) and a detailed analysis of potential solutions.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be reviewed in an all encompassing manner to provide the best long term solutions. The contributing factors identified by the Task Force include:

- * Inefficient Medical Care Delivery Systems
- * Overbuilt Health Care Facilities
- * Cost of New Medical Technology and Facilities
- * Malpractice Insurance and Protective Measure costs
- * Limited Competition For Providers / Insurers
- * Health Care Delivery System Waste, Overhead And Administrative Costs
- * Limited Wellness Promotion And Resources
- * Large Population of Under / Uninsured Residents
- * Cost Shifting Between Health Plans and Programs
- * Life Style Diseases and Injuries
- * Mandated Benefit Coverage
- * Limited Access to Private Health Plans

² 1990 Health Care Cost Containment Task Force Report

- * No Managed Care Delivery Systems in Place
- * Lack of End User Involvement and Education

Although a long and far reaching list each contributing area must be comprehensively addressed to achieve the stated goal of stabilized medical costs in Alaska and basic health care access for all Alaskans'.

SPECIFIC FINDINGS

The Health Care Cost Containment Task Force has been reviewing the causes for the rapidly rising costs in the State of Alaska not only for State sponsored plans, but health care costs statewide.

1. Health care expenditures in Alaska have *increased 300% over the last 10 years, the second highest in the nation*
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 3.0 Billion in FY 2000 (see exhibit one on page 10).*
3. The number of *uninsured residents in Alaska* has increased at an alarming rate to an *estimated 90,000* uninsured residents, representing *16.5% of the total population in Alaska. At this rate twenty five percent of Alaskas' population will be uninsured by the year 2000 (see exhibit two on page 11).*
4. The cost of providing health coverage for *State employees and their dependents* has been reduced and *stabilized at \$385.00 (per month, per employee) for FY 90 and 91.* This compares favorably with the most recent Survey of State's health care plans that showed *only one other state (Arizona) where premiums were reduced,* and only three other State's premiums were held at the 1989 level³. It is important to note that while these were important short term measures, a long term solution to this problem must be implemented soon to avoid further large rate increases.
5. One area that has come to light, and is significant in its impact on health care expenses, is cost or liability shifting between programs. It is an item of significant impact. When a health program either reduces benefits or payments the natural reaction by health care providers is to shift those costs to other payors.

³ 1990 Martin A. Segal Company Summary of State Health Plans

SURVEY RESULTS

The survey done by the Task Force was designed to give greater insight to health insurance plans offered by Alaska employers, the costs for these plans, who is covered by health insurance, along with additional data and perspectives from health care providers.

Over 300 surveys were mailed to various groups in Alaska including, municipalities, school districts, health care providers and private sector employers.

The survey questions were tailored to gather specific information relative to each category of respondent.

Questions ranged from those eligible / ineligible for employer health plans, number of employees, plan design, employee / employer contributions, cost containment measures implemented, premium costs, ideas to help reduce ever increasing health care costs and the reasons for these increasing costs. The questionnaires sent to health care providers had additional questions to determine their specific perspective about rising health care costs and certain contributing factors *ie.*; bad debt, malpractice insurance costs and others.

The survey results gave us information that previously was not available such as, range of employer sponsored health plan designs, eligibility, associated premium costs, cost containment strategies employed, respondents perspective, and impressions about the health care delivery system in Alaska.

In comparison to the State of Alaska active employee health plan, the survey results showed that the state no longer had either the most expensive health plan (64% of respondents plans premium or premium equivalent was in excess of the states \$385. per month) and no longer was the States plan the best in coverage (54% of respondents provide similar or better benefits).

Surprisingly 94% of the respondents do offer some form of health insurance to their full-time employees while none of the respondents provide coverage for part-time, seasonal, or occasional employees.

The majority of respondents have implemented ways to reduce their health plan costs. Seventy one percent of respondents have implemented at least two cost containment measures. Sixty percent have also made benefit changes in the last two years.

In addition respondents also are implementing alternate financing of health insurance. Thirty one percent of the respondents have self insured their plans.

The survey confirmed earlier information that the majority of health insurance in Alaska is underwritten by three carriers, Aetna, Blue Cross and Great West insurance companies.

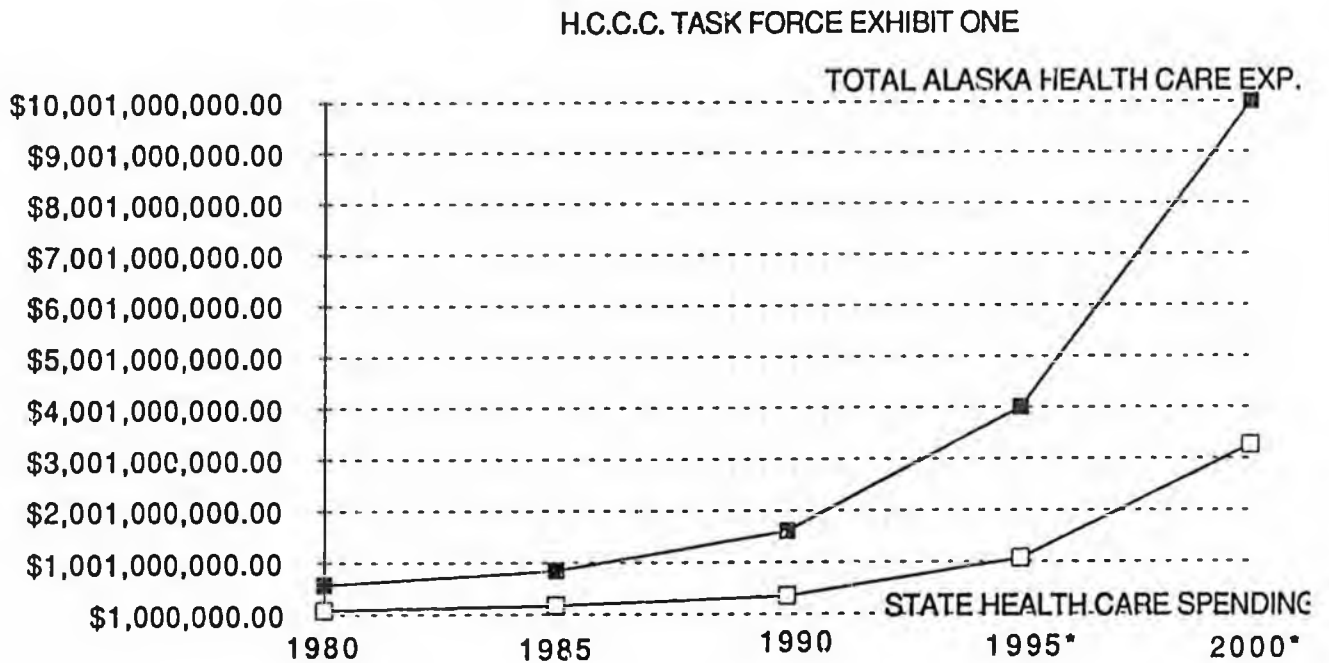
THE FUTURE

The State of Alaska Health Care Cost Containment Task Force has reviewed and recommended ways to reduce health care costs in the short term, but in order to assure quality affordable health care protection for all Alaskans a long term strategy such as the Alaska State Health Resources Authority (ASHRA) outlined in the legislative recommendations, section 8, of this report must be implemented.

In addition, because of the size and scope of the health care related problems facing the state of Alaska the Task Force recommends that a group comprised of a cross section of Alaska employers, health care providers, legislature, Executive branch, nonprofit, uninsureds and consumers continue the work of the Health Care Cost Containment Task Force to continue towards the goal of assuring quality affordable health care for all Alaskans.

EXHIBIT : ONE

Exhibit one demonstrates the rise in health care spending in Alaska from 1980 through the year 2000.



Source, Noble Lowndes

Illustrates total health care expenditures in Alaska

1980=\$576. million, 1985=\$852. million, 1990=\$1.608 billion
1995=\$4.0 billion*, 2000=\$10.0 billion*

Illustrates health care spending by the State .

