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

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

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

Where Does Medicaid Fit?

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

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

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

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

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

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What Are the Governors Doing?

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

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

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

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

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

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

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

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

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

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

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

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

How Are the Governors Reaching Out?

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

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

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

What Happens Beyond the Task Force?

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

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

To The Rescue

Toward Solving America's Health Cost Crisis

A report by
Families USA Foundation

in cooperation with
Citizen Action

November 1990

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EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

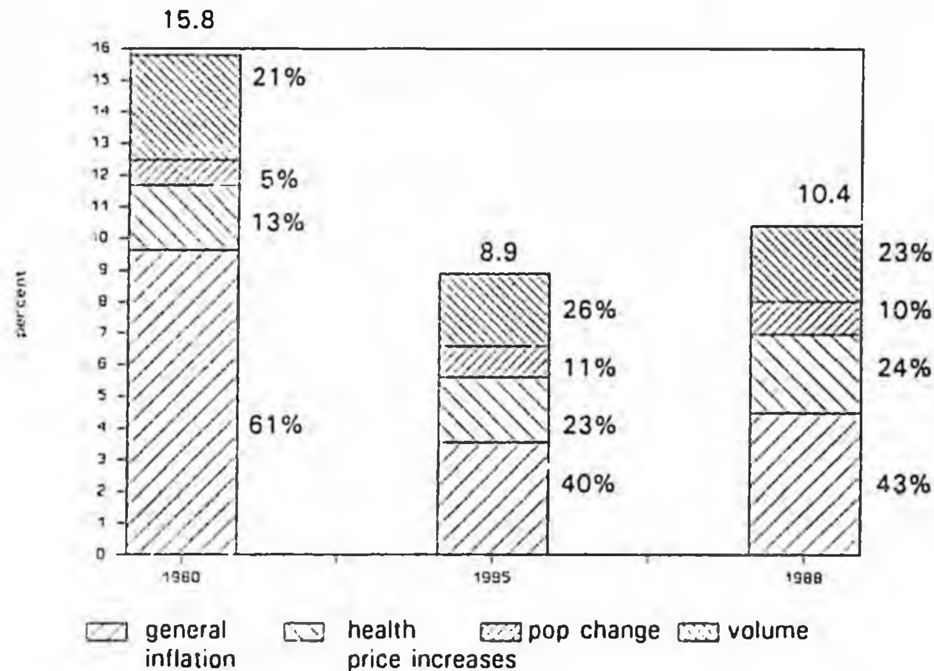
CAUSES OF EXCESSIVE HEALTH CARE INFLATION

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

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

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

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



Source: Health Care Financing Administration

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

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

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

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

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

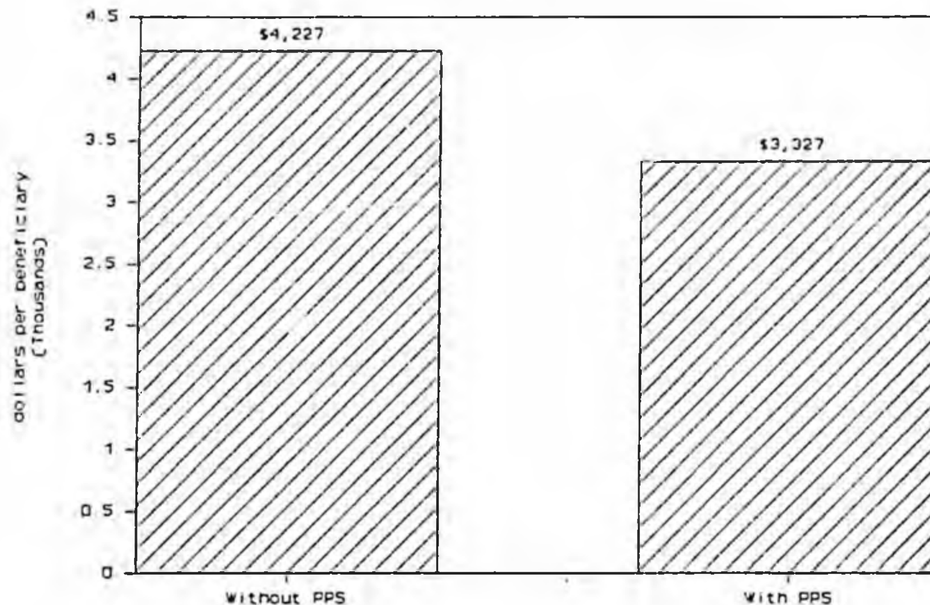
CONTROLLING HEALTH CARE EXPENDITURES

THE 2% SOLUTION -- MAKING A NATIONAL COMMITMENT

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

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

Prospective Payment System Savings
1991 costs per beneficiary



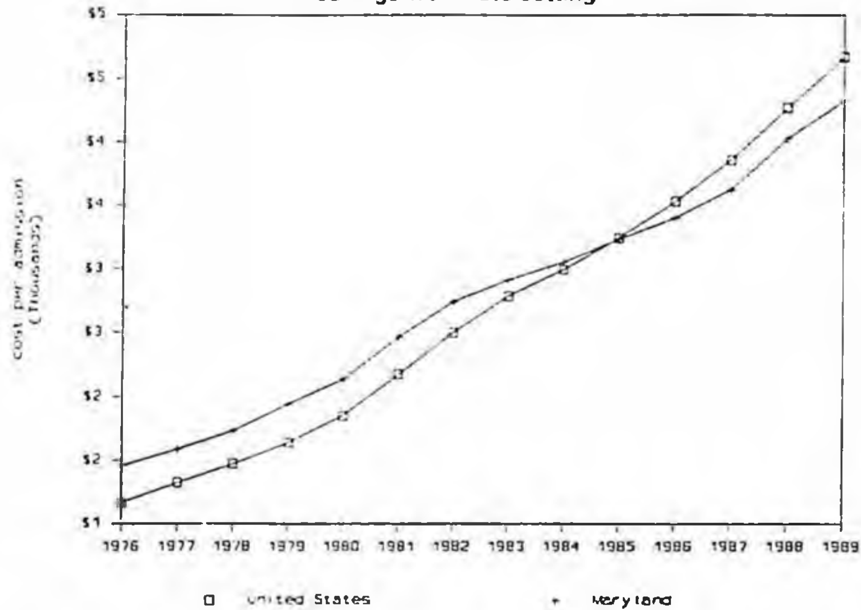
Source: Committee on Ways & Means, *1990 Green Book*, p. 238

