

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672

7435 SENATE HEALTH EDUCATION & SOCIAL SERVICES

Section 19 - Military Authority.

The governor is commander-in-chief of the armed forces of the State. He may call out these forces to execute the laws, suppress or prevent insurrection or lawless violence, or repel invasion. The governor, as provided by law, shall appoint all general and flag officers of the armed forces of the State, subject to confirmation by a majority of the members of the legislature in joint session. He shall appoint and commission all other officers.

Section 20 - Martial Law.

The governor may proclaim martial law when the public safety requires it in case of rebellion or actual or imminent invasion. Martial law shall not continue for longer than twenty days without the approval of a majority of the members of the legislature in joint session.

Section 21 - Executive Clemency.

Subject to procedure prescribed by law, the governor may grant pardons, commutations, and reprieves, and may suspend and remit fines and forfeitures. This power shall not extend to impeachment. A parole system shall be provided by law.

Section 22 - Executive Branch.

All executive and administrative offices, departments, and agencies of the state government and their respective functions, powers, and duties shall be allocated by law among and within not more than twenty principal departments, so as to group them as far as practicable according to major purposes. Regulatory, quasi-judicial, and temporary agencies may be established by law and need not be allocated within a principal department.

Section 23 - Reorganization.

The governor may make changes in the organization of the executive branch or in the assignment of functions among its units which he considers necessary for efficient administration. Where these changes require the force of law, they shall be set forth in executive orders. The legislature shall have sixty days of a regular session, or a full session if of shorter duration, to disapprove these executive orders. Unless disapproved by resolution concurred in by a majority of the members in joint

session, these orders become effective at a date thereafter to be designated by the governor.

Section 24 - Supervision.

Each principal department shall be under the supervision of the governor.

Section 25 - Department Heads.

The head of each principal department shall be a single executive unless otherwise provided by law. He shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and shall serve at the pleasure of the governor, except as otherwise provided in this article with respect to the secretary of state. The heads of all principal departments shall be citizens of the United States.

Revisor's note - Senate Joint Resolution No. 2, "changing the name of the secretary of state to lieutenant governor" in 16 sections of the Alaska Constitution, approved by the voters August 25, 1970, inadvertently omitted express amendment of this section.

Section 26 - Boards and Commissions.

When a board or commission is at the head of a principal department or a regulatory or quasi-judicial agency, its members shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and may be removed as provided by law. They shall be citizens of the United States. The board or commission may appoint a principal executive officer when authorized by law, but the appointment shall be subject to the approval of the governor.

Section 27 - Recess Appointments.

The governor may make appointments to fill vacancies occurring during a recess of the legislature, in offices requiring confirmation by the legislature. The duration of such appointments shall be prescribed by law.

Art. III, Sec. 23

Sec. 24.08.110. Bills carry over. A bill introduced but not receiving final action in the first regular session of a legislature carries over in the same reading or status into the second regular session of the same legislature. (§ 40 ch 157 SLA 1959)

Revisor's notes. — Formerly AS
24.30.120. Renumbered in 1985.

Article 2. Constitutional Amendments and Executive Orders.

Section

200. Constitutional amendments

210. Executive orders

Sec. 24.08.200. Constitutional amendments. The legislature may propose amendments to the state constitution through the adoption of a joint resolution by an affirmative vote of two-thirds of the membership of each house. Resolutions proposing constitutional amendments shall be treated as bills. (§ 41 ch 157 SLA 1959)

Revisor's notes. — Formerly AS
24.30.130(a). Renumbered in 1985.

Sec. 24.08.210. Executive orders. An executive order proposing a change in the executive branch and requiring the force of law under art. III, sec. 23, Constitution of the State of Alaska shall be submitted to the presiding officer of each house on the day the house organizes. The legislature has 60 days of a regular session, or a full session if of shorter duration to disapprove the order. Unless disapproved by a special concurrent resolution introduced in either house, concurred in by a majority of the members in joint session, the order becomes effective at a date thereafter to be designated by the governor. An order submitted to but not disapproved by the legislature shall be published in the bound session laws and any codification of state law. (§ 12 ch 47 SLA 1961)

Revisor's notes. — Formerly AS
24.30.130(b). Renumbered in 1985.

University of Alaska)

Judiciary (the programs and activities of the Alaska Court System and the Department of Law, and the legal and substantive review of bills referred to it for that purpose)

Labor and Commerce (the programs and activities of the Department of Labor relating to labor-management relations, industrial safety, unemployment compensation, and workers' compensation and the programs and activities of the Department of Commerce and Economic Development)

Community and Regional Affairs (the programs and activities of the Department of Community and Regional Affairs and other matters relating to political subdivisions)

Resources (the programs and activities of the Departments of Fish and Game, Natural Resources, and Environmental Conservation)

Rules (interpretation of the Uniform Rules, calendar, the internal administration of the house and matters pertaining to the management of the legislature as a whole)

State Affairs (programs and activities of the Office of the Governor and the Departments of Administration, Military Affairs and Public Safety, and programs and activities of the Department of Transportation and Public Facilities relating to public facilities)

Transportation (programs and activities of the Department of Transportation and Public Facilities relating to transportation and other legislative matters relating to transportation).

(b) The committee chairmen are authorized to form such subcommittees as they determine to be necessary.

SPECIAL AND JOINT COMMITTEES

RULE 21. SPECIAL AND JOINT COMMITTEES. (a) A special committee is a committee of one house. A special committee may be established only by the adoption of a simple resolution. The presiding officer of each house appoints the members of a special committee and designates a member to chair the special committee unless otherwise ordered by the house. The persons who chair like committees of each house may arrange for the committees to meet jointly to receive testimony and deal with other matters which may be expedited by joint committee action.

(b) A joint committee is a committee of both houses. A joint committee may be established only by the adoption of a concurrent resolution. The presiding officer of each house appoints one-half of the members of a joint committee. The persons who co-chair a joint committee shall be chosen in the manner provided by the presiding officers.

(c) A resolution establishing a special or joint

committee shall specify the date or conditions of termination of the committee. A standing committee may meet between sessions. A special or joint committee may meet during the session or between sessions, or both, as authorized by the resolution which establishes the committee. A standing, special, or joint committee which acts between legislative sessions may consider any legislative matter which is consistent with the jurisdiction of the committee. A standing, special, or joint committee which acts between legislative sessions constitutes a subcommittee of the Legislative Council for administrative purposes. A special or joint committee may expend money only in accordance with an appropriation made for the work of the committee.

(d) A committee may not be established unless authorized by law or by the Uniform Rules.

OPEN AND EXECUTIVE SESSIONS

RULE 22. OPEN AND EXECUTIVE SESSIONS. (a) All meetings of a legislative body are open to all legislators, whether or not they are members of the particular legislative body that is meeting, and to the general public except as provided in (b) of this rule.

(b) A legislative body may call an executive session at which members of the general public may be excluded for the following reasons:

(1) discussion of matters, the immediate knowledge of which would adversely affect the finances of a government unit;

(2) discussion of subjects that tend to prejudice the reputation and character of a person;

(3) discussion of a matter that may, by law, be required to be confidential.

(c) When a legislative body desires to call an executive session in accordance with (b) of this rule, the body shall first convene as a public meeting and the question of holding an executive session shall be determined by a majority vote of the members present.

(d) The provisions of this rule may not be interpreted as permitting the exclusion of a legislator from an executive session, whether or not the legislator is a member of the body that is meeting. A legislator not a member of the body holding an executive session shall, however, be subject to the same rules of confidentiality and decorum as pertain to regular members of the body.

COMMITTEE MEETINGS

RULE 23. COMMITTEE MEETINGS. (a) Written notice of the time, place and subject matter of all meetings of standing, special, and joint committees during a week shall be provided by the person who chairs the committee to the chief clerk or secretary by 4:00 p.m. on the preceding Thursday. The person who chairs the committee to which a bill or resolution is first referred shall provide to the chief clerk or secretary written notice of the time and place of the first

to be scheduled shall automatically be referred to the next committee of reference on the fourth day following the transmittal of the request to the chair.

(c) Bills in the Rules Committee of each house shall be placed on the daily calendar in second reading within three days after receipt of a request signed by a majority of the full membership of the committee and the presiding officer following the procedure provided in (a) of this rule to place a particular item of legislation on the calendar.

(d) Nothing in this rule prevents an oral motion to discharge a bill from committee by any member of the body at any time.

RESOLUTIONS

RULE 49. RESOLUTIONS. (a) The only type of instrument other than a bill or citation authorized under these Uniform Rules is a resolution. The types and uses of resolutions are as follows:

(1) A simple resolution is a formalized motion passed by one house only and bearing the heading "House Resolution" or "Senate Resolution". It may be used to express the will, wish, view, opinion, sympathy, or request of the house adopting it. The simple resolution shall be used to establish a special committee. It does not require committee referral, three readings, or a roll call vote. Approval of a simple resolution requires a majority vote of the full membership of the house.

(2) A special resolution headed "House Special Resolution" or "Senate Special Resolution" is used only for the purpose of expelling a member under provisions of Sec. 12, Art. II, of the State Constitution. The special resolution requires a referral to the Rules Committee, three readings, and a two-thirds vote of the full membership of the house for approval.

(3) A concurrent resolution is similar to the simple resolution but reflects the will, wish, view or decision of both houses speaking concurrently. It is used particularly to handle the internal business of the legislature, e.g., adjournment of the legislature, suspension and amendment of the Uniform Rules, requesting action of executive agencies and interim committees, and fixing the time and place for joint assemblies. This resolution is also used for establishing joint committees. This resolution does not require committee referral, three readings, or anything other than approval of a majority vote of the full membership of each house unless otherwise required by the rules.

(4) A special concurrent resolution is employed to consider disapproval of an executive order of the governor laid before the legislature under provisions of Sec. 23, Art. III, of the State Constitution. This resolution must be considered by a joint committee and may be adopted by a majority vote of the full membership of the legislature in joint session without recourse to three readings.

Rule 49.

SCR

7

FISCAL NOTE

REQUEST: SENATE HESS COMMITTEE
 Revision Date: _____ Affected Agency: Legislative Affairs Agency
 Title: Amend Uniform Rules, Create Educat BRU: Legislative Council
 Sponsor: Kerttula Component: Session Expenses

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING	FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services	0.00	0.00	0.00	0.00	0.00	
Travel	0.00	0.00	0.00	0.00	0.00	
Contractual	0.00	0.00	0.00	0.00	0.00	
Supplies	0.00	0.00	0.00	0.00	0.00	
Equipment	0.00	0.00	0.00	0.00	0.00	
Land & Structures	0.00	0.00	0.00	0.00	0.00	
Grants, Claims	0.00	0.00	0.00	0.00	0.00	
Miscellaneous	0.00	0.00	0.00	0.00	0.00	
TOTAL OPERATING	0.00	0.00	0.00	0.00	0.00	0.00
CAPITAL	0.00	0.00	0.00	0.00	0.00	
REVENUE	0.00	0.00	0.00	0.00	0.00	
FUNDING: (THOUSANDS OF DOL)	0.00	0.00	0.00	0.00	0.00	
General Fund	0.00	0.00	0.00	0.00	0.00	
Federal Fund	0.00	0.00	0.00	0.00	0.00	
Other	0.00	0.00	0.00	0.00	0.00	
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00
POSITIONS:	0.00	0.00	0.00	0.00	0.00	
Full-Time	0.00	0.00	0.00	0.00	0.00	
Part-Time	0.00	0.00	0.00	0.00	0.00	
Temporary	0.00	0.00	0.00	0.00	0.00	
	0.00	0.00	0.00	0.00	0.00	

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY)

Prepared By: Senate HESS Committee Phone: 465-3818
 Division: *Senate HESS Committee* Date: 10-Apr-91
 Approved By: Sturgulewski
 Agency: Legislature Date: 10-Apr-91

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR Sturgulewski
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

HOUSE LETTER OF INTENT

CSHCR 4 (FINANCE) am

It is the intent of the Legislature that the Joint Committee on School Improvement study possible amendments to the public school foundation formula including additional state aid for those school districts that have a longer school year than required by state law or that hold a summer school.

Adopted by the House 5/6/91



Official Business

Alaska State Legislature

Senate

Committee on Finance

MEMORANDUM

Pouch V
State Capitol
Juneau, Alaska 99811

TO: Senator Arliss Sturgulewski, Chair
Senate Health, Education, and Social
Services Committee

FROM: Senator Jay Kerttula

SUBJ: Senate Concurrent Resolution 7 --
Education Committee

DATE: March 12, 1991

I would appreciate it if you would schedule SCR 7 --
establishing a standing committee on education.

I have attached a list of committees which consider education in other state legislatures. As you are well aware, the HESS committees are second only to Finance in the volume of bills which are heard. The Alaska Constitution gives us a high duty in the area of education, and I believe that a standing committee would give us the time and forum to pay sufficient attention to this important topic. It is an anachronism that, while our Constitution makes a strong legislative commitment to education, Alaska is one of only nine states which does not have a standing committee on education in both houses of the legislature.

I urge your consideration of SCR 7. The National Education Association supports this resolution.

JK:kh



Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811

SPONSOR STATEMENT SENATOR JAY KERTTULA

SENATE CONCURRENT RESOLUTION 7 STANDING COMMITTEE ON EDUCATION

Senate Concurrent Resolution 7 would change the uniform rules to establish a standing committee on education.

The Alaska Constitution gives us a high duty in the area of education, and I believe that a standing committee would give us the time and forum to pay sufficient attention to this important topic. There are 40 other states which have a standing committee on education, some of these states emphasis education to an even greater extent by having standing committees on both education and postsecondary education. It is an anachronism that, while our Constitution makes a strong legislative commitment to education, Alaska is one of only ten states which does not have a standing committee on education in both houses of the legislature.

I urge passage of SCR 7. The National Education Association supports this resolution.



Senator Jay Kerttula

1 are state clerical
and separate education
committees

2 copy bill

3 atoms general
U GA - Dept of Ed

4 letter from H 555
Federal structure date

CS FOR SENATE CONCURRENT RESOLUTION NO. 7 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

**Offered:
Referred:**

Sponsor(s): SENATOR KERTTULA

A RESOLUTION

1 **Proposing an amendment to the Uniform Rules of the Alaska State Legislature creating**
2 **and relating to the jurisdiction of the Education standing committees, and relating to the**
3 **jurisdiction of the Health and Social Services standing committees; and providing that the**
4 **amendment will take effect on the convening of the First Session of the Eighteenth Alaska**
5 **State Legislature.**

6 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 *** Section 1. Rule 20(a) of the Uniform Rules of the Alaska State Legislature is amended to read:**

8 (a) Each house has the following standing committees with the jurisdiction indicated:

9 Finance (all appropriation, revenue, capital improvement, and bonding measures, the
10 executive budget, and the programs and activities of the Department of Revenue)

11 Health [, EDUCATION] and Social Services (the programs and activities of the
12 Department of Health and Social Services and [,] the Department of Corrections [EDUCATION,
13 AND THE UNIVERSITY OF ALASKA])

14 Education (the programs and activities of the Department of Education and the
15 University of Alaska)

1 Judiciary (the programs and activities of the Alaska Court System and the Department
2 of Law, and the legal and substantive review of bills referred to it for that purpose)

3 Labor and Commerce (the programs and activities of the Department of Labor relating
4 to labor-management relations, industrial safety, unemployment compensation, and workers'
5 compensation and the programs and activities of the Department of Commerce and Economic
6 Development)

7 Community and Regional Affairs (the programs and activities of the Department of
8 Community and Regional Affairs and other matters relating to political subdivisions)

9 Resources (the programs and activities of the Departments of Fish and Game, Natural
10 Resources, and Environmental Conservation)

11 Rules (interpretation of the Uniform Rules, calendar, the internal administration of the
12 house and matters pertaining to the management of the legislature as a whole)

13 State Affairs (programs and activities of the Office of the Governor and the Departments
14 of Administration, Military and Veterans' Affairs, and Public Safety, and programs and activities
15 of the Department of Transportation and Public Facilities relating to public facilities)

16 Transportation (programs and activities of the Department of Transportation and Public
17 Facilities relating to transportation and other legislative matters relating to transportation).

18 * Sec. 2. The amendment proposed by this resolution takes effect on the convening of the First
19 Session of the Eighteenth Alaska State Legislature.

*Drafter: Cook
Ordered OAPR*

DRAFTS

*OK
Howard*

SENATE CONCURRENT RESOLUTION NO. 7

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

**Introduced: 1/30/91
Referred: Health, Education and Social Services**

A RESOLUTION

1 Proposing an amendment to the Uniform Rules of the Alaska State Legislature creating
2 and relating to the jurisdiction of the Education standing committees, and relating to the
3 jurisdiction of the Health and Social Services standing committees; and providing that the
4 amendment will take effect on the convening of the First Session of the Eighteenth Alaska
5 State Legislature.

6 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

7 * **Section 1.** Rule 20(a) of the Uniform Rules of the Alaska State Legislature is amended to read:

8 (a) Each house has the following standing committees with the jurisdiction indicated:

9 Finance (all appropriation, revenue, capital improvement, and bonding measures, the
10 executive budget, and the programs and activities of the Department of Revenue)

11 Health [, EDUCATION] and Social Services (the programs and activities of the
12 Department of Health and Social Services [, THE DEPARTMENT OF EDUCATION, AND THE
13 UNIVERSITY OF ALASKA]) *Corrections*

14 Education (the programs and activities of the Department of Education and the
15 University of Alaska)

1 Judiciary (the programs and activities of the Alaska Court System and the Department
2 of Law, and the legal and substantive review of bills referred to it for that purpose)

3 Labor and Commerce (the programs and activities of the Department of Labor relating
4 to labor-management relations, industrial safety, unemployment compensation, and workers'
5 compensation and the programs and activities of the Department of Commerce and Economic
6 Development)

7 Community and Regional Affairs (the programs and activities of the Department of
8 Community and Regional Affairs and other matters relating to political subdivisions)

9 Resources (the programs and activities of the Departments of Fish and Game, Natural
10 Resources, and Environmental Conservation)

11 Rules (interpretation of the Uniform Rules, calendar, the internal administration of the
12 house and matters pertaining to the management of the legislature as a whole)

13 State Affairs (programs and activities of the Office of the Governor and the Departments
14 of Administration, Military Affairs, and Public Safety, and programs and activities of the
15 Department of Transportation and Public Facilities relating to public facilities)

16 Transportation (programs and activities of the Department of Transportation and Public
17 Facilities relating to transportation and other legislative matters relating to transportation).

18 * Sec. 2. The amendment proposed by this resolution takes effect on the convening of the First
19 Session of the Eighteenth Alaska State Legislature.



NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

ANCHORAGE REGIONAL OFFICE

1411 W 33RD AVENUE
ANCHORAGE, ALASKA 99503
(907) 274-0536
FAX: (907) 274-0551

JUNEAU OFFICE

105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 586-3090
FAX: (907) 586-2744

FAIRBANKS REGIONAL OFFICE

2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 450-4435
FAX: (907) 456-2159

March 25, 1991

To: **Senator Sturgulewski, Chair
Members, Senate HESS Committee**

Re: **SCR 7; "Proposing an amendment to the Uniform Rules of Alaska State Legislature creating and relating to the jurisdiction of the Education standing committees, and relating to the jurisdiction of the Health and Social Services standing committees; and providing that the amendment will take effect on the convening of the First Session of the Eighteenth Alaska State Legislature."**

NEA-Alaska supports and encourages the creation of a separate standing committee for public education and the university system.

The current HESS Committees have policy responsibility for two of the most comprehensive agencies in state government. The magnitude of load which is always before the HESS committees is substantial and may periodically preclude adequate consideration of critical policy issues.

Public Education and Health and Social Services are also a substantial part of the operating budget of the State and must effectively monitor entitlement formula funding and many federal programs as well.

It is our opinion that the changes proposed by SCR 7 would result in better and more timely policy decisions, continuity in appropriate legislative oversight, and the ability to be more responsive to the increasing and ever changing needs in public education.

The opportunity and potential need for interim work by a standing Education committee would permit legislators to more closely focus on specific programs, services, and needs in our public schools and university system.

Thank you for your consideration of our position and recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: **Senator Kerttula**

STATES WITH STANDING COMMITTEES ON EDUCATION

ALABAMA
ARIZONA
ARKANSAS
CALIFORNIA
COLORADO
CONNECTICUT
DELAWARE
FLORIDA
GEORGIA
HAWAII
IDAHO
ILLINOIS (two committees in each house)
INDIANA
IOWA
KANSAS (two committees in each house)
KENTUCKY
LOUISIANA
MAINE
MASSACHUSETTS
MINNESOTA
MISSISSIPPI (two committees in each house)
MISSOURI (House has two committees)
NEBRASKA
NEW HAMPSHIRE
NEW JERSEY (House has two committees)
NEW MEXICO
NEW YORK (two committees in each house)
NORTH CAROLINA (two committees in each house)
NORTH DAKOTA
OHIO
OKLAHOMA (HOUSE has two committees)
OREGON
PENNSYLVANIA
SOUTH CAROLINA
SOUTH DAKOTA
TENNESSEE
TEXAS (House has two committees)
UTAH
WASHINGTON (two committees in each house)
WEST VIRGINIA



EDUCATION

Committees that consider matters concerning education.

ALABAMA

Sen. Chip Bailey
Chairman
Senate Education Cmte.
State Capitol
Montgomery, AL 36130
(205) 261-7880

Rep. Stephen A. McMurrian
Chairman
House Education Cmte.
State Capitol
Montgomery, AL 36130
(205) 261-7723

Assemblyman Teresa Hughes
Chairman
Assembly Education Cmte.
Rm. 3111, State Capitol
Sacramento, CA 95814
(916) 445-9431

Sen. Diane Watson
Chairman
Jt. Oversight Cmte. on
GAIN Implementation
Rm. 210, 1127 11th St.
Sacramento, CA 95814
(916) 445-0371

Sen. George Stuart
Chairman
Senate Higher Education
Cmte.
38 Senate Office Bldg.
Tallahassee, FL 32399
(904) 487-5623

Rep. Michael Friedman
Chairman
House Education K-12
Cmte.
226 House Office Bldg.
Tallahassee, FL 32399
(904) 488-7451

Rep. Rod Tam
Chairman
House Education Cmte.
Rm. 403, State Capitol
Honolulu, HI 96813
(808) 548-4053

Rep. Brian T. Taniguchi
Chairman
House Higher Education
& The Arts Cmte.
Rm. 431, State Capitol
Honolulu, HI 96813
(808) 548-6208

ALASKA

Sen. Paul A. Fischer
Chairman
Senate Health, Education
& Social Services Cmte.
P.O. Box V
Juneau, AK 99811
(907) 465-2111

Rep. Johnny Ellis
Chairman
House Health, Education
& Social Services Cmte.
P.O. Box V
Juneau, AK 99811
(907) 465-2111

Sen. Leroy Greene
Chairman
Jt. Cmte. On School
Facilities
Rm. 305, 1127 11th St.
Sacramento, CA 95814
(916) 324-6384

COLORADO

Sen. Al Meiklejohn
Chairman
Senate Education Cmte.
State Capitol
Denver, CO 80203
(303) 866-5000

Rep. Jeanne Faatz
Chairman
House Education Cmte.
State Capitol
Denver, CO 80203
(303) 866-5000

Rep. Walter Young
Chairman
House Higher Education
Cmte.
224 House Office Bldg.
Tallahassee, FL 32399
(904) 488-3711

GEORGIA

Sen. John C. Foster
Chairman
Senate Education Cmte.
State Capitol
Atlanta, GA 30334
(404) 656-2000

Sen. W. W. Fincher Jr.
Chairman
Senate Higher Education
Cmte.
State Capitol
Atlanta, GA 30334
(404) 656-2000

Rep. William C. Mangum
Jr.
Chairman
House Education Cmte.
State Capitol
Atlanta, GA 30334
(404) 656-2000

Rep. Thomas B. Buck III
Chairman
House University System
of Georgia Cmte.
State Capitol
Atlanta, GA 30334
(404) 656-2000

IDAHO

Sen. J. L. 'Je y' Thorne
Chairman
Senate Education Cmte.
State Capitol
Boise, ID 83720
(208) 334-3576

Rep. Janet S. Hay
Chairman
House Education Cmte.
State Capitol
Boise, ID 83720
(208) 334-3015

ARIZONA

Sen. Jacques Steiner
Chairman
Senate Education Cmte.
Senate Wing, State
Capitol
Phoenix, AZ 85007
(602) 542-3171

Rep. Bev Hermon
Chairman
House Education Cmte.
House Wing, State
Capitol
Phoenix, AZ 85007
(602) 542-5896

CONNECTICUT

Sen. Kevin P. Sullivan
Rep. Naomi K. Cohen
Co-Chairmen
Jt. Education Cmte.
3100, Legis. Office Bldg.
Hartford, CT 06106
(203) 240-0420

DELAWARE

Sen. David B. McBride
Chairman
Senate Education Cmte.
Legislative Hall
Dover, DE 19901
(302) 736-4000

Rep. Tina Fallon
Chairman
House Education Cmte.
Legislative Hall
Dover, DE 19901
(302) 736-4000

HAWAII

Sen. Bertrand Kobayashi
Chairman
Senate Education Cmte.
Rm. 213, State Capitol
Honolulu, HI 96813
(808) 548-6228

ILLINOIS

Sen. Arthur L. Berman
Chairman
Senate Elementary &
Secondary Education
Cmte.
Rm. 605E, State House
Springfield, IL 62706
(217) 782-8492

Sen. Jeremiah E. Joyce
Chairman
Senate Higher Education
Cmte.
Rm. M103F, State House
Springfield, IL 62706
(217) 782-8200

Rep. Richard T.
Mulcahey
Chairman
House Elementary &
Secondary Education
Cmte.
Rm. 2099M, Stratton
Bldg.
Springfield, IL 62706
(217) 782-8190

ARKANSAS

Sen. Clarence E. Bell
Chairman
Senate Education Cmte.
State Capitol
Little Rock, AR 72201
(501) 371-3000

Rep. G. W. Turner Jr.
Chairman
House Education Cmte.
State Capitol
Little Rock, AR 72201
(501) 371-3000

CALIFORNIA

Sen. Gary Hart
Chairman
Senate Education Cmte.
Rm. 2037, State Capitol
Sacramento, CA 95814
(916) 445-2522

FLORIDA

Sen. Bob Johnson
Chairman
Senate Education Cmte.
34 Senate Office Bldg.
Tallahassee, FL 32399
(904) 487-5213

Sen. Malama Solomon
Chairman
Senate Higher Education
Cmte.
Rm. 205, State Capitol
Honolulu, HI 96813
(808) 548-4341

Rep. Helen F.
Satterthwaite
Chairman
House Higher Education
Cmte.
Rm. 2031J, State House
Springfield, IL 62706
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INDIANA

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State House
Indianapolis, IN 46204
(317) 232-3140

Rep. Philip Warner
Rep. Paul Robertson
Co-Chairmen
House Education Cmte.
State House
Indianapolis, IN 46204
(317) 232-3140

IOWA

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Chairman
Senate Education Cmte.
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Rep. C. Arthur Ollie
Chairman
House Education Cmte.
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KANSAS

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Chairman
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Sen. August Bogina Jr.
Chairman
Senate Ways & Means
Cmte.
Rm. 120-S, State House
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(913) 296-7362

Rep. Don Crumbaker
Chairman
House Education Cmte.
Rm. 182-W, State House
Topeka, KS 66612
(913) 296-7685

Rep. William W. Buntin
Chairman
House Appropriations
Cmte.
Rm. 314-S, State House
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KENTUCKY

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Senate Education Cmte.
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Rep. Roger Noe
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House Education Cmte.
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LOUISIANA