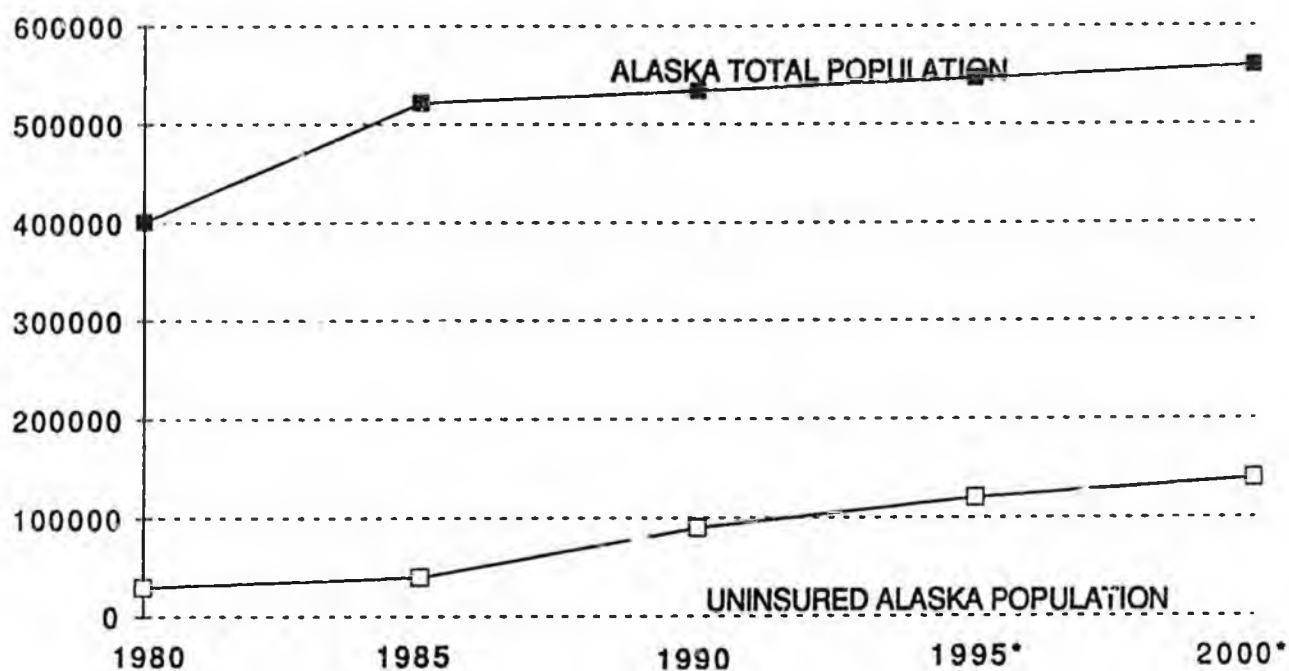
1980=\$75. million, 1985=\$175. million, 1990=\$350. million
1995=\$1.068 billion*, 2000=\$3.26 billion*

* estimate

EXHIBIT : TWO

Exhibit two illustrates Alaskas total population and the population of residents without health insurance (uninsured).

H.C.C.C. TASK FORCE EXHIBIT TWO - COMPARISON OF ALASKAS UNINSURED TO TOTAL POPULATION



Source, Noble Lowndes

Illustrates total Alaska population.

1980= 401,000. 1985= 522,000, 1990= 534,000
1995= 547,000, 2000= 560,000

Illustrates the uninsured population in Alaska.

1980= 30,000, 1985= 40,000, 1990= 90,000
1995= 120,000*, 2000= 140,000*

* estimates

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION ONE

TASK FORCE WORK PLAN AND OBJECTIVES

WORK PLAN AND OBJECTIVES

One of the major realizations of the previous year's work was that the health cost experience and expectations of any one particular group, such as state employees, cannot be viewed in isolation. Influences from the cost of service to all other health care consumers and correlated systemic factors contribute a significant portion to any one group's eventual cost, regardless of use.

Last session the work plan for the Task Force was redesigned to address unresolved health care cost issues identified in the February, 1990 report to the legislature. These issues included concerns about such long term and destabilizing effects as cost shifting, uncompensated care, and health delivery system inefficiencies. Other issues were identified that in a preliminary way held promise for some measure of control or alleviation of the health care cost spiral. In addition to this work, the Task Force would monitor closely the effects of cost containment measures established for state employee health plans and seek appropriate containment measures for retired public employees.

The main objectives of the plan were to understand, in as complete a manner possible, the financial nature of Alaskans' health care and health care delivery system. Secondly, the Task Force sought a broad spectrum of opinions about what could be done to preserve or improve access to quality affordable health care for all Alaskans in the context of financial trends and constraints.

These objectives were served by analyses of all health care funding and expenditures in the state, and informational surveys of municipalities, school districts, health care providers, and health care facilities. Information on the Alaskan perspective was additionally obtained from three public hearings and other meetings with the following groups:

- * Alaska School Board Association
- * Alaska Municipal League
- * Alaska Municipal Finance Officers' Association
- * Alaska Hospital and Nursing Home Association
- * Alaska State Medical Association
- * Alaska Chiropractic Society
- * Anchorage Medical Society
- * Alaskan private sector employer group
- * National Education Association of Alaska
- * Alaska State Employees Association
- * Public Employees Retirement System Advisory Board
- * Teachers Retirement System Advisory Board

The Task Force recognized that the health care problems it was addressing were also being discussed in other states, public forums, and by research groups throughout the nation. Indeed, the issue has attracted considerable attention in professional journals and other print media. An appreciation for the larger context of health care cost and access, viable solutions were gained through meetings and discussions with the following:

- * National Governors' Association Conference on Affordable Health Care
- * American Federation of State, County and Municipal Employees, Washington, D.C.
- * Families USA Foundation (Senior citizen advocacy group)

- * National Leadership Commission on Health Care
- * Physicians Payment Review Commission (Congressional)
- * State of Maryland, Health Services Cost Review Commission
- * State of Washington
- * State of Hawaii
- * State of Minnesota
- * State of Wisconsin
- * State of Arizona
- * State of New Mexico
- * State of Massachusetts
- * State of Oregon
- * State of Oklahoma
- * State of Utah
- * State of Kansas
- * State of South Carolina
- * State of Louisiana
- * State of California
- * State of Colorado
- * State Alliance for Universal Health Care

The health care funding and expenditure analyses were based in part on all federal, state, and local government expenditures for different categories of health care and groups of people. State data included, in addition to employee and retiree costs, the health costs of prisoners, medicaid, Pioneer Homes, Alaska Psychiatric Institute, and rural health aides, among others. Similarly, federal data included military and military dependents' expenditures, Indian Health Service, veterans, and medicare. In all categories the number of Alaskans benefitted were determined or estimated. Alaska Department of Labor statistics were used for the private sector labor force to estimate the private sector's contribution. Two recent studies, the 1990 Health Care Cost Containment Task Force Report and the Families USA Foundation gave new estimates of the

number of Alaskans who are without health insurance or any other type of medical care. In contrast to the funding and expenditure side, revenue reports of all major health care institutions were obtained and consolidated.

Municipalities and school districts were target groups for the informational survey because they are large employee groups whose health care cost increases most directly affect state budgetary considerations. The survey sought specific information on their health plan cost increases over the last ten years, the nature of the benefit, and cost containment features employed. The survey also had questions on the effectiveness of cost containment measures and solicited opinions on what could be done to slow medical inflation.

Survey forms sent to health care facilities and health care providers were to determine the nature of their employees' health care coverage and cost experience. Additional information requested concerned the nature of their business as providers. This information included percentages of practice devoted to different categories of payors (medicare, medicaid, state employee, et. al.), the amount of uncompensated services, its increase, and the amount of fee and rate increases over the last ten years.

The expenditure and funding analyses and the survey information provided a useful foundation for meetings with the Alaskan groups listed above. They illustrated the overall nature of the issue and brought focus to the discussions. In addition to the information gained, the meetings with the second group listed above underscored the gravity with which other health care professionals, public officials, labor and management organizations view the health care cost and accessibility issue. It gave the Task Force a sense of commonality in its search for a solution.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION TWO

STATE EMPLOYEE AND RETIREE PLAN UPDATE & RESULTS

STATE OF ALASKA
EMPLOYEE AND RETIREE HEALTH PLAN UPDATE

The Health Care Cost Containment Task Force continued to review and monitor the health plans for actives and retirees during the last year.

ACTIVE EMPLOYEE HEALTH PLAN

This work resulted in the continued moratorium on premium increases for the active employees plan. This resulted in the monthly premiums being held at the \$ 385.00 level until January 31, 1992 allowing state agencies substantial relief from increasing costs associated with health insurance. This resulted in savings in excess of \$20 million for FY90, 91.

The Task Force strongly encourages the State to continue to review the possibility of self or alternate funding the plan to improve the plans financial position and overall management. In addition, the State should during the Request For Proposal process for the state plan request proposals for both an all inclusive and unbundled basis. That is, major components (cost containment, utilization review, etc.) should be bid collectively and separately to determine the most advantageous end result.

RETIREES HEALTH PLAN

The Task Force reviewed and recommended cost management techniques that could be utilized by the retirees health plan to improve the plans financial experience, without compromising the current level of benefits.