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

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

Maryland vs. United States 1976-1988

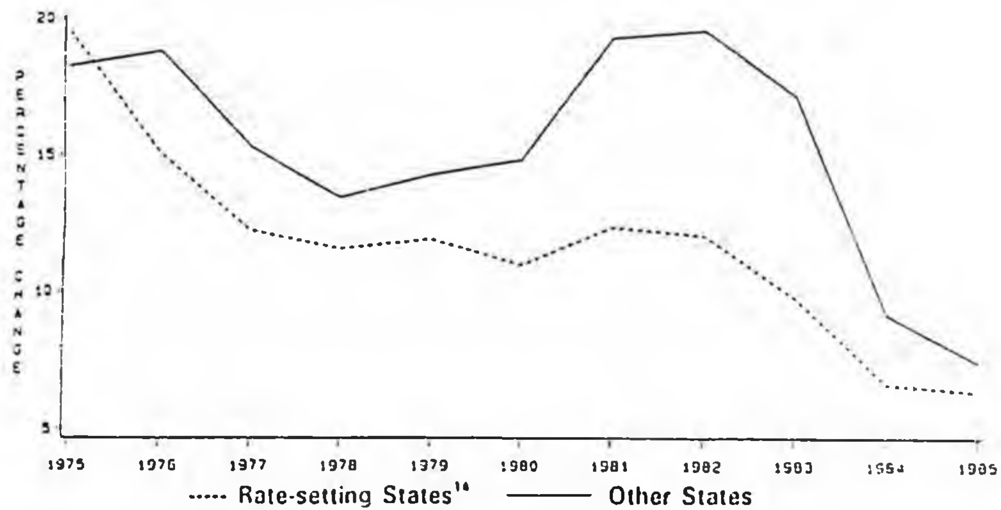
savings from rate-setting



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

Rate-Setting States vs. United States

Change in Gross Inpatient Revenue per Admission



Source: Johns Hopkins Center for Hospital Finance and Management

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

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

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

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

ACHIEVING THE SAVINGS

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

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

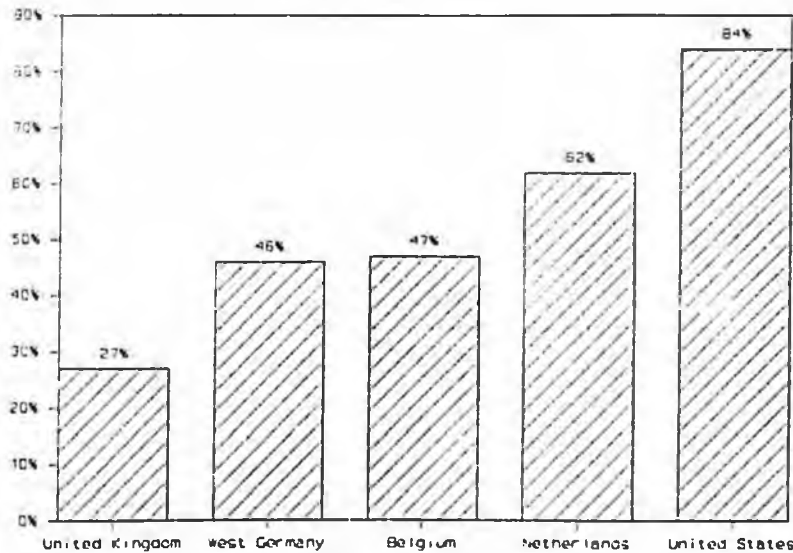
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes.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

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

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

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

Specialists by Country
percent of physicians, 1980



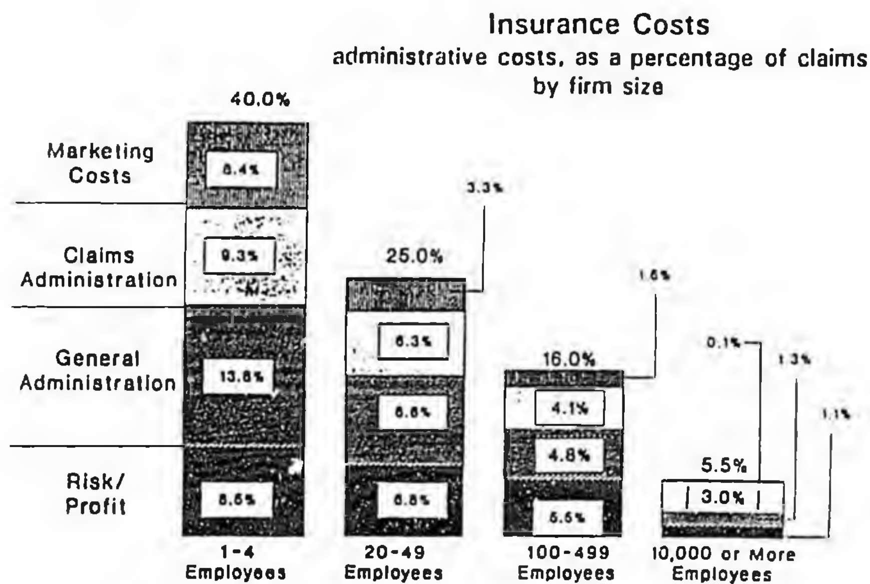
Source: *Journal of the American Medical Association*

INSURANCE ADMINISTRATIVE SAVINGS

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

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

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



Source: Hay/Huggins, Inc.