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Chairman
Senate Education Cmte.
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House Education Cmte.
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Baton Rouge, LA 70804
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Rep. Robert Adley
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MAINE

Sen. Stephen C. Estabrook
Rep. Nathaniel J. Crowley Sr.
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MARYLAND

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Sen. Catherine I. Riley
Chairman
Senate Finance Cmte.
Presidential Wing, Senate
Office Bldg.
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Del. Anne Scarlett
Perkins
Chairman
House Constitutional &
Administrative Law
Cmte.
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Del. Charles J. Ryan
Chairman
House Appropriations
Cmte.
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MASSACHUSETTS

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Rep. Nicholas A. Palonegolos
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Jackson, MS 39215
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Senate Education Cmte.
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Rep. Annette N. Morgan
Chairman
House Education-
Elementary & Secondary
Cmte.
Rm. 235, State Capitol
Jefferson City, MO 65101
(314) 751-4485

Rep. Kenneth B. Jacob
Chairman
House Education-Higher
Cmte.
Rm. 110B, State Capitol
Jefferson City, MO 65101
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MONTANA

Sen. H. W. 'Swede'
Hammond
Chairman
Senate Education &
Cultural Resources
Cmte.
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Helena, MT 59620
(406) 444-4852

Rep. Ted Schye
Chairman
House Education &
Cultural Resources
Cmte.
Rm. 313, State Capitol
Helena, MT 59620
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NEBRASKA

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Chairman
Education Cmte.
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Lincoln, NE 68509
(402) 471-2730

NEVADA

Sen. Raymond D.
Rawson
Chairman
Senate Human Resources
& Facilities Cmte.
Legislative Bldg.
Carson City, NV 89710
(702) 885-3649

Alaska Office & Capitol 7215	Assemblyman James J. Spinello Chairman Assembly Education Cmte. Legislative Bldg. Carson City, NV 89710 (702) 883-3631	NEW YORK Sen. James H. Donovan Chairman Senate Education Cmte. Rm. 304, State Capitol Albany, NY 12247 (518) 435-2631	Rep. J. Fred Bowman Chairman House Community Colleges Subcmte. Rm. 619, Legis. Office Bldg. Raleigh, NC 27611 (919) 733-4910	Rep. Carolyn Thompson Chairman House Education Cmte. Rm. 305-A, State Capitol Oklahoma City, OK 73105 (405) 521-2711
Casky State Cmte. Capitol MO 65101	NEW HAMPSHIRE Sen. George Dismard Chairman Senate Education Cmte. Rm. 209, Legis. Office Bldg. Concord, NH 03301 (603) 271-3095	Sen. Kenneth P. La Valle Chairman Senate Higher Education Cmte. Rm. 805, Legis. Office Bldg. Albany, NY 12247 (518) 455-3121	Rep. Edward Warner Chairman (House) The University of North Carolina Subcmte. State Legis. Bldg. Raleigh, NC 27611 (919) 733-1110	Rep. Robert McGowan Chairman House Higher Education Cmte. Rm. 304, State Capitol Oklahoma City, OK 73105 (405) 521-2711
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Education

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House Education Cmte.
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DISTRICT OF
COLUMBIA

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Mason
Chairman
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Cmte.
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Rep. Aina Sives T. Nua
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House Education Cmte.
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(684) 633-4439

SCR

10

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO: SCR 10

Revision Date: _____
Title: Establishing a Health Resources
and Access Task Force.
Sponsor: Senator Duncan
Requestor: Senator Duncan

Department Affected: Legislative Affairs Agency
BRU: Legislative Council

Component: Council & Subcommittees
Session Expenses, Legis. Oper Budget

COMPONENT SERIAL NO: 783

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	68.4	42.0	0	0	0	0
TRAVEL	22.5	11.0	0	0	0	0
CONTRACTUAL	92.0	46.0	0	0	0	0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	182.9	99.0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	182.9	99.0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL	182.9	99.0	0	0	0	0

POSITIONS:

FULL-TIME	1	0	0	0	0	0
PART-TIME	0	1	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary)

SCR 10 establishes a Health Resources and Access Task Force within the Legislative Branch. The following is requested to adequately support the task force:

Prepared By: Pamela A. Stoops, Director
Division: Administrative Services

Pamela A. Stoops

Phone: 465-3850
Date: 2/26/91

Approved By: Warren W. Endicott, Executive Director
Agency: Legislative Affairs Agency

Warren W. Endicott

Date: 2/26/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

PERSONAL SERVICES

Staff is requested as follows to assist the Health Resources & Access Task Force.

Legislative Assistant - Range 21A

\$4,155 x 12 months = \$49,860

\$49,860 x 37% benefits = \$68,427

68.4

Funding for FY 93 is for seven months. The task force is terminated February 1, 1993.

TRAVEL

It is anticipated there will be 3 meetings of the Health Resources & Access Task Force.

3 meetings x 12 members = 36 airfares

36 airfares x \$436 = \$15,696

2 days per diem x 36 = 72

72 days x \$95 = \$6,840

22.5

It is assumed that the travel costs for the two Executive Branch members will be absorbed within their existing budgets.

CONTRACTUAL

Professional services funding to carry out the task force duties--\$90,000.

90.0

Advertising - advertising of public notice of meetings--\$2,000.

2.0

SUPPLIES

Supplies for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

EQUIPMENT

Equipment for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

Anchorage - 7M^{1/2} w/ SCFD 4/12/91 w/ Bill Barnes

Presume 30-40000 no Health Ins.
Some can buy
some poor
some uninsurable

Theoretical - 10 Physicians by
contract. 20000 a month - Pay +
Office Rent parents. Enroll-
age by both parties. (1) Catastrophic
included (2) Certain other labs etc -

Use British model. Assign 1/2 PF
in panel. If child is dependent
also 1/2 - 10 Docs - 2.4M
300,000 to surgeons = 3.0M.

Enroll -
12M^{1/2} ^{sum PF} 3 to run Fund of 9M -

need for optals etc - Doc works w/
medical office for health care.
Can only spend what brings in.

Bill Barnes - have access to
health care. Bill getting opened -
Alternatives -

~~Rod Wilson~~ -- said Don would
do it.

Says 25% of fees now are
in paperwork.

Just people who are uninsured.
People who had no other access.
Also able to pay a fee.

Alaska State Legislature

SENATOR ARLISS STURGULEWSKI, Chairman
SENATOR PAUL FISCHER, Vice Chairman
SENATOR SAM COTTEN
SENATOR LYMAN HOFFMAN
SENATOR CURT MENARD



P.O. BOX V
ROOM 427
STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3762

Senate Committee on Health, Education and Social Services

MEMORANDUM

03 March 1991

TO: Terri Lauterbach
Legislative Legal Services

FROM: Senator Arliss Sturgulewski
Chair, Senate HESS Committee

Please have a HESS Committee substitute drafted for SCR 10 incorporating the changes on the attached bill draft. I would appreciate getting the draft back this afternoon.

F A X T R A N S M I T T A L M E M O
TO: Terri Lauterbach
DEPT: 10606 FAX #: 465-3827
FROM: HESS PHONE: 465-3818
CO: Helissa Ford FAX #: 465-3810
Post-It brand fax transmittal memo 7671

NO. OF PAGES
2

FAX COVER SHEET

DATE: 11 MARCH 91

TIME: 3:40

TO:

Don Renfro

Dillingham City Schools

847-5634

FROM:

Senator Sturgulewski's Office

Melissa Fouse

Pouch V, Juneau, Alaska 99811

907-465-3818

FAX 907-465-3810

This cover sheet plus 6 pages

FAX COVER SHEET

DATE: 11 March 1991

TIME: 4:15

TO:

Dr. Holloway

SITKA School District

747-5330

FROM:

Senator Sturgulewski's Office

Melissa Fouse

Pouch V, Juneau, Alaska 99811

907-465-3818

FAX 907-465-3810

*We have added Sitka to the teleconference sites.
The bill is to be up first on the committee
schedule at 8 am.*

This cover sheet plus 6 pages

FROM SB 57

CS FOR SENATE BILL NO. 7 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS KERTTULA, Fischer, Rodey, Menard, Jones

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state aid for education; and providing for an effective date."

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

3 *> SB 57 Section #1 deleted*

* Section 1. AS 14.17.041(a) is amended to read:

4 (a) For funding communities that have an average daily membership of less than 200 in
5 grades K-6 or less than 200 in grades 7-12, combined elementary and secondary instructional
6 units are determined under the following table:

7	ADM	No. Instructional Units
8	1 - 10	2
9	11 - 20	2 + ((ADM-10)/5)
10	21 - 60	4 + ((ADM-20)/8)
11	61 - <u>240</u> [120]	9 + ((ADM-60)/12)
12	<u>241</u> [121] - 525	<u>24 + ((ADM-240)/14)</u>
13		[14 + ((ADM-120)/15)]

14 * Sec. 2. AS 14.17.041(b) is amended to read:

1 (b) For funding communities that are not included under (a) of this section,

2 (1) instructional units for elementary students are determined by the formula: units
3 = 16 [15] + ((ADM-200)/17), where ADM is the number of students in average daily
4 membership in grades kindergarten through 6;

5 (2) instructional units for secondary students are determined by the formula: units
6 = 19 [18] + ((ADM-200)/13), where ADM is the number of students in average daily
7 membership in grades 7 through 12.

8 * Sec. 3. AS 14.17.041 is amended by adding a new subsection to read:

9 (e) A municipality that is a school district with an ADM of 750 or less that consists of
10 one funding community shall increase the elementary and secondary instructional units received
11 under (a) or (b) of this section by multiplying the instructional units by a percentage determined
12 under the following table:

District ADM	Percentage
1 - 250	1.12
251 - 525	1.08
526 - 750	1.06

17 * Sec. 4. AS 14.17.056 is amended to read:

18 Sec. 14.17.056. INSTRUCTIONAL UNIT VALUE. The instructional unit value is
19 \$63,000 [\$60,000].

20 * Sec. 5. This Act takes effect July 1, 1991.

ALASKA DEPARTMENT OF EDUCATION
 PROJECTED FY92 FOUNDATION PROGRAM
 AASA PROPOSED PROGRAM REVISIONS

EFFECT OF COMMITTEE SUBSTITUTE SB 7 (HES) vs. SB 54
 at \$60,000

PREPARED 2/13/91
 REVISED 3/11/91

	FY92 ADM	NEW TABLES AASA SEC. 3 PROPOSAL	NEW TABLES AASA SEC. 2 PROPOSAL	SEC. 4 SINGLE SITE MUNICIPALITIES < 750 ADM	TOTAL COST OF SEC. 2,3 & 4 UNIT VALUE AT \$60,000
* ADAK	715	\$152,400	\$0	* ₂ 237,000	\$152,400
* ALASKA GATEWAY	499	\$0	\$157,800	\$0	\$157,800
ALEUTIAN REGION	33	\$0	\$0	* ₂ 42,600	\$0
ALEUTIANS EAST	359	\$0	\$58,800	\$0	\$58,800
* ANCHORAGE	42070	\$240,000	\$14,400	\$0	\$254,400
ANNETTE ISLANDS	411	\$0	\$173,400	* ₂ 165,000	\$173,400
BERING STRAIT	1398	\$0	\$225,000	\$0	\$225,000
BRISTOL BAY	265	\$0	\$153,000	* ₂ 81,000	\$153,000
CHATHAM	384	\$0	\$70,800	\$0	\$70,800
CHUGACH	110	\$0	\$0	\$0	\$0
COPPER RIVER	578	\$0	\$157,200	\$0	\$157,200
CORDOVA	438	\$0	\$196,200	\$187,800	\$384,000
CRAIG	413	\$0	\$174,600	\$165,600	\$340,200
DELTA/GREELY	870	\$139,200	\$0	* ₂ 262,800	\$139,200
DILLINGHAM	485	\$0	\$241,800	\$234,000	\$475,800
* FAIRBANKS	14683	\$374,400	\$0	\$0	\$374,400
GALENA	150	\$0	\$39,000	\$150,000	\$189,000
HAINES	44	\$0	\$177,000	\$0	\$177,000
HOONAH	230	\$0	\$119,400	\$165,600	\$285,000
HYDABURG	108	\$0	\$0	\$96,600	\$96,600
* IETAROD	394	\$0	\$63,000	\$0	\$63,000
* JUNEAU	5328	\$120,000	\$0	\$0	\$120,000
KAKE	172	\$0	\$53,400	\$129,600	\$183,000
* KASHUNAMIUT	192	\$0	\$96,000	* ₂ 180,600	\$96,000
* KENAI	9724	\$600,000	\$572,400	\$0	\$1,172,400
KETCHIKAN	2796	\$120,000	\$0	* ₂ 350,400	\$120,000
KLAWOCK	200	\$0	\$82,800	\$143,400	\$226,200
KODIAK	241	\$130,800	\$0	\$0	\$130,800
KUSPUK	413	\$0	\$82,800	\$0	\$82,800
LAKE AND PENN.	420	\$0	\$0	\$0	\$0
LOWER KUSKOKWIM	2835	\$0	\$93,000	\$0	\$93,000
LOWER YUKON	1352	\$0	\$393,000	\$0	\$393,000
* MATSU	9997	\$480,000	\$117,000	\$0	\$597,000
NENANA	180	\$0	\$72,000	\$155,400	\$227,400
NOME	778	\$160,800	\$0	* ₂ 276,600	\$160,800
NORTH SLOPE	1406	\$174,000	\$158,400	\$0	\$332,400
NORTHWEST ARCTIC	1584	\$174,000	\$132,000	\$0	\$306,000
PELICAN	48	\$0	\$0	\$58,200	\$58,200
PETERSBURG	707	\$120,000	\$0	\$189,000	\$309,000
* PRIBILOF	153	\$0	\$600	* ₂ 122,400	\$600
RAILBELT	338	\$0	\$99,000	\$0	\$99,000
SITKA	1745	\$120,000	\$0	* ₂ 291,600	\$120,000
SKAGWAY	130	\$0	\$10,200	\$111,000	\$121,200
SOUTHEAST	557	\$0	\$66,600	\$0	\$66,600
SOUTHWEST	485	\$0	\$47,400	\$0	\$47,400
ST MARY'S	116	\$0	\$0	\$127,800	\$127,800
TANANA	109	\$0	\$0	\$122,400	\$122,400
UNALASKA	298	\$0	\$172,800	\$157,800	\$330,600
VALDEZ	765	\$133,200	\$0	* ₂ 228,000	\$133,200
WRANGELL	520	\$120,000	\$0	\$193,200	\$313,200
YAKUTAT	152	\$0	\$34,800	\$126,000	\$160,800
YUKON FLATS	371	\$0	\$39,600	\$0	\$39,600
YUKON/KOYUKUK	510	\$0	\$59,400	\$0	\$59,400
YUPIIT	330	\$0	\$30,600	\$0	\$30,600

TOTALS	\$3,358,800	\$4,435,200	\$2,513,400	\$10,307,400
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* NOT INCLUDED IN ORIGINAL BILL *₂ NOT A MUNICIPALITY *₂ REVER. SB 54

ALASKA DEPARTMENT OF EDUCATION
 PROJECTED FY92 FOUNDATION PROGRAM
 AASA PROPOSED PROGRAM REVISIONS

EFFECT OF COMMITTEE SUBSTITUTE SB 7 (HES) vs. SB 54
 at \$63,000

PREPARED 2/13/91
 REVISED 3/11/91

NEW TABLES
 AASA SEC. 3
 PROPOSAL

NEW TABLES
 AASA SEC. 2
 PROPOSAL

SEC. 4
 SINGLE SITE
 MUNICIPALITIES
 < 750 ADM

SEC. 5
 INCREASE
 UNIT VALUE
 BY \$3,000

TOTAL COST
 OF SEC. 2,3,4 & 5
 UNIT VALUE AT
 \$63,000

	FY92 ADJ 715	NEW TABLES AASA SEC. 3 PROPOSAL	NEW TABLES AASA SEC. 2 PROPOSAL	SEC. 4 SINGLE SITE MUNICIPALITIES < 750 ADM	SEC. 5 INCREASE UNIT VALUE BY \$3,000	TOTAL COST OF SEC. 2,3,4 & 5 UNIT VALUE AT \$63,000
*1 ADAK		\$160,020	\$0	*2 248,850	\$0	\$382,500
ALASKA GATEWAY	477	\$0	\$165,690	\$0	\$242,880	\$408,570
ALEUTIAN REGION	33	\$0	\$0	*2 44,730	\$0	\$38,310
ALEUTIANS EAST	399	\$0	\$61,740	\$0	\$192,360	\$254,100
*1 ANCHORAGE	42,070	\$252,000	\$15,120	\$0	\$10,064,760	\$10,331,880
ANNETTE ISLANDS	411	\$0	\$182,070	*2 173,250	\$0	\$309,210
BERING STRAIT	1398	\$0	\$236,250	\$0	\$839,500	\$1,075,500
BRISTOL BAY	265	\$0	\$160,650	85,050	\$0	\$282,960
CHATHAM	384	\$0	\$74,340	\$0	\$174,660	\$249,000
CHUGACH	110	\$0	\$0	\$0	\$80,040	\$80,040
COPPER RIVER	57	\$0	\$165,060	\$0	\$265,950	\$431,010
CORDOVA	438	\$0	\$206,010	\$197,190	\$140,430	\$543,630
CRAIG	413	\$0	\$183,330	\$173,880	\$117,510	\$474,720
DELTA/GREELY	870	\$146,160	\$0	*2 275,940	\$0	\$407,160
DILLINGHAM	485	\$0	\$253,890	\$245,700	\$184,890	\$684,480
*1 FAIRBANKS	14683	\$393,120	\$0	\$0	\$3,644,520	\$4,037,640
GALENA	150	\$0	\$40,950	\$157,500	\$74,760	\$273,210
HAINES	441	\$0	\$185,850	\$0	\$135,960	\$321,810
HOONAH	230	\$0	\$125,370	\$173,880	\$80,070	\$379,320
HYDABURG	108	\$0	\$0	\$101,430	\$51,030	\$152,460
*2 IDITAROD	394	\$0	\$66,150	\$0	\$258,000	\$324,150
*1 JUNEAU	5328	\$126,000	\$0	\$0	\$1,305,870	\$1,431,870
KAKE	172	\$0	\$56,070	\$136,080	\$64,260	\$256,410
*2 KASHUNAMIUT	192	\$0	\$100,800	*2 189,630	\$0	\$193,170
*1 KENAI	9724	\$630,000	\$601,020	\$0	\$2,666,340	\$3,897,360
KETCHIKAN	2796	\$126,000	\$0	*2 367920	\$0	\$813,990
KLAWOCK	200	\$0	\$86,940	\$150,570	\$72,180	\$309,690
KODIAK	2411	\$137,340	\$0	\$0	\$743,400	\$880,740
KUSPUK	413	\$0	\$86,940	\$0	\$259,620	\$346,560
LAKE AND PENN.	420	\$0	\$0	\$0	\$315,330	\$315,330
LOWER KUSKOKWIM	2835	\$0	\$97,650	\$0	\$1,666,680	\$1,764,330
LOWER YUKON	1352	\$0	\$412,650	\$0	\$692,520	\$1,105,170
*1 MATSU	9997	\$504,000	\$122,850	\$0	\$2,501,220	\$3,128,070
NENANA	180	\$0	\$75,600	\$163,170	\$78,450	\$317,220
NOME	778	\$168,840	\$0	*2 290430	\$0	\$443,580
NORTH SLOPE	1406	\$182,700	\$166,320	\$0	\$657,630	\$1,006,650
NORTHWEST ARCTIC	1584	\$182,700	\$138,600	\$0	\$823,200	\$1,144,500
PELICAN	48	\$0	\$0	\$61,110	\$30,780	\$91,890
PETERSBURG	707	\$126,000	\$0	\$198,450	\$186,960	\$511,410
*2 PRIBILOF	153	\$0	\$630	*2 128520	\$0	\$93,870
RAILBELT	338	\$0	\$103,950	\$0	\$152,700	\$256,650
SITKA	1745	\$126,000	\$0	*2 306180	\$0	\$540,360
SKAGWAY	130	\$0	\$10,710	\$116,550	\$53,010	\$180,270
SOUTHEAST	557	\$0	\$69,930	\$0	\$294,720	\$364,650
SOUTHWEST	485	\$0	\$49,770	\$0	\$318,060	\$367,830
ST MARY'S	116	\$0	\$0	\$134,190	\$68,490	\$202,680
TANANA	109	\$0	\$0	\$128,520	\$63,930	\$192,450
UNALASKA	298	\$0	\$181,440	\$165,690	\$114,450	\$461,580
VALDEZ	765	\$139,860	\$0	*2 289400	\$0	\$348,210
WRANGELL	520	\$126,000	\$0	\$202,860	\$152,220	\$481,080
YAKUTAT	152	\$0	\$36,540	\$132,300	\$63,540	\$232,380
YUKON FLATS	371	\$0	\$41,580	\$0	\$266,340	\$307,920
YUKON/KOYUKUK	570	\$0	\$62,370	\$0	\$333,930	\$396,300
YUPIIT	330	\$0	\$32,130	\$0	\$223,020	\$255,150

TOTALS \$3,526,740 \$4,656,960 \$2,639,070 \$33,258,840 \$44,081,610

*1 NOT INCLUDED IN ORIGINAL BILL *2 NOT A MUNICIPALITY *3 FORMER SB54

	A	B	C	D	E	F
1	ALASKA DEPARTMENT OF EDUCATION					PROJECTED FY92
2	FOUNDATION FUNDING PROGRAM					FOUNDATION
3	PREPARED 2/28/91 REVISED 3/11/91					SBS4 SEC. 2&3
4			PROJECTED FY92	PROJECTED FY92	PROJECTED FY92	SINGLE SITE < 750
5		FY91 FOUNDATION	FOUNDATION	PRORATION TO	FOUNDATION	PRORATION TO
6		STATE AID	STATE AID	GOV. BUDGET	SB54 SEC. 2&3	GOV. BUDGET
7		100% ENTITLEMENT	100% ENTITLEMENT	OF \$514,648.9	SINGLE SITE < 750	OF \$514,648.9
8	ADAK	\$2,083,942	\$2,173,342	\$1,993,966	\$2,325,742	\$2,070,899
9	ALASKA GATEWAY	\$4,329,618	\$4,346,718	\$4,150,894	\$4,504,518	\$4,226,782
10	ALEUTIAN REGION	\$680,468	\$680,468	\$649,580	\$680,468	\$638,038
11	ALEUTIANS EAST	\$3,078,324	\$2,916,674	\$2,761,582	\$2,976,074	\$2,759,740
12	ANCHORAGE	\$156,404,478	\$162,149,942	\$154,035,162	\$162,404,342	\$151,243,197
13	ANNETTE ISLANDS	\$1,170,462	\$1,305,462	\$1,202,955	\$1,479,462	\$1,329,015
14	BERING STRAIT	\$12,271,870	\$12,719,470	\$12,042,819	\$12,944,470	\$12,002,513
15	BRISTOL BAY	\$1,663,843	\$1,663,201	\$1,564,588	\$1,816,201	\$1,672,266
16	CHATHAM	\$2,554,523	\$2,556,923	\$2,416,102	\$2,627,723	\$2,430,361
17	CHUGACH	\$1,461,376	\$1,421,776	\$1,357,243	\$1,421,776	\$1,333,129
18	COPPER RIVER	\$5,221,136	\$5,087,336	\$4,872,912	\$5,244,536	\$4,941,282
19	CORDOVA	\$2,301,985	\$2,265,566	\$2,152,343	\$2,649,566	\$2,472,770
20	CRAIG	\$1,689,191	\$2,138,924	\$2,044,181	\$2,479,724	\$2,330,705
21	DELTA/GREELY	\$4,269,949	\$4,244,749	\$4,034,316	\$4,383,949	\$4,087,174
22	DILLINGHAM	\$2,936,054	\$2,915,918	\$2,766,849	\$3,391,718	\$3,160,598
23	FAIRBANKS	\$57,115,905	\$60,237,647	\$57,299,228	\$60,612,047	\$56,554,887
24	GALENA	\$1,085,274	\$1,202,673	\$1,142,397	\$1,391,673	\$1,298,408
25	HAINES	\$2,374,218	\$2,258,312	\$2,148,693	\$2,435,312	\$2,274,930
26	HOONAH	\$1,446,196	\$1,405,719	\$1,341,162	\$1,690,719	\$1,586,256
27	HYDABURG	\$956,647	\$981,799	\$940,656	\$1,077,799	\$1,015,965
28	IDITAROD	\$4,163,521	\$4,386,121	\$4,178,107	\$4,449,121	\$4,159,889
29	JUNEAU	\$20,344,548	\$20,626,989	\$19,574,123	\$20,746,989	\$19,294,049
30	KAKE	\$1,083,087	\$1,036,056	\$984,246	\$1,219,056	\$1,137,752
31	KASHUNAMIUT	\$1,308,396	\$1,390,596	\$1,316,122	\$1,486,596	\$1,378,977
32	KENAI	\$37,253,584	\$39,335,955	\$37,186,201	\$40,508,355	\$37,490,371
33	KETCHIKAN	\$9,952,787	\$10,378,089	\$9,823,392	\$10,498,089	\$9,729,472
34	KLAWOCK	\$1,333,158	\$1,290,491	\$1,232,295	\$1,516,691	\$1,424,223
35	KODIAK	\$12,155,260	\$11,967,600	\$11,368,229	\$12,098,400	\$11,267,816
36	KUSPUK	\$4,716,683	\$4,684,283	\$4,474,963	\$4,767,683	\$4,475,527
37	LAKE AND PENINSUL	\$5,386,950	\$5,474,080	\$5,219,843	\$5,474,080	\$5,124,842
38	LOWER KUSKOKWIM	\$27,176,760	\$27,763,760	\$26,419,988	\$27,856,760	\$26,005,706
39	LOWER YUKON	\$10,288,288	\$9,908,488	\$3,350,139	\$10,300,888	\$9,512,169
40	MAT-SU	\$39,817,389	\$42,994,356	\$40,977,731	\$43,591,356	\$40,788,112
41	NENANA	\$1,577,456	\$1,503,966	\$1,440,715	\$1,731,366	\$1,631,887
42	NOME	\$4,912,948	\$4,913,430	\$4,691,919	\$5,074,230	\$4,761,042
43	NORTH SLOPE	\$7,888,743	\$8,057,882	\$7,527,663	\$8,390,282	\$7,643,528
44	NORTHWEST ARCTIC	\$13,286,800	\$11,464,556	\$10,800,846	\$11,770,556	\$10,841,889
45	PELICAN	\$581,637	\$561,341	\$536,524	\$619,541	\$582,228
46	PETERSBURG	\$2,981,875	\$3,051,475	\$2,900,737	\$3,360,475	\$3,136,299
47	PRIBILOF	\$1,344,889	\$1,415,689	\$1,340,006	\$1,416,289	\$1,312,292
48	RAILBELT	\$2,966,307	\$3,013,707	\$2,890,592	\$3,112,707	\$2,938,104
49	SITKA	\$6,441,269	\$6,305,158	\$5,971,077	\$6,425,158	\$5,959,595
50	SKAGWAY	\$904,356	\$822,752	\$780,012	\$943,952	\$878,530
51	SOUTHEAST	\$4,842,342	\$5,096,142	\$4,858,522	\$5,162,742	\$4,832,642
52	SOUTHWEST	\$4,667,542	\$5,029,342	\$4,772,904	\$5,076,142	\$4,721,288
53	ST. MARY'S	\$1,307,241	\$1,304,147	\$1,248,926	\$1,431,947	\$1,349,015
54	TANANA	\$1,165,181	\$1,168,693	\$1,117,149	\$1,291,093	\$1,213,510
55	UNALASKA	\$1,616,402	\$1,668,678	\$1,576,402	\$1,999,278	\$1,854,213
56	VALDEZ	\$2,674,681	\$2,699,117	\$2,531,133	\$2,832,317	\$2,594,186
57	WRANGELL	\$2,478,311	\$2,603,887	\$2,481,159	\$2,917,087	\$2,731,154
58	YAKUTAT	\$1,131,374	\$1,157,318	\$1,106,088	\$1,318,118	\$1,238,841
59	YUKON FLATS	\$4,973,684	\$4,788,884	\$4,574,146	\$4,828,484	\$4,531,311
60	YUKON/KOYUKUK	\$5,449,696	\$5,421,496	\$5,152,263	\$5,481,496	\$5,108,335
61	YUPIIT	\$3,491,802	\$3,503,802	\$3,323,991	\$3,533,802	\$3,285,139
62	OTHER	\$9,704,648	\$10,285,221	\$10,003,119	\$10,285,221	\$10,286,052
63	TOTALS	\$526,467,054	\$541,746,166	\$514,648,900	\$552,054,166	\$514,648,900