These recommended cost management techniques were ratified by the Public Employees Retirement System and the Teachers Retirement System boards and are currently being implemented. These changes will not only reduce the premium requirements but also may improve the funds future.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION THREE

HEALTH CARE EXPENDITURES IN ALASKA

AND

THE UNITED STATES

HEALTH CARE EXPENDITURES IN THE UNITED STATES

The amount spent on health care in the United States exceeded \$606 billion in 1989, which is approximately twelve percent of our gross national product. Health care expenditures in the U.S. are increasing at the rate of approximately twenty percent per year each of the last five years

The U.S. spends \$1.152 million per minute on health care and is increasing \$230,000. per minute.

The U.S. spends 12 % of our GNP on health care more than any of our allied neighbors (Canada=7.5%, Japan=8%, Great Britain=7%). These expenditures have a substantial negative effect on our ability to remain competitive in the world market place.

Health care expenses consumed 11.6% of U.S. residents disposable income in 1989 and impacts every purchase decision made today. For example it is estimated that \$700.00 of the purchase price for each new Chrysler automobile goes to pay for employee health care, as compared to foreign models at about \$300.00. This demonstrates the additional financial burden of this sizable expense on our ability as a nation to compete in world markets for products and services.

Americans spent more for health care in 1989 than we did for food stuffs.

Of substantial additional concern is that while as a nation we spend more on health care than any other nation (12% of GNP), fewer have access to health care protection, it is estimated that 58 million U.S. residents are without health insurance.

ALASKA HEALTH CARE EXPENDITURES

The amount spent on health care in Alaska exceeded \$1.5 billion in 1990 up from \$480 million in 1979. Alaska health care expenditures are increasing at the second fastest pace of the fifty states.

Alaska spends approximately \$2850.00 per minute on health care and is increasing by \$534.00 every minute. At the current rate of growth, and without health care reform, the total health care expenditures in Alaska will exceed \$10 billion by the year 2000.

Even though Alaska continues to spend more on health care there are fewer residents covered by health insurance. The Task Force estimates show that 90,000 Alaska residents are uninsured and without change 25% Alaskas' population will be uninsured by the year 2000.

With the increasing economic burden of health care expenditures, and the increasing number of residents without health care protection, Alaska is at a greater disadvantage than other states and nations to further its economy.

EXHIBITS THREE THRU SEVEN (On the following pages)

SOURCE: NOBLE LOWNDES 1991

Exhibit Three illustrates 1989 U.S. health care expenditures by source of payment, private sector employers, federal programs, state and local government programs, consumers and all others.

Exhibit Four illustrates 1989 Alaska health care expenditures by source of payment, private sector employers, federal programs, state and local government programs, consumers and all others.

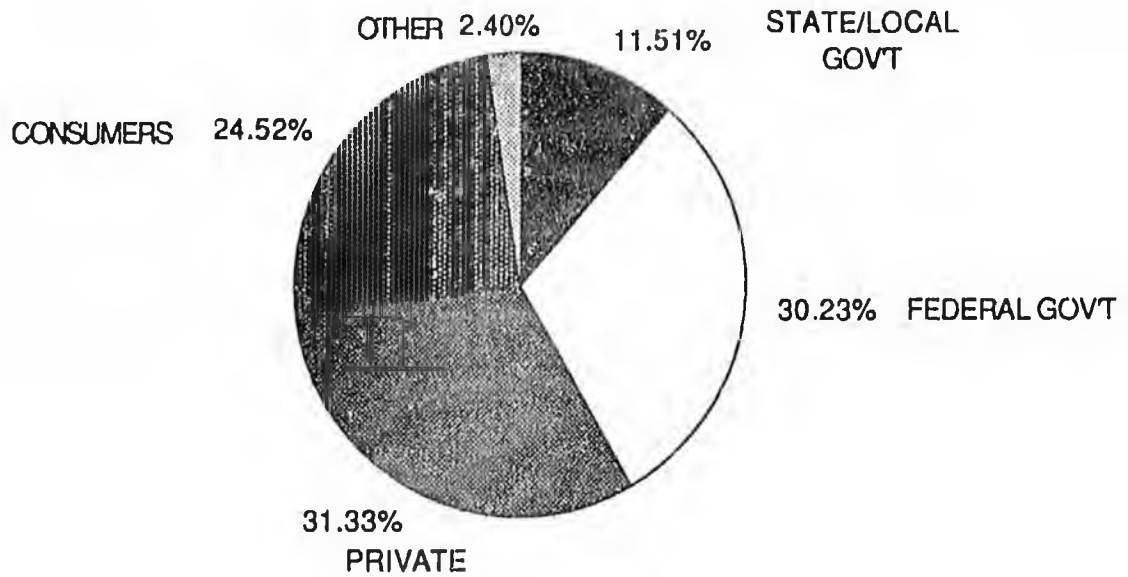
Exhibit Five illustrates Alaska health care expenditures from 1979 to 1989 and breaks down by payor (private sector, federal programs and state programs)

Exhibit Six illustrates Alaska state spending for 1989 categorized by program, medicaid, employees, retirees, municipal and political subdivisions, workers compensation, and other state funded health programs.

Exhibit Seven illustrates total Alaska health care expenditures as compared to total population to determine per capita expenses for health care.