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

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

UNIVERSAL COVERAGE

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

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

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

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

CONCLUSION

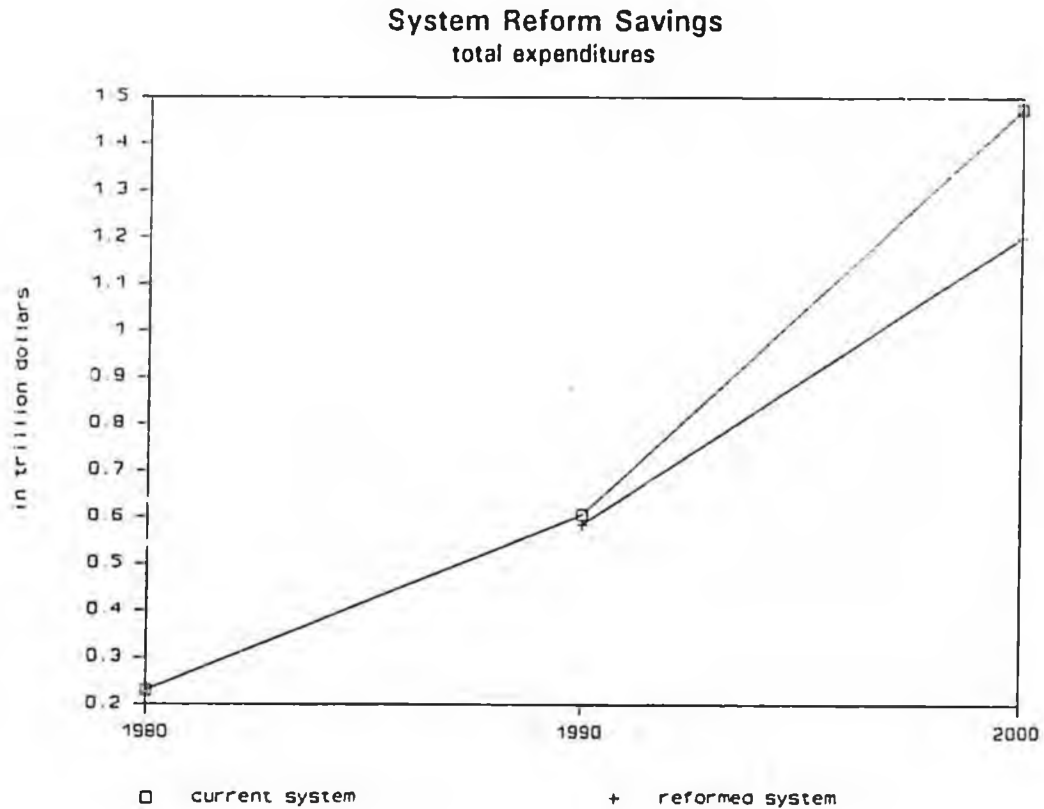
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

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

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

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

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



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

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	22,667,039	389,069	(3,805,249)	(629,995)	18,620,864	(4,046,175)
ALASKA	3,228,864	52,890	(534,023)	(124,503)	2,613,223	(515,640)
ARIZONA	23,306,882	313,035	(3,866,095)	(835,211)	18,918,612	(4,388,270)
ARKANSAS	11,097,073	193,713	(1,867,838)	(282,744)	9,140,204	(1,956,868)
CALIFORNIA	223,595,772	3,283,773	(37,113,065)	(8,154,865)	181,611,615	(41,984,157)
COLORADO	18,819,641	328,250	(3,119,607)	(762,585)	15,265,699	(3,553,942)
CONNECTICUT	20,996,403	354,133	(3,463,197)	(940,296)	16,947,048	(4,049,355)
DELAWARE	4,138,620	60,393	(691,154)	(125,720)	3,382,140	(756,480)
DISTRICT OF COLUMBIA	3,500,076	67,223	(593,286)	(70,790)	2,903,224	(596,852)
FLORIDA	90,060,126	1,210,959	(15,089,001)	(2,344,533)	73,837,551	(16,222,576)
GEORGIA	37,733,919	538,227	(6,309,527)	(1,087,148)	30,875,471	(6,858,448)
HAWAII	7,653,634	109,434	(1,262,304)	(323,721)	6,177,043	(1,476,590)
IDAHO	3,959,138	71,591	(659,214)	(145,671)	3,225,845	(733,294)
ILLINOIS	69,779,254	1,240,749	(11,547,728)	(2,963,833)	56,508,442	(13,270,812)
INDIANA	28,504,460	497,770	(4,717,173)	(1,201,718)	23,083,338	(5,421,122)
IOWA	13,620,316	271,924	(2,257,420)	(588,209)	11,046,611	(2,573,704)
KANSAS	14,677,643	257,370	(2,425,163)	(642,393)	11,867,457	(2,810,186)
KENTUCKY	15,737,895	291,848	(2,649,529)	(414,825)	12,965,388	(2,772,507)
LOUISIANA	20,590,574	410,813	(3,475,688)	(517,528)	17,008,171	(3,582,403)
MAINE	6,645,638	105,620	(1,099,393)	(272,017)	5,379,847	(1,265,790)
MARYLAND	31,074,629	458,792	(5,196,582)	(907,527)	25,429,311	(5,645,318)
MASSACHUSETTS	42,436,773	725,588	(7,030,106)	(1,730,655)	34,401,601	(8,035,173)
MICHIGAN	54,691,321	967,289	(9,055,599)	(2,289,721)	44,313,290	(10,378,031)
MINNESOTA	25,755,773	429,535	(4,239,365)	(1,200,744)	20,745,199	(5,010,574)
MISSISSIPPI	11,044,767	193,386	(1,860,928)	(270,833)	9,106,391	(1,938,375)
MISSOURI	31,946,064	536,740	(5,284,951)	(1,336,112)	25,861,740	(6,084,324)
MONTANA	3,486,657	69,350	(583,844)	(115,140)	2,857,023	(629,634)
NEBRASKA	8,580,707	159,869	(1,417,323)	(387,626)	6,935,627	(1,645,080)
NEVADA	8,837,119	112,469	(1,458,356)	(354,811)	7,136,421	(1,700,698)
NEW HAMPSHIRE	6,351,711	85,896	(1,045,852)	(273,909)	5,117,846	(1,233,865)
NEW JERSEY	42,383,428	701,136	(7,014,626)	(1,744,086)	34,325,852	(8,057,576)
NEW MEXICO	7,076,082	112,592	(1,179,766)	(235,763)	5,773,146	(1,302,936)
NEW YORK	115,121,894	2,064,813	(19,206,482)	(3,993,908)	93,986,317	(21,135,578)
NORTH CAROLINA	32,183,511	489,202	(5,377,481)	(980,695)	26,314,536	(5,868,975)
NORTH DAKOTA	3,606,280	73,636	(599,931)	(144,244)	2,935,741	(670,539)
OHIO	61,941,308	1,100,776	(10,267,317)	(2,531,973)	50,242,794	(11,698,514)
OKLAHOMA	14,232,334	293,934	(2,400,143)	(381,102)	11,745,023	(2,487,311)
OREGON	15,269,405	258,617	(2,537,250)	(574,818)	12,415,954	(2,853,451)
PENNSYLVANIA	69,555,852	1,237,755	(11,558,415)	(2,674,454)	56,560,738	(12,995,113)
RHODE ISLAND	6,448,659	109,254	(1,070,219)	(250,613)	5,237,081	(1,211,578)
SOUTH CAROLINA	15,222,478	239,954	(2,544,917)	(464,043)	12,453,472	(2,769,006)
SOUTH DAKOTA	3,773,731	67,320	(625,132)	(156,856)	3,059,063	(714,667)
TENNESSEE	27,908,735	456,767	(4,683,098)	(765,810)	22,916,594	(4,992,141)
TEXAS	88,910,873	1,544,835	(14,903,874)	(2,620,198)	72,931,636	(15,979,237)
UTAH	7,[illegible]93,526	123,948	(1,238,664)	(317,448)	6,061,362	(1,432,164)
VERMONT	2,753,403	43,861	(454,743)	(117,254)	2,225,268	(528,135)
VIRGINIA	34,364,026	507,109	(5,735,435)	(1,069,528)	28,066,172	(6,297,854)
WASHINGTON	27,295,859	429,823	(4,533,675)	(1,006,614)	22,185,394	(5,110,465)
WEST VIRGINIA	7,844,814	165,857	(1,325,762)	(197,336)	6,487,573	(1,357,240)
WISCONSIN	26,967,957	480,209	(4,460,714)	(1,159,098)	21,828,364	(5,139,603)
WYOMING	1,634,548	36,516	(272,443)	(65,427)	1,333,192	(301,354)
TOTAL	$1,476,507,197	$24,325,619	($245,708,644)	($52,756,656)	$1,202,367,516	(274,139,681)