	G	H	I	J	K
1	ALASKA DEPARTMENT OF EDUCATION				
2	FOUNDATION FUNDING PROGRAM				
3	PREPARED 2/28/91 REVISED 3/11/91 <i>JK</i>				
4					
5		COLUMN C	COLUMN D	COLUMN E	COLUMN F
6		LESS	LESS	LESS	LESS
7		COLUMN B	COLUMN B	COLUMN B	COLUMN B
8	ADAK	\$89,400	(\$89,976)	\$241,800	(\$13,043)
9	ALASKA GATEWAY	\$17,100	(\$178,724)	\$174,900	(\$102,836)
10	ALEUTIAN REGION	\$0	(\$30,888)	\$0	(\$42,430)
11	ALEUTIANS EAST	(\$161,650)	(\$316,742)	(\$102,250)	(\$318,584)
12	ANCHORAGE	\$5,745,464	(\$2,369,316)	\$5,999,864	(\$5,161,281)
13	ANNETTE ISLANDS	\$135,000	\$32,493	\$309,000	\$158,553
14	BERING STRAIT	\$447,600	(\$229,051)	\$672,600	(\$269,357)
15	BRISTOL BAY	(\$642)	(\$99,255)	\$152,358	\$8,423
16	CHATHAM	\$2,400	(\$138,421)	\$73,200	(\$124,162)
17	CHUGACH	(\$39,600)	(\$104,133)	(\$39,600)	(\$128,247)
18	COPPER RIVER	(\$133,800)	(\$348,224)	\$23,400	(\$279,854)
19	CORDOVA	(\$36,419)	(\$149,642)	\$347,581	\$170,785
20	CRAIG	\$449,733	\$354,990	\$790,533	\$641,514
21	DELTA/GREELY	(\$25,200)	(\$235,633)	\$114,000	(\$182,775)
22	DILLINGHAM	(\$20,136)	(\$169,205)	\$455,664	\$224,544
23	FAIRBANKS	\$3,121,742	\$183,323	\$3,496,142	(\$561,018)
24	GALENA	\$117,399	\$57,123	\$306,399	\$213,134
25	HAINES	(\$115,906)	(\$225,525)	\$61,094	(\$99,288)
26	HOONAH	(\$40,477)	(\$105,034)	\$244,523	\$140,060
27	HYDABURG	\$25,152	(\$15,991)	\$121,152	\$59,318
28	IDITAROD	\$222,600	\$14,586	\$285,600	(\$3,632)
29	JUNEAU	\$282,441	(\$770,425)	\$402,441	(\$1,050,499)
30	KAKE	(\$47,031)	(\$96,841)	\$135,969	\$54,665
31	KASHUNAMIUT	\$92,200	\$7,726	\$178,200	\$70,581
32	KENAI	\$2,082,371	(\$67,383)	\$3,254,771	\$236,787
33	KETCHIKAN	\$425,302	(\$129,395)	\$545,302	(\$223,315)
34	KLAWOCK	(\$42,667)	(\$100,863)	\$183,533	\$91,065
35	KODIAK	(\$187,660)	(\$787,031)	(\$56,860)	(\$887,444)
36	KUSPUK	(\$32,400)	(\$241,720)	\$51,000	(\$241,156)
37	LAKE AND PENINSULA	\$87,130	(\$167,107)	\$87,130	(\$262,108)
38	LOWER KUSKOKWIM	\$585,000	(\$758,772)	\$678,000	(\$1,173,054)
39	LOWER YUKON	(\$379,800)	(\$938,149)	\$12,600	(\$776,119)
40	MAT-SU	\$1,176,967	\$1,160,342	\$3,773,967	\$970,723
41	NENANA	(\$73,490)	(\$136,741)	\$153,910	\$54,431
42	NOME	\$482	(\$221,029)	\$161,282	(\$151,906)
43	NORTH SLOPE	\$169,139	(\$361,080)	\$501,539	(\$245,215)
44	NORTHWEST ARCTIC	(\$1,822,244)	(\$2,485,954)	(\$1,516,244)	(\$2,444,911)
45	PELICAN	(\$20,296)	(\$45,113)	\$37,904	\$591
46	PETERSBURG	\$69,600	(\$81,138)	\$378,600	\$154,424
47	PRIBILOF	\$70,800	(\$4,883)	\$71,400	(\$32,597)
48	RAILBELT	\$47,400	(\$75,715)	\$146,400	(\$28,203)
49	SITKA	(\$136,111)	(\$470,192)	(\$16,111)	(\$481,674)
50	SKAGWAY	(\$81,604)	(\$124,344)	\$39,596	(\$25,826)
51	SOUTHEAST	\$253,800	\$16,180	\$320,400	(\$9,700)
52	SOUTHWEST	\$361,800	\$105,362	\$408,600	\$53,746
53	ST. MARY'S	(\$3,094)	(\$58,315)	\$124,706	\$41,774
54	TANANA	\$3,512	(\$48,032)	\$125,912	\$48,329
55	UNALASKA	\$52,276	(\$40,000)	\$382,876	\$237,811
56	VALDEZ	\$24,436	(\$143,548)	\$157,636	(\$80,495)
57	WRANGELL	\$125,576	\$2,848	\$438,776	\$252,843
58	YAKUTAT	\$25,944	(\$25,286)	\$186,744	\$107,487
59	YUKON FLATS	(\$184,800)	(\$399,538)	(\$145,200)	(\$442,373)
60	YUKON/KOYUKUK	(\$28,200)	(\$297,433)	\$31,800	(\$341,361)
61	YUPIIT	\$12,000	(\$167,811)	\$42,000	(\$206,683)
62	OTHER	\$580,573	\$298,471	\$580,573	\$581,404
63	TOTALS	\$15,279,112	(\$11,818,154)	\$25,587,112	(\$11,818,154)

7-LS0681NP ✓
Lauterbach
3/4/91

CS FOR SENATE CONCURRENT RESOLUTION NO. 10 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS DUNCAN, Kerttula, Pourcnot, Menard

A RESOLUTION

1 Establishing a Health Resources and Access Task Force.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent
4 in the last 10 years from \$480 million to over \$1.5 billion; and

5 WHEREAS an estimated 90,000 residents of the state cannot afford to pay their medical bills,
6 are not covered by a group health insurance plan, do not qualify for public assistance programs, and
7 cannot afford to pay individual health insurance premiums; and

8 WHEREAS, if current trends continue, it is estimated that expenditures for health care in the
9 state could increase to at least \$10 billion by the year 2000 and over 25 percent of the state's residents
10 may be uninsured; and

11 WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved
12 savings in the costs of health care to the state totaling over \$20 million in fiscal years 1990 and 1991;
13 and

14 WHEREAS every resident should have access to a basic level of health care regardless of
15 income and should not become financially destitute before obtaining health care; and

16 WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

1 ways to manage health care expenditures in the state;

2 **BE IT RESOLVED** by the Alaska State Legislature that the Health Resources and Access Task
3 Force is established with the following primary purposes:

4 (1) to design a cost-efficient program that allows access to a basic level of health care
5 services for all state residents;

6 (2) to continue the work of the Health Care Cost Containment Task Force in seeking
7 ways to achieve savings in the cost of health care in the state; and

8 (3) to define a strategy for implementing a health care program covering all Alaskans and
9 a strategy for continuing to contain the costs of health care in the state; and be it

10 **FURTHER RESOLVED** that the task force shall

11 (1) solicit advice and information from the medically indigent, health care consumer
12 groups, the insurance industry, health care providers, labor organizations, emergency services personnel,
13 large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service,
14 actuaries, the public, and others;

15 (2) investigate and gather data relating to health care quality, access, delivery, payment
16 systems, and financing in the state, especially in rural areas;

17 (3) ascertain and review successful health care protection methods in other states,
18 territories, and countries and other health care alternatives, including ways of providing health care for
19 persons without insurance or with limited health care protection;

20 (4) continue to update an accurate estimate of the number of people who are unable to
21 receive necessary health care services in the state, which patients are generating unpaid medical bills,
22 which state residents are uninsured or lack adequate insurance, which health care providers are providing
23 uncompensated care, who is paying for the cost of uncompensated care, and the total cost of
24 uncompensated care in the state;

25 (5) identify those health care services necessary to achieve an acceptable minimum level
26 of health care for all state residents and to examine those health care services that provide the most care
27 for the most people at the least cost, including prevention services;

28 (6) monitor and evaluate experience under the state employee and retiree health plans;

29 (7) evaluate the potential benefits of health education, wellness plans, and prevention
30 plans for all residents;

31 (8) develop strategies to support health care professions training and the retention of
32 health care professionals in the state;

1 (9) recommend ways to coordinate services among nonprofit health care providers, profit
2 making health care providers, the state division of public health, the United States Department of
3 Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in
4 order to achieve a more efficient and effective health care delivery system;

5 (10) review ways to maximize the use of federal funds for health care programs in the
6 state;

7 (11) investigate ways to reduce costs associated with malpractice insurance coverage,
8 including its effect on the cost of health care in the state;

9 (12) consider the feasibility of redistributing funds currently spent by the state on health
10 care in order to provide residents with affordable and equitable care;

11 (13) provide advice and assistance to other public agencies involved in health care
12 programs; and

13 (14) pursue other sources of funding for the expenses of the task force; and be it

14 **FURTHER RESOLVED** that the task force shall consist of 17 members as follows:

15 (1) three members of the Senate appointed by the President of the Senate;

16 (2) three members of the House of Representatives appointed by the Speaker of the
17 House;

18 (3) three persons representing the executive branch, appointed by the Governor;

19 (4) eight members chosen by the members appointed under paragraphs (1) - (3) as
20 follows: one individual representing the medically indigent, one individual representing private employers
21 who are not health care providers, two individuals representing health care providers, one individual
22 representing the health insurance industry, one individual representing nonprofit organizations, one
23 consumer of health services who is not an employer or health care provider, and one individual
24 representing labor organizations; and be it

25 **FURTHER RESOLVED** that the members of the task force shall elect from among themselves
26 a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the
27 public where all interested parties may provide information; and be it

28 **FURTHER RESOLVED** that, within funds made available for the purpose, the task force may
29 hire staff and contract for services to perform its duties; and be it

30 **FURTHER RESOLVED** that the task force shall report its findings and recommendations to
31 the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

32 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on February 1, 1993.

OK

CS FOR SENATE CONCURRENT RESOLUTION NO. 10 ()

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:

Referred:

Sponsor(s): SENATORS DUNCAN, Kerttula, Pourchot, Menard

A RESOLUTION

1 Establishing a Health Resources and Access Task Force.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 ND WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent
~~in the last 10 years from \$480 million to over \$1.5 billion; and~~

4 ~~in the last 10 years from \$480 million to over \$1.5 billion; and~~
5 *OK* WHEREAS ^{AN ESTIMATED} over 90,000 residents of the state cannot afford to pay their medical bills, are not
6 covered by a group health insurance plan, do not qualify for public assistance programs, and cannot
7 afford to pay individual health insurance premiums; and

8 *OK* WHEREAS, if current trends continue, it is estimated that expenditures for health care in the
9 state ^{could} ~~will~~ increase to at least \$10 billion by the year 2000 and over 25 percent of the state's residents
10 ^{may} ~~will~~ be uninsured; and

11 WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved
12 *OK* savings in the costs of health care ^{to} in the state totaling over \$20 million in fiscal years 1990 and 1991;
13 and

14 WHEREAS every resident should have access to a basic level of health care regardless of
15 income and should not become financially destitute before obtaining health care; and

16 WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

1 ways to manage health care expenditures in the state;

2 **BE IT RESOLVED** by the Alaska State Legislature that the Health Resources and Access Task

3 Force is established with the following primary purposes:

4 (1) to design a cost-efficient program that allows access to a basic level of health care
5 services for all state residents;

6 (2) to continue the work of the Health Care Cost Containment Task Force in seeking
7 ways to achieve savings in the cost of health care in the state; and

8 (3) to define a strategy for implementing a health care program covering all Alaskans and
9 a strategy for continuing to contain the costs of health care in the state; and be it

10 **FURTHER RESOLVED** that the task force shall

11 (1) solicit advice and information from the medically indigent, health care consumer
12 groups, the insurance industry, health care providers, labor organizations, emergency services personnel,
13 large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service,
14 actuaries, the public, and others;

15 (2) investigate and gather data relating to health care quality, access, delivery, payment
16 systems, and financing in the state, especially in rural areas;

17 (3) ascertain and review successful health care protection methods in other states,
18 territories, and countries and other health care alternatives, including ways of providing health care for
19 persons without insurance or with limited health care protection;

20 (4) continue to update an accurate estimate of the number of people who are unable to
21 receive necessary health care services in the state, which patients are generating unpaid medical bills,
22 which state residents are uninsured or lack adequate insurance, which health care providers are providing
23 uncompensated care, who is paying for the cost of uncompensated care, and the total cost of
24 uncompensated care in the state;

25 (5) identify those health care services necessary to achieve an acceptable minimum level
26 of health care for all state residents and to examine those health care services that provide the most care
27 for the most people at the least cost, including prevention services;

28 (6) monitor and evaluate experience under the state employee and retiree health plans;

29 (7) evaluate the potential benefits of health education, wellness plans, and prevention
30 plans for all residents;

31 (8) develop strategies to support health care professions training and the retention of
32 health care professionals in the state;

1 (9) recommend ways to coordinate services among nonprofit health care providers, profit
 2 making health care providers, the state division of public health, the United States Department of
 3 Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in
 4 order to achieve a more efficient and effective health care delivery system;

5 (10) review ways to maximize the use of federal funds for health care programs in the
 6 state;

7 (11) investigate ways to reduce costs associated with malpractice insurance coverage,
 8 including its effect on the cost of health care in the state;

9 ? (12) consider the feasibility of redistributing funds currently spent[?] by the state on health
 10 care in order to provide residents with affordable and equitable care;

11 (13) provide advice and assistance to other public agencies involved in health care
 12 programs; and

13 ? (14) pursue other sources of funding for the expenses of the task force; and be it

14 **FURTHER RESOLVED** that the task force shall consist of 16 members as follows:

15 (1) three members of the Senate appointed by the President of the Senate;

16 (2) three members of the House of Representatives appointed by the Speaker of the
 17 House;

18 (3) three persons representing the executive branch, appointed by the Governor;

19 (4) ~~seven~~ ⁸ members chosen by the members appointed under paragraphs (1) - (3) as
 20 follows: one individual representing the medically indigent, one individual representing private employers
 21 who are not health care providers, two individuals representing health care providers, one individual
 22 representing nonprofit organizations, one consumer of health services who is not an employer or health
 23 care provider, and one individual representing labor organizations; and be it

24 **FURTHER RESOLVED** that the members of the task force shall elect from among themselves
 25 a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the
 26 public where all interested parties may provide information; and be it

27 **FURTHER RESOLVED** that, within funds made available for the purpose, the task force may
 28 hire staff and contract for services to perform its duties; and be it

29 **FURTHER RESOLVED** that the task force shall report its findings and recommendations to
 30 the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

31 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on February 1, 1993.

SENATE CONCURRENT RESOLUTION NO. 10
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Kerttula, Pourchot, Menard

Introduced: 2.13/91
Referred: HESS and Finance

A RESOLUTION

1 Establishing a Health Resources and Access Task Force.

2 BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

3 WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent
4 in the last 10 years from \$480 million to over \$1.5 billion; and

5 WHEREAS over 90,000 residents of the state cannot afford to pay their medical bills, are not
6 covered by a group health insurance plan, do not qualify for public assistance programs, and cannot
7 afford to pay individual health insurance premiums; and

8 WHEREAS, if current trends continue, it is estimated that expenditures for health care in the
9 state will increase to at least \$10 billion by the year 2000 and over 25 percent of the state's residents
10 will be uninsured; and

11 WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved
12 savings in the costs of health care in the state totaling over \$20 million in fiscal years 1990 and 1991;
13 and

14 WHEREAS every resident should have access to a basic level of health care regardless of
15 income and should not become financially destitute before obtaining health care; and

16 WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

Est. has become actual

1 ways to manage health care expenditures in the state;

2 **BE IT RESOLVED** by the Alaska State Legislature that the Health Resources and Access Task
3 Force is established with the following primary purposes.

4 (1) to design a cost-efficient program that allows access to a basic level of health care
5 services for all state residents;

6 (2) to continue the work of the Health Care Cost Containment Task Force in seeking
7 ways to achieve savings in the cost of health care in the state; and

8 (3) to define a strategy for implementing a health care program covering all Alaskans and
9 a strategy for continuing to contain the costs of health care in the state; and be it

10 **FURTHER RESOLVED** that the task force shall

11 (1) solicit advice and information from the medically indigent, health care consumer
12 groups, the insurance industry, health care providers, labor organizations, emergency services personnel,
13 large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service,
14 actuaries, the public, and others;

15 (2) investigate and gather data relating to health care quality, access, delivery, payment
16 systems, and financing in the state, especially in rural areas;

17 (3) ascertain and review successful health care protection methods in other states,
18 territories, and countries and other health care alternatives, including ways of providing health care for
19 persons without insurance or with limited health care protection;

20 (4) continue to update an accurate estimate of the number of people who are unable to
21 receive necessary health care services in the state, which patients are generating unpaid medical bills,
22 which state residents are uninsured or lack adequate insurance, which health care providers are providing
23 uncompensated care, who is paying for the cost of uncompensated care, and the total cost of
24 uncompensated care in the state;

25 (5) identify those health care services necessary to achieve an acceptable minimum level
26 of health care for all state residents and to examine those health care services that provide the most care
27 for the most people at the least cost, including prevention services;

28 (6) monitor and evaluate experience under the state employee and retiree health plans;

29 (7) evaluate the potential benefits of health education, wellness plans, and prevention
30 plans for all residents;

31 (8) develop strategies to support health care professions training and the retention of
32 health care professionals in the state;

1 (9) recommend ways to coordinate services among nonprofit health care providers, profit
2 making health care providers, the state division of public health, the United States Department of
3 Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in
4 order to achieve a more efficient and effective health care delivery system;

5 (10) review ways to maximize the use of federal funds for health care programs in the
6 state;

7 (11) investigate ways to reduce costs associated with malpractice insurance coverage,
8 including its effect on the cost of health care in the state;

9 (12) consider the feasibility of redistributing funds currently spent by the state on health
10 care in order to provide residents with affordable and equitable care;

11 (13) provide advice and assistance to other public agencies involved in health care
12 programs; and

13 (14) pursue other sources of funding for the expenses of the task force; and be it

14 **FURTHER RESOLVED** that the task force shall consist of 14 members and two alternates as
15 follows:

16 (1) three members of the Senate appointed by the President of the Senate, one of whom
17 shall be designated as an alternate;

18 (2) three members of the House of Representatives appointed by the Speaker of the
19 House, one of whom shall be designated as an alternate;

20 (3) two persons representing the executive branch, appointed by the Governor;

21 (4) eight members chosen by the members appointed under paragraphs (1) - (3) as
22 follows: one individual representing the medically indigent, two individuals representing private
23 employers who are not health care providers, two individuals representing health care providers, one
24 individual representing nonprofit organizations, one consumer of health services who is not an employer
25 or health care provider, and one individual representing labor organizations; and be it

26 **FURTHER RESOLVED** that the members of the task force shall elect from among themselves
27 a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the
28 public where all interested parties may provide information; and be it

29 **FURTHER RESOLVED** that, within funds made available for the purpose, the task force may
30 hire staff and contract for services to perform its duties; and be it

31 **FURTHER RESOLVED** that the task force shall report its findings and recommendations to
32 the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

1 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on February 1, 1993.

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

Rec'd 6/27/91
WALTER J. HICKEL, GOVERNOR

P.O. Box 11
Juneau, Alaska 99811-0650
Phone: (907) 465-3082

June 27, 1991

Dear Health Care Interest,

As you may know, Senate Concurrent Resolution 10, creating the Health Resources and Access Task Force, recently passed the Legislature. This Task Force combines the missions of the Universal Health Care Task Force and the Health Care Cost Containment Task Force. However, the future of this project remains uncertain due to recent budget cuts. The entire fiscal note for SCR 10 which included funding for project staff, travel, and contractual services was zeroed out.

The primary purpose of the Health Resources and Access Task Force is to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs. The Task Force is made up of 17 members, with three each from the Senate, the House, and the Executive Branch. These nine members select the remaining eight public members. The Senate members are Senators Duncan, Collins and Kerkula. The House members are Representatives Ellis, Boyer, and Navarre. The Executive Branch members are Commissioner Theodore Malz (Department of Health and Social Services), Commissioner Millet Keller (Department of Administration), and Commissioner Glenn Olds (Department of Commerce and Economic Development). For the purposes of getting the Task Force started, Senator Duncan and Representative Ellis have agreed to serve as temporary co-chairs until, as according to SCR 10, the Task Force members can choose a chair from among themselves.

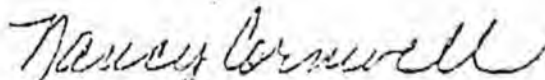
The Health Resources and Access Task Force is soliciting applications for the eight public members. Please review the announcement on the back of this letter and reply by July 12 if you are interested in being considered.

The mailing address for the Task Force is:

Health Resources and Access Task Force
P.O. Box Y
Juneau, Alaska 99811

If you would like further information, please call either Senator Jim Duncan at 465-4766 or Representative Johnny Ellis at 561-7628. It has been my pleasure to work on this project.

Sincerely,



Nancy Cornwell

Project Director, Universal Health Care Task Force



HEALTH RESOURCES AND ACCESS TASK FORCE

SOLICITS PUBLIC MEMBERS

The Health Resources and Access Task Force was created by the Legislature to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs.

The Task Force is soliciting applications for eight public members representing the following interests:

- (1) medically indigent
- (1) private employers (not health care providers)
- (2) health care providers
- (1) health insurer that offers health insurance in Alaska
- (1) nonprofit organizations
- (1) consumer of health services, not an employer or provider
- (1) labor organizations

If you are interested in being considered, send a resume (MAXIMUM OF 2 PAGES) TO:

Health Resources and Access Task Force
P.O. Box Y
Juneau; Alaska 99811

Resume must be postmarked by July 12, 1991. Note on the resume which of the public member categories listed above you believe you best represent. For further information, call 465-2933.

To: Rick Urion

Date: 01 March 91

RE: HCR 5 and SCR 10--talking points/DRAFT

From: David E. Johnson M.D., Alaska State Medical Association

This resolution, as introduced for consideration in both bodies in the Alaska state legislature, is flawed both in its "whereas" clauses and in its "resolveds". The "whereas" clauses in the current draft of the resolution are in some cases opinions masquerading as verities, and in other cases opinions masquerading as established public policies. Taken in sum, the clauses are sufficiently inflammatory and over-simplified that they significantly detract from rather than enhance the "resolveds". The "resolveds" are so broad-ranging that the task set out is impossible without vastly more resources than are projected.

We propose a new and much less grandiose set of "whereas" statements that can serve as a starting point that all participants can accept. The specific language could be something like this:

WHEREAS expenditures for health care in Alaska have risen faster than the overall cost of living index in the period 1980 to 1990; and

WHEREAS a substantial number of Alaskans are not covered by a group health insurance plan and do not qualify for existing state or federal public assistance programs, and some of them cannot afford to pay individual health insurance premiums or medical bills; and

WHEREAS increasing costs for health care and for health care insurance are a problem confronting all Alaskans and Alaskan institutions in both the public and private sector; and

WHEREAS Alaska has no explicit, stated health plan against which health status or health facilities or health expenditures can be measured; and

WHEREAS even a definition of what constitutes a basic level of health care and what is society's obligation to provide that basic level of health care has not been established by the legislature; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate ways to manage state health care expenditures;

The problem with the "resolveds" is that a volunteer group is being given an exhaustive charge to address a very large number of issues on a very short timetable. That means that in all likelihood the bulk of the task will fall to the staff, the tough issues will be ducked, and the task force will

perpetuate itself.

Just the first **BE IT RESOLVED** has three sections that are, in fact, at least six separate and daunting tasks:

- (1) to design a cost-efficient program that
 - a) that allows (YET UNDEFINED) access
 - b) to a (YET UNDEFINED) basic level of health care services
 - c) for all state residents;
- (2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and
- (3) to define
 - a) a strategy for implementing a (BASIC OR COMPREHENSIVE?) health care program covering all Alaskans and
 - b) a strategy for continuing to contain the costs of health care in the state;

We would support narrowing the scope of work by eliminating item 3 from the first resolved and items 4, 7, 8, 11, 13, and 14 from the second resolved. Each of these items is worthy and worthwhile, and the issues raised need to be addressed, but they widen the scope of work to the point that it is virtually undoable.

The problem with the "whereas" statements is that they are taken whole cloth from the **State of Alaska Health Care Cost Containment Task Force Report to the Seventeenth Legislature**. This document, with little footnoting or explicit citation of references, presents an earnest but oversimplified snapshot of one particular point of view. In a tumble of highly questionable summaries of history, even more questionable estimates of what might come in the future, and subjective statements of social purpose and responsibility, the document provides a shaky foundation for any policy-making decisions.

To illustrate a highly questionable summary of history, refer to page 4 (bold face type is in the original): *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.* What is included in "health care costs"? "Two and three times"?--that's a range of 50%, not consistent with exactitude claimed in other statistics. All other goods and services? Is there any change in the population or in services rendered that explains any of the increase?

To illustrate an even more questionable estimate of what might come in the future, refer to exhibits one and two on pages 10 and 11. On page 10 Noble

Lowndes is cited as the source of the opinion that health care spending will increase exponentially, and that the state's share of health care expenditures will increase from 13% of the total in 1980 to nearly 33% twenty years later. On page 11 the same source is cited with the estimate that an exponential increase in costs will result in only a linear increase in the number of uninsureds, who will increase in this estimate from 7 1/2% of the population in 1980 to 25% of the population in the year 2000.

Earnest but very subjective statements regarding social purpose and responsibility include the summarizing sentence of the executive summary on page 6: *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.* On page 21 we read: *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.* On page 28 a paragraph states: *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.* And the section titled General Observations in its entirety reads as follows: *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, the Health Care Cost Containment Task Force, recommended long term strategies needed to assure the medical delivery system remains accessible and affordable.*

The Alaska State Medical Association urges the legislature to define a task more clearly and less emotionally, and to focus the task force on a potentially attainable goal.

THE CRISIS IN HEALTH INSURANCE

In the U.S., the ticket to health care is insurance. If you are in good health and have a well-paying job with a large firm, chances are you have a ticket, and your employer pays for it. But if you work for yourself, have a low-paying job, or are sick, chances are you'll have to pay for the ticket yourself—if you can buy one at all.