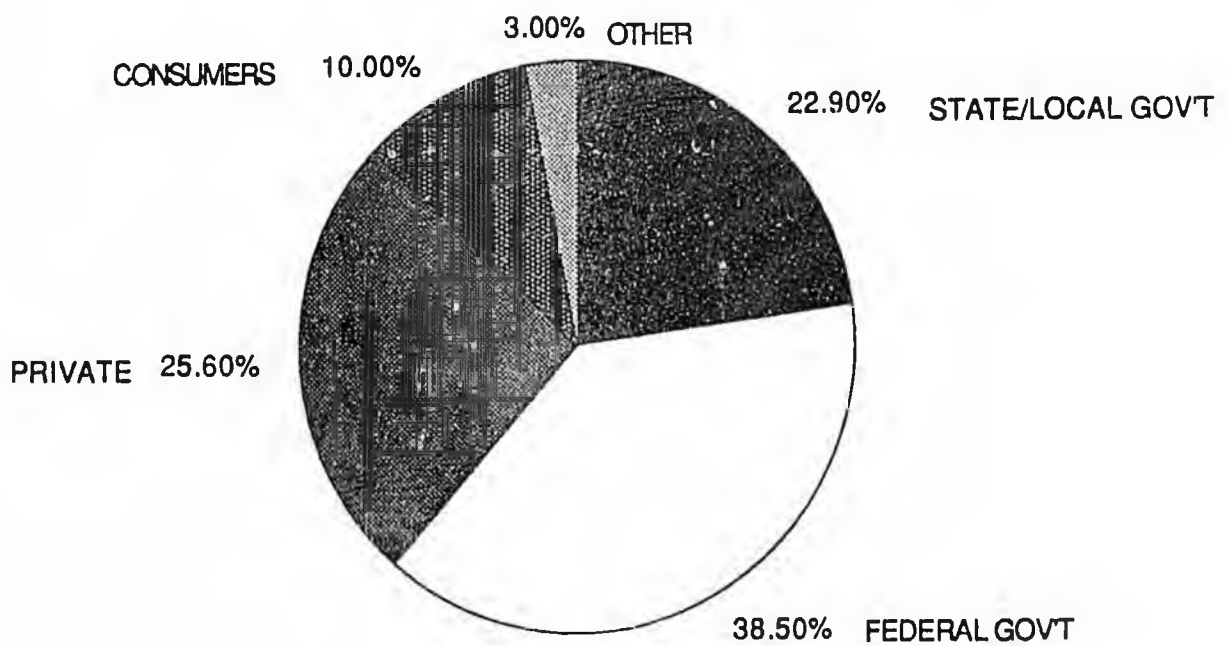
HCCC-TF EXHIBIT THREE

PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYOR



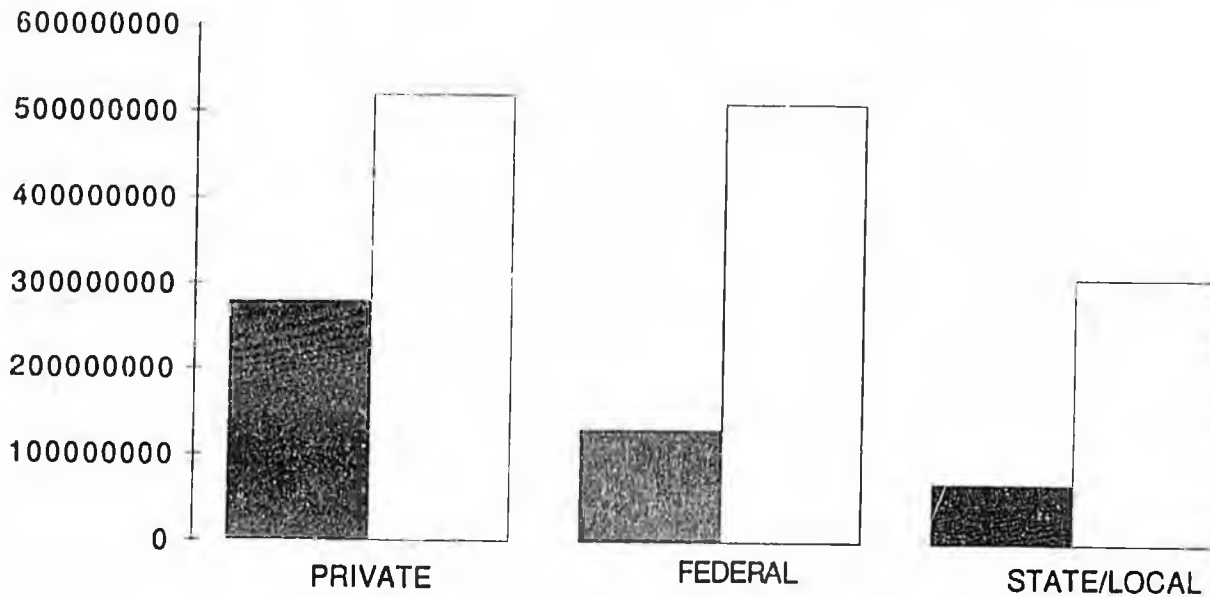
HCCC-TF EXHIBIT FOUR

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYOR



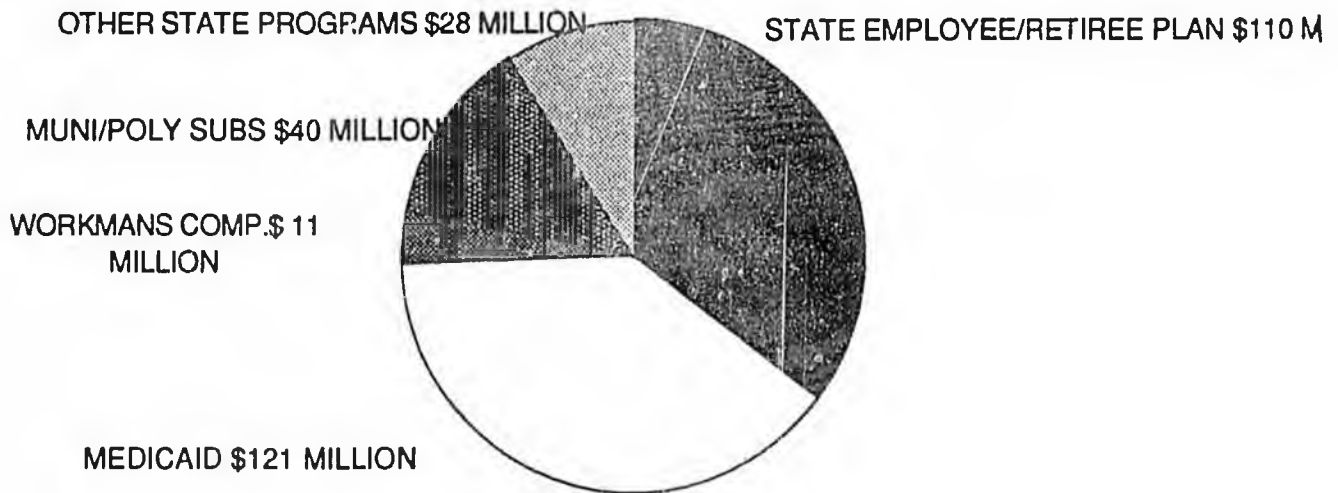
HCCC-TF EXHIBIT FIVE

STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989



HCCC-TF EXHIBIT SIX

1989 STATE OF ALASKA HEALTH CARE EXPENDITURES BY STATE PROGRAM



HCCC-TF EXHIBIT SEVEN

STATE OF ALASKA
PER CAPITA HEALTH CARE EXPENDITURE ANALYSIS
1979-1989

	1979	1984	1989
POPULATION	401,000	522,000	534,000
HEALTH CARE EXP. \$480. MILLION		\$710. MILLION	\$1.34 BILLION
PER CAPITA HEALTH CARE EXP. \$1197.00		\$1360.00	\$2524.00

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FOUR

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

The Task Force in its expanded role, has investigated the problems and causes of rapidly rising health care expenditures in Alaska. The Task Force used public testimony, surveys, research (statewide & nationally) along with a detailed analysis of the delivery and financing of health care in Alaska in its investigation.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be dealt with in an all encompassing manner to provide long term relief and health care expenditure management.

LIFE STYLE RELATED

Alaska residents like those in the lower 49 have seen increasing health care treatments due to life style injuries and diseases. These include alcohol and drug abuse, sports related injuries, cancer, AIDS and heart disease as the major expenditure causes in Alaska.

COST SHIFTING FROM OTHER HEALTH PROGRAMS

Alaska has to recognize the impact of cost shifting on the total cost of health care. When other programs either cut back or reimburse providers at lower levels these liabilities are directly transferred to other payors.

In addition, when programs make either enhancements or reductions in benefit levels these add additional costs or program burdens.

UNINSURED / UNDERINSURED ALASKA RESIDENTS

It is estimated that there are 90,000 Alaska residents that are with out health care protection, in addition there are a substantial number that do not have adequate coverage.

These residents are prevented from regular preventative care that would eliminate more serious and costly future health care needs. Also compounding the health care cost problem is when the uninsured / underinsured residents receive treatment they cannot afford. This is recognized by the health care provider as uncompensated care, but this cost is generally spread out among the other payors.

NEED FOR PREVENTATIVE CARE, WELLNESS INCENTIVES AND HEALTH CARE EDUCATION

More and more evidence points out the significant value in promoting wellness and preventative medicine. Through health education and programs that cover and promote preventative medicine Alaskans could improve their overall health and help reduce unnecessary expenditures.

Health care education and preventative medicine programs must be designed with up to date information and continually adjusted to changing medical trends, findings and advancements. These programs must also continually educate the public and recognize changes in lifestyle, surroundings and perception of health.

One example of a health promotion, education and prevention program is the "Healthy Beginnings Program" recommended by the Health Care Cost Containment Task Force and instituted by the State for the employee health insurance plan in early 1990.

The "Healthy Beginnings Program" is a program for women and their babies starting with the first trimester, with screening for potential moderate or high risk pregnancies to determine steps necessary to eliminate or reduce the risk of a premature or unhealthy delivery.

The program centers around early intervention, education and wellness along with continued communication with the mother throughout her pregnancy.

Since the inception of the "New Beginnings Program" mothers who have participated in the program are reducing the number of low birth weight deliveries. The program has also saved the State Employee health plan millions of dollars.

Promoting health education, wellness and prevention is a cost effective way to help assure Alaska residents are receiving health care at the appropriate time and level of treatment necessary.

HIGH COST OF MEDICAL TECHNOLOGY AND WASTE

During the last five years two new facets of medical inflation have come to light. These are new technology and waste in the medical delivery system.

In recent years new technology in the form of equipment, procedures, treatments and medicines has greatly improved our ability as a nation to prolong life. While this has had a substantial effect on being able to keep people alive it has also come with substantial additional health care expenditures.

Alaska has also participated in this race for the newest and best medical technology. While we too have been able to improve the longevity of our residents the cost has been significant.

A method must be developed to assure that the technology is available to residents without duplication or undue cost to the health care delivery system. In addition we must weigh the benefits and cost of any new technology that has a substantial effect on the Alaska health care delivery system.

DIRECT AND INDIRECT MALPRACTICE INSURANCE COSTS

Malpractice insurance premiums and the associated costs continue to be a significant component of health care expenditures in Alaska. While many attempts have been made to improve and or reform the system no significant in roads have been made to reduce the overall costs.

Malpractice premiums paid to insurance companies are only one part of the equation. Of equal importance and much more difficult to measure is the practice of defensive medicine by health care providers attempting to avoid a "claim".

The problem is not only one of cost but of those providers who go without coverage or inadequate protection. It is estimated that approximately 25% of physicians and 50% of obstetric / gynecologic practitioners in Alaska are uninsured for malpractice.

The malpractice problem must be dealt with in any comprehensive strategy to manage health care expenditures in Alaska, it should be done on a systemic approach, including loss prevention, education, financing of protection and the ability to project and limit losses.

HEALTH INSURANCE CARRIERS ROLE

Health insurance carriers play an important role in the delivery and financing of health insurance in Alaska. In Alaska there are only seven insurance companies with any volume selling health insurance policies. Three nonresident companies have control of approximately 90% of the market place.