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

COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES BY STATE UNDER ALTERNATIVE POLICIES IN 1990
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	9,522,402	194,638	(178,794)	(267,894)	9,270,352	(252,050)
ALASKA	1,242,929	26,459	(23,357)	(50,932)	1,195,100	(47,830)
ARIZONA	8,105,810	156,601	(152,028)	(291,921)	7,818,461	(287,348)
ARKANSAS	4,706,750	96,908	(88,387)	(121,620)	4,593,652	(113,099)
CALIFORNIA	84,754,469	1,642,760	(1,589,709)	(3,117,188)	81,690,332	(3,064,137)
COLORADO	8,045,268	164,212	(151,054)	(325,362)	7,733,064	(312,204)
CONNECTICUT	8,815,608	177,163	(165,471)	(405,325)	8,422,175	(393,633)
DELAWARE	1,547,100	30,213	(29,023)	(47,620)	1,500,670	(46,430)
DISTRICT OF COLUMBIA	1,559,131	33,630	(29,307)	(31,931)	1,531,523	(27,608)
FLORIDA	31,411,102	605,802	(589,111)	(840,263)	30,587,530	(823,572)
GEORGIA	13,669,245	269,257	(256,468)	(395,572)	13,286,461	(382,784)
HAWAII	2,797,343	54,746	(52,478)	(117,620)	2,681,991	(115,352)
IDAHO	1,748,435	35,815	(32,830)	(64,245)	1,687,175	(61,260)
ILLINOIS	30,597,883	620,704	(574,422)	(1,343,072)	29,301,094	(1,296,789)
INDIANA	12,362,662	249,017	(232,055)	(532,810)	11,846,815	(515,847)
IOWA	6,615,476	136,034	(124,228)	(294,600)	6,332,683	(282,794)
KANSAS	6,426,779	128,754	(120,622)	(289,497)	6,145,414	(281,365)
KENTUCKY	7,021,825	146,002	(131,888)	(186,001)	6,849,938	(171,888)
LOUISIANA	9,545,115	205,516	(179,412)	(240,437)	9,330,783	(214,332)
MAINE	2,687,926	52,838	(50,430)	(112,449)	2,577,885	(110,041)
MARYLAND	11,627,792	229,518	(218,175)	(342,905)	11,296,230	(331,562)
MASSACHUSETTS	17,947,477	362,987	(336,913)	(753,437)	17,220,115	(727,362)
MICHIGAN	23,874,781	483,902	(448,200)	(1,031,175)	22,879,307	(995,473)
MINNESOTA	10,857,061	214,882	(203,724)	(514,127)	10,354,092	(502,969)
MISSISSIPPI	4,638,528	96,744	(87,129)	(114,055)	4,534,088	(104,439)
MISSOURI	13,373,361	268,513	(251,010)	(578,860)	12,812,003	(561,358)
MONTANA	1,641,223	34,694	(30,837)	(53,992)	1,591,087	(50,136)
NEBRASKA	3,933,640	79,977	(73,851)	(181,791)	3,757,975	(175,664)
NEVADA	3,115,213	56,264	(58,355)	(125,858)	2,987,264	(127,949)
NEW HAMPSHIRE	2,258,658	42,971	(42,350)	(99,597)	2,159,682	(98,976)
NEW JERSEY	17,368,763	350,755	(326,039)	(735,990)	16,657,489	(711,274)
NEW MEXICO	2,757,688	56,326	(51,778)	(91,096)	2,671,140	(86,547)
NEW YORK	50,354,750	1,032,956	(945,534)	(1,792,954)	48,649,219	(1,705,532)
NORTH CAROLINA	12,259,381	244,731	(230,076)	(376,230)	11,897,807	(361,574)
NORTH DAKOTA	1,751,185	36,838	(32,900)	(71,797)	1,683,326	(67,859)
OHIO	27,193,403	550,681	(510,491)	(1,146,344)	26,087,249	(1,106,154)
OKLAHOMA	6,824,669	147,045	(128,280)	(184,441)	6,658,993	(165,676)
OREGON	6,523,595	129,377	(122,415)	(246,256)	6,284,301	(239,294)
PENNSYLVANIA	30,541,650	619,207	(573,360)	(1,221,936)	29,365,561	(1,176,089)
RHODE ISLAND	2,701,187	54,656	(50,708)	(107,859)	2,597,276	(103,911)
SOUTH CAROLINA	6,011,186	120,041	(112,815)	(183,631)	5,834,781	(176,405)
SOUTH DAKOTA	1,662,251	33,678	(31,205)	(70,916)	1,593,808	(68,443)
TENNESSEE	11,328,956	228,505	(212,657)	(314,445)	11,030,359	(298,597)
TEXAS	37,380,724	772,828	(702,025)	(1,111,317)	36,340,210	(1,040,514)
UTAH	3,085,385	62,007	(57,912)	(129,926)	2,959,554	(125,831)
VERMONT	1,117,014	21,942	(20,957)	(48,544)	1,069,456	(47,558)
VIRGINIA	12,931,845	253,690	(242,614)	(404,510)	12,538,410	(393,434)
WASHINGTON	11,084,596	215,026	(207,913)	(408,369)	10,683,339	(401,257)
WEST VIRGINIA	3,846,712	82,973	(72,306)	(97,342)	3,760,037	(86,675)
WISCONSIN	11,980,357	240,232	(224,859)	(528,175)	11,467,555	(512,802)
WYOMING	821,858	18,268	(15,458)	(32,805)	791,862	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(22,177,039)	584,596,673	(21,381,674)