Tickets are becoming harder to get. Between 31 million and 37 million people have no health insurance, either because they can't afford it or because insurance companies refuse to sell them a policy at any price.

Others lose their tickets. People who once had insurance may suddenly find themselves without it when employers discontinue health-care coverage or go out of business; or when insurance companies cancel policies or become insolvent.

Millions more have no protection against a catastrophic illness. They may have some insurance, but lack coverage for the very conditions that will one day require unusually heavy expenditures.

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with Califor-


nia's insurance counseling program. "Most of these people are three paychecks away from disaster."

The health-insurance crisis is a fairly recent phenomenon. At the beginning of World War II, few Americans owned a health-insurance policy. As recently as 1965, most had coverage only for hospital stays. The health-insurance system as we know it today evolved in the 1960s and 1970s. Under that system, workers came to expect their employers to supply medical coverage for them, with employers and employees splitting the cost.

That worked well for a while. More workers had health insurance, and their coverage broadened to include doctors' visits, prescription drugs, and even treatment for mental illness. But now the system stitched together over the last 50 years is unraveling, and people are being deprived of needed health care.

In this, the first of a two-part report, we look at why people lose their health coverage, and we rate the major-medical and hospital-surgical policies that are available to individuals—a temporary remedy for some people. Next month we will examine some possible cures for the health-insurance crisis.

WHO LOSES IT? WHAT HAPPENS?

 People without health insurance include men and women who work for small businesses, the self-employed, part-time workers, young people just starting their careers, the disabled, the divorced, and those taking early retirement but still too young for Medicare. Some of the uninsured are also poor. Medicaid, the Federal and state program that covers medical expenses for the indigent, currently pays the bills for only 38 percent of the nation's poor.

People without health insurance may not get medical care. One million families each year try to obtain care when they are sick, but cannot afford to pay for it. Even if they are not ill, people without insurance postpone preventive care until more costly treatment is necessary—or until it's too late.

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year.

A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

Women are particularly at risk. Uninsured women are much less likely than insured women to have screening tests for breast and cervical cancer or for glaucoma. If they are pregnant, they often do without prenatal care. Some five million women between the ages of 15 and 44 are covered by private health-insurance policies that don't include maternity coverage.

Crisis: Delayed care

John Andrusyshyn worked in a Nevada casino. Three summers ago, he noticed a mole growing on his chest, but said nothing about it to his family. He could not afford to pay another bill, so he put off seeing a doctor. Andrusyshyn was not eligible for insurance from his employer until he had been at his job for a year; he couldn't afford his own coverage on the \$880-a-month he was bringing home to support his wife, Karen, and two children, Laura and Nikolai (pictured at right).

Several months went by before Karen insisted he go to a doctor. Because dermatologists in Reno were booked up, three more months passed before a doctor examined him. By then, the mole had ulcerated, and John was so desperate for treatment he paid for the visit with a bad check.

The diagnosis was a malignant melanoma that was already coursing through his body. By the time he underwent surgery, he was eligible for insurance from the casino. But Karen had to scrape together \$56 a week to pay his share of the premiums, forgoing food and other necessities. The policy covered the hospital bill, but not the \$4000 surgeon's fee. On John's medical records, doctors noted: "Patient has no money; we'll do the best we can."

Soon afterward, the Andrusyshyns traded in their mobile home for a '62 Airstream trailer plus \$1500 in cash, borrowed a credit card from a relative, and headed for Canada where John was born. As a Canadian citizen, he was entitled to free medical care. In Montreal, doctors tried various cancer treatments, including brain surgery, which he could not have paid for in Nevada. But treatment came too late. Last fall, at the age of 54, John Andrusyshyn died.

"Had we had the medical care available in Nevada like we have here, he would have said something to me," Karen says. "A little thing like an early diagnosis could have added four or five years to his life. That would have meant a lot to this family."



Lack of prenatal care translates into babies who are too small when they are born and babies who die soon after birth. The U.S. trails 23 other nations in the percentage of babies born with an inadequate birth weight and ranks 22nd in the rate of infant mortality, behind such countries as East Germany, Spain, and Singapore.

Shifting the cost

When the uninsured are able to obtain health care, everyone pays. Each year thousands of people are dumped into emergency rooms of public hospitals because private hospitals don't want patients who can't pay.

In 1988, unpaid hospital bills totaled more than \$8-billion, up 10 percent from the previous year. To recoup the costs of unpaid care, hospitals and doctors simply raise their fees to those who do pay—primarily the private insurance carriers and the Federal government.

Such cost-shifting drives up the price of insurance, resulting in even more people who can't afford coverage. In New Jersey, for example, every hospital bill now carries a 13 percent surcharge, reflecting the hospital revenue lost to unpaid bills. That, in turn, feeds into higher insurance premiums.

Cost-shifting accounts for about one-third of the increase in insurance premiums, which are rising as much as 50 percent a year. The cost of medical care—which is increasing two to three times faster than the rate of inflation—is responsible for the rest.

Unaffordable premiums

The higher the price tag for insurance, the more people who go without it. Firms with fewer than 100 workers employ about one-third of the work force in the U.S., but only about half of them offer health insurance to their employees. Small-business owners say they have enough trouble staying afloat without assuming the heavy burden of health-insurance premiums.

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 48 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987, 25 percent of the uninsured workers for very large employers, most of whom offered health insurance.

People who want coverage and must buy it on their own have little choice but to pay what the insur-

ance company demands. In many instances, that can mean thousands of dollars each year. And premiums continue to rise dramatically.

Consider Stephen Beidner, a part-time worker at a California winery. When he first took out a policy with a company called Consumers United Insurance in 1985, he paid \$912 a year. By 1989, his premium had jumped to nearly \$3600.

Last year, after Beidner had arthroscopic surgery for a knee injury, the company hiked his premium a whopping 93 percent to \$6900. After Beidner protested, the company reconsidered his case and let him raise his deductible from \$100 to \$1000. His new premium: \$2177 a year.

Less coverage for many

Beidner is hardly alone in having to settle for less coverage. Spiraling premiums also affect millions of people whose employers provide their health insurance.

One major employee-benefits sur-

vey found that employers now spend an average of \$2700 annually to cover each employee. In many cases, employers are shifting some of those ever-increasing costs to their workers by requiring them to pay a greater share of the premium and a larger portion of their medical expenses through higher deductibles and copayments. Other companies, such as American Airlines, try to reduce their insurance bill by refusing to cover preexisting health conditions for new employees.

In 1984, Hewitt Associates, a benefits consulting firm, found that 37 percent of large employers paid the full premium for their workers. By 1988, that figure was down to 24 percent. In 1984, 53 percent of large firms paid all hospital room-and-board charges for their workers; in 1988, the figure was 29 percent.

Losing coverage

About half of all large- and medium-sized firms try to trim their

Crisis: Benefits end, costs don't

David Curnow, 47, was a partner in a San Diego law firm. One Saturday, while riding his bicycle, he was struck by an uninsured motorist. After two months in intensive care, Curnow emerged a quadriplegic, paralyzed from the chest down.

His law firm had self-insured its employees' health coverage, agreeing to cover the first \$7500 of a worker's claim, and paying premiums to an "excess-risk carrier" to cover the rest.

After the first \$7500 was paid, the carrier refused to pay its share of Curnow's bills. Months passed. Doctors, hospitals, and companies providing necessary medical supplies dunned Curnow for payment.

Eventually the carrier paid most of Curnow's bills, which totaled nearly \$250,000. But he is still waiting to be reimbursed for the services of the

home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some \$1500 each month—comes out of his pocket.

Curnow has another problem—how to pay for his continuing medical bills when insurance benefits from the law firm run out. If he doesn't work again, his disability will eventually qualify him for Medicare. But he will still have no insurance for services Medicare doesn't cover. Nor will he be able to buy any. Companies usually don't sell Medicare-supplement policies to the disabled under age 65. If he goes back to work, he must find a job in a large law firm whose insurance company doesn't require employees to be in perfect health. If he opts for a conversion policy from the company now insuring employees in his old firm, he will have to pay \$6000 a year.

"How many sick and disabled people do you know who can afford to pay \$6000 a year for health insurance?" he asks.



insurance outlays by self-insuring. They invest the money they would otherwise spend on premiums and pay employees' claims directly when they arise.

The Employee Retirement Income Security Act (ERISA) exempts these self-insured plans from state insurance regulations meant to protect consumers. For example, employers may not have to offer certain coverages, such as care for newborn children, or provide for continuation of coverage when employees leave.

Employers hire a third-party administrator, or TPA, to handle the

claims. Because the administrator may be the local Blue Cross plan, employees may think that Blue Cross (or some other insurer) is actually underwriting their coverage. Little do they know that the loopholes created by ERISA can leave them without insurance if things go wrong.

If the employer goes out of business or drops the coverage, employees could be out of luck.

The woes at HMOs

When a health maintenance organization closes its doors, the people who received medical care there may also be left uninsured.

Established as alternatives to traditional insurance policies, HMOs provide a variety of prepaid health services to their members. Unfortunately, a number of HMOs have fallen on hard times.

Several states don't require conversion policies or continuation of coverage for members whose HMO has gone out of business. Even in states that do, HMO members have no assurance that their new coverage will be anything like the old. They may well find themselves assuming a greater portion of their medical expenses.

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going

bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

After the bankruptcy filing, Blue Cross and Blue Shield of Ohio took over Maxicare's subscribers. Stroup assumed that his \$12,000 annual drug bill would be covered for the rest of his life. But Blue Cross had other ideas. It offered Stroup, who had turned 65, a Medicare-supplement policy that covered his drugs only after he paid a \$2500 deductible and \$1000 in coinsurance.

Stroup and his wife must now pay some \$7000 a year for insurance premiums and drugs out of their \$10,000 income from Social Security disability. They expect their \$60,000 life savings to be depleted in 3½ years.

Clinging to coverage

Millions of Americans have yet to lose their insurance but could at any time fall victim to an insurance company's business practices. As health-care providers continually raise their fees and pass on the higher cost of medical care to insurance companies, the companies respond by insuring fewer people. People who must buy coverage on their own and workers in small firms feel this pinch the hardest.

Insurance companies are not charities. Their goal is to make a

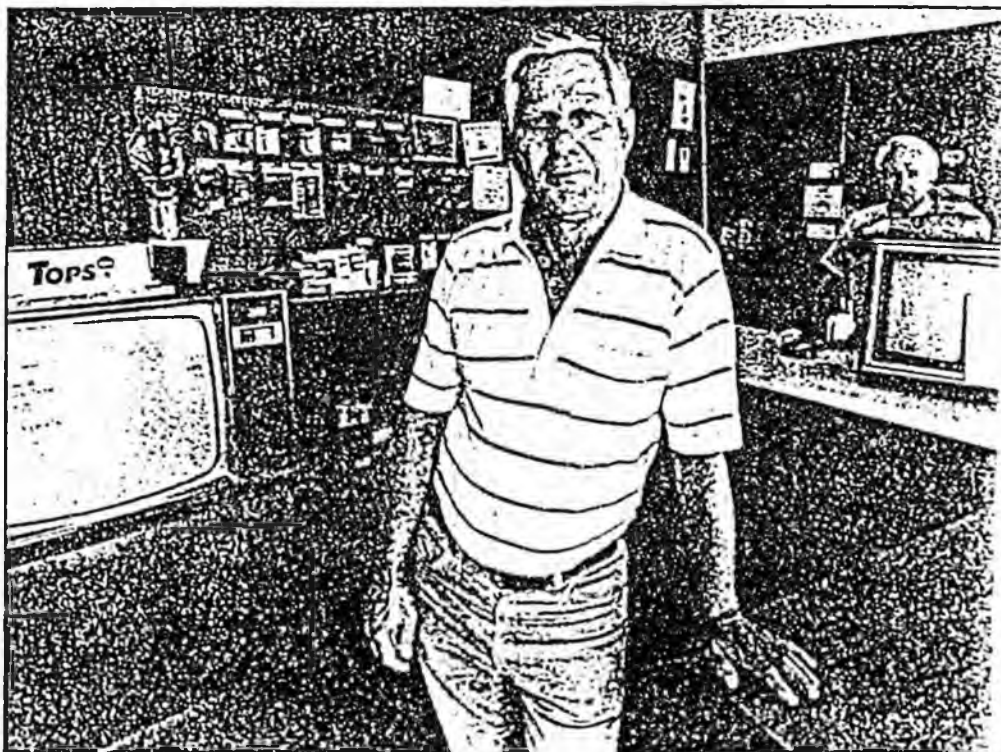
Crisis: Unaffordable premiums

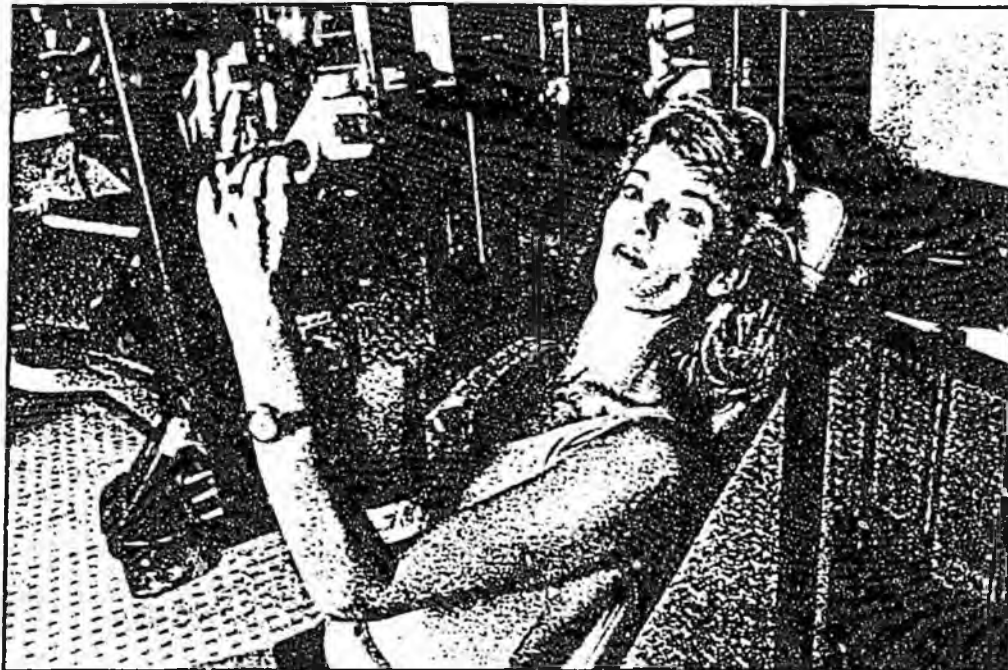
Lloyd Pudiwitr owns a TV repair shop in Bakersfield, Calif. He has seven full-time employees and one part-timer. For years, he paid half the premium for his employees' health coverage. But by the end of 1988, the premiums had become so high he could no longer afford to pay his share. "It's one of those things that could break you," he says. His employees now pay the entire cost of their coverage.

Like many small employers, he changed carriers every few years, searching for the lowest premiums. Two years ago Pudiwitr, who is 55, had a heart attack, and the wife of one of his employees, Ian Sutherland (pictured in background), had cancer surgery.

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from \$272 to \$543, and the premium for Sutherland doubled from \$421 to \$842.

Luckily, Sutherland turned 65 and became eligible for Medicare, but he still must pay \$450 a month for his wife's coverage. Pudiwitr has a long way to go until Medicare pays his bills, and he doesn't know what he'll do when his premiums rise again. "It's almost to the point where I can't afford it. If it doubles again, there's no way I can pay \$1000 a month for health insurance," he says. "I didn't have any idea this would happen to people."





Crisis: Locked in

Kay Nichols, a fitness counselor at a Gainesville, Fla., health club, is in the pink of health except for glaucoma, an eye disease that can cause blindness if not treated. Not long ago, her employer wanted to switch insurance carriers to take advantage of lower premiums. When the health club found another insurer, the agent told Nichols that she would not be covered, even though her glaucoma is under control.

Nichols looked into a conversion policy from her present company but found she would have to pay \$6000 for six months of coverage for her family. She tried Blue Cross, but its policy would have excluded coverage for glaucoma.

When her employer learned of her plight, he decided to keep the current policy despite its higher premiums. "If the premiums get phenomenally high, they can't keep the policy just for me, and I understand that," Nichols says. At the same time, she realizes she has a problem that won't go away. "Maybe I don't want to stay with this company the rest of my life," she says. "It makes me worry."

Nichols is 38.

profit, and they can increase their odds of success by insuring good risks who are unlikely to have health problems. Competition among carriers for the healthiest risks has become cutthroat.

In large businesses with many employees, it doesn't matter if some employees have serious medical conditions. The risk they pose can easily be spread among the healthy workers. But in a small group with few employees, insurance companies cannot collect enough in premiums to pay the claims of those who are sick. So the rules for insuring workers in small businesses are more rigorous.

Insurers use a controversial scheme to insulate themselves from risk. They offer to insure employees in a small firm (usually those with fewer than 25 workers) at a "low-ball" premium for at least the first year. If members of the group experience costly health problems in the second and third years, the carrier tosses the firm into a pool with other groups whose health-care costs are high and jacks up its premiums as much as 200 percent.

By placing firms into several "rate tiers," insurance companies can bid for the healthiest groups with rock-bottom premiums. But employers and their employees who have had serious health problems are stuck with their present insurance carrier; they can't move to another because no other company is likely to take them at any premium. Worse, the present carrier may decide not to renew the group's coverage, forcing

employers and employees to find other insurance. And that may be impossible.

No coverage for the sick

Companies insuring small groups require employees and their dependents to meet tough health requirements, just as they do for individuals buying policies on their own. No carrier wants to insure employees and dependents who have had heart attacks or cancer. They will either exclude them from the policy or decline to insure the group altogether. Sometimes a single employee with a serious disease is enough to earn a rejection slip for the whole group.

Increasingly, insurance companies are turning down people with far less serious health conditions than cancer or heart disease, excluding everyone except those in perfect or near-perfect health. "We don't want to buy a claim," is how one company official puts it.

Many people who become ill while they are working may find themselves without insurance when they leave the security of their employer's policy. Indeed, many are held hostage to their current job just to keep their insurance.

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns \$19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to

five weeks, she needs a lifesaving infusion of antibodies that costs about \$2400.

The firm's Blue Cross policy has been paying most of the bills. But as a result of those expenses, the cost of coverage has risen sharply—both for the firm, which pays the premiums for its employees, and for the employees, who must pay the premiums for their dependents.

"When I was given my review, I was told I might look around to see if I can find another job," Turner says. "They intimated that if I did leave, it could lower the cost of their insurance."

If Turner leaves her job, it's unlikely her daughter will ever again have coverage. And there's no way she can pay for the monthly infusions herself. "Without the medicine, my daughter dies. That's the black and white of the situation," Turner says. *Continued*

WHICH POLICIES ARE BEST?

If you lose your health-insurance coverage for any reason, you can remain uninsured and take your chances, or you can venture into the marketplace for an individual policy. Be forewarned: You won't find a buyer's market. And even if you're in good health, you may have few options.

This report will help guide you through the process. We evaluated 71 policies from 40 insurance companies and Blue Cross and Blue Shield organizations. We rate those policies and list their features beginning on page 546. Before plunking down \$2000 or \$3000 for coverage, however, you'll need to know a little about how these policies work.

Declining coverage
The proportion of employees in group health plans at large- and medium-sized firms dropped 14 percent from 1986 to 1988.

Types of policies

There are three basic kinds of health-insurance coverage:

- Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.
- Hospital-surgical policies.** These cover hospital services and surgical procedures only.
- Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 539.

What's covered

Major-medical policies typically pay for most hospital services, including room and board; operating and recovery rooms; nursing care; and treatment in intensive-care units, emergency rooms, and outpatient facilities. They also pick up the tab for lab tests, X-rays, anesthesia, medical supplies, ambulance services, and physicians' office visits. Most pay for prescription drugs and cover confinements in skilled-nursing facilities, if necessary, following a hospital stay.

Some policies, however, don't pay for assistant surgeons or for stand-by surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit

the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

Hospital-surgical policies cover hospital room and board, often for a specified number of days; treatment in intensive-care and outpatient facilities; medical supplies; surgeon's fees; diagnostic tests relating to an operation; some radiation and chemotherapy; and sometimes second opinions. But they cover almost no expenses incurred outside a hospital. They won't pay for a doctor's office visit to check on a persistent cough, or to have your child's cast removed, or for any medical condition that does not require hospitalization. Most don't cover prescription drugs that you may need outside a hospital.

Generally, both major-medical and hospital-surgical policies pay for 30 days of inpatient treatment for mental illness and substance abuse. Some major-medical policies cover outpatient treatment as well. If they do, insurers limit the number of visits per year or even the dollar amount of their payments.

Maternity benefits

All the major-medical and hospital-surgical policies in our study pay for expenses arising from pregnancy complications. But with the exception of some Blue Cross and Blue Shield plans, they usually don't cover routine prenatal care or routine deliveries.

If you want coverage for that, you'll have to buy a separate rider, and at some companies, you'll need to decide on the rider the day you take out the policy. Some carriers won't let you buy the rider later (on the grounds that you'll probably use the coverage, and they'll be stuck with a claim). Many major-medical and hospital-surgical policies don't offer riders for routine maternity care, period.

Riders will pay up to a maximum benefit that policyholders select, usually \$500, \$1000, \$2000, or \$2500. Rarely do they cover the full cost of a normal delivery, which averaged \$4334 in 1989.

Another drawback is that companies don't pay the full benefit during the first two years the policy is in

force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

Annual premiums for pregnancy riders ranged from \$316 at Golden Rule for a \$1000 benefit to \$2640 at Prudential for a benefit that would cover the hospital stay but only \$1050 of an obstetrician's fee. (An obstetrician's services for prenatal care and delivery can cost as much as \$4500 in some areas.)

What's not covered

Both major-medical and hospital-surgical policies cover only medically necessary care. Don't count on them to pay for routine physicals or other preventive services. (Some of them, however, cover Pap smears, mammograms, and well-child care.) Nor do companies pay for cosmetic surgery, fertility treatment, dental care, hearing aids, surgical treatment of obesity, treatment for self-inflicted injuries, or procedures that are considered experimental.

How policies pay

Insurance companies compute the amount of your reimbursement check according to their own complex formulas. The amount may be higher or lower depending on the following:

Eligible expenses. When you submit a bill for a service covered by a major-medical policy, the insurer compares it with the amount it normally pays for that service. If the charge is lower than what the company determines is "usual," "customary," "reasonable," or "common," then the entire bill is eligible for reimbursement. If it's greater, the carrier will consider only a portion of it.

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 50th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

hospital's posted charge, the hospital's cost, or a negotiated fee.)

Obviously, the higher the reimbursement standard, the more you'll receive. Unfortunately, policies don't spell that out, and some insurance companies were reluctant to explain their reimbursement standards to us.

Some hospital-surgical policies work differently, paying up to a maximum amount for each covered procedure or service listed in the policy. There's usually a fee schedule for hospital room and board, one for surgeon's fees, another for outpatient services, and a maximum amount the policy will pay for all other hospital services. This is the equivalent of a hospital-surgical policy's eligible charge.

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon

who performs an appendectomy as little as \$260 or as much as \$480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was \$846 for an appendectomy. The policy pays as little as \$390 or as much as \$720 for a hysterectomy; but a hysterectomy cost an average of \$1737 in 1989.

Coinsurance. Once the insurer determines how much of your bill it will consider, it still pays only a portion. You pay the rest. That's called "coinsurance."

Most major-medical policies pay 80 percent of eligible expenses, leaving policyholders to pay the remaining 20 percent plus that part of the cost not covered at all.

Suppose a physician charges \$3000 for an angioplasty (a cardiac procedure), but the carrier considers only \$2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive

\$2088 (80 percent of \$2610). He or she will then have to pay the remaining 20 percent, or \$522, plus the \$390 that's not eligible for reimbursement.

With some policies from Blue Cross and Blue Shield, a policyholder who used a "participating physician" would pay less. Participating physicians agree not to bill patients in excess of what Blue Cross and Blue Shield pays. This can be a significant advantage. Plans with this feature are noted in the Ratings.

Some major-medical policies require policyholders to pay less than the usual 20 percent coinsurance. For example, American Republic's *UltraCare* policy requires no coinsurance at all. Policies from Bankers Life and Casualty and its affiliated companies require none if policyholders select a deductible of at least \$5000—that is, if the policy-

PAY BY THE DAY? BY THE DISEASE?

THE WORST TYPES OF INSURANCE

The worst buys in health insurance are hospital-indemnity policies and dread-disease policies. Hospital-indemnity policies pay a fixed amount each day you're in the hospital. Dread-disease policies pay benefits only if you contract cancer or some other specified illness.

Such policies are a profitable staple for many well-known insurance companies and for the American Association of Retired Persons (AARP). They're sold to unsophisticated buyers through enticing but sometimes misleading advertising.

"Cash benefits of \$2250 a month, \$525 a week, \$75 a day . . . You cannot be turned down . . . No salesman will call . . ." reads a flyer for a hospital-indemnity policy from Physicians Mutual. "Use these cash benefits any way you choose . . . Get extra benefits when you may need them most," promises an ad for a policy sold by the AARP.

The deal is simple and understandable. You get a fixed dollar amount for each day you spend in the hospital. No complicated deductibles or coinsurance. Trouble is, the fixed benefit is skimpy to start with and grows less valuable with each passing year.

At Physicians Mutual, a person can choose a daily benefit of \$30, \$50, or \$75. AARP's top benefit is \$75 for those age 50 to 64 and \$45 for those 65 and older. But with the cost of a day in the hospital averaging around \$800, even the most generous hospital-indemnity plans will barely dent your bill. Furthermore, to collect the high benefits touted by some of the ads, you'll need to be hospitalized as long as a month—an unlikely prospect, since the average stay is only about seven days. Finally, the benefit does not change. In time, inflation in hospital and medical costs inevitably shrinks its value.

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a \$19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American

Family Life, a large seller of this type of insurance, would pay a maximum of \$4100; a policy from American Fidelity Assurance would cover as much as \$6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

Companies also sell riders to cover such dread diseases as smallpox, polio, rabies, diphtheria, and typhoid fever. We don't know why anyone would buy them, since these diseases are now extremely rare.

Compared to other health coverages, these types of insurance are cheap. For the top daily benefit from Physicians Mutual, a 45-year-old man or woman would pay about \$233 a year. A family would pay \$540.

Insurers usually issue hospital-indemnity policies to anyone, whether or not they are in good health. But carriers often require a waiting period before covering policyholders for pre-existing health conditions.

Most companies selling cancer insurance will not, however, issue policies to people who already have cancer. Nor do they usually pay benefits to anyone who is diagnosed as having the disease before the policy has been in force for 30 days.

These policies are no substitute for comprehensive health coverage. The price is low, but so are the benefits. With a dread-disease policy, you're also gambling that you'll contract one of the covered diseases. If you don't, the policy won't cover you.

Companies often market these policies as a supplement to other insurance. But we don't recommend them even for that. The \$300, \$400, or \$500 you'd spend for inferior coverage may equal the difference in premium between a skimpy hospital-surgical policy and a more comprehensive major-medical policy. Or it may cover the cost of taking a lower deductible on a good major-medical policy.

THE CRISIS IN HEALTH INSURANCE

holder pays the first \$5000 of covered expenses.

Other companies require policyholders to pay more. You might find policies with a 70/30 percent or even a 50/50 percent cost-sharing arrangement, especially if you don't use doctors and hospitals specified by the insurer.

Coinsurance maximums. Most policies specify a maximum dollar amount of coinsurance, typically \$1000 (but it can be as much as \$2500 or \$5000), that policyholders must pay annually. After they've reached that amount, the carrier pays 100 percent of all additional, eligible medical expenses.