Alaska health insurance carriers have made constrictions in their underwriting standards and at the same time generally set premiums based on cost of claims plus overhead expenses & profit and instituted cost containment programs.

This limited the risk for carriers but placed additional burdens on access to health insurance adding to the population of those underinsured / uninsured.

It is recognized that writing and servicing health insurance policies in Alaska may be some what more expensive than in the other 49 states. However, Alaska is a large and growing marketplace that needs affordable health protection.

GROWTH OF NEW MANDATED COVERAGES AND HEALTH CARE SPECIALTIES

Alaska like most other states has passed a number of measures (sixteen since 1985) that mandate additional coverages for health care services in health insurance policies. This proliferation of mandated coverages adds to overall health care expenditures in Alaska.

Although many of these measures can be justified, in the future all measures that expand the mandated coverage list should be evaluated by the legislature for total long term impact on the health care delivery system in Alaska.

New health care specialties have become an important component in the Alaska health care delivery system however, the trade off is a reduction in primary care providers especially in the rural areas.

HEALTH CARE PROFESSIONAL TRAINING AND RETENTION

The future of the health care delivery system in Alaska revolves around the ability to train and retain quality health care professionals in Alaska. The programs in place today must be revisited and revised to keep up with the primary and emergency care needs of Alaska especially in rural Alaska.

GENERAL OBSERVATIONS

Alaska has no central authority to provide health care planning, review of delivery, quality, access, and financing of health care protection. Alaska needs to have, in place, as the Health Care Cost Containment Task Force recommended, long term strategies to assure the medical delivery system remains accessible and affordable.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FIVE

HEALTH CARE DELIVERY SYSTEM
FINDINGS AND SURVEY RESULTS

ALASKA HEALTH CARE DELIVERY SYSTEM FINDINGS

The Task Force in its expanded duties reviewed the health care delivery system in Alaska and its important role in managing health care expenditures in Alaska.

During this review the Task Force recognized the importance in continuing the work already done in building a health care delivery system of which we can be proud. But in order to continue to expand and improve the system certain long range plans and controls must be implemented.

ALASKA LARGE GEOGRAPHIC AREA AND RURAL POPULATION

Alaska has an enormous land area and residents in largely rural areas that require health care. Alaska does have a good rural health care delivery system, but it is not immune from the problems such as long distance travel for care, limited health care services in some areas, difficulty in attracting and retaining health care professionals in rural areas and small facilities with limited services.

However only about 20% of the health care expenditures in Alaska are expended in the areas outside of the cities of Anchorage, Fairbanks and Juneau.

URBAN ALASKA HEALTH CARE DELIVERY SYSTEMS

Alaska expends about 80% of its health care dollars in its three largest cities (Anchorage, Fairbanks, Juneau) creating another set of complexities in delivering health care to Alaska residents.

Because the urban areas have larger populations and many rural residents receive health care in these cities, they are able to generally support more health care facilities and providers normally found in cities of like size.

The isolation from neighboring states also creates the need for self supporting health care delivery systems.

OUT OF STATE HEALTH CARE DELIVERY SYSTEMS

Alaska's health care delivery system relies on the systems of other states for certain treatments and as an alternate choice for residents.

Many Alaska residents choose to receive treatment or hospitalization in other states for a variety of reasons. These include the lack of available care in state or simply as a matter of convenience or comfort.

It is difficult to determine the amount of health care that is provided to residents by out of state providers. However, the out of state delivery system provides an important alternate delivery system and an equally important safety valve.

This system of receiving care must be continually monitored to assure that it provides care with out detracting or escalating health care costs for Alaska.

OTHER HEALTH CARE DELIVERY SYSTEMS IN ALASKA

Alaska has a number of other programs providing health care to residents. These include, Indian Health Service (I.H.S.), Civilian Health And Medical Programs for Uniformed Services (CHAMPUS), Veterans Administration (VA), Medicare, Medicaid and Public Health Systems.

In order assure and maintain an efficient health care delivery system in Alaska all systems must, when feasible, coordinate and share information to prevent duplication, gaps in service and fueling medical inflation.

SURVEY RESULTS

The survey done by the Task Force was designed to give greater insight to health insurance plans offered by Alaska employers, the costs for these plans, who is covered by health insurance, and additional data and perspectives from health care providers.

Over 300 surveys were mailed to various groups in Alaska including, municipalities, school districts, health care providers and private sector employers.

The survey questions were tailored to gather specific information relative to each category of respondent.

Questions ranged from those eligible / ineligible for employer health plans, number of employees, plan design, employee/employer contributions, cost containment measures implemented, premium costs, ideas to help reduce ever increasing health care costs and the reasons for these increasing costs.

Questionnaires sent to health care providers had additional questions to determine their specific perspective about rising health care costs and certain contributing factors *ie.*; bad debt, malpractice insurance costs and others.

The survey results gave us information that previously was not available. These include the range of employer sponsored health plan designs, eligibility, associated premium costs, cost containment strategies employed, and respondents perspective, and impressions about the health care delivery system in Alaska.

In comparison to the State of Alaska active employee health plan, the survey results showed:

- (1) the state no longer had either the most expensive health plan (64% of respondent's plans premium or premium equivalent was in excess of the states \$385. per month) and,
- (2) no longer was the State's plan the best in coverage (54% of respondents provide similar or better benefits).

With respect to the number of respondents offering health insurance;

- (1) surprisingly 94% do offer some form of health insurance to their full-time employees while,
- (2) none of the respondents provide coverage for part-time, seasonal, or occasional employees.

The majority of respondents have implemented ways to reduce their health plan costs;

- (1) seventy one percent have implemented at least two cost containment measures, and
- (2) sixty percent have also made benefit changes in the last two years.

In addition respondents also are implementing alternate financing of health insurance. Thirty one percent have self insured their plans.

The survey confirmed earlier information that the majority of health insurance in Alaska is underwritten by three carriers: Aetna, Blue Cross and Great West.

The survey asked specific questions about respondent's opinions relating to cost containment techniques that have worked for them and those that did not. Results showed that 55% of respondents felt that second surgical opinions and preferred provider organizations did not demonstrate significant savings. Seventy percent felt that utilization review, large case management and self insurance had positive results.

Respondents offered the following ways to control health care cost (shown with the percent of respondents offering each).

Statewide plan.....	67%
Malpractice reform.....	55%
Regulate provider rates.....	53%
Provide insurance for uninsured..	50%

In addition, the survey asked respondents their views of the major contributors to rising cost of health care in Alaska (shown with the percent of respondents for each).

Health care providers.....	67%
Malpractice insurance.....	64%
Overbuilt facilities.....	59%
Insurance carriers.....	55%
Plan members.....	48%
New technology.....	46%

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SIX

TASK FORCE RECOMMENDATIONS

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

RECOMMENDATIONS

The Health Care Cost Containment Task Force has over the last twenty-two 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 components that should be focused on as a minimum starting point to bring health care expenditures in control for Alaska.

- * Cost shifting from other programs
- * Federal program cost shifting
- * Improve health care delivery and financing systems
- * Uninsured / underinsured Alaska State residents
- * Accessibility of care
- * Mandated coverage costs
- * Improve the involvement and education for end users
- * Collect current and meaningful health care data
- * Institute preventative medicine programs

The Health Care Cost Containment Task Force makes the following recommendations which are designed to provide affordable quality health care access for all Alaska residents.

A. Create an authority that would establish and maintain health care provider payment and utilization schedules taking into consideration geographic location, actual provider cost, availability, and medical necessity (potentially using an established system as a foundation). The schedules will be used by all public sector employers and available to private sector as well.

And:

Would establish a voluntary health care protection procurement and financing pool to maximize purchasing power for;

- i. State, local government and political subdivisions.
- ii. Underinsured / uninsured for State residents.
- iii. Public / small employers plan.

This authority would be governed by a board and would assure that access to quality affordable was available to all Alaskans.

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

C. Expanded monitoring and certifying of facilities expansion and substantial equipment technological purchases to assure need and eliminate duplication or unnecessary expense. This would require revision of the C.O.N. statutes currently in place.

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

E. Provide quality affordable health care access for Alaska residents who are underinsured / uninsured.

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

G. Promote health care professional training and retention in Alaska.

H. Develop a way for the sole proprietor and small employer to provide health coverage to employees and their dependents.

I. Continue to evaluate alternate and self funding as an option for the state employees and retirees plans. Include in the next Request For Proposal a request for bids on a comprehensive and unbundled basis.

J. Form a cross section focus task force to continue to study and make recommendations to assure quality, affordable, health care access for all Alaskans.

TASK FORCE RECOMMENDATIONS FOR LEGISLATION

The Task Force recognizes the need for specific legislation to provide for a comprehensive approach to produce cost effective quality health care access to all Alaska residents.