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

SOURCE: Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

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

A. HEALTH EXPENDITURES BY STATE

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

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

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

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

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

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

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

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

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

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

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

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

Scenario #1

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

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

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

Scenario #2

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

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

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

Scenario #3

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

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

EMERGENCY!

Rising Health Costs in America
1980 - 1990 - 2000

A Families USA Foundation Report

in Cooperation with

Citizen Action

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

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

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

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

THE 1980s: RISING COSTS

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

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

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

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

- Spending for employer-based health insurance premiums increased 164% in the past decade, from $66 billion to $174 billion.

- An increasing portion of every family's budget is going to pay for health care as shown by the 157% rise in out-of-pocket spending from 1980 to 1990 (excluding the cost of employee premium contributions), from $63 billion to $162 billion.

- State government spending for Medicaid increased 156% between 1980 and 1990, from $10.7 billion to $27.4 billion.

- Massachusetts ($3,031), California ($2,894), New York ($2,818), Nevada ($2,757) and Rhode Island ($2,707) have the highest levels of per capita health spending in 1990. South Carolina ($1,689), Idaho ($1,726), Mississippi ($1,751), Wyoming ($1,756) and Utah ($1,784) have the lowest levels of per capita health spending in 1990.

- In Arizona (160.7%), Alaska (157.2%), Florida (152.3%), New Mexico (152.2%) and Maine (150%) per capita health expenditures increased at least 150% from 1980 to 1990.

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

THE 1980s: DECLINING ACCESS

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

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

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

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

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

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

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

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

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

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

One of the ways employers have responded to escalating premiums is by charging employees a greater share of the premiums. The percentage of employees paying $100 or more a month for family health insurance rose from 5 percent in 1986 to 16 percent in 1988. Average employee payments for individual coverage rose 32 percent between 1988 and 1989.[8] These increased cost demands on employees result in employees, especially low-wage employees, declining health insurance because it is unaffordable.

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

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

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

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

▾ By 2000, health care spending will rise to $5,515 per person, an increase of 443% from 1980.

▾ From 1980 to 2000, overall health care spending will be six and one-half times higher.

▾ Employers and employees will have to absorb a 529% increase from 1980 to 2000, from $66 billion to $412 billion for employer-based health coverage.

▾ Families will experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from $63 billion to $386 billion, not counting the employee share of health insurance premiums.

▾ By the year 2000, state governments can expect to see a 480% increase in Medicaid expenditures, from 1980 spending levels of $11 billion to $62 billion in 2000.

▾ In the 1980-2000 period, per capita spending will increase fastest in Arizona (493%), Alaska (485%), New Mexico (473.9%), Florida (473.7%), Maine (468.5%), North Dakota (467.6%) and Washington (466%).

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

ENDNOTES

1. Katherine R. Levit, Mark S. Freeland and Daniel Waldo, "Health spending and ability to pay: Business, individuals and government," **Health Care Financing Review**, Spring 1989, p. 9.

2. The estimates in this report are based on the most recent data from the Census Bureau. These estimates, 31.8 million persons nationally, are lower than previous estimates of approximately 37 million uninsured persons because the Census Bureau now asks if uninsured persons are covered by insurance form someone not living in the household, e.g. a noncustodial parent.

3. Unless otherwise noted, data are the results of analysis by Lewin/ICF, Inc.

4. See **A Call for Action**, The Pepper Commission, The U.S. Bipartisan Commission on Comprehensive Health Care, Final Report, September 1990, p. 23-6.