A few policies tie coinsurance maximums to the size of the deductible you select. The higher the deductible, the lower the maximum.

Several policies give a break to families. Usually two members must each pay the maximum coinsurance amount. The company will then pay 100 percent of all eligible expenses for other members who have not reached their maximums.

Lifetime maximums. Most major-medical and hospital-surgical policies cap the benefits they'll pay over a lifetime at \$1-million or sometimes \$2-million. A few have no cap, and others have a separate lifetime maximum for each illness or injury.

A company will sometimes give new lifetime benefits to policyholders who have generated enough claims to reach their lifetime cap. This is an important feature if the cap is low.

Deductibles. Most companies require policyholders to satisfy deductibles each year before benefits are paid. (Some hospital-surgical policies have no deductibles.) Deductibles can be as low as \$100 or as high as \$20,000. That means a policyholder must pay the first \$100 (or \$20,000) of expenses before the company pays any benefits. Obviously, a \$20,000 deductible buys only catastrophic protection.

Sometimes a policy links the deductible to an illness or health condition; you would have to satisfy the deductible with each new illness. If the deductible is large and you have several different illnesses, you may never collect any benefits.

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a \$1000 deductible," says John Hartnedy, the chief actuary at

Golden Rule. "You don't want first-dollar coverage. It may cost \$80 to take care of a \$50 bill."

As with most insurance, the higher the deductible, the lower the premium. A 45-year-old man in Chicago who chooses a \$500 deductible for Benefit Trust Life's *Tele-Med* policy would pay an annual premium of \$1443. If he selected a \$2500 deductible, he would pay only \$839.

Sometimes, for a small, extra premium, companies will waive the deductible or a portion of it if you are injured in an accident.

Can you renew?

Few companies will guarantee to renew your coverage. Of those in our study, only American Republic, Benefit Trust Life, and Metropolitan sell "guaranteed renewable" policies. The company can raise the premium, but it must continue your coverage.

Most policies, however, are now "conditionally renewable." The company can refuse to renew your policy only if it also refuses to renew all other similar policies in your state. You have some protection because the company can't single you out for cancellation. But you can still lose your coverage.

Some insurance companies use conditionally renewable policies as a lever to force insurance regulators to grant the rate increases those companies want. Certified Life, First National Life, Golden Rule, and Washington National told us they had canceled policies. In some cases, they offered policyholders alternative coverage.

A few policies are "optionally renewable." A company can opt not to renew your insurance whether or not it renews coverage for others who have the same policy. Prudential, State Farm, and Blue Cross and Blue Shield plans in Illinois, Kansas, Ohio, and Oklahoma have optionally renewable policies. (Prudential and Blue Cross and Blue Shield of Oklahoma at least say they won't cancel your policy if your health has deteriorated.)

Many companies also give themselves the option of not renewing if they find you have another policy that is similar.

Are you insurable?

People who have medical problems, however minor, are second-class citizens in the world of health insurance.

Virtually no commercial carriers

and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

If you have less serious conditions, you may get coverage, but on unfavorable terms.

Conditions that usually affect one part of the body are candidates for "exclusion riders." That is, companies will offer a policy, but exclude coverage for those conditions or that body part, either for a short period or for as long as the policy is in force. If you have had a recent knee operation, glaucoma, migraine headaches, varicose veins, arthritis, a cesarean delivery, or if your child suffers from chronic ear infections, your policy will probably carry an exclusion rider. "Any condition that would produce an immediate claim would be ridered out," says Frank Fugiel, a vice president at Washington National.

If you have a medical condition that affects your general health—for example, you're significantly overweight or have mild high blood pressure—you may get coverage, but at a price 15 to 100 percent higher than the standard premium.

Companies in our survey told us that between one-quarter and one-half of all their policies carry exclusion riders, higher-than-standard premiums, or both.

Insurers, however, are not restrictive in identical ways. Washington National will exclude coverage for your eyes if you had a cataract operation a year ago. Prudential will not. If you suffered from migraine headaches in the past but have had no treatment for the last two years, Central States Health and Life will cover future treatment for such headaches; Time will issue a policy but exclude coverage for migraines.

If a company rejects you, that fact will be recorded at the Medical Information Bureau in Boston, an industry clearinghouse. The next time you apply for coverage, the new carrier may check your file at the bureau. If it finds you've been turned down, that rejection could trigger further scrutiny of your health.

Even if your health is perfect, you still may be a less-than-perfect risk. In their quest for applicants who are

Truth will out
When you fill out
an application for
health insurance,
be honest about
your medical condition.
If you don't
reveal all your
health problems
and the company
finds out about
them when you file
a claim, it could
rescind your policy
and leave you
without coverage
when you need it
most.

unlikely to file claims, insurance companies blackball people in certain occupations. Some companies have long lists of jobs that are unacceptable, either for an individual policy or for a policy sold to employees in small firms. Chances are the insurance company won't cover you if it considers your work hazardous or if people in your profession are more likely to file claims or switch jobs frequently.

Better off at the Blues?

Historically, most Blue Cross and Blue Shield plans took all comers for individual health insurance, offering "open-enrollment" policies that anyone could buy. Even if your health was bad, you could count on getting a policy from the Blues.

Today, only 22 of the 74 Blue Cross and Blue Shield plans in the U.S. still make policies available to everyone. But their "open-enrollment" policies may require policyholders to pay a larger portion of their expenses than policies offered to those in good health. For example, the open-enrollment major-medical plan sold by Empire Blue Cross Blue Shield in New York requires 20 percent coinsurance for all services. By contrast, its high-rated *Tradition Plus Wraparound* policy, sold only to those with no medical problems, requires no coinsurance on hospital services and also offers a much lower deductible.

Most Blue Cross and Blue Shield organizations now "underwrite." That is, they evaluate an applicant's health much the same way their commercial competitors do. They decline people with cancer and heart disease and sometimes issue policies with exclusion riders and higher premiums.

It's hard to say whether you'll have an easier time buying coverage from the Blues than from commercial insurers. Most of the Blue Cross plans we contacted refused to respond to our survey. Through other sources, we obtained the plans sold by uncooperative Blues and evaluated them along with the others.

Blue Cross plans that do not exclude health conditions or charge higher premiums for them may simply refuse to sell you a policy. On the other hand, a Blue Cross plan might be more lenient than a commercial insurer. Empire Blue Cross Blue Shield does not require blood tests to detect AIDS. Kentucky Blue Cross and Blue Shield insures

women with fibrocystic breast disease. Commercial carriers often require blood tests and almost always exclude coverage for fibrocystic breasts.

Preexisting conditions

If you get a policy from Blue Cross and Blue Shield or a commercial insurer, you still may have to wait a year or two to be covered for

medical conditions you already have.

Most policies say that a preexisting condition is one for which a policyholder has received treatment or for which a reasonably prudent person *should have sought* treatment during the previous two years. Some policies have shorter or longer "look-back" periods. Those are noted in the Ratings. *Continued*

THE LAST RESORT HIGH-RISK POOLS

If you can't buy health insurance and you live in one of 23 states listed below, your insurer of last resort is a high-risk pool created for the people insurance carriers don't want. Similar to the high-risk plans for drivers who've been in accidents, health-insurance pools originated in the 1970s as the industry's alternative to national health insurance. But only in the last few years have states begun to get serious about them.

To obtain coverage, you usually must be a state resident for at least six months (a year in some states), and must have received a rejection notice from at least one carrier (Montana and Florida require two rejections).

If a carrier will insure you only at a premium exceeding the price of coverage from the pool, or if the insurance you're offered carries exclusion riders, you will also be eligible for a pool policy in most states.

The rules differ from state to state. Illinois, Iowa, Minnesota, and Nebraska, for example, allow people infected with the HIV virus to obtain a pool policy; South Carolina does not. In some states you can't get pool coverage if you're eligible for a conversion policy when you leave an employer group, even though the pool policy may be better than the conversion option.

Florida, Illinois, Iowa, Minnesota, North Dakota, Tennessee, Washington, and Wisconsin make Medicare-supplement policies available through their pools. That's a boon to the disabled under age 65 who rely on Medicare but can't find insurance to fill Medicare's gaps.

Pool coverage is similar to that offered by a major-medical policy, although benefits for mental and nervous disorders, organ transplants, and pregnancy may be less comprehensive. You may, however, pay more out-of-pocket than you would with a major-medical policy. Some plans require a high deductible, greater coinsurance, and relatively low lifetime-benefit maximums—\$500,000 or even \$250,000.

Premiums are no bargain, which is not surprising since policyholders in the pool will almost certainly file claims. For example, a policy with a \$500 deductible from the Illinois pool will cost a 45-year-old man living in Chicago \$3844 a year. That's twice as much as he'd pay for the most expensive individual policy in our study available to Chicagoans.

Long waiting lists

Pool policies provide decent coverage, but they are available only to a fraction of those who need them. CU surveyed the pools last spring and found that they now cover only 55,500 people nationwide. Pools in Illinois, Maine, and Oregon currently limit the number they can insure. The Illinois pool can issue only 4500 policies. The wait to buy into the Illinois pool is now at least a year.

It's hard to see how the pools can meet even the existing need. They operate at a loss, despite the high premiums. In most states, losses are covered by assessments against all health-insurance carriers doing business in the state. In return, some states relieve insurers from part of their obligation to pay taxes on the premiums they collect.

But the insurance industry is pressing the states to pick up more of the bill from the public purse. "We're not in the business of giving away insurance at a loss to these people," says Carl Schramm, president of the Health Insurance Association of America.

The 23 states with high-risk pools are: California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Maine, Minnesota, Montana, Louisiana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming. (The pools in California, Colorado, Georgia, Louisiana, Texas, Utah, and Wyoming are not fully operational.) Your state insurance department can tell you how to contact your state's pool.

THE CRISIS IN HEALTH INSURANCE

To encourage applicants to reveal all their medical conditions, some companies waive their

usual waiting periods if you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

What policies cost

The premiums you pay are based on your age, your sex, and where you live.

At Banker's Life and Casualty, a healthy 45-year-old man living in Chicago would pay \$1245 a year; a 45-year-old woman, \$1625; a 55-year-old man, \$1748; and a 55-year-old woman, \$1852.

The premium for a 40-year-old man, his 35-year-old wife, and two children would come to \$3382.

A few Blue Cross plans still use "community rates," charging everyone the same premium regardless of their age or where they live. Other things being equal, older people are usually better off at a company using community rates. A 45-year-old man and a 60-year-old man living in Philadelphia would pay the same \$2192 premium at Independence Blue Cross and Pennsylvania Blue Shield. But at Time, a company not using community rates, the 45-year-old man would pay only \$1580; the 60-year-old, \$3375.

With most policies, premiums increase as you get older. If you buy a policy at age 40, expect the premium to increase when you turn 45.

In addition to age-related increases, the rising cost of medical care also pushes up premiums every year or two. The premiums for policies in our study increased an average of 11 percent a year over the past five years. But premiums for some policies rose as much as 40 or 50 percent in a single year.

Pricing tricks

As a sales gimmick, some companies use a pricing scheme that gives policyholders a deceptively low premium the first year and very high premiums in later years.

When a company that uses so-called select and ultimate rates accepts you for coverage, it knows you're in good health and charges a low (select) premium to reflect the fact that you're not likely to file claims in the immediate future. But as the years go on, and as you make claims, the company will jack up the

premium to the highest (ultimate) level.

Companies that don't use select and ultimate rates spread the anticipated costs of your claims over all the years you own the policy, so your premiums will be more stable. If you buy from a company using select and ultimate rates, you may face premium increases that far exceed what you can afford.

State insurance regulators don't require insurers to disclose whether they use select and ultimate rates, so it's often hard to know. It's a good idea, though, to ask whether a company you're considering uses such rates and to avoid their policies, especially if you plan to keep the coverage for several years. One carrier, Aid Association for Lutherans, gives buyers in some states a choice between policies with select and ultimate rates and those without, and clearly points out the differences in its sales material. (Our Ratings include Aid Association's policy without select and ultimate rates.)

Managed care and PPOs

Until recently, insurance companies seldom questioned physicians' fees. But to hold down their own costs, companies have now inserted a variety of "managed care" requirements into their policies.

As a result, you may have to ask the insurance company for prior approval for any elective surgery. You may have to use an outpatient facility for such procedures as arthroscopic surgery, dilation and curettage, and cataract removal. You may be required to seek second opinions before surgery. If you don't follow the rules, the company may reduce your benefit or increase the coinsurance and deductible you'll have to pay.

Some Blue Cross and Blue Shield plans offer Preferred Provider Organizations (PPOs). Those are groups of doctors who have agreed to discount their fees. If you sign up for a PPO and use a non-PPO doctor, you may have to pay as much as 40 or 50 percent of the doctor's bill yourself and also suffer other penalties.

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our

study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

A few other insurers also declined to participate. Celtic Life, a company waging a public campaign to educate people about shopping for health insurance, refused to shed any light on its policies or selling practices. A newcomer to health insurance, A.L. Williams, a company better known for its life-insurance policies, also declined to participate. A third company, World Insurance, claimed that if it won a favorable rating from CONSUMER REPORTS, it would not have the capacity to handle all the applications.

We rated the major-medical and hospital-surgical policies by measuring the coverage and cost-sharing features of each against actual claims, ranging from minor to catastrophic, filed by 25,000 employees. The average annual claims for a single person in the reference group totaled \$1387; for families, it was \$3175.

A policy that covers everything would pay 100 percent of those amounts. Of course, health-insurance policies are not designed to cover 100 percent of claims. But the best policies pay the most.

The best policy we found, a major-medical plan sold by Blue Cross and Blue Shield of Minnesota, would pay \$1230 (or 89 percent) for singles and \$2810 (or 89 percent) for families if you used physicians in the plan's preferred-provider organization. The worst, a hospital-surgical policy from Pyramid Life, would have paid only \$490 (or 35 percent) for singles and \$950 (or 30 percent) for families.

The Ratings show what percentage of the average annual claims each policy would pay after accounting for deductibles, coinsurance, coinsurance maximums, and other cost-sharing features spelled out in the contract.

Since most people want a policy that provides coverage for catastrophic expenses, we also measured how well each would pay for two major illnesses. One was a \$19,774 claim for colon-cancer sur-

The wrong job Occupations some insurance companies consider unacceptable for health coverage:

Tree trimmers
Explosives handlers
House painters
Window cleaners
Heavy-equipment operators
Rodeo performers
Police officers
Doormen
Models
Freelance artists
Waiters
Masseurs
Hospital aides
Maids
Musicians
Bartenders
Fry cooks
Janitors
Street cleaners
Doctors
Lawyers
Pro athletes
Fishermen
Railroad workers
Test drivers
Car-wash workers
Dancers
Beauticians
Movers
Zoo attendants

gery and follow-up chemotherapy. The other was a \$49,767 claim for care of a serious heart attack, including an angioplasty procedure (see box on page 544).

A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave

weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's life-

time benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

We could not obtain rate-increase histories or certain other information for noncooperative Blue Cross and Blue Shield plans or for new policies. Where we lacked information that might affect a plan's score,



BLUE CROSS AND BLUE SHIELD ABANDONING THE MISSION

Sick people cannot buy a policy from Blue Cross and Blue Shield of Kentucky. The plan evaluates an applicant's health and rejects those with such afflictions as cancer, heart disease, emphysema, and AIDS.

Competition from commercial carriers has forced the plan to turn sick people away in order to keep its premiums affordable and attract new customers. At one time, Kentucky's Blue Cross and Blue Shield plan sold as much as 90 percent of all health insurance in the state. Today it sells just 30 percent.

The Kentucky plan, typical of many Blue Cross and Blue Shield organizations today, is a far cry from what such plans used to be. Founded by organized medicine in the 1930s, Blue Cross (and later Blue Shield) had two missions. The first was to make sure hospitals and doctors got paid. The second was to provide health insurance for the greatest number of people.

For years, the Blues had a virtual insurance monopoly. In some places, they were so powerful that they were able to negotiate large discounts from hospitals and use the savings to carry out their mission of community service. For example, Blue Cross plans subsidized such money-losers as individual health policies for the sick and Medicare-supplement coverage for the elderly.

As nonprofit organizations, the Blues had certain privileges. They paid no Federal income taxes and, in many states, no taxes on the premiums they collected.

"Community rating" was once the Blues' trademark. Everyone in the community—large employer groups, small employer groups, and individuals buying policies on their own—were in the same risk pool. They paid the same rates regardless of their age and sex, where they lived, or how sick they were.

That all began to change in the 1960s. Commercial insurers started skimming the best risks from the Blue Cross pool by offering lower premiums than the Blues charged. As large groups and then small ones took out cheaper policies with commercial carriers, the Blues increasingly found themselves covering people with health problems the commercial carriers didn't want. As healthy people deserted the pool, the Blues had little choice but to raise premiums higher and higher to cover the claims made by the sick people who remained.

In many areas, the plans also saw their hospital discounts whittled away. Some states now mandate smaller discounts and allow all insurers to receive them.

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned com-

munity rating a few years ago in favor of the kind of pricing used by its commercial competitors.

Most Blue Cross and Blue Shield plans now resemble Kentucky's. Many have become mutual insurance companies. They've lost their tax exemption from the Federal government, and they no longer try to provide coverage for everyone. Less than one-third still take all comers for health insurance. Of the 37 state regulators responding to a CU survey, only nine consider their local Blue Cross and Blue Shield plan an insurer of last resort.

"We think the Blues in our state do a pretty good job. But everyone here dislikes them, from their subscribers to the legislators," says one state insurance regulator who asked not to be identified. "They are some of the most defensive people you can imagine. Everything we ask for is a fight."

We know what he means. We asked 29 Blue plans to send us information about their policies. Only nine would do so, forcing us to seek information from state regulators, who sometimes couldn't or wouldn't help us. The California Insurance Department told us it had no rates on file for Blue Cross of California. When we asked the plan for a history of its rate increases, an official told us that information was "proprietary." When we asked the Washington Insurance Department to give us rate-increase data for the Washington and Alaska plan, the department said it could not oblige because Blue Cross had a right in that state to keep such information a secret.

"As their risk pool gets creamed, there's mission schizophrenia at the Blues," says Susan Sherry, an official at Families USA, a health-advocacy group. "It's the classic example of competition, and consumers are the real losers."

Some Blue Cross and Blue Shield plans, mostly in the Northeast, still cling to the old mission. But even for them, holding on is increasingly difficult.

In New York, a person no matter how sick can always get health insurance from Empire Blue Cross Blue Shield. It won't be the top-of-the-line policy, but it will provide some coverage.

Empire, which still uses community rates, can sell insurance even to people with terminal illnesses because their policies are heavily subsidized from premiums paid by large employer groups and from the savings obtained by negotiating a 13 percent discount with New York hospitals.

Even so, Empire officials say that the discount is not large enough, and that over the last few years some 100,000 people have left the pool, either going with commercial carriers or doing without coverage altogether. The plan has had to increase premiums on all its policies 40 to 50 percent to cover the claims of the sick people who remain.

"Our goal is to stay with the mission," says Eric Schlesinger, Empire's chief marketing officer. "But in the end, we will have a community price so high that no one will pay it, and the number of uninsured will skyrocket."

we assigned values representing the average for all plans in our survey. This lack of actual information for a plan is denoted by a dash in the Ratings. The plans are listed in order of an overall quality index that takes into account all the rating factors.

Recommendations

Naturally, you want a policy that will pay as many of your bills as possible, so coverage should be your first concern.

Unfortunately, there are few policies for any one individual to choose from. Your options boil down to a policy from one of the few remaining commercial carriers selling this insurance or one from your local

Blue Cross and Blue Shield plan.

The best coverage is provided by a good major-medical plan. The plans listed high in the Ratings require policyholders to pay very few of their medical expenses.

A number of Blue plans—in Minnesota, New Jersey, New York, and Pennsylvania—ranked high. People in those states should certainly consider them. As the Ratings show, however, Blue Cross and Blue Shield organizations in other states offer mediocre or poor policies.

Fortunately, some good commercial plans are widely available. Look first at the high-rated policies offered by American Republic and Benefit Trust Life.

Maternity benefits from some of the Blues were better than those offered by most commercial carriers. Many Blue plans treat pregnancy as an illness and pay normal benefits, which will cover most of the cost of having a baby. But some offer maternity benefits only on family policies. Presumably a single woman who became pregnant would not have coverage.

Some Blue Cross and Blue Shield plans offer a choice of a regular insurance policy and a PPO. You might consider a PPO if you're willing to use its doctors rather than your own. The PPOs offered by Blue Cross and Blue Shield in Arizona, Illinois, Minnesota, and Washington and by Blue Shield of California ranked higher in our Ratings than those organizations' traditional insurance plans because they require their subscribers to pay less coinsurance.

Policies from First National and Washington National provide good benefits for catastrophic expenses but fall short in other important areas, such as policy cancellations or rate increases.

Note that the policy from the largest seller of individual major-medical insurance, Golden Rule, ranks near the bottom. The policy provides only average coverage. And the company has a history of large rate increases and canceled policies.

Once you have considered a policy's coverage and other dimensions, look at the premium. If two policies are comparable, pick the one with the lowest premium.

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay \$806 a year for a

hospital-surgical plan, compared with \$1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

The highest room-and-board coverage offered by the hospital-surgical policy from Blue Cross and Blue Shield of Maine, for example, is \$276. Some of the state's hospitals have room-and-board charges that exceed \$400.

Hospital-surgical plans provide fewer benefits, and those benefits may not increase with the cost of medical care. Unless the carrier lets you upgrade, the benefits you buy today may be inadequate if you need hospital care several years from now.

If you can't swing the premiums for a high-rated major-medical policy, consider reducing the premium with a higher deductible, then budget to cover small medical expenses yourself.

If you're not in perfect health, it's hard to buy coverage at any price. It may nevertheless be worthwhile to shop several carriers to see if they'll issue coverage with exclusion riders.

If you live in Alabama, Hawaii, Maryland, Michigan, New Hampshire, New Jersey, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Virginia, or the District of Columbia, you will be able to buy an "open-enrollment" policy from Blue Cross and Blue Shield at least sometime during the year.

In Maine, the Blue Cross and Blue Shield organization accepts anyone for coverage, but will add exclusion riders for three years on policies for people with various health conditions.

If you live in one of 23 states with a high-risk pool, you may be able to purchase coverage from the pool.

There's no insurer of last resort for people living in the other 15 states. Short of getting a job with a large business or marrying someone who works for one, people who are unacceptable to insurance companies are out of luck. They have no choice under the current system but to join the growing ranks of the uninsured.

Ratings begin on page 54

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CATASTROPHIC CLAIMS

PERCENTAGE GAMES

As part of our evaluation of health-insurance policies for the accompanying report, we measured how much each policy would help defray the actual bills run up by two patients in apparent good health who were suddenly stricken with a life-threatening illness—colon cancer and heart attack.

The case of colon cancer cost a total of \$19,774, including \$13,471 in hospital bills and \$3665 for surgery.

The best plan we found, from Blue Cross and Blue Shield of Minnesota, would have paid about 92 percent of the \$19,774 if the policyholder used only "preferred provider" doctors. (If the policyholder went to other physicians, the plan would pay up to 88 percent.) The highest-rated policy from a commercial carrier, American Republic's *UltraCare* with no coinsurance, would have paid 97 percent. A less generous major-medical plan, from Washington National, would have paid 87 percent of the claim. Least helpful was a hospital-surgical policy from Pyramid Life. It would have paid only 49 percent of the bill, leaving the patient about \$10,000 in debt.

The treatment for the heart-attack patient came to \$49,767. It included an angioplasty (a procedure to open blocked arteries) that cost \$5730 in surgical fees, and a 21-day hospital stay that piled up bills of \$34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the \$49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a \$28,030 debt as well as the heart attack.

CONTINUING COVERAGE

WHEN YOU LEAVE A GROUP PLAN

If you leave a job, you may have two options for continuing your health insurance short of shopping for an individual policy on your own. Depending on the size of the firm you worked for and on your state's insurance regulations, you may be able to continue your group coverage for a short time as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Or you may be able to obtain an individual policy through a process known as conversion. Both options, though, will usually cost a lot more than you would spend for group coverage.

Because it is less expensive and generally offers better coverage than a conversion policy, your first line of defense should be COBRA.

COBRA: How it works

If you worked for a business with 20 or more employees, COBRA entitles you and your dependents to continued coverage for at least 18 months under your former employer's plan. If you are disabled and eligible for Social Security disability benefits when your employment ends, you can obtain an additional 11 months of coverage, for a total of 29 months.

If you are insured through your spouse's plan at work and your spouse dies, you become divorced or separated, or your spouse becomes eligible for Medicare, COBRA provides for coverage of up to 36 months.

COBRA requires that you pay 102 percent of your group insurance premium. If your employer has been paying a portion, you will have to assume that cost in addition to what you were already paying, plus an extra 2 percent for administrative costs. Disabled people who take COBRA coverage must pay as much as 150 percent of the premium for the extra 11 months.

You can lose coverage if you don't pay the premiums, if you become eligible for Medicare, if your employer discontinues health insurance for employees still working there, or if you join another plan.

However, if you join another plan and have an existing medical condition for which that plan imposes a waiting period, you can still keep your COBRA benefits until they would normally run out. By that time, your preexisting condition may be covered under the new plan. But you could be without coverage for that condition if your COBRA benefits stop before the waiting period on the new policy is over.

If you work for a company that has self-insured its workers' health coverage, you are entitled to COBRA benefits, even though such plans are normally exempt from other insurance regulations.

If you are not eligible for COBRA because your former firm employs fewer than 20 workers (or is a church organization), you may still have some protection under state laws. If your state provides for "continuation" of benefits, you may be able to stay on your employer's group policy for as little as three months in some states or as long as 18 months in others. (Those benefits are usually not available to workers in self-insured plans.)

The following states do *not* have comprehensive continuation laws: Alabama, Alaska, Arizona, Delaware, Florida, Hawaii, Idaho, Indiana, Louisiana, Michigan, Mississippi, Nebraska, Pennsylvania, Wisconsin, and Wyoming.

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few

thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

After COBRA coverage runs out, or if you're not eligible for it, your next options are to take a conversion policy or shop for individual coverage. (Unless, of course, you're covered under a new employer's health plan or become eligible for Medicare.)

The law requires that every employer who normally offers conversion policies to workers who leave also offer them to former employees once their COBRA benefits run out. Fifteen states, as well as the District of Columbia, don't require employers to offer conversion policies to employees who leave. They are: Alabama, Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Louisiana, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey, North Dakota, and Oklahoma.

If an insurance company terminates a group plan, employees may also be out of luck. Two-thirds of the states require insurers that cancel group policies to offer conversion options to people losing their coverage.

Even when it is offered, conversion coverage is almost always inferior to what you received from your group plan. (Twenty-four states require companies to offer conversion policies with major-medical or comprehensive benefits.) If you currently have major-medical coverage, a conversion policy may provide only hospital-surgical benefits and only pay up to a fixed amount each day for hospital room and board and surgical procedures (see page 538).

For example, CIGNA, an insurer that offers several conversion options to employees converting from the group policies it underwrites, pays only \$250 for hospital room and board if an employee chooses its top-of-the-line conversion coverage. For employees in a top-of-the-line group policy, CIGNA would pay most of the hospital charge, which runs considerably more than \$250. (The average cost of a day in the hospital is about \$800.)

While benefits are low, the prices of conversion policies are high, reflecting the fact that it is mostly people in poor health who buy this coverage. CIGNA, for example, charges a 45-year-old man or woman living in Chicago an annual premium of \$4736 for its most generous conversion policy with a \$500 deductible. By comparison, American Republic, the top-ranked commercial company in our study, would charge a 45-year-old man in Chicago \$1904; a 45-year-old woman, \$2240.