Two separate but interrelated pieces of legislation are being recommended and endorsed by the task force. These are:

ALASKA STATE HEALTH RESOURCES AUTHORITY (ASHRA)

Creation of the Alaska State Health Resources Authority (ASHRA) SB 83, HB 71 which once enacted would be empowered to manage the access, delivery, quality, planning and financing of health care in Alaska.

The authority would be implemented in two phases:

PHASE ONE

By July 1, 1992 create and begin implementation of a statewide health care provider reimbursement schedules and utilization standards, which shall be used by all Alaska public employers and available for use by all other Alaska employers by application to the authority.

This provision requires the authority to create a system or method that streamlines or results in cost efficient payments to providers, and includes schedules of maximum allowable reimbursement for health care related services. These schedules would be based on actual provider cost, geographic regions, and availability of care. In addition, this provision creates the statewide utilization standards system to monitor, track and validate patterns of treatment by health care providers. This assures that cost efficient and cost

effective care is provided with out compromising the quality of care for participants in the authority.

The authority would also be required to issue an impact statement on all certificate of need applications within 60 days of notice. this will allow the authority to determine the cost implication of these proposed certificates or changes to existing certificates.

IMPACT

The goal of this phase is to reduce the rise in medical inflation for participants in the authority to at or about Consumer Price Index from its current level of about 20% per year. Another goal is to minimize cost shifting to other health care programs. With out this phase, health care expenditures in Alaska would top \$10 billion by the year 2000. The State of Alaska's portion of this increase would exceed 3.0 billion. At the same time the ranks of uninsured residents would total 25% of our population. (exhibits one, and two)

PHASE TWO (optional procurement of insurance)

Beginning after July 1, 1992, the Authority is directed to procure or provide comprehensive group health insurance for Alaska public employers and other employers in the state who elect to participate.

This would expand the pool of subscribers and maximize the opportunities for health care cost management and should realize significant additional savings for those participating in the authority.

In addition to creating the most comprehensive, cost effective, and efficient method of providing a variety of types of health care plans, the Authority must meet the coverage requirements resulting from negotiated agreements.

The authority is also required to review and where feasible provide health insurance protection for the uninsured and underinsured Alaska residents.

No later than January 1, 1993 the authority would develop and offer a health insurance protection plan for the sole / small Alaskan employer.

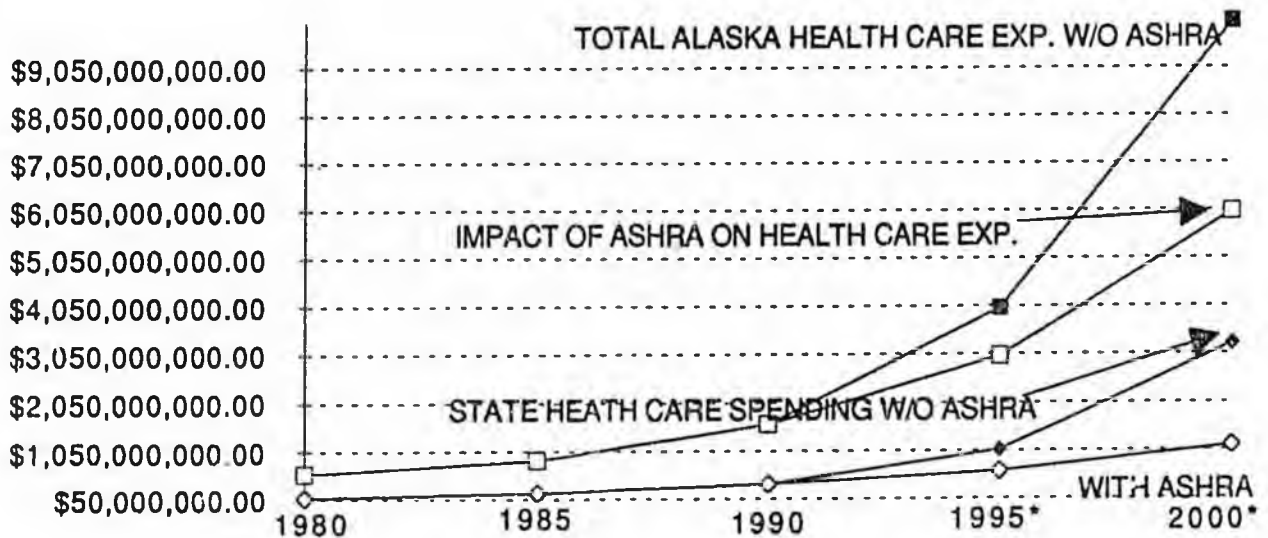
IMPACT

Phase two would bring together the provider reimbursement and utilization management components with the delivery and financing of health care in Alaska. This will enable the state, through the authority, to provide access to quality cost effective health care for all Alaska residents.

ASHRA EXHIBIT ONE; illustrates the estimated impact on total and the states portion of health care expenditures as compared without the effect of ASHRA. Total health care expenditures would be reduced in the year 2000 from \$10 billion to under \$6.0 billion and the states portion would be reduced from \$3.28 billion to \$2.0 billion. For a total estimated cost of health care savings of \$4.0 billion in the year 2000.

ASHRA EXHIBIT ONE

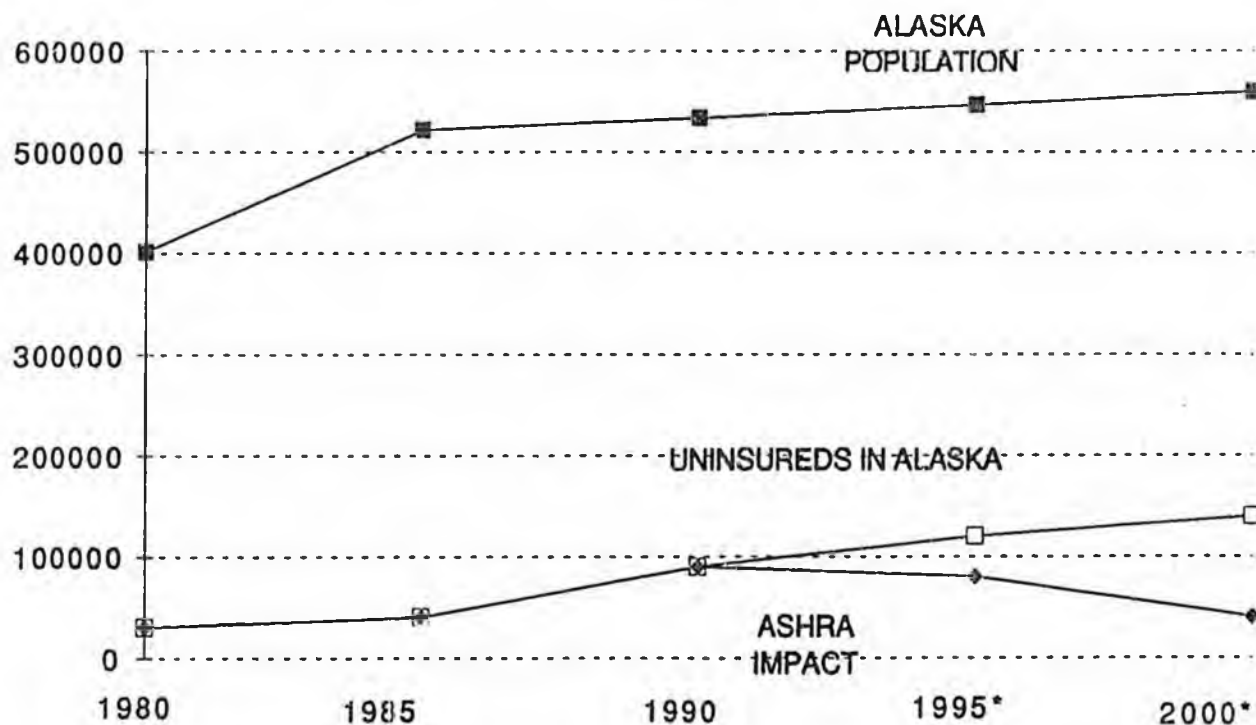
ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA



ASHRA EXHIBIT TWO; illustrates the estimated impact of ASHRA on the uninsured population in Alaska. ASHRA would reduce by the year 2000 the number of Alaska residents without health insurance to about 40,000 from the 120,000 projected without ASHRA.

ASHRA EXHIBIT TWO

ESTIMATED IMPACT OF ASHRA ON THE UNINSURED POPULATION IN ALASKA



COMPANION LEGISLATION

THE CERTIFICATE OF NEED PROGRAM (C.O.N.), SB 84, HB 69

Proposed legislation would amend AS 18.07 to create a rational frame work for the planning and development of all health care services in the state to ensure promotion and protection of public health, the providing of equitable access to health services, and the avoidance of unnecessary increases in health care costs.