5. These practices are described in "The Crisis in Health Insurance," **Consumer Reports**, August 1990, p. 533-7.

6. Jack Needleman, Judith Arnold, John Sheils and Lawrence S. Lewin, "The Health Care Financing System and the Uninsured," submitted to the Office of Research, Health Care Financing Administration, Department of Health and Human Services, April 4, 1990. The Joint Economic Committee estimates the number of the underinsured at 70 million. See **Medical Alert**, a staff report of the Subcommittee on Education and Health of the Joint Economic Committee, October 1989.

7. Committee Analysis, Select Committee on Aging, U.S. House of Representatives, October 26, 1988.

8. United States Department of Labor, Bureau of Labor Statistics, **News**, (Washington, D.C., USDL 90-160, March 30, 1990).

Table 1

PER CAPITA HEALTH SPENDING
1980 - 2000

STATE	1980	1990	% Change 1980-1990	% Change Rank	2000	% Change 1980-2000
ALABAMA	924	2,286	147.4%	13	5,201	462.8%
ALASKA	921	2,367	157.2%	2	5,390	485.5%
ARIZONA	848	2,211	160.7%	1	5,031	493.0%
ARKANSAS	844	1,944	130.4%	46	4,423	424.1%
CALIFORNIA	1,186	2,894	143.9%	17	6,584	454.9%
COLORADO	996	2,415	142.5%	20	5,496	451.8%
CONNECTICUT	1,148	2,699	135.2%	39	6,136	434.7%
DELAWARE	960	2,268	136.3%	36	5,160	437.6%
DISTRICT OF COLUMBIA	1,241	2,586	108.4%	51	5,882	374.1%
FLORIDA	962	2,427	152.3%	3	5,520	473.7%
GEORGIA	883	2,072	134.7%	40	4,714	434.0%
HAWAII	993	2,469	148.5%	9	5,619	465.6%
IDAHO	708	1,726	143.9%	18	3,928	455.0%
ILLINOIS	1,093	2,619	139.6%	29	5,953	444.6%
INDIANA	919	2,201	139.4%	30	5,004	444.3%
IOWA	993	2,351	136.6%	35	5,343	437.9%
KANSAS	1,057	2,548	141.1%	22	5,792	448.0%
KENTUCKY	806	1,875	132.5%	43	4,266	429.1%
LOUISIANA	940	2,185	132.4%	44	4,972	428.9%
MAINE	870	2,175	150.0%	5	4,945	468.5%
MARYLAND	1,041	2,436	134.1%	42	[illegible],541	432.5%
MASSACHUSETTS	1,284	3,031	136.0%	38	6,890	436.5%
MICHIGAN	1,097	2,569	134.3%	41	5,840	432.5%
MINNESOTA	1,110	2,480	123.4%	49	5,641	408.1%
MISSISSIPPI	759	1,751	130.6%	45	3,984	424.6%
MISSOURI	1,033	2,568	148.6%	8	5,837	465.1%
MONTANA	859	2,059	139.7%	27	4,686	445.6%
NEBRASKA	1,016	2,452	141.4%	21	5,576	448.8%
NEVADA	1,109	2,757	148.5%	10	6,272	465.3%
NEW HAMPSHIRE	813	1,981	143.6%	19	4,505	453.8%
NEW JERSEY	930	2,224	139.2%	32	5,056	443.8%
NEW MEXICO	711	1,792	152.2%	4	4,078	473.9%
NEW YORK	1,257	2,818	124.2%	48	6,408	409.8%
NORTH CAROLINA	773	1,833	137.1%	34	4,170	439.5%
N[illegible] DAKOTA	1,066	2,661	149.7%	6	6,051	467.6%
[illegible]	1,039	2,493	140.0%	26	5,667	445.6%
[illegible]HOMA	906	2,139	136.2%	37	4,867	437.3%
[illegible]EGON	940	2,312	146.0%	15	5,260	459.8%
PENNSYLVANIA	1,021	2,536	148.3%	11	5,763	464.2%
RHODE ISLAND	1,184	2,707	128.6%	47	6,153	419.7%
SOUTH CAROLINA	706	1,689	139.2%	31	3,842	444.4%
SOUTH DAKOTA	952	2,322	144.0%	16	5,278	454.7%
TENNESSEE	952	2,262	137.7%	33	5,145	440.8%
TEXAS	915	2,192	139.7%	28	4,987	445.3%
UTAH	741	1,784	140.8%	23	4,062	448.0%
VERMONT	815	1,956	140.1%	25	4,448	445.9%
VIRGINIA	863	2,076	140.5%	24	4,724	447.2%
WASHINGTON	929	2,311	148.7%	7	5,258	466.0%
WEST VIRGINIA	843	2,088	147.6%	12	4,752	463.4%
WISCONSIN	1,097	2,449	123.2%	50	5,5[illegible]7	407.3%
WYOMING	714	1,756	146.1%	14	3,998	460.0%
TOTAL	$1,016	$2,425	138.7%		$5,515	442.8%

SOURCE: Lewin/ICF estimates

Table 2

TOTAL HEALTH SPENDING
1980 - 2000
(in thousands of dollars)