Despite those drawbacks, a conversion policy may be your only option if you have health problems. (Insurers must make these policies available to anyone regardless of their health.)

If only one member of your family suffers from some medical condition, you may want to take the conversion policy for him or her and try to find cheaper, individual coverage for the rest of the family. In some states, a person with health problems may be eligible for coverage from the high-risk pool, although in certain states, if you're eligible for a conversion policy, you can't have pool coverage.

If you're considering buying an individual policy instead of taking your conversion option when COBRA coverage ends, do your shopping well in advance. The slightest health problem can disqualify you, and it may take time for an insurer to collect your medical records and decide if it's willing to issue coverage. Once your COBRA benefits run out, you have only 31 days in most states to sign up for a conversion policy.

RATINGS

Health-insurance policies

Listed by types. Within types, listed in order of estimated overall quality, based on policies for a single person. (Family policies closely tracked single policies in overall quality.) Differences of less than 5 points were judged insignificant. Companies marked with an asterisk did not respond to our survey. Dashes indicate we could not obtain information; in those cases we assigned values representing the average for all policies.

1 Annual premiums. These are annual premiums for 45-year-old men and women

living in Chicago. For a company not selling there, the premium is for the company's major operating territory. Family premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with \$500 deductibles. If the company does not offer a \$500 deductible, we show the premium for the closest deductible to \$500; footnotes (on pages 548-549) state the deductible on which the price is based. Premiums for maternity rider show the cost of adding coverage for routine pregnancies.

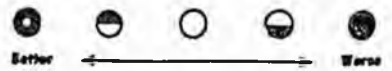
2 Quality index. A summary of how the policy performed for a single person.

3 Payout. The percentage the policy paid

for a single person and for a family on an average mix of claims filed by 25,000 policyholders. We used a \$1000 coinsurance maximum for each policy. If the policy did not offer this amount, we used its maximum that was closest to \$1000. Most plans require 20 percent coinsurance. Exceptions are noted in the Comments.

4 Catastrophic claims. Measures how well a policy would have paid after the deductible was met on two actual claims involving catastrophic illness—one for treatment of colon cancer; the other, a serious heart attack. A policy that scored a **4** paid more than 96 percent of the expenses for both claims. A policy with a **3** paid more

		Annual premiums				
		Men	Women	Family	Mat	
Major-medical						
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	\$1493 1 2	\$1962 1 2	\$5100 1 2		Included
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 2	1815 2	3923 2		Included
American Republic	UltraCare, no coinsurance	1904 2	2240 2	5012 2	\$608	
Blue Cross and Blue Shield of New Jersey	Medallion	1843 2 3	1843 2 3	4759 2 3		Included
Benefit Trust Life	MMI	1794 3	2096 3	4319 3		Included
Empire Blue Cross Blue Shield	Tradition Plus Wraparound (LGL 3252)	2392 2	2392 2	6126 2		Included
Independence Blue Cross w/Penn. Blue Shield	Major Medical w/Plan 100	2192 2	2192 2	5159 2		Included
Blue Cross and Blue Shield of Minnesota	Aware Care (F2239)	658 2	882 2	2226 2		Included
American Republic	UltraComp	1632 2	1953 2	4333 2	636	
American Republic	UltraCare, 20% coinsurance	1596 2	1877 2	4200 2	608	
Blue Cross of Washington and Alaska*	Personal Prudent Buyer, Low Option 200, Wash.	1092 2 3	1092 2 3	2376 2 3		None
Blue Cross and Blue Shield of Alabama*	ALPHA Plan	1308 2 3 4	1308 2 3 4	3432 2 3 4	72	
Blue Cross and Blue Shield of Illinois*	Non-Group PPO	1543	1932	4363	261	
Blue Cross and Blue Shield of Montana*	Personal Choice Plan	1851	1851	4241		Included
Blue Cross and Blue Shield of Montana*	Healthy Montanan Plan	1553	1553	3554		Included
Blue Cross and Blue Shield of New Jersey	Direct Payment Supplemental Major Medical	3167 2	3167 2	6135 2		Included
Blue Cross and Blue Shield of Indiana*	Personal Security	1293	1374	2935	1164	
Blue Cross and Blue Shield of Oklahoma*	Health Check	1764 2	1764 2	3780 2		Included
Blue Cross and Blue Shield of Maryland*	Personal Comp	1001	1001	2604		Included
Central States Health & Life	Individual Major Medical (569-570, 571-572)	1463 2	1900 2	3721 2	781	
Time	24 Karat (502)	1580 2	1876 2	3854 2	490	
Benefit Trust Life	Telo-Med	1443	1822	3878	1257	
Bankers Life and Casualty	VIP V (CR-G002)	1245 2	1625 2	3382 2		None
Bankers Multiple Line	The Spectrum Plan (D-G002)	1245 2	1625 2	3382 2		None
Union Bankers	The Spectrum Plan (MM-89)	1245 2	1625 2	3382 2		None
Blue Shield of California*	Preferred	1952	1952	3299		None
Blue Cross and Blue Shield of New Jersey	Blue Care	1261 2	1261 2	3400 2		Included
Blue Cross of Washington and Alaska*	Traditional Individual in Alaska	1933	1933	4123		None
Blue Cross of California*	Personal Prudent Buyer	1680	1680	3888	3360	
Blue Cross and Blue Shield of Illinois*	Non-Group Comprehensive	1838 2	1992 2	4886 2		None
Blue Cross and Blue Shield of Maine	Blue Alliance	1294 2	1294 2	2580 2		Included
Empire Blue Cross Blue Shield	Tradition Plus Comprehensive (LGL 3253)	1507 2	1507 2	3228 2		Included
Benefit Trust Life	AMM2	1496	1751	3603		None
Blue Cross and Blue Shield of Arizona*	Preferred Care	716	716	1928		None
Aid Association for Lutherans	TotalMed II (4945)	1708 2	1724 2	4032 2	1850	



than 90 percent. A policy with a ○ paid at least 81 percent, and a policy with a ⊖ paid at least 75 percent of the expenses.

5 Lifetime maximum. Total benefits a policy will pay over a policyholder's life.

6 Maternity coverage. This shows the quality of the maternity rider that covers routine pregnancies and deliveries. If a policy offered coverage for complications only if policyholders buy a rider for routine coverage, it scored a ●. It scored a ⊖ if it offered coverage for complications without requiring purchase of the rider.

7 Renewability. Guaranteed means the policy is guaranteed renewable for the poli-

cyholder's life. Conditional means that the company can cancel it along with all similar policies. Optional means the company can cancel an individual policy.

8 Rate history. A ● indicates that over a five-year period the company has raised rates on the policy less than the medical consumer price index, which averaged 7.2 percent each year over the period. A ⊖ means that it raised rates at least 17 percent a year.

9 Preexisting illness. The waiting period is the number of months a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for dis-

closed illnesses. The look-back period is how far back in time the insurance company will investigate for preexisting illness.

10 Available to anyone. A "yes" indicates the policy is available to any applicant regardless of health status.

11 Exclusion riders. A "yes" indicates the company will issue coverage with exclusions for certain conditions or for certain parts of the body.

12 Higher rates. A "yes" means the company will issue coverage but at higher premiums for some medical conditions.

13 Other coverage. Additional coverages and features a policy may offer. See Key.

Payout					Preexisting illness										Comments	Telephone
Quality index	Single	Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mo.	Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage			
2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	
85	89%	89%	●	None	●	Conditional	●	24	3	No	Yes	Yes	a,b,c	A	800-382-2000	
83	84	87	●	None for basic policy	●	Conditional	⊖	12	12	Yes	No	No	a,c,d	C	717-255-0820	
81	82	68	⊕	\$1-million per condition	○	Guaranteed	●	24	24	No	Yes	Yes	a,d	B	800-247-2190	
80	88	88	●	None	●	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500	
80	86	85	○	1-million	●	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500	
80	83	82	●	1-million	●	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757	
80	83	83	●	None for basic policy	●	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100	
79	76	72	●	None	⊖	Conditional	●	24	3	No	Yes	Yes	a,c,h	—	800-382-2000	
78	74	60	●	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190	
77	75	61	●	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190	
75	82	67	—	1-million	⊖	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663	
75	75	60	—	None for hospital	○	Conditional	●	12	24	No	Yes	No	a	J	800-392-5705	
75	73	61	—	1-million	⊖	Optional	●	12	12	No	No	No	a,c,h	E	312-938-7209	
74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210	
74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210	
74	74	74	●	None for basic policy	●	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500	
74	62	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075	
74	77	72	—	1-million	⊖	Optional	●	12	6	No	Yes	No	a,c,h	K	918-560-2121	
74	73	72	—	1-million	●	Conditional	⊖	9	No limit	No	Yes	No	a,c,d	—	800-992-2308	
73	73	60	●	1-million	○	Conditional	●	12	24	No	Yes	Yes	a	—	402-397-1111	
73	72	60	⊖	2-million	○	Conditional	●	24	12	No	Yes	Yes	a	—	800-333-1203	
72	71	58	⊖	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500	
71	75	64	●	None	⊖	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000	
71	75	64	●	None	⊖	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000	
71	75	64	●	None	⊖	Conditional	●	24	24	No	Yes	Yes	a,g	—	214-939-0821	
71	73	60	—	2-million	●	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150	
71	70	70	●	100,000 per year	●	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500	
71	75	60	—	1-million	⊖	Conditional	●	12	12	No	Yes	No	a	—	800-752-6663	
71	68	55	—	2-million	⊖	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-6000	
71	70	56	—	1-million	⊖	Optional	●	12	12	No	No	No	a	—	312-938-7209	
70	67	72	—	None for basic policy	⊖	Conditional	●	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966	
70	61	59	●	500,000	●	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757	
69	72	60	○	1-million	⊖	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500	
69	75	62	—	1-million	⊖	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	600-543-2944	
69	71	60	●	2-million	○	Conditional	●	24	No limit	No	Yes	Yes	a,d	—	414-734-5721	

Ratings
Continued

		Annual premium			
	Policy	Men	Women	Family	
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	\$ 928	\$ 987	\$2108	\$1164
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 ¹	2044 ¹	4359 ¹	Includ
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 ¹	1169 ¹	2454 ¹	Includ
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2085	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1208	1208	2653	Includ
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Includ
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 ¹	2042 ¹	4030 ¹	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 ²	1748 ²	3382 ²	Non-
First National Life	Major Medical (MM-286)	1005 ¹	1137 ¹	2142 ¹	748
Blue Shield of California*	Coronet	2941 ¹	2941 ¹	4229 ¹	Non-
Pyramid Life	G91	1501 ²	1863 ²	4015 ²	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3623	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 ¹	940 ¹	1814 ¹	Non-
Prudential	Pru-Med (PM-83)	1228 ² ¹ ¹	1584 ² ¹ ¹	3127 ² ¹ ¹	2641
Washington National	Classic Choice (AM283F)	1764 ²	2205 ²	3249 ²	901
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 ¹	1579 ¹	3451 ¹	Includ
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 ¹	1968 ¹	4729 ¹	Includ
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 ¹	2004 ¹	3742 ¹	Includ
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 ¹	1250 ¹	2472 ¹	Includ
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 ¹	1216 ¹	2966 ¹	Includ
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 ¹	756 ¹	1848 ¹	Includ
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 ¹	1162 ¹	2846 ¹	Non-
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 ¹	1033 ¹	2058 ¹	Includ
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 ¹	814 ¹	1844 ¹	Includ
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 ¹	1266 ¹	2683 ¹	51
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 ¹	1336 ¹	2796 ¹	Includ
Blue Cross and Blue Shield of New Jersey	Co-op Protection Plan and Series 14/20	1992 ¹	1992 ¹	3439 ¹	Includ
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	806 ²	1043 ²	2137 ²	Non-
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 ²	1043 ²	2137 ²	Non-
Union Bankers	Major Hospital Surgical (HS-09)	806 ²	1043 ²	2137 ²	Non-
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 ¹	853 ¹	2177 ¹	Non-
Certified Life	Hospital Surgical Protection (CER-G020)	806 ²	1043 ²	2137 ²	Non-
Pyramid Life	G95	1016 ² ¹	1250 ² ¹	2472 ² ¹	6-
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 ¹	839 ¹	1886 ¹	In-

- ¹ \$500 deductible on hospital services only.
- ² Rates for nonsmokers.
- ³ \$350 deductible on nonhospital only.
- ⁴ \$500 deductible for each condition every 3 years.
- ⁵ \$300 deductible only for supplies and drugs.
- ⁶ \$250 for nonhospital services.
- ⁷ \$300 deductible.
- ⁸ \$200 deductible.
- ⁹ \$200 deductible for each hospital admission.

- ¹⁰ \$500 deductible on nonhospital only.
- ¹¹ \$400 deductible.
- ¹² \$750 deductible.
- ¹³ \$300 deductible for each hospital admission; \$500 for all services.
- ¹⁴ \$1000 deductible.
- ¹⁵ \$200 deductible for nonhospital services.
- ¹⁶ Atlanta rates; \$500 deductible for each condition.
- ¹⁷ \$100 deductible for hospital inpatient stays

- only; \$1000 for other services.
- ¹⁸ No deductible required.
- ¹⁹ \$250 deductible.
- ²⁰ \$60 deductible for each hospital admission

Key to Other Coverages
a-Prescription drugs for home use.
b-Preventive care for all ages.
c-Participating physicians for all families
d-Mammography
e-Pap smears.

		Payout						Preexisting illness									
		Quality index	Single	Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate history	Waiting period, mo.	Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage	Comments	Telephone
69	74%	60%	—	\$1-million	○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075		
68	66	65	—	1-million	●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164		
68	66	65	—	1-million	●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164		
68	70	62	—	1-million	●	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600		
68	74	61	—	1-million	●	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663		
67	70	58	●	1-million	○	Conditional	●	12	No limit	No	Yes	No	a	—	800-868-2500		
67	70	67	—	1-million	●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622		
67	71	68	—	1-million	●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011		
65	62	51	●	1-million	○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211		
64	75	64	●	None	●	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000		
64	65	53	●	1-million	○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850		
63	65	53	—	2-million	●	Conditional	●	12	12	No	Yes	No	a,c,d	—	800-624-5150		
63	72	60	●	2-million	○	Conditional	●	24	24	No	Yes	Yes	a,d,e	—	913-722-1110		
62	74	60	●	1-million	○	Conditional	●	12	24	No	Yes	No	a	—	817-297-4123		
61	62	51	—	1-million	●	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944		
61	63	55	○	None	○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642		
61	71	59	●	2-million	○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500		
81	77	80	●	None	●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820		
77	76	77	●	None	●	Conditional	○	12	12	Yes	No	No	c	C	215-564-2100		
76	70	70	—	None	●	Conditional	●	6	6	Yes	No	No	c	B,L	313-225-8000		
76	76	75	—	None	●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200		
71	63	66	—	None	●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200		
70	71	75	—	500,000	●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797		
68	58	50	●	none	●	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211		
67	55	53	—	none	●	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3535		
67	59	59	—	1-million	●	Conditional	—	12	12	No	No	No	c	F	406-444-8210		
66	62	66	—	1-million	●	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	216-687-7218		
62	65	67	○	None	●	Conditional	●	12	12	No	No	No	f	B,H	201-822-4500		
61	63	66	○	None	●	Conditional	●	12	12	Yes	No	No	f	C,H	201-822-4500		
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000		
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000		
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000		
53	55	45	●	1-million	●	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311		
50	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000		
42	35	30	●	2-million	○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110		
67	68	72	●	None	●	Conditional	●	11	24	Yes	No	No	d	B	212-490-4757		

I-Participating physicians for families below some income levels.
 g-\$50/year for preventive care per person.
 h-Well-child care.
 i-Major-medical coverage after \$2500 deductible is met.
 j-Major-medical coverage after \$25,000 of covered expenses are incurred.

Key to Comments

A-Consurance on hospital and \$10 copayments
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for physicians' visits.
 B-No consurance.
 C-Consurance only for certain services.
 D-Less consurance after the first year.
 E-If PPO doctors not used, consurance and consurance maximums are higher.
 F-30 percent consurance.
 G-Pays a set amount for hospital room and board.
 H-Surgical-fee schedule.
 I-Pays set amount for all services for each day in the hospital.

J-Routine maternity rider offered only with family policies.
 K-Routine maternity coverage is included as part of policy only with family policies.
 L-Maternity coverage only for delivery and hospital stays—no doctor visits covered.
 M-Routine maternity coverage and coverage for maternity complications offered only with family policies.
 N-No maternity coverage even for complications unless rider is purchased.

THE CRISIS IN HEALTH INSURANCE

PART 2

Last month, in the first part of this series, we looked at the problems millions of Americans have in obtaining and keeping health insurance. We evaluated 71 individual health-insurance policies sold by 40 commercial carriers and Blue Cross and Blue Shield organizations, and discussed other alternatives for people who lose their group insurance.

This month, we go beyond the short-term remedies to examine the various solutions to the health-insurance crisis that have been proposed by insurance companies, physician organizations, and the business community. We also visit Canada to look at how that nation pays for its health care. The Canadian example is considered by some as a model for the U.S.

HEALTH INSURANCE FOR ALL?

The American health-care system is the costliest in the world. The U.S. spends 171 percent more on health care per person than Great Britain; 124 percent more than Japan; 88 percent more than West Germany; and 38 percent more than Canada.

Over the last five years, the cost of health care in the U.S. has risen 42 percent, faster than the cost of food, housing, or transportation. In 1990, the nation's medical bill will total some \$666-billion, or about \$2564 for every man, woman, and child. Health-care spending now consumes 11½ percent of Gross National Product; by the end of the decade, it could account for as much as 15 percent.

Not all of those dollars pay for medical treatment. The cost of administration, claims handling, and insurance-company bureaucracy eats up at least \$65-billion, almost 10 per-

cent of the total. "We waste more of our medical dollars on bureaucracy and paper pushing than any other country," says Dr. David Himmelstein, national coordinator of Physicians for a National Health Program.

Despite the vast sums poured into health care, the U.S. ranks 12th in life expectancy, behind Japan, Italy, France, and the Scandinavian countries. It ranks 21st in the number of deaths of children under age 5; 22nd in infant mortality; and 24th in the percentage of babies born with an adequate birthweight (Bulgaria, Hong Kong, and the Soviet Union all do better on that last measure).

Among industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens.

A joint venture

The U.S. health-care system is built on a lucrative partnership of

fee-for-service medicine and private insurance. For years, doctors and hospitals had carte blanche to set their own fees and pass the cost of their services along to private insurance carriers or to their patients. Insurance companies (and patients) rarely questioned the amount of those bills. "No one ever paid us to go fight with doctors," says one insurance executive.

If fees rose higher than the premiums the insurance companies needed to pay claims and turn a profit, the insurers simply raised the price of coverage. Policyholders could either pay the higher premiums or go uninsured.

The cost of medical care has now forced insurance premiums so high that millions of people are going uninsured. "The whole system keeps pricing more and more people out of it," admits Howard Bolnick, president of Celtic Life, a seller of health insurance. "The mar-

ket is working efficiently, but it's less than optimum from society's point of view."

Decades of debate

As more people are squeezed out of the American health-care system, and as basic public-health statistics underline the system's comparative inadequacies, a decades-old debate over public-health policy has been rekindled. The debate has been simmering for some 80 years.

In the years before World War I, in the 1930s, in 1949, in 1965, and again in the 1970s, the U.S. seemed on the verge of establishing universal health insurance. A 1939 issue of CONSUMER REPORTS noted: "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'"

A decade later, in 1949, we reported: "As the new Congress meets, prospects for national health insurance have never looked better. There are a number of reasons why 1949 may see a Federal insurance law passed at last. The American public has overwhelmingly demonstrated its approval of health insurance in many surveys, in legislative programs of consumer, civic, and labor groups, in government policy reports, and in endorsements by political leaders. Soaring prices have made the cost of medical care even more difficult for most families to afford."

Sixteen years later, a national health-insurance program still hadn't come to pass, despite the committed leadership of President Lyndon Johnson. In 1965, after powerful lobbying against national health insurance by organized medicine, Congress voted to authorize it only for the elderly, in the form of Medicare. (At the same time, it established Medicaid, a new government program for the poor.)

Even then, the Medicare Act was tailored to the economic demands of the American Medical Association and Blue Cross and Blue Shield, the primary insurance carrier of the day. Fee-for-service medicine and the Blue Cross method of reimbursing health-care providers became part and parcel of Medicare. They laid the foundation for

today's towering health-care costs. (Blue Cross and Blue Shield also got the job of paying Medicare claims for the Government.)

Again in the 1970s, there was serious talk of universal health insurance. But President Jimmy Carter could not muster the political backing needed to fulfill his campaign pledge to implement it.

How has a system that costs so much and still falls short managed to survive and resist reform?

The power of the AMA

Fearful that universal health insurance will lower the incomes of its 271,000 members, the American Medical Association has for years denounced national health insurance as "socialized medicine." More to the point, the AMA has paid politicians handsomely to view national health insurance in the same light.

The AMA is one of the largest contributors to political campaigns, appearing near the top of almost every list of the big money raisers, the big contributors, and the big trade association political action committees (PACs) compiled by the Federal Elections Commission.

During a 15-month period ending in March 1990, the AMA ranked second on the election commission's list of the top 50 PACs in amount of receipts, second in total spending (which includes funds for advertising and mailings as well as contributions), and seventh in the amount of cash on hand, with some \$2-million in reserve to bankroll future campaigns.

In the 1988 Congressional elections, the AMA spent \$5.3-million, including \$2.3-million in direct contributions to House and Senate candidates. From January 1989 through March of this year, it has given money to 348 members of Congress, including eight of the 12 Congressional members of the Pepper Commission, a bipartisan group composed of members of Congress and industry representatives that was established to study health-care financing and recommend changes. The Commission was chaired by Sen. John D. Rockefeller IV, D-W.Va.

To replenish its coffers, the AMA embarked on a special effort last year to discredit the Canadian health-care system, often viewed as a model for reform in the U.S. In what it called its "Strengthening the U.S. health-care system" campaign, the AMA wrote to member physicians: "We need your help to con-

tinue reaching millions of Americans. We must tell them the facts about the dangers in a Canadian-type health-care system—before it's too late. Help us continue publishing our messages in leading magazines and newspapers . . ." Enough doctors sent checks that the AMA was able to buy ads disparaging the Canadian system in major magazines. (For one example, see the illustration on page 610.)

The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some \$4.1-million on behalf of political candidates.

Insurance doubt

The insurance industry's stake in the battle is the \$175-billion it collects each year in health-insurance premiums. In a letter sent to member companies last summer, Carl Schramm, president of the Health Insurance Association of America (HIAA), warned that "a move in the United States to a Canadian approach to health-care financing is antithetical to our interests." Schramm subsequently told CU: "We'd be out of business. It's a life-and-death struggle."

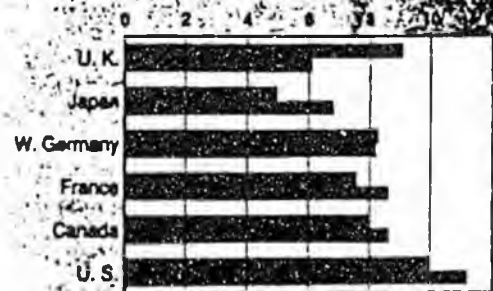
The insurance industry also shovels money at politicians. American Family Corp., the fifth-largest seller of health insurance, particularly dread-disease and cancer policies, ranks eighth on the election com-

Doctors on the picket line Just as organized medicine in the U.S. has opposed universal medical insurance, many Canadian physicians were none too fond of the notion. When Saskatchewan became the first province to adopt universal medical coverage, doctors there went on strike. When Quebec followed suit in 1970, its doctors also staged a short strike.

HIGH COSTS, POOR RESULTS

Though the U.S. spends a higher percentage of its Gross Domestic Product on health care than these five industrialized nations, its record on infant mortality is poorest of the group. (Gross Domestic Product is monetary value, at market prices, of all goods and services created in a country in a given year. Infant mortality is a commonly used measure of the overall health of a nation, reflecting how well medical services are delivered throughout its population.)

■ Health expenditures as a percentage of Gross Domestic Product
■ Infant mortality per thousand births



Sources: Health Care Financing Review, 1988; Annual Supplement UN Children's Fund, State of the World's Children, 1988; Organization for Economic Cooperation and Development, Health Data Bank.

mission's list of the top 50 corporate campaign contributors, ahead of such giant corporations as Boeing, Citicorp, and Ford Motor Co. It donated some \$250,000 from the beginning of 1989 through March of this year. Three other large sellers of health insurance—The Travelers, Metropolitan, and Prudential, all of which collect well over \$1-billion in health-insurance premiums each year—are also among the top 50 corporate contributors.

But the insurers don't limit themselves to campaign contributions. Their forte is "educational" lobbying. "We produce lots of research bulletins that are classy little numbers," HIAA president Schramm told CU. When the Pepper Commission issued its report last March, its recommendations for reforming sales practices in the small-employer market were strikingly similar to those of the HIAA. "The Pepper Commission basically ceded the small-group issues to us," Schramm says. "They [the commission's recommendations] are our proposals."

Changes in the wind

But public dissatisfaction with the current system has once again brought health insurance onto the

national agenda. Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 percent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals." This year, a Los Angeles Times poll asking a similar question found that 66 percent of Americans would prefer a health-insurance system similar to Canada's. "People are far ahead of the political leadership on this issue," says Susan Sherry, an official at Families USA, a senior citizens health-advocacy group.

The business community has also become vocal on the issue. Some corporate leaders are calling for changes that they would have considered unthinkable a few years ago. "We need fundamental reform. Whether we have the courage to move forward remains to be seen," says Walter Maher, a lobbyist for Chrysler Corp. Chrysler says that workers' health insurance adds \$700 to the cost of every car it builds in the U.S.—an amount that must come down if the company is to remain competitive.

Not all doctors side with the AMA. The 68,000-member American College of Physicians is calling for reforms that would guarantee all Americans access to medical services and reduce the waste and inefficiency in the present system. The 3000 members of Physicians for a National Health Program have a similar goal. (Those groups, however, don't back their programs with political contributions.)

Privately, even some insurance-industry executives recognize that universal health insurance is probably inevitable, and they have been preparing for their eventual role in it. "Some companies are saying, 'If we can survive until there's national health insurance, we have a shot at administering it,'" says an official at one Blue Cross and Blue Shield organization.

Solving the crisis

A number of remedies for the health-insurance crisis have been proposed by various interest

groups. Some are limited; others are more far-reaching. Some deal only with controlling costs of the health-care system. Others confront the more basic question of providing access to care for everyone. Among the proposals likely to be part of the public debate in the coming months are these:

1. Encourage people to use fewer medical services by writing higher deductibles into policies. The theory behind this proposal is that when people pay a greater share of their bills, they'll use health care more frugally. As a result, the argument goes, health-care costs will decrease, premiums will rise more slowly, and more people will be able to afford coverage.

Such a notion assumes that people prescribe their own medical care. Most of the time they don't; their doctors do.

Health-care providers also stimulate much of the demand for elective medical care. Hospitals now advertise in magazines, on television, and on billboards—drumming up business for their inpatient psychiatric services, for example, when such cases might be handled more appropriately on an outpatient basis. As part of its corporate-image promotion, General Electric advertises magnetic resonance imaging machines (MRIs) on television. "It doesn't hurt to have people aware of MRIs," says a GE spokesperson. If people ask for MRIs instead of ordinary X-rays, hospitals will have no choice but to shell out \$1.4-million to \$2-million for a machine.

Higher deductibles may indeed make some people think twice before seeking care in the first place. While discouraging unnecessary services is a reasonable goal, there's an obvious danger that people will postpone necessary treatment. Then more costly procedures may be necessary, or it may be too late.