By amending AS 18.07 the Certificate Of Need program would regain an important role in the approval process for health care facilities, technology, modification, expansion or change of purpose. This change would not only provide the system an early warning device but a way to accurately measure the initial and future cost impact to the total health care delivery system.

The task force has identified that the cost of facilities and technology has a direct impact on the total cost of health care and, therefore, should be prospectively managed.

PROPOSED RESOLUTION

THE HEALTH RESOURCES AND ACCESS TASK FORCE

The task force recommends the adoption of a concurrent resolution creating a HEALTH RESOURCES AND ACCESS TASK FORCE to continue the study of this issue study forward recommendations regarding access to affordable, quality health care for all Alaskans.

The foundation of knowledge, education and demonstrated success of the Health Care Cost Containment Task Force must be built upon in order to see implementation of long term solutions to the health care crisis in Alaska.

The ideal approach is to take the expertise developed in the Health Care Cost Containment Task Force and combine the ambitions of the

Universal Task Force (ch.179, SLA 1990) to create a hybrid focus group to simultaneously work on the management of health care expenditures in Alaska while improving access to quality health care.

It is envisioned that the work plan and resources of the group would have the depth to investigate all facets of health care access and financing in Alaska as compared to alternate solutions implemented by other countries, provinces, states and other health care programs.

This focus group membership should include:

- Legislative Branch
- Executive Branch
- Private Sector Employers
- Non Profit Sector
- Health Care Consumer
- Health Care Providers
- Medically Indigent
- Labor Organization

It is important to have further work done in this area, and to provide information and input to the Alaska State Health Resources Authority.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SEVEN

OPEN / UNRESOLVED ALASKA
HEALTH CARE DELIVERY ISSUES

OPEN / UNRESOLVED
ALASKA HEALTH CARE
DELIVERY ISSUES

The Health Care Cost Containment Task Force has, in its effort to find the cause of the rapidly increasing cost of health care in Alaska, found several contributing factors that need further investigation.

DELIVERY AND ACCESS

Delivery of health care in Alaska has been found to be one of the greatest contributors to the increasing cost of health care. Traditional approaches to delivering health care when applied to the large geographic area of Alaska has created a hodge podge of service which is often inadequate, underutilized and thus more costly than what can be offered through a coordinated statewide system of delivery. In addition, the increasing population of underinsured and uninsured receiving uncompensated care causes additional strain on urban, as well as, rural facilities and providers.

Included within the problems of delivery and access to health care in Alaska are answers to some of the increased cost of health care. Some of these are overbuilt facilities, new technology which is often underutilized, a lack of prevention programs, the need for statewide planning, and inadequate financing of health care for all Alaskans.

UNINSURED / UNDERINSURED

The health of small businesses in Alaska is often dependent upon a limited number of individuals each of whom is very important to the operation of an organization which has no insurance for its employees or must pay an unreasonable price for limited coverage.

As the cost of health care increases, many of these sole proprietorships and small businesses and their employees are forced to join the ranks of the underinsured or uninsured.

HIDDEN COSTS

Malpractice insurance coverage is a continuing problem not only adding to the cost of some medical procedures but increasing health care cost in general. Many health care providers believe it is necessary to practice defensive medicine as a means to lessen potential liability. This induced caution is reflected in additional laboratory test, unnecessary use of technology, exploratory surgery, increased inpatient time, and other practices that increase the cost of health care for everyone.

MANAGING THE SYSTEM

Oversight will be necessary in any effort to coordinate access to federal state and local delivery systems. Attempts to merge or attract additional sources of financing and coordinate the use of facilities for persons needing health care in Alaska will require guidance. Even the operation and activities of the Alaska State Health Resources Authority the creation of which is supported by this Task Force as recommended in section 8 will require at least periodic oversight.

These issues represent some of the more obvious areas causing the cost of health care to increase and indicate a need to continue the work that has been started. While the work of the Health Care Cost Containment Task Force has brought to light some areas where millions of dollars in cost savings have already been achieved much more remains to be done. To establish realistic, reliable and efficient controls on the cost of health care and provide access to all Alaskans will require a great deal more work than has been completed to date

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION EIGHT

ATTACHMENTS



NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

ANCHORAGE REGIONAL OFFICE

1411 W 33RD AVENUE
ANCHORAGE, ALASKA 99503
(907) 274-0536

JUNEAU OFFICE

105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 586-3090

FAIRBANKS REGIONAL OFFICE

2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 456-4435

February 11, 1991

To: **Senator Pearce, Chair**
Members, Senate Labor and Commerce Committee

Re: **SB 83; "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."**

NEA-Alaska supports and encourages your favorable consideration of SB 83. It represents a sound and viable alternative to the cost, quality, and utilization of health care services, especially as it may pertain to public school district employees.

Currently, school district employees are covered by a variety of health care plans with a broad range of benefits at differing levels of premium costs.

Many districts are disadvantaged in their ability to maximize benefit coverages at reasonable costs and have seen these costs increase at alarming rates in recent years.

Access to utilization standards, more efficient administrative and provider reimbursement systems, and the opportunity for reducing premium costs and for improving benefits through participation in expanded group pools represents substantial opportunity for employers and employees alike.

Implementation of the provisions in SB 83 is a critical step if we are to effectively deal with health care costs in Alaska.

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: **Senator Duncan**



ALASKA STATE EMPLOYEES ASSOCIATION
AFSCME Local 52, AFL-CIO

February 11, 1991

Hon. Jim Duncan, State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

On behalf of the Alaska State Employees Association and its 9,000 members statewide, I want to thank you for introducing Senate Bill 83, which seeks to establish an Alaska State Health Resources Authority to help cap the state's increasing health care costs.

As you know from your experience with the Alaska Health Care Cost Containment Task Force, health care costs to Alaskans exceeded \$1.5 billion in 1989 and have been rising at a rate of more than 20% each of the past five years. These cost increases have concomittantly increased the costs of health insurance premiums for all Alaskan employers, including the State of Alaska, making it more and more difficult for them to continue health care coverage for their employees.

Clearly, something needs to be done to bring down or, at the very least, check Alaska's spiraling health care costs and SB 83 takes the right approach.

For its part, ASEA/AFSCME Local 52 has agreed to a defined contribution to health care costs in its collective bargaining agreement with the state, but this is only a step in what should be a comprehensive attempt to contain costs throughout Alaska.

Furthermore, SB 83 makes inherently good public policy. Such an approach benefits union's, such as ASEA, by mitigating their health care costs; it benefits the State by lowering its operating costs; and it benefits private sector employers by reducing their cost of doing business with the state.

Again, my thanks to you and your colleagues on the Health Care Cost Containment Task Force for tackling a complex, difficult and controversial subject.

Respectfully yours,

Buddy Maupin
Buddy Maupin, Business Manager
ASEA/AFSCME Local 52, AFL-CIO

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FAIRBANKS OFFICE
250 Cushman St., Suite 500
Fairbanks, AK 99701
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NFIB Alaska

National Federation of
Independent Business

February 11, 1991

The Honorable Jim Duncan
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

I have previously shared the results of the entire poll with your office. Now that you have introduced SB 83 - Alaska State Health Resource Authority - the objective of this letter is to share with you some thoughts on the bill.

The idea of a voluntary health insurance program appears to be a viable means of providing health insurance to the uninsured population in Alaska. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive. A voluntary pooling approach is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

The key elements to NFIB/Alaska members support of the concept of pooling are: the program would be voluntary, administered by private insurance companies and affordable.

For your records the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72.2% No 17.0% Undecided 10.8%

a. If this pooling of employers in order to purchase health insurance was available, would you participate?

Yes 50.2% No 19.3% Undecided 30.5%

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278



The Guardian of
Small Business

Senator Duncan
February 11, 1991
Page: 2

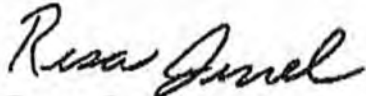
b. Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90.0% No 5.2% Undecided 4.8%

NFIB/Alaska hopes this information regarding the views of small business owners on this issues will be useful to you. If you have any questions regarding this information, please do not hesitate to contact me.

I look forward to working with you on SB 83 and other issues of importance to the small business members of NFIB/Alaska.