STATE	1980	1990	% Change 1980-1990	Rank	2000	% Change 1980-2000
ALABAMA	3,598,838	9,522,402	164.6%	21	22,667,039	529.8%
ALASKA	370,082	1,242,929	235.9%	3	3,228,864	772.5%
ARIZONA	2,305,619	8,105,810	251.6%	1	23,306,832	910.9%
ARKANSAS	1,929,340	4,706,750	144.0%	37	11,097,073	475.2%
CALIFORNIA	28,080,581	84,754,469	201.8%	5	223,595,772	696.3%
COLORADO	2,878,913	8,045,268	179.5%	14	18,819,641	553.7%
CONNECTICUT	3,566,669	8,815,808	147.2%	32	20,996,403	488.7%
DELAWARE	570,197	1,547,100	171.3%	17	4,138,620	625.8%
DISTRICT OF COLUMBIA	791,551	1,559,131	97.0%	51	3,500,076	342.2%
FLORIDA	9,376,859	31,411,102	235.0%	4	90,060,126	860.5%
GEORGIA	4,822,254	13,669,245	183.5%	12	37,733,919	682.5%
HAWAII	958,674	2,797,343	191.8%	8	7,653,634	698.4%
IDAHO	668,050	1,748,435	161.7%	24	3,959,138	492.6%
ILLINOIS	12,489,958	30,597,883	145.0%	35	69,779,254	458.7%
INDIANA	5,047,369	12,362,662	144.9%	36	28,504,460	464.7%
IOWA	2,894,898	6,615,476	128.5%	49	13,620,316	370.5%
KANSAS	2,498,938	6,426,779	157.2%	26	14,677,643	487.4%
KENTUCKY	2,951,766	7,021,825	137.9%	45	15,737,895	433.2%
LOUISIANA	3,954,402	9,545,115	141.4%	42	20,590,574	420.7%
MAINE	978,536	2,687,926	174.7%	15	6,645,638	579.1%
MARYLAND	4,388,016	11,627,792	165.0%	20	31,074,629	608.2%
MASSACHUSETTS	7,367,870	17,947,477	143.6%	38	42,436,773	476.0%
MICHIGAN	10,158,071	23,874,781	135.0%	46	54,691,321	438.4%
MINNESOTA	4,525,259	10,857,061	139.9%	44	25,755,773	469.2%
MISSISSIPPI	1,914,580	4,638,528	142.3%	41	11,044,767	476.9%
MISSOURI	5,079,283	13,373,361	163.3%	23	31,946,064	528.9%
MONTANA	676,015	1,641,223	142.8%	39	3,486,657	415.8%
NEBRASKA	1,595,143	3,933,640	146.6%	33	8,580,707	437.9%
NEVADA	887,542	3,115,213	251.0%	2	8,837,119	895.7%
NEW HAMPSHIRE	749,188	2,258,658	201.5%	6	6,351,711	747.8%
NEW JERSEY	6,848,103	17,368,763	153.6%	27	42,383,428	518.9%
NEW MEXICO	925,932	2,757,688	197.8%	7	7,076,082	664.2%
NEW YORK	22,066,936	50,354,750	128.2%	50	115,121,894	421.7%
NORTH CAROLINA	4,546,873	12,259,381	169.6%	18	32,183,511	607.8%
NORTH DAKOTA	696,115	1,751,185	151.6%	30	3,606,280	418.1%
OHIO	11,215,407	27,193,403	142.5%	40	61,941,308	452.3%
OKLAHOMA	2,740,186	6,824,669	149.1%	31	14,232,334	419.4%
OREGON	2,474,037	6,523,595	163.7%	22	15,269,405	517.2%
PENNSYLVANIA	12,117,790	30,541,650	152.0%	29	69,555,852	474.0%
RHODE ISLAND	1,121,337	2,701,187	140.9%	43	6,448,659	475.1%
SOUTH CAROLINA	2,203,405	6,011,186	172.8%	16	15,222,478	590.9%
SOUTH DAKOTA	657,535	1,662,251	152.8%	28	3,773,731	473.9%
TENNESSEE	4,368,396	11,328,956	159.3%	25	27,908,735	538.9%
TEXAS	13,012,429	37,380,724	187.3%	10	88,910,873	583.3%
UTAH	1,082,735	3,085,385	185.0%	11	7,493,526	592.1%
VERMONT	416,395	1,117,014	168.3%	19	2,753,403	561.2%
VIRGINIA	4,615,580	12,931,845	180.2%	13	34,364,026	644.5%
WASHINGTON	3,836,548	11,084,596	188.8%	9	27,295,859	611.1%
WEST VIRGINIA	1,644,557	3,846,712	133.9%	47	7,844,814	377.0%
WISCONSIN	5,164,568	11,980,357	132.0%	48	26,967,967	422.2%
WYOMING	335,414	821,858	145.0%	34	1,634,546	387.3%
TOTAL	$230,166,741	$605,978,347	163.3%		$1,476,507,197	541.5%