There is even some doubt as to whether any savings would result from a switch to higher deductibles. "Our experience has shown that higher deductibles have not prevented our [claim] costs from going up," says Andy Perkins, a vice president at The Travelers.

2. Do away with state-mandated benefits. Each state requires that health-insurance policies sold there include certain coverages. These so-called state mandates vary among states, but many require insurers to cover newborn babies, adopted children, prenatal care, and

On the offensive To counteract positive media portrayals of universal health insurance programs in Canada and elsewhere, the American Medical Association launched a national advertising campaign in 1989. This ad ran in Newsweek.

CRISIS IN HEALTH INSURANCE

mammographic screening. They may also offer employees the option of continuing their coverage when they leave a job.

The insurance industry contends that some mandated benefits, such as coverage for visits to psychologists, podiatrists, chiropractors, and social workers, are of questionable value and unnecessarily raise the price of insurance. However, the industry has no estimate of the overall premium savings that would result.

In CU's view, repealing mandated coverage moves in the wrong direction—toward less access to care. To shave a few dollars off premiums, more women would lose their prenatal care, more newborns and children would go without preventive treatment, and more employees would have no coverage when they left their jobs.

3. Design stripped-down policies. Some insurance-company and Blue Cross and Blue Shield executives have suggested designing policies with limited benefits that they can sell for about half the price of more comprehensive coverage.

While such basic policies might improve the overall statistics on the uninsured, they, too, would result in less coverage for individuals. We reported on some of them last month. An "affordable" basic policy from Blue Cross and Blue Shield of Oklahoma, for instance, covers only 21 days of hospital care. That might be enough for most sicknesses, but a catastrophic illness or injury would leave a policyholder uninsured and possibly on the road to bankruptcy. A person whose serious heart attack cost almost \$50,000 would have been left \$10,000 in debt by an affordable hospital-surgical policy sold by Pyramid Life, the policy that ranked at the bottom of our Ratings last month.

4. Institute "managed care." Under the rubric of "managed care," insurance companies are belatedly paying attention to what their dollars are buying. Managed care includes formal programs for monitoring the quality of treatment and determining whether it's appropriate for the patient's condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals, and to obtain approval from insurance companies before starting a proposed course of treatment.

Managed care attempts to put controls on doctors—ironically some of the same controls doctors have feared from a national health-insurance program. In the process, it is creating a brand-new profession, health-care cost management, one of the fastest growing segments of the health-care industry. Health-care cost management firms are expected to generate some \$7-billion in revenue in the next few years—revenue that will, of course, come from insurance premiums.

Whether the savings in the cost of health care will be greater than the money spent to "manage" it remains to be seen. "None of this stuff has done anything to make the fundamental health-care system cost less and [be] more efficient," says Curt Fuhrmann, president of the individual health division of Washington National. And even if managed care eventually reduces the nation's health-care bill, it will do nothing to expand access to medical services for people who currently have no insurance coverage.

5. Establish risk pools. The insurance industry wants each state to set up a high-risk pool that would provide policies for people the companies don't want to insure. Such pools are yet another way for the industry to shed a group of policyholders who are not profitable. The HIAA further proposes that the states pick up the tab for pools' losses; that is, make up the difference between what the pools collect in premiums and what they pay out in claims.

Last spring, when we surveyed the risk pools that had been organized in 19 states, we found that they covered only about 55,500 people in total, and all the pools were operating at a loss. Pool administrators estimated that at least 413,000 people in those states needed pool coverage but couldn't obtain it. In Illinois, for example, the waiting list was so long that people have to wait at least a year for coverage.

6. Expand Medicaid coverage. When Medicaid was first established in the mid-1960s, it covered some 70 percent of those with incomes below the poverty line. Today Medicaid covers just 38 percent, because states and the Federal government have raised their eligibility standards.

The insurance industry and the American Medical Association want to reverse that trend by requiring Medicaid to cover anyone whose

income falls below the official poverty line, currently \$12,675 for a family of four, \$8075 for a couple; and \$6314 for a single person.

Under some proposals, people whose incomes are as high as twice the poverty level could "buy" Medicaid benefits. Under other proposals, these people would have to turn to the private market for their coverage. It's hard to see how any family whose income is around \$13,000—or even \$26,000—can afford some of the policies we rated last month. Premiums for families of four ranged from about \$2000 to more than \$6000 a year.

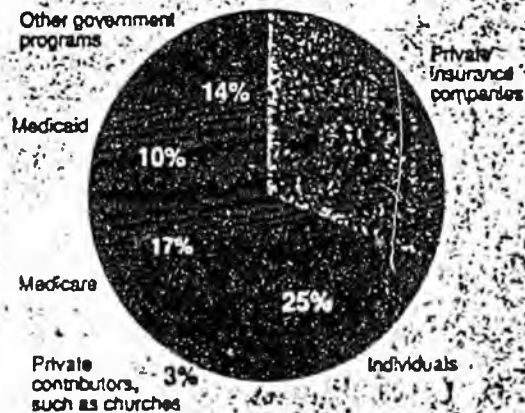
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

Putting Medicaid cards into the hands of more people wouldn't necessarily assure them access to health care. Many doctors refuse to treat Medicaid patients because reimbursement rates are low. Reforming Medicaid would expand coverage for some, but it would also increase the government bureaucracy needed to determine eligibility. It is at best a stopgap measure that will do little to curb waste in the health-care system.

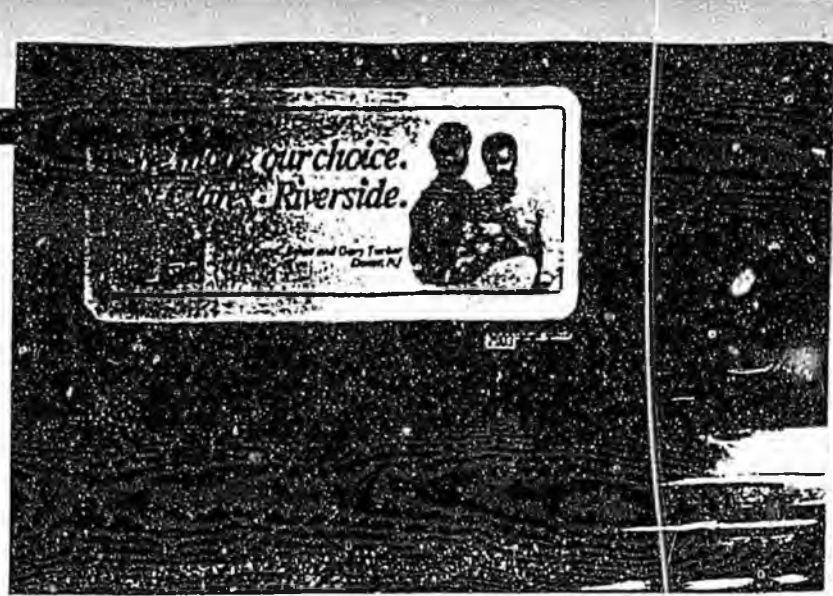
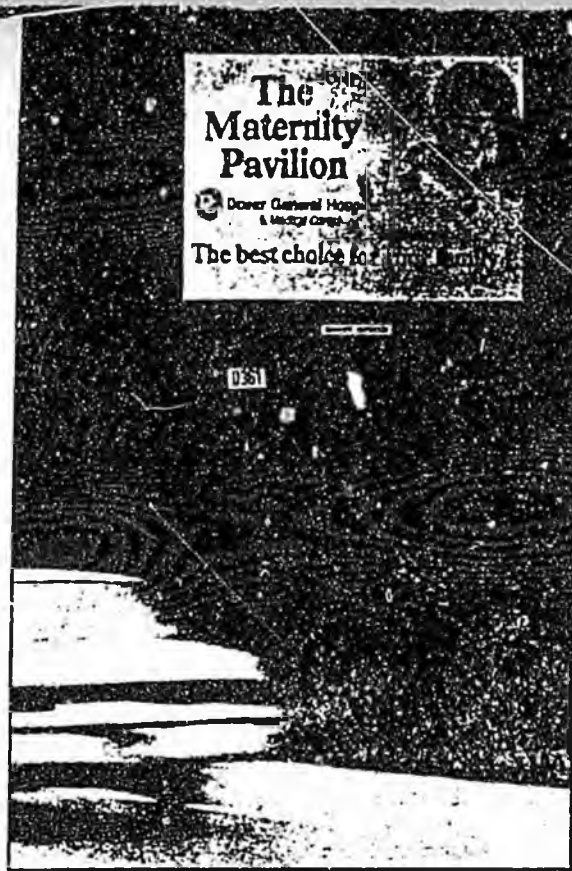
7. Reform insurance-company practices. One plan proposed by insurers themselves would excuse people who were once covered under a small employer's group policy from satisfying a new waiting period for pre-existing illnesses

WHO WRITES THE CHECKS?

As costly as the private-insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1990



Signs of the times Hospitals in some parts of the country now advertise to fill their beds, partly because of recent insurance-company rules requiring that more procedures be done on an outpatient basis. These two billboards beckon motorists along a New Jersey highway.

Paying for long-term care
The Pepper Commission has recommended a publicly funded program to pay for nursing-home expenses and for home care needed by people of all ages. That would eliminate the need for most nursing-home insurance. CU supports this approach.

when their employers change carriers or when they change jobs. In those cases, people with health problems would have immediate coverage. This proposal would also prohibit insurers from excluding coverage for certain health conditions or parts of the body by means of exclusion riders.

But insurers still don't want to take on any unnecessary risk. So their proposal also calls for the establishment of a reinsurance agency (essentially a company that insures insurance companies) to assume the risk of waiving pre-existing conditions clauses and eliminating exclusion riders. Insurers themselves would fund the reinsurance program through assessments, but if assessments proved to be inadequate, the government could be called on to make up the difference.

Another industry-sponsored proposal would limit the sometimes huge annual increases experienced by employees who work for small firms—to no more than 15 percent above an insurance company's general yearly rate increase for all its policyholders.

Both of those proposals would help people already safely inside the insurance loop. But they won't help people with health problems who are outside the system or who must buy their own coverage.

8. Require all employers to offer coverage. The main proponent of this approach is Senator Edward Kennedy. He is sponsoring

a bill that would require all employers to offer insurance to employees who work at least 17½ hours a week. Under Kennedy's bill, employers would also have to pay 80 percent of the cost of a basic package of benefits for their full-time employees.

Others have proposed variations on Kennedy's plan. These so-called pay-or-play approaches to health-care coverage would require employers to offer insurance to their workers or pay into a special government-operated fund that would provide the coverage. In other words, employers would either "play" by providing coverage or "pay" into the special fund. The Pepper Commission recommended such a plan.

To win support of the AMA, Kennedy's bill does not address cost containment. More people would be covered, but most doctors and hospitals would still have a blank check. That omission, a serious one in CU's view, has also given employers and the insurance industry reason for opposing this approach.

Lobbyists for small business argue that the costs of providing coverage are too great for many marginal firms. Unless small businesses receive tax relief in exchange for providing coverage, this approach could give them a powerful incentive to hire employees to work fewer than 17½ hours a week. Seasonal and part-time workers could still be left without insurance.

Congress is likely to give pay-or-play proposals serious consideration in the next few years. At

best, these proposals can expand insurance coverage for some people. At worst, they fail to offer a way to curb health-care costs. They also perpetuate the current system of private insurance with all its administrative waste. In fact, they would add another layer of administrative bureaucracy in creating the special government fund for workers whose employers would still not provide coverage.

9. Introduce universal health insurance. This is the approach Canada has taken to fund medical care for its citizens. Under this system, everyone is entitled to health care, and the public pays the bills through tax dollars rather than through insurance premiums.

Providers of health care charge a fee for their services, just as in the U.S. But their fee schedules must be negotiated with the government, which has an incentive to control costs, since tax increases are as politically unpopular in Canada as in the U.S.

In CU's view, the first eight of these proposals fall short of the goal of affordable health care for all Americans. They would still limit employment options—forcing some people to stay on a job that may otherwise be unsatisfactory simply to keep their health insurance. They could still force a person to spend as much as \$12,000 a year to cover a family under a conversion policy. Some sick people would still have to settle for an inferior hospital-indemnity policy just because it is better than nothing. Worst of all, many Americans would still be denied proper health

care simply because they couldn't afford to buy insurance.

Recommendations

The few reforms that were won in the past were simply bargains struck with doctors and insurance companies. People who could least afford the cost of medical care or insurance were sloughed off onto

public programs. The public assumed the cost of health care for those patients through Medicare and Medicaid while health-care providers and insurance companies kept control of the system and retained for themselves the ability to profit from those who could pay.

Meaningful reform must provide for universal access to health care;

cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

The only model for reform that attempts to meet those criteria is the Canadian system. It is not a system

DOCTORS VS. INSURERS

THE BATTLE OVER FEES

Insurance companies and the Federal government say they're trying to control health-care costs. And in the process, they're going head to head with the medical establishment.

Insurers are now requiring many policyholders to obtain approval before beginning a course of treatment. They require that policyholders have certain types of surgery done in hospital outpatient facilities and that they obtain second opinions before having any surgery performed. They are also establishing preferred-provider organizations, PPOs, in which doctors agree to reduce their fees to the insurer in exchange for more patients; the insurer lowers deductibles and coinsurance as an inducement for policyholders to use PPO doctors.

Since 1984, the Federal government has limited the fees it pays to doctors who treat Medicare patients. It will soon implement a new way of paying doctors based on the relative value of the various services they perform. This new system is aimed at reducing the fees of some highly compensated specialists, such as anesthesiologists and radiologists, and increasing the fees of others, such as family doctors. The system also includes limits on billing and on the number of services performed.

So far, all these efforts at taming health-care costs have been about as successful as trying to squeeze a balloon. When insurers or the Federal government clamp down on costs in one area, costs expand rapidly in another. "We pay less per claim, but we pay for more claims," says Carl Fuhrmann, president of the individual health division in Washington National, a seller of health insurance. "A lot of this stuff works initially, but after a while the system adapts and finds a way around it." Nowhere is that more evident than in the war over bills that has erupted between doctors and insurance companies.

The fine art of bill coding

Pressure from insurance carriers to limit physician payments, as Medicare does, has spawned a new industry devoted to teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system.

"Reimbursement guaranteed. You'll improve your reimbursement, or you'll get your money back," reads an advertisement for one such company, Medbooks. "Start now to bill for all of the services you provide—and receive all of the payments you're entitled to!" reads a flyer for St. Anthony Publishing Inc., a company that proclaims it has grown into an industry leader in "five short years."

The primers sold by these new firms tell physicians how to choose certain billing codes over others that would net them less income. There are some 7000 codes representing all the services physicians perform, and doctors customarily list the

codes on the bills they present to patients and their insurance companies.

For example, one newsletter reported that insurance companies are not paying if doctors use the code for "hospital discharge/day management" when they discharge hospital patients. It advised doctors to use either the code for "medical conference by physician regarding medical management with patient, and/or relative, guardian, or other, approximately 25 minutes" or a code for a higher level of daily hospital visit. The newsletter recommended that doctors use both codes for a while and see which one insurance companies will go for.

A physicians' newsletter from St. Anthony Publishing carried this headline: "Updating superbill brings financial rewards." Superbills are the detailed bills that patients receive for the procedures doctors perform. St. Anthony advised doctors in family practice that adding and billing separately for such services as minimal [office] visits, brief [office] visits, injections, such as tetanus and DPT, new patient office visits, supplies, and brief follow-up consultations could bring an increase in weekly revenue of \$845, or \$40,560 a year (based on 48 weeks).

The books and newsletters also offer guidance on "unbundling"—that is, charging separately for services that were once priced together or "bundled." Unbundling almost invariably means more income.

Another newsletter from St. Anthony Publishing described one medical office in which doctors were performing dilatation and curettage procedures 10 to 15 times a week. When the doctors were shown how to charge separately for dilatation and for curettage, and even for sterile surgical dressings, the average payment from insurance companies increased from \$300 to \$535, and the practice increased its revenue some 78 percent.

Insurers strike back

To combat these practices, insurance companies are now hiring firms to "rebundle" the bills that come into their claims departments. Indeed, a rival industry has sprung up to scrutinize bills for evidence of the billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers "medical claims editor" computer software that will rebundle a \$2500 bill for performing an appendectomy (\$1500) with a laparotomy (\$1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only \$1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on books, seminars, and software is doing little to improve the health of Americans.

of "socialized medicine," in which doctors and hospitals work for the government and patients are assigned to clinics. Canadians are free to pick their doctors and hospitals. The Canadian health-care system costs less than the U.S. system and delivers more, mostly because it spends less on administration and bureaucracy. Canada spends about 1 to 2½ percent of every health-care dollar on administering health claims, compared with 10 to 11 percent spent by private insurers in the U.S.

A move to a universal health-care system modeled on Canada's would save money in other ways. Because medical care would be available to everyone, there would be no need for medical-payments coverage under workers' compensation insurance or automobile-insurance policies, or for the liability portion of homeowners insurance that goes to cover injury claims.

As we explain in the report that begins below, Canada has by no means found the ideal system. It is

facing the same cost pressures on medical care as the U.S. and European countries, and, like those nations, it is examining ways to contain them. But public debate there has long since moved away from reforming insurance practices and toward targeting the country's resources to improve the health of its people.

The U.S. should take the best of the Canadian system and add to it the techniques that have shown the most promise for controlling health-care costs and curbing the overuse of health-care services that occurs in both countries. Those techniques include establishing "practice guidelines" for physicians (which define procedures that are effective under various circumstances) and assessing whether new technologies are effective in treating disease. Borrowing the best from Canada and adding effective cost containment would produce a uniquely American system that would serve all citizens.

It may be that the American

model will evolve first in one of the states. (The Canadian system was patterned after universal hospital coverage introduced in the province of Saskatchewan in the 1940s.)

Some states are already looking for ways to improve access to health care for their residents. In California, for instance, there is a serious proposal in the legislature for the state to pay for health care, including long-term care, for all Californians. In New York, the state legislature recently passed a state-subsidized insurance plan for young children of the working poor, a step some see as a move in the direction of universal health insurance.

"In the next decade, if you don't have a national health system, the insurance companies will continue to selectively deinsure. No matter how many premiums you've paid, you'll never know if you'll be next," says Dr. Jane Fulton, a professor of health policy at the University of Ottawa. "That risk should be intolerable to Americans."

A LOOK AT THE CANADIAN ALTERNATIVE

Near downtown Montreal, a pregnant woman arrives at a *centre local de services communautaires*. Here at the CLSC, as the center is called, she receives regular checkups and counseling on the right foods to eat during her pregnancy.

When it's time for her to deliver,

she will go to a local hospital. One of the two doctors who has been caring for her will deliver the baby. After the baby is born, she can bring it back to the CLSC for immunizations and follow-up care.

A social worker at the center will help her adjust to the demands of motherhood if she needs help, and a staff nurse will visit two weeks after the baby is born to give breastfeeding advice and answer other questions.

If the nurse finds that the mother lacks the skills to care for her baby, or detects more serious problems such as child abuse or neglect, more intensive counseling, either in the mother's home or at the CLSC, will be scheduled. When the mother needs a break, she can take the baby to the CLSC's day-care center, where women from the surrounding community drop off their children for a few hours each week.

The woman will pay nothing for these services. She simply presents her orange-and-yellow health card, issued by the government of Quebec. That card entitles her to free medical care at any of the 158 CLSCs in the province or from any

doctor or hospital she chooses.

The CLSCs in Quebec, as well as similar community health centers in other provinces, represent an attempt at integrating medical care and social services within the framework of Canada's universal health-care system.

CLSCs help community residents find housing or day care for elderly or sick parents. Some offer smoking-cessation clinics. At others, elderly residents from the surrounding community can come by for a hot lunch at noon or for flu shots. A few CLSCs function as mini-hospitals where patients are admitted and kept overnight for observation and treatment.

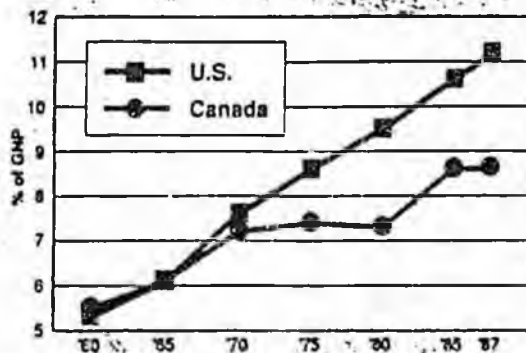
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

How the system evolved

Twenty-five years ago, just before Canada began phasing in universal insurance for medical services, the U.S. and Canadian health-care systems were on parallel tracks. Both

THE ROAD NOT TAKEN

Canada and the U.S. were spending about the same percentage of their Gross National Products on health care in 1965, just before Canada established its publicly funded insurance system for medical services. Since then, the U.S., which has retained private insurance, has spent a greater portion of GNP on health care.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988

countries were spending about 6 percent of Gross National Product on health care. By 1987, as health-care costs increased throughout the industrialized world, Canadians were spending 8.6 percent, while Americans were spending 11.2 percent.

But by then, the two countries were already on very different tracks. In 1966, Canada passed its Medical Care Act, entitling all residents to medical care funded through the tax system. (Free hospital care had been established in 1957.) About the same time in the U.S., the president of the American Medical Association declared that health care was a privilege, not a right—an issue still not fully resolved in the U.S. today.

No private insurance

Canada outlawed private insurance for any services covered by its universal programs. Insurance companies there can sell health policies only to pay for uncovered services, such as private rooms in hospitals, medical expenses incurred in foreign countries, and dental care. When Canadians go to a hospital or see a doctor, they simply show their medical card, issued by the provincial government. The doctor then bills the government and is reimbursed according to fee schedules negotiated earlier. (Hospitals receive an annual budget that covers virtually all patient costs. They are paid one-twelfth of their budget each month.)

Since the billing forms used by doctors are standardized and only the government pays the bills, processing costs are low and providers receive payment in about 30 days. Patients don't have to cope with the deductibles, coinsurance, coinsurance maximums, or out-of-pocket expenses that are part of virtually every American health-insurance policy. Nor do they have to fill out complicated forms. There are no user fees, and doctors cannot "balance bill"—that is, charge more than the negotiated fee. (In the U.S., doctors can bill patients for more than the insurance company's allowable charge.)

Canada's program covers most medical services. However, eyeglasses, prescription drugs for people under 65, out-of-hospital dental care for adults, and cosmetic surgery are usually not covered in most provinces. Some provincial governments also pay for a few



Prenatal care At a clinic near downtown Montreal, Dr. Stephen DiTommaso examines Sandra Gail Dagleish while her son Anfoibe watches. Pregnant women are closely monitored at Canadian clinics and offered services ranging from nutritional counseling to home visits after their babies are born.

Photo: CYNTHIA JOHNSON

nonphysician services, such as physiotherapy, podiatry, and chiropractic treatments.

Fee-for-service doctors

Although Canada replaced private insurance policies with a public-insurance system, it retained fee-for-service medicine; that is, most doctors receive fees for the services they perform, rather than a salary. Today physicians' incomes are among the highest in Canada—four to five times higher than the average industrial wage. (In the U.S., the average physician in private practice earns five to six times the average industrial wage.)

Each year, medical associations and the provincial governments negotiate an overall increase in the fee schedule. The associations then allocate the increases among various specialties and services.

The negotiated fees, however, tend to be lower than in the U.S. (where doctors also care for patients who can't pay). In Quebec, for instance, medical groups have negotiated a fee of \$217 for doctors who perform cesarean sections (they receive \$87 more if there are complications and \$109 more if the delivery is at night or on the weekend). They receive a fee of \$174 for performing an appendectomy. (Here and elsewhere in this report, all Canadian figures are given in U.S. dollars.) In the U.S., the average physician fee for delivering a baby by cesarean is \$1222, and the

surgeon's fee for performing an appendectomy averages \$846.

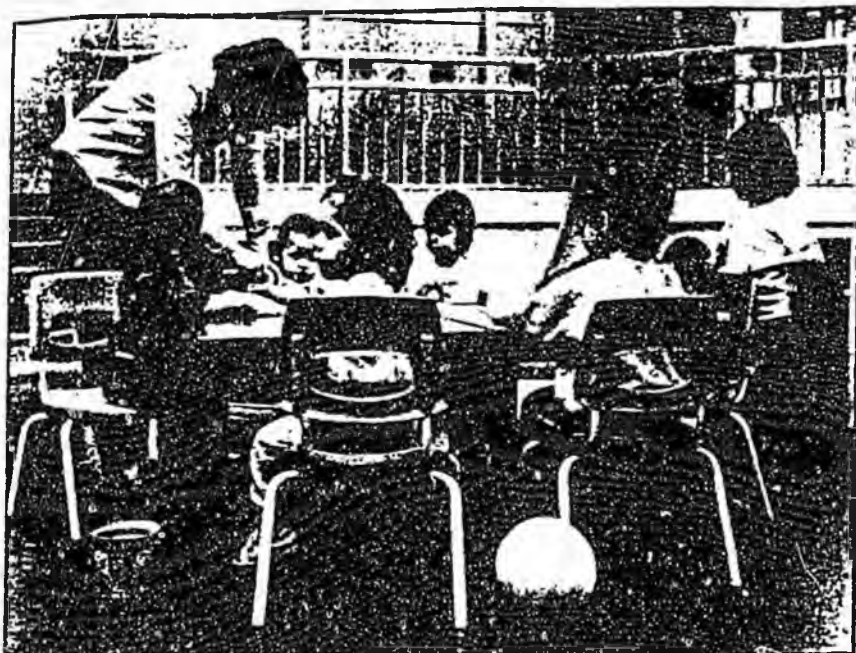
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two health-care systems, according to Dr. David Himmelstein of Physicians for a National Health Program.

Compared with the U.S., Canada spends much less on health care, but its system is still the second most expensive in the world, a statistic some trace to an oversupply of doctors who bill for too many services and to overutilization of medical services by patients. The government gives Canadian doctors considerable autonomy in their practice of medicine. And they have no insurance companies looking over their shoulders as do doctors in the U.S.

Hospital budgets

Hospitals also negotiate their budgets with the provincial ministries of health. Budgets are based on a baseline amount that the hospital spent in 1969. Each year, the ministries grant increases for inflation, for new programs, and for increased activity in the hospital's services.

Because the ministries have tended to hold increases to less than the actual rate of inflation, hospitals



Child's play Pierrette Croteau, a child-care worker at the Montreal clinic, helps toddlers and preschoolers at the facility's day-care center. Each day the center looks after 10 to 20 neighborhood children whose parents drop them off either for half-day or full-day care.

have had to redistribute their funds internally to live within their budgets. Ottawa Civic Hospital, for instance, closed 82 beds in 1989 but was able to serve more people than the previous year by shifting patients to outpatient care and surgical day-care centers, eliminating overnight stays for preadmission testing, and shortening the length of stays. Canadian health-policy planners say that reducing the number of days patients spend in hospitals is vital if the system is to get its costs under control.

In the U.S., hospitals in states without limits on hospital rates can simply raise their daily charges and pass them along to insurance companies that pay the bills for patients who are not on Medicare. Insurers then pass them along to policyholders. (For Medicare patients, the Government pays a fixed amount based on the diagnosis.)

New technology

Provincial governments also control the introduction of expensive new technology like magnetic resonance imaging machines, which take sharp pictures of internal organs, and lithotripters, which crush kidney stones and gallstones with sound waves. A hospital can raise private funds to buy an MRI, but since the money to operate it comes from the government, hospitals generally don't do that. Further-

more, doctors can't bill the government for use of the equipment unless it is authorized.

The introduction of new technology has, therefore, gone more slowly than in the U.S. Critics of the system, mostly doctors and hospitals, contend that as a result, some people are being deprived of state-of-the-art treatment. But other Canadians, including health-policy planners and government officials, say there is a benefit in introducing new technology more slowly. They argue that by waiting for reasonable evidence that new technology really works they can make a more informed decision about whether to commit scarce resources to it.