Sincerely,



Resa Jerrel
NFIB/Alaska
State Director

RESOLUTION

BE IT RESOLVED BY THE JUNEAU FORUM ON THE 1991 ALASKA CONFERENCE ON AGING:

WHEREAS health care expenditures in Alaska have risen from \$480 million in 1979 to over \$1.5 billion in 1989, a per capita increase of \$1327.00 per person per year; and

WHEREAS the number of uninsured or underinsured Alaskans is now estimated at over 90,000 persons; and

WHEREAS a large number of the uninsured and underinsured are senior citizens; and

WHEREAS the Alaska State Health Care Cost Containment Task Force was created early in 1989 to find ways to control the ever increasing cost of health care in Alaska; and

WHEREAS the Alaska State Health Care Cost Containment Task Force has as a result of its research and investigation identified ways to control the rising cost of health care in Alaska; and

WHEREAS the Task Force has endorsed Senate Bill 83 and the changes proposed therein necessary to rising health care cost; and

WHEREAS the Juneau Forum of the 1991 Alaska Conference on Aging has reviewed the findings and recommendations of the Alaska State Health Care Cost Containment Task Force;

BE IT RESOLVED by the Juneau Forum of the 1991 Alaska Conference on Aging that the rising cost of health care is a serious problem for senior citizens; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the cost containment measures proposed in Senate Bill 83; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the Legislatures passage Senate Bill 83, creating the Alaska State Health Resources Authority.

Adopted:

**JUNEAU FORUM
1991 ALASKA CONFERENCE ON AGING**

By: *Dorian Connors on Aging*

Chairperson: *Lauris S. Parker*
Lauris S. Parker

AASB

ASSOCIATION OF ALASKA SCHOOL BOARDS

1990 CORE RESOLUTIONS



passed by the membership
1990 ANNUAL STATEWIDE CONFERENCE

ASSOCIATION OF ALASKA SCHOOL BOARDS

TUESDAY, NOVEMBER 13, 1990

SUBJECT: ADMINISTRATION
90-36
HEALTH INSURANCE

WHEREAS, the Alaska Legislature through the work of the Health Care Cost Containment Task Force is looking at measures to control the rate of increase in the cost of health care for all Alaskans; and

WHEREAS, the cost of health insurance has increased sharply in recent years and shows no signs of stabilizing; and,

WHEREAS, school districts are required to operate within a fixed budget and need to stabilize costs as much as possible to allow for reasonable planning for a sound educational program; and,

WHEREAS, the increasing cost of providing health insurance to school employees has a significant impact on the operating budget of school districts in Alaska; and,

WHEREAS, Alaska school districts have demonstrated that insurance pooling has been an effective means of stabilizing insurance costs for their types of coverage;

NOW THEREFORE BE IT RESOLVED that the Association of Alaska School Boards aggressively investigate the feasibility of pooling for school district employee health insurance as a viable alternative for providing cost containment on a significant budget item.



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

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

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

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

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

Who are the medically indigent?

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

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

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

Should the health system be restructured?

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

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

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

Can change be expected?

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

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

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

"In an era of federal budget deficits and tight state budgets, how to assist the medically indigent has become a question of what is the most efficient allocation of limited dollars."

Katherine Swartz and Debra Lipson, *Strategies for Assisting the Medically Uninsured*

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

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

Conclusion

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

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



FYI

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STATE ACTIVITY

Hawaii

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

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

Massachusetts

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

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

California

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

A task force authorized under Chapter 829 (AB 350) will report to the legislature March 1, 1990 on the statutory responsibility of employers

to provide employees with insurance and changes in insurance rate-setting practices to ensure that coverage is both available and affordable.

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

Oregon

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

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

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

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

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

Other

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

MEDICAL INDIGENCY PROJECT

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

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INFORMATION CLEARINGHOUSE

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

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

MEETINGS AND SEMINARS

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

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HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

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

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

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

INSURANCE STATUS

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

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

- o Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.² Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.³
- o Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- o Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

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

¹ Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

² Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in *Hunger Action Forum*, Vol. 2, No. 8, August 1989.

³ Paula Braveman, MD, et al., "Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," *The Western Journal of Medicine*, 1988 December; 149: 708-11.

FINANCING INSURANCE COVERAGE

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

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

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

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

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

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

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

WHOSE RESPONSIBILITY?**STATE**

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

COLORADO

The Colorado Health Care Access Act (HB 1034) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

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

GEORGIA

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

physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

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

INDIANA

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

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

MISSOURI

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

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

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

OTHER

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

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

FEDERAL

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

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already

has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

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

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

LABOR/BUSINESS

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

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

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

and eliminate unnecessary procedures."

"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do not offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs." Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

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

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



FYI



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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

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

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

TECHNICAL ASSISTANCE UPDATE

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

1989 HEALTH CARE LEGISLATION REVIEW

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

MEDICAL INDIGENCY ProjectNotes

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

INFORMATION CLEARINGHOUSE

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

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

MEETINGS AND SEMINARS

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

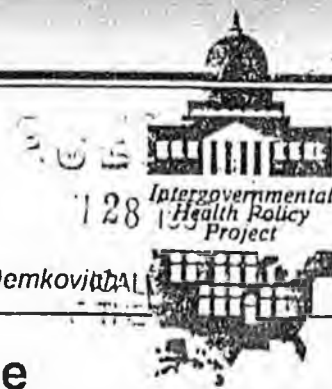
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StateSide

Discussions with Health Policymakers

by Linda Demkovich



January 1991

Alliance Strives for Universal Coverage

In 1988, after a legislative effort that would have allowed all Minnesota residents to buy into a basic "Chevrolet" insurance plan to cover health care costs fell apart in a dispute over financing, Rep. Paul Anders Ogren decided it was time to do what has become known in the political world as "networking."

The themes sounded again during the debate over the Minnesota insurance plan, Ogren said, "was that it will become a magnet for people who are ill, that it will put [the state] at an economic disadvantage relative to its neighbors, that the problem has to be solved by federal action, because of the sheer complexity and the cost."

Looking around, however, Ogren realized that many other states were also trying to address the problems of the uninsured and that a few — most notably Massachusetts and Oregon — had actually succeeded in enacting substantive reforms. The problem, in his view, was that they were doing so in isolation, with no means for sharing information and learning how to avoid each other's mistakes. "There was no resource network for progressive legislators pushing for universal health care at a state level," he observed.

That's when the Minnesota Democrat hit on the idea of launching the State Alliance for Universal Health Care — "as sort of a signal to legislators across the country that we can be a damned sight bolder than we've been thus far."

In mid-December, in concert with the Health Committee of the National Conference of State Legislatures (NCSL), the Alliance co-sponsored

a special two-day seminar on the theme "Expanding Access to Health Care." The session, a follow-up to the Alliance's first formal meeting, which was held in August 1990 in Nashville, took place just before the NCSL's regular state-federal assembly in Washington, D.C., and attracted 60 attendees. Among the featured speakers were Sen. Edward M. Kennedy (D-MA) and maverick Senator-elect Paul Wellstone (D-MN).

In separate interviews after the seminar, State Health Notes talked about the Alliance and the prospects for enactment of a universal health care system with both Ogren and Ohio Rep. Robert F. Hagan (D), who is member of the Alliance's board of directors.

"A Dollar is A Dollar"

The immediate aim of the Alliance is to build "a coalition of legislative leaders... committed to the guarantee of universal health care in each of our states." Longer term, according to the mission statement drafted in April 1990, "our collective efforts must and will culminate in a national resolution, through the Congress and President" in support of universal care.

At present, neither Ogren nor Hagan sees signs that federal policymakers are close to achieving that goal or that they are committed to helping the states achieve it by eliminating some of the barriers that Congress has, over the years, thrown in the states' way.

"The reason for the proliferation of organizations like the Alliance," said Hagan, the chief sponsor of the Universal Health Insurance for Ohio

(UHIO) plan, which is modeled on Canada's national health system, "is the realization that the federal government cannot do it." Problems — ranging from the failure of the savings and loan industry and the burgeoning budget deficit at home to the threatening situation in the Persian Gulf — will continue to divert Washington policymakers from the health system crisis, the Ohio lawmaker said.

At the same time, Hagan said, the federal government has thrown up roadblocks — things such as ERISA, the federal pension law that bars states from requiring companies that self-insure to comply with mandated health insurance benefits and risk-pool laws, and a cumbersome waiver process that discourages the states from experimenting with Medicaid reforms. "I would like to see a waiver granted that would allow one state to implement a single-payer system and work it out over a period of five to ten years," he said.

The concept underlying the UHIO plan is not a new one, after all, Hagan continued. "This is something that has been implemented in Canada. At some point, we have to admit that someone had a better idea." Like Canada, which sold its system province to province, "we have to go state to state until we convince [the federal government] of the need for a national plan." Until that happens, "we'll have to take responsibility for our own problems. What I've realized is that when they are viewed from that perspective, the problems are not nearly as big."

Part of the problem, Ogren says, is that liberal congressional leaders like Kennedy have been unwilling to admit