In the U.S., when a new machine comes on the market, its use tends to spread rapidly throughout the medical community—often before there has been time to assess the technology's effectiveness. Once a hospital or a group of doctors buys a new machine, the incentive to use it to recoup the investment exists side by side with the need to use it to improve medical care. That inevitably drives up health-care costs.

No Canadian who is acutely ill is denied prompt medical care. If patients need emergency care and the local hospital has no facilities or equipment to provide it, they are transported to the nearest hospital that does. If necessary services are available only in another province,

or in the U.S., the patient goes there, and his or her provincial government pays the entire bill.

The slower implementation of technology sometimes means waiting lists for some procedures, however. A person complaining of headaches doesn't immediately receive a CAT scan and may have to wait several weeks for one. But if doctors suspect the person has a life-threatening ailment such as a brain tumor, a CAT scan will be done right away. The same is true of such costly procedures as coronary-artery bypass surgery.

"None of my patients has ever suffered or been deprived of medical care because of this system," says Dr. Philip Berger, a physician who treats AIDS patients in downtown Toronto. "I treat the poorest and the sickest, and they get everything they need." Even the costly drug AZT is supplied free to AIDS patients by the Ontario government.

Who pays the bill?

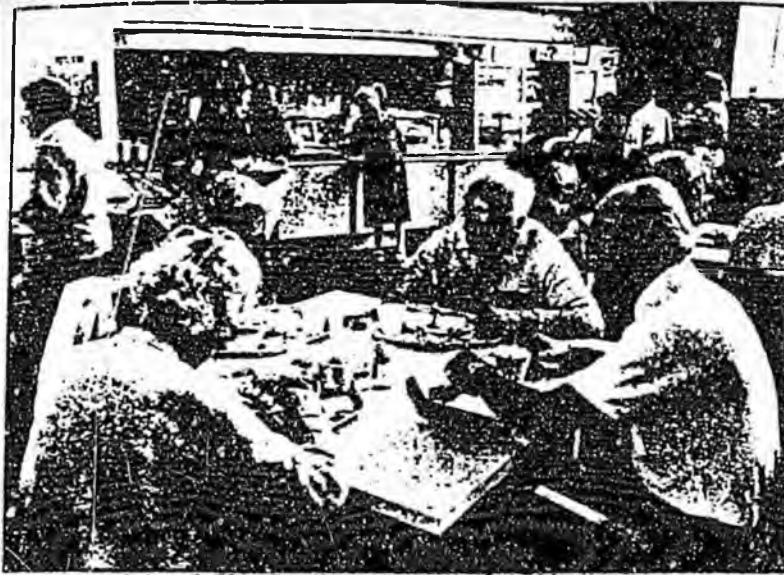
The Canadian federal government pays part of the health bill for each province. It pays more of the cost for poorer provinces and less for wealthier ones. The provinces themselves fund the rest of their health-care budgets, which usually account for about one-third of their total annual spending.

At both the federal and provincial level, the money to pay for health care is raised through a combination of personal income taxes; corporate taxes; excise taxes on gasoline, tobacco, and alcohol; and lottery profits.

In Alberta and British Columbia, residents also pay a special insurance premium earmarked for health care. In Alberta, a family of any size pays \$552 a year; a single person pays \$276. Ontario did away with insurance premiums earlier this year and replaced them with an employer health tax. In Ontario, employers with a payroll greater than \$347,826 (U.S.) would pay a rate of 1.95 percent. Employers with smaller payrolls pay less. (Quebec and Manitoba levy a similar tax.) Unlike U.S. payroll taxes, the employee does not pay a matching amount.

A Canadian with a taxable income of \$26,086 (U.S.) living in Ontario would pay about \$7184 a year in Federal and provincial taxes. Of that, roughly \$1340, or about 19 percent, goes to fund health care.

In the U.S., a person with \$26,086



A place for the elderly The Montreal Center feeds about 100 elderly men and women from the surrounding community each noon. The cost of lunch is nominal—the U.S. equivalent of \$2.99. The 158 clinics across the province of Quebec tailor their programs to the needs of the communities they serve.

in taxable income would pay \$4776 in Federal income taxes and perhaps another \$1304 in state taxes, bringing his or her total income tax to about \$6080. None of that money would pay for his or her health care. The person would also pay Social Security taxes, of which about \$378 would go to fund Medicare.

The American (or his or her employer) would pay for his or her medical care through private insurance; that typically costs \$1500 to \$2000 a year. In addition, he or she would have to pay out of pocket the deductibles, coinsurance, and other expenses not covered by the insurance policy. Together, those out-of-pocket costs can easily run between \$500 and \$1000 per year.

Looking ahead

There's virtually no debate in Canada about whether there should be a publicly funded insurance system or whether all people should have access to health care. There is plenty of debate, however, about whether the dollars the country spends on health care are spent in the right place.

Like other industrialized countries, Canada is also experimenting with ways to control costs. In Quebec, for example, there are caps on doctors' incomes. When a general practitioner's gross quarterly income (before taxes and practice expenses) reaches the U.S. equivalent of \$37,102, the government will pay him or her only 25 percent of the usual fee for the rest of the quarter. In effect, then,

Quebec has put a damper on the ability of general practitioners to gross much more than \$148,000 a year. (In the U.S., the typical general practitioner earns about \$216,900 before taxes and practice expenses. But high practice expenses, including the cost of dealing with the fragmented private and public insurance systems and the cost of malpractice insurance, reduced that to a mean net income of about \$95,000 in 1988.)

In Canada, as elsewhere, doctors and the medical establishment have been vocal in demanding more resources. The community health centers are controversial, for example, because traditional medical practitioners see them as diverting health-care dollars from new equipment, more operating rooms, and larger fees.

Most Canadians like their health-care system, and would dispute the American Medical Association ad in U.S. magazines last year that characterized their system (without actually naming it) as "underfinanced, over-extended, and ill-equipped."

Dr. Eugene Vayda, a U.S. and Canadian citizen who is a professor of medicine at the University of Toronto, has practiced under both the Canadian and U.S. health-care systems. "It's a pleasure to practice in a system where everyone has the same buying power," he says. "It allows you to focus on the patients and their needs. The Canadian system is so much better than the U.S., you can't even speak of them in the same breath."

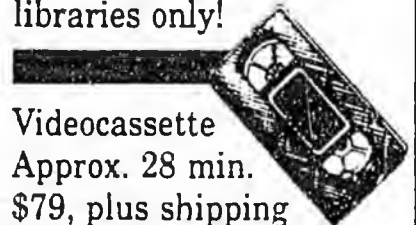
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Falling through the net

90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON

Daily News reporter

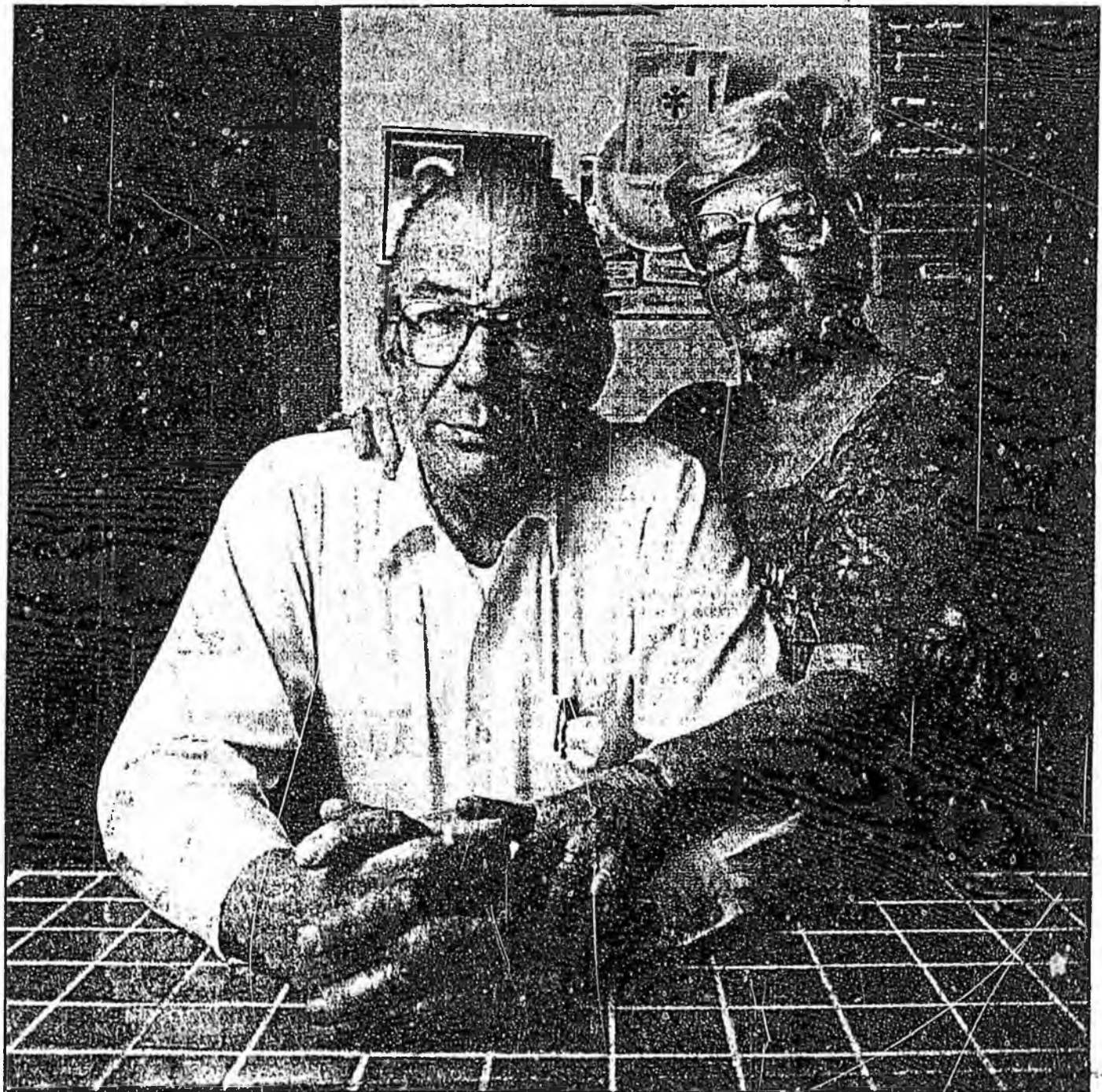
Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with fluid. The date was June 16, 1989, a day that for the Waltons marked a turning point in struggles against both a severe physical disability and a crippling financial burden.

Walton was rushed to Ketchikan Memorial, then Providence Hospital in Anchorage for a difficult recovery period in which he slipped in and out of consciousness. Walton, a career Army veteran, fell back on a military benefits program to pick up more than 70 percent of the medical bills from more than two dozen creditors.

But Walton didn't have any supplementary insurance. And his life savings of \$2,000 wasn't enough to pay his share of the bills and still keep current on an old batch of medical bills resulting from his wife's stay in a Las Vegas hospital.

At an age when many couples are busying planning their retirements, the Waltons sold their trailer, moved in with Margaret's mother in Mountain View and filed for protection from creditors. The bankruptcy petition filed earlier this year lists assets of \$3,639 and debts — almost all of them medical — of \$22,944.

"We get phone call after phone call from the hospitals," said Margaret Walton. "Naturally, they want their money. I can't blame them for that. But we just don't have



A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.

The Waltons are part of an increasing number of Alaskans who run the risk of financial ruin if they get seriously sick or injured. They are among the unfortunates in an Alaska health-care system that is out of control.

For more than a decade, the costs of state medical care have leaped ahead at rates frequently exceeding 20 percent a year. Today, Alaska health care carries an annual price tag of more than \$1.5 billion, according to one state study.

Insurers have been raising their rates to match the medical costs. That has made it harder and harder for employers to offer — or self-employed people to purchase — good medical coverage. Today, an estimated 90,000 Alaskans — nearly double the number of a decade ago — lack adequate medical insurance or don't have any insurance at all, according to a state legislative task force study.

"There's a huge gaping hole" in the medical safety net, said Heidi Thomas, a counselor for homeless women at the Clare House in Anchorage. For the women who seek refuge at the Clare House, just getting in the front door of a doctor's office can be a challenge. "The homeless have medical needs but often no insurance to cover them," Thomas said.

Doctors and hospital officials say they try not to turn away those who can't pay. As proof, they point to bad debt that continues to mount even as the economy improves.

Providence Hospital, for example, recorded \$4 million in bad debt in 1987, near the height of a severe recession. In 1990, a red-hot year for the state economy, bad debt increased to \$9.1 million.

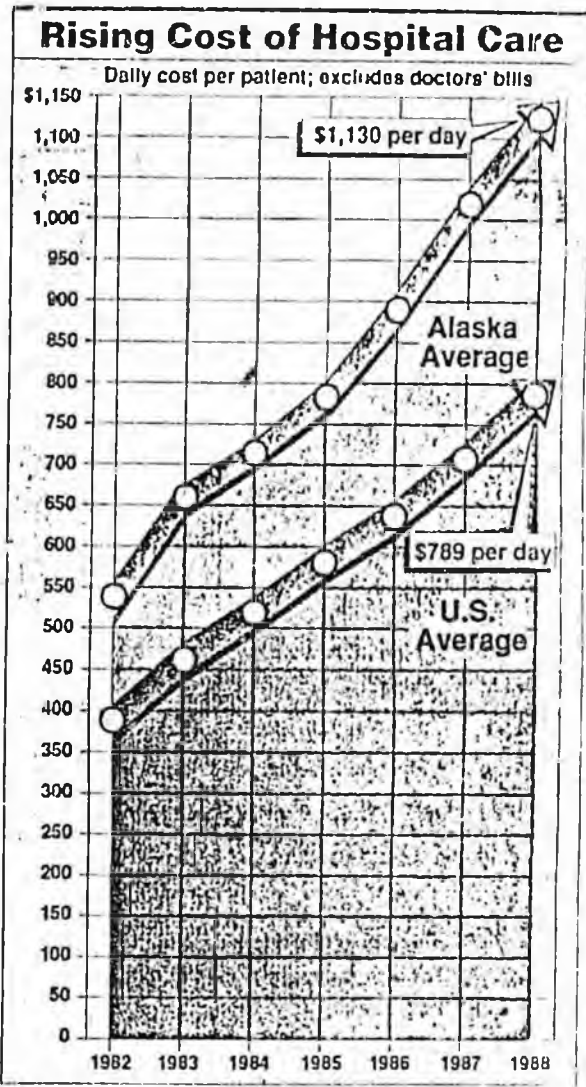
The more bad debt increases, the more the hospital raises prices to help compensate for the costs of the unpaid care, said Dave Hennigan, a Providence Hospital financial officer.

Doctors often do the same, and many have been able to keep earning more money each year.

Anchorage doctors' incomes have risen at roughly the same 6 percent annual rate noted in a national survey by the American Medical Association, according to Ray Schalow, executive director of the Alaska State Medical Association.



FRAN DURNER / Anchorage Daily News



Sonja Javier, who had no insurance from her seasonal job, sought and eventually found help to fix a painful infection of her teeth. "I can't believe I live in a state that has so much money it pays you to live here but none for my teeth," said Javier. Others without insurance depend on a patchwork of state aid and charity.

The national survey reported that the average U.S. physician's net income before taxes rose from \$104,100 in 1983 to \$144,700 in 1988, the last year in which statistics were available.

Schalow said Anchorage doctors are willing to tighten their belts to help keep costs under control.

"I can tell you we are willing to come to the table and take our hits like anybody else," said Schalow.

But there is no consensus about how to address the twin problems of rising numbers of uninsured patients and skyrocketing costs.

Doctors and hospitals want to attack the mounting bad debt by creating some sort of universal health insurance — possibly through a state-subsidized insurance pool — that would be available to all Alaskans. They are forming a private task force to develop draft legislation.

Meanwhile, insurer and employers

are pressing proposals to help limit costs. One bill introduced by Sen. Jim Duncan, D-Juneau, would attempt to clamp down on medical costs with a rate-setting board roughly akin to the public utilities commission.

That bill — in its present form — is certain to be fought by the health-care industry officials.

"It's fair to say they're not real pleased with this," Duncan said.

□

Alaska's health-care problems are part of a national crisis that has triggered a soul-searching debate — in Congress, the health-care industry and academia — about the costs of medicine and who should bear it.

In Alaska, those costs have soared higher and often faster than those of almost any other state.

Spend a day in an Anchorage private hospital, and your bill will average more than \$1,500, according to Medicaid statistics. That's more than double the daily cost of 1983.

That's also over 25 percent higher than the national average, according to American Hospital

Association statistics.

Visit an Anchorage doctor for a checkup, and you'll pay an average of \$46.17 compared to the national average of \$34.76, according to Runzheimer International, a Wisconsin-based consulting firm.

Drop by an Anchorage dentist for teeth cleaning and you'll pay an average of \$64.50, about 31 percent more than the national average, according to the Runzheimer survey.

Last year, more than \$340 million of the health-care spending came straight out of the state budget. That spending included \$263 million for Medicaid and other entitlement programs and \$78 million for child health, mental health and other services.

On a per capita basis, state health-care spending topped \$2,800 in 1990 and if left unchecked would exceed \$18,000 per capita by the year 2000, according to Jeff Malek, a San Francisco-based health consultant who has been studying Alaska health costs for a state task force.

Please see Page F-4, BILLS

BILLS: Insurers, doctors ha

Continued from Page F-1

□
What forces push up the cost of Alaska health care?
Hospitals and doctors point to the state's higher-than-average wage costs in an extremely labor-intensive health-care industry. Much of the labor is highly skilled and often in short supply.

"I could go down to Kentucky and get a dental assistant for \$5 an hour," said Ken Wynne, an Anchorage dentist. In Alaska, such help is hard to find and "makes anywhere from \$9 to \$15 an hour," Wynne said.

Doctors also cite malpractice insurance costs that for some specialties have more than tripled since 1986.

An Alaska obstetrician, for example, may pay \$70,000 for a year's malpractice insurance, nearly 90 percent higher than in California, according to Ron Neupauer, underwriting manager for the Medical Insurance Exchange of California, which writes policies in Alaska.

"It's not that there are so many claims in Alaska," Neupauer said. "But my goodness, when there is one it's in the multimillion-dollar range, and there's not that many obstetricians to spread the risk around," he said.

The state task force, in a draft report, cited other reasons for rising costs of Alaska health care.

Alaska doctors, for example, lack the competition from health maintenance organizations and other discount health-care systems common in the Lower 48. Such systems may offer a 25 percent savings from traditional fee-for-service care, according to a Rand Corp., study in Seattle.

The state task force also pointed to the overexpansion by hospitals in the 1980s. That has pushed up operating expenses and might force administrators to charge more for services, Malek said.

Humana Hospital-Alaska, for example, opened a \$23.5 million wing in 1986. The new tower increased Humana's capacity from 199 beds to 238, according to the American Hospital Association.

But Humana has had a hard time bringing in patients to help pay off the expansion. In 1989, the hospital association reported Humana had a 37 percent occupancy. That's substantially below the 70 percent national average.

Despite the low occupancy rate, Humana reported a 1989 profit of \$4.5 million on revenues of \$61 million.

Lyn Whitley, a Humana spokeswoman, said the expansion is a long-range project and the beds will be needed. In the meantime, the hospital has cut costs by staffing less than 160 of the hospital's beds.

The upward spiral of health care has left both insurers and employers scrambling to find ways to keep costs under control.

One major push has been aimed at people who are insured.

The state, for example, has offered one of

It's fair to say (health care officials) are not real pleased with this. ♪

— Sen. Jim Duncan
on his attempt to start a rate-setting board



Alaska's most comprehensive health-insurance packages. But the cost jumped from \$218 a month in 1984 to \$425 a month in fiscal year 1989.

Then, in May 1989, the state signed an agreement with the employees' union calling for precertification of surgery, auditing of medical bills, modest reductions in certain coverage limits and other cost-cutting steps. The new policy booklet developed from that agreement also advised — much to the dismay of Alaska hospital officials — for subscribers to shop around and check rates of Lower 48 hospitals.

Since the new plan went into effect, the cost of insuring state workers has declined to \$385 a month.

But policy restrictions aren't always painless to employees. Some businesses make their workers pay much larger shares of monthly premiums and much higher deductibles. And sometimes the policies don't cover the really big bills the employee desperately needs paid.

Rolando Standridge, for example, has a

Five different ideas on costs

Veterans Administration job that comes with a family health-insurance package that promises to pay 85 percent of all bills, once a deductible is met. But it won't cover pre-existing medical conditions. And that means the insurance won't pay a penny to help treat the heart ailment of Ron Standridge, her husband of one year.

Ron is a self-employed jeweler who hasn't been able to afford his own insurance. He has had several serious heart operations and may need more surgery.

But the couple can't pay off Ron's old medical bills, much less take on any new ones, according to Rolinda. Earlier this year, the couple filed for bankruptcy, listing debts to hospitals and doctors of more than \$20,000.

"I'm not sure what will happen," Rolinda said. "We'll be going to our first meeting of creditors soon."

Other workers, struggling to survive on part-time or seasonal employment, find they can't work enough hours to qualify for insurance benefits.

Sonja Javier is a 41-year-old Anchorage woman who has worked in the housekeeping division of the Anchorage Holiday Inn. She had steady hours during the summer tourist season but said she was asked to come into work only a few times in the lean fall and winter months.

Javier said she didn't have enough time on the job to qualify for health insurance offered through her local union.

She wanted that coverage to help finance treatment of rotting teeth that were infecting her body.

"The infection has really been spreading. At one point last June I had blue streaks traveling all the way up my neck," said Javier.

Javier has less than half of her original 32 teeth, and the survivors perch unsteadily on the soft flesh of the sickly gums.

"Right now, it embarrasses me to even to go out and look for another job. When I keep my mouth closed, I'm OK. But when I open my mouth, forget it. When I talk, I start foaming at the mouth."

The pain had been building for more than a year.

Javier first sought help from the Anchorage Neighborhood Health Center, the only center set up to aid low-income people. She said she couldn't secure an appointment from the dental clinic, which later shut down due lack of funds.

Then she sought help from several dentists but said she was refused treatment because she had no money to pay for the costly job of pulling her teeth, treating the gums and fitting dentures.

"I wasn't asking for something unreasonable. I said, 'Give me a payment plan.'" Javier said. "If that's crazy, I'm sorry. But I can't believe I live in a state that has so much money it pays you to live here but none for my teeth."

The infection kept getting worse, and Javier resorted to begging antibiotics from friends to help keep the pain at bay. Two weeks ago, after a trip to the Providence

Emergency Room and several telephone calls to the Southcentral Dental Society, Javier finally found Wynne, the Anchorage dentist.

"She had three badly abscessed teeth that were really terrible," Wynne said. "She was in real pain."

Wynne pulled the three infected teeth on Feb. 7 and has agreed to see Javier for follow-up treatment and worry about the billings later. He said most Anchorage dentists attempt to do at least some charity work, and many participate in a rotating weekly on-call roster. Those signed on to the roster agree to treat emergencies, no matter what the patient's ability to pay.

But for the first six months of this year, no dentists have signed up for the on-call roster. So Wynne found himself unexpectedly drafted to treat Javier. "It's a highly unusual situation. We'll have to do something about the roster at the next dental society meeting," Wynne said.

Employees aren't the only ones feeling the bite of cost-control efforts.

Insurers and others who pay medical bills also are targeting hospitals, doctors and others who provide medical services.

The strongest thrust so far has come from the federal government, which has developed programs to help finance the care of the elderly, disabled and poor. In recent years, the government, sometimes working with the state, has set tough new limits on reimbursements. Due largely to these restrictions, Providence Hospital has seen its unreimbursed costs for contract care skyrocket from \$8.1 million in 1987 to \$30 million in 1990.

Providence, in turn, increases its rates to help compensate for the loss of federal payments, Hennigan said.

Thus the hospital — despite the rising tide of bad debt and payment shortfalls — was able to earn a net income of \$8.2 million from revenues of \$119.3 million, according to a hospital financial statement.

But Alaska insurers don't want to get stuck with subsidizing the government care. They are attempting to curb their medical costs with contract agreements in which hospitals and doctors agree to limit fees to amounts approved by the companies.

The most aggressive, has been launched by Blue Cross of Washington and Alaska, which this month announced a new "participating provider" network of 94 state doctors.

The doctors won't charge more than what Blue Cross considers "customary and reasonable." The program is designed in part to eliminate any surprises subscribers get when their medical costs are higher than the norm.

Doctors have long fought such price-control efforts, and so far, only 22 percent of the state's eligible doctors have opted to join the new network. "Once they get a hold, they'll ratchet down, or try to freeze rates," said Doug G. Smith, an

BILLS: Insurers, doctors have different ideas on cutting costs

Continued from Page F-1

orthopedic surgeon who refused to join the network. "These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

Doctors, as well as hospitals, also are preparing to fight Duncan's bill to set up a much more wide-ranging price-control system.

Duncan's bill would establish a nine-member board composed of public, labor and private sector representatives including at least one person from the health-care industry. The board would set maximum rates that doctors, hospitals and pharmacists could charge for their services. Those charges would vary from region to region and could increase only when approved by the authority.

Doctors might not like those rates, but the proposed legislation would forbid them from trying to collect more money by billing subscribers for a balance due.

The rate schedule would initially cover the 135,000 Alaskans insured by state,

municipal and school district insurance plans. But Duncan hopes many state businesses would choose to join the program to help keep down employee health-insurance costs.

The legislation includes several other provisions, including one measure that would create insurance pools that small employers could join to try and get better rates.

"With this bill, Alaska would come out of the dark ages and to the forefront of national cost-control efforts," said Malek, the California consultant who helped draft the legislation.

But doctors and hospital officials think the legislation unfairly singles their operations out as the cause of the state's health-care crisis.

"We cannot support any legislation that has, as its primary method of health-care cost controls, regulating reimbursements to physicians and hospitals," said Harlan Knudson, executive director of the Alaska State Hospital & Nursing Home Association.

"It's crazy, unless we ad-

dress the whole damn (health care) problem," said Schalow, of the state medical association.

Health-care industry officials, in a recent policy paper, declare the need for a comprehensive state health plan. Some technologies, they say, may have to be rationed because there's just not enough money to pay for their routine use.

They also seek universal health insurance so more of their patients could pay for treatment.

Such a plan may be developed by a state health-care task force, then submitted to the legislature. But Schalow said the doctors don't have enough representation on the task force, and will develop their own plan.

Doctors and hospitals also are seeking further reform of state liability laws to help curb the cost of malpractice insurance.

"Liability insurance premiums for malpractice have reached levels that physicians can no longer afford nor can their patients afford through increased fees," the policy paper stated.

Duncan said he knows his legislation may face a tough fight from the health-care industry. But he hopes for allies among major state employers hurt by the rising cost of health-care insurance.

"Our goal is not to reduce the quality of health care, or put people out of business. We just want to make this whole system work," Duncan said.

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HEALTH CARE REFORM: Rx FOR A HEALTHY AMERICA

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

- Health care costs have risen so dramatically that states -- who finance health care for the needy, directly provide services through public health and other programs, and pay for health benefits as employers -- find it increasingly difficult to fund other critical state priorities.
- Despite the expenditure of ever-increasing amounts of money, access to health care services is limited and may become increasingly limited.
- The shifting of costs and responsibilities from one payor to another in the system is exacerbating the problems of both cost and access and is contributing to an inefficient system.
- The current health care system is not structured to encourage the delivery of preventive health care services, which Governors increasingly understand is critical to a healthy and productive citizenry.

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

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

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