SOURCE: Lewin/ICF estimates

Table 3a

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

STATE	OUT OF POCKET b/	EMPLOYER SPONSORED	NON GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	1,137,579	756,469	186,631	44,044	77,669	193,143	551,715	651,587	3,598,838	924
ALASKA	88,948	121,467	7,286	6,155	13,720	13,720	17,773	101,013	370,082	921
ARIZONA	582,995	698,587	72,743	36,635	NA	NA	328,804	585,855	2,305,919	849
ARKANSAS	582,892	369,379	86,883	23,012	65,441	175,772	300,778	325,184	1,929,340	844
CALIFORNIA	6,111,415	7,281,598	710,178	370,271	1,401,953	1,401,953	4,164,002	6,639,211	28,080,581	1,186
COLORADO	695,272	933,532	74,885	43,390	87,470	99,272	302,454	642,638	2,878,913	996
CONNECTICUT	1,026,949	1,228,813	238,910	43,829	179,702	179,702	611,034	57,729	3,566,669	1,148
DELAWARE	160,160	136,750	28,466	5,787	23,279	23,279	87,529	98,949	570,197	959
DISTRICT OF COLUMBIA	168,707	123,705	28,275	6,661	86,588	86,588	148,616	142,410	791,551	1,241
FLORIDA	2,814,989	1,778,637	478,882	96,866	165,422	237,456	2,153,010	1,651,597	9,376,859	962
GEORGIA	1,499,191	1,132,191	233,268	54,378	157,967	317,264	614,894	813,100	4,822,254	883
HAWAII	217,889	277,774	24,639	12,659	49,435	49,435	92,413	234,429	958,674	993
IDAHO	157,700	192,682	18,680	9,178	18,331	35,112	83,928	172,443	666,050	709
ILLINOIS	3,400,615	4,201,372	906,180	222,739	612,487	612,487	2,339,686	194,392	12,489,958	1,093
INDIANA	1,497,890	1,805,812	411,938	97,491	155,513	208,516	754,790	115,419	5,047,369	919
IOWA	817,145	979,140	238,551	51,426	102,750	133,838	486,426	85,621	2,894,898	993
KANSAS	674,088	796,112	204,462	42,979	96,399	111,000	443,405	130,491	2,498,938	1,057
KENTUCKY	945,732	738,292	181,148	31,508	97,004	208,798	397,782	373,522	2,951,768	809
LOUISIANA	1,198,552	880,118	196,340	40,451	133,052	293,670	470,671	741,550	3,954,402	940
MAINE	284,943	280,438	77,439	13,382	41,117	93,826	170,001	8,389	978,536	870
MARYLAND	1,286,977	1,149,042	211,012	46,508	164,234	164,234	698,873	667,136	4,388,016	1,041
MASSACHUSETTS	1,961,518	2,207,911	437,646	88,910	500,501	538,807	1,529,777	104,800	7,367,870	1,284
MICHIGAN	2,648,628	3,441,020	718,157	159,462	550,719	550,719	1,771,676	317,690	10,158,071	1,097
MINNESOTA	1,243,181	1,498,322	301,198	83,258	269,169	337,614	704,635	27,881	4,525,259	1,110
MISSISSIPPI	619,332	410,989	0	23,328	48,684	168,171	281,274	262,076	1,914,580	759
MISSOURI	1,482,558	1,652,437	436,857	98,288	120,224	183,065	1,006,024	99,831	5,079,283	1,033
MONTANA	158,707	182,422	19,068	9,501	22,871	41,158	73,442	168,847	676,015	859
NEBRASKA	469,733	532,375	134,464	30,893	47,389	64,430	260,572	55,287	1,595,143	1,016
NEVADA	202,680	261,305	22,759	12,294	23,073	23,073	112,798	229,561	887,542	1,109
NEW HAMPSHIRE	227,069	260,611	53,749	9,906	28,738	45,157	107,879	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,168	458,158	85,935	388,438	388,438	1,146,073	92,675	6,840,103	930
NEW MEXICO	228,563	248,079	25,581	14,411	22,376	49,875	91,184	247,833	925,932	711
NEW YORK	5,502,085	8,045,460	1,304,282	248,347	2,334,327	2,334,327	4,012,129	285,380	22,066,936	1,257
NORTH CAROLINA	1,443,006	1,100,169	227,200	52,419	133,398	278,833	578,692	729,155	4,546,873	773
NORTH DAKOTA	199,350	223,808	59,960	13,989	18,626	29,678	120,945	23,759	696,115	1,068
OHIO	3,218,536	4,009,817	954,293	190,723	373,505	458,355	1,818,967	191,410	11,215,407	1,039
OKLAHOMA	840,211	581,953	139,726	28,583	99,177	173,587	433,308	443,642	2,740,188	906
OREGON	558,453	705,573	68,503	33,498	81,525	102,339	319,286	604,859	2,474,037	940
PENNSYLVANIA	3,485,617	3,967,694	860,052	161,365	487,881	599,683	2,385,775	168,722	12,117,790	1,021
RHODE ISLAND	291,130	358,994	72,062	12,411	69,551	95,300	204,278	17,604	1,121,337	1,184
SOUTH CAROLINA	663,690	437,942	95,613	25,117	77,334	189,059	230,513	484,138	2,203,405	706
SOUTH DAKOTA	202,638	199,249	58,778	15,537	17,815	38,808	99,529	25,381	657,535	952
TENNESSEE	1,377,091	1,038,889	226,380	45,904	119,232	270,798	629,946	662,156	4,368,396	952
TEXAS	4,244,744	3,070,355	832,707	159,455	419,882	588,238	1,878,299	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	26,122	55,887	79,516	268,814	1,082,735	741
VERMONT	119,592	133,428	29,474	5,360	19,259	41,687	63,594	4,002	416,395	815
VIRGINIA	1,402,784	1,123,908	234,835	46,655	160,351	208,611	593,161	845,275	4,615,580	863
WASHINGTON	852,112	1,071,822	99,177	52,104	169,065	169,065	400,188	1,025,015	3,838,548	929
WEST VIRGINIA	551,141	396,291	89,965	18,220	34,764	71,711	252,528	229,937	1,644,557	843
WISCONSIN	1,349,249	1,765,318	381,282	78,756	296,468	408,568	822,555	52,372	5,164,568	1,097
WYOMING	78,091	108,783	8,364	4,876	7,400	7,400	32,597	87,905	335,414	714
TOTAL	$63,140,884	$65,626,957	$12,948,686	$3,123,818	$10,697,188	$13,147,306	$37,246,701	$24,228,100	$230,166,741	$1,016

a/ Includes personal health expenditures and administrative costs

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

SOURCE: Lewin/ICF estimates

Table 3b

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1000 a/
(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	2,814,760	2,012,389	416,532	101,765	183,013	425,482	1,932,843	1,655,817	9,522,402	2,286
ALASKA	329,687	427,212	29,864	24,057	60,360	60,360	80,357	231,034	1,242,929	2,367
ARIZONA	1,972,363	2,379,617	240,868	137,174	222,669	367,652	1,367,192	1,418,276	8,105,810	2,211
ARKANSAS	1,449,372	892,449	198,921	57,525	103,787	292,830	990,607	721,250	4,706,750	1,944
CALIFORNIA	20,379,570	25,640,378	2,335,173	1,471,282	3,574,078	3,574,078	14,853,732	12,928,177	84,754,469	2,894
COLORADO	2,097,807	2,670,571	263,730	139,260	304,439	304,439	959,276	1,295,747	8,045,268	2,415
CONNECTICUT	2,278,555	3,303,221	432,925	82,800	514,939	514,939	1,578,669	89,760	8,815,808	2,690
DELAWARE	454,368	365,183	70,128	14,539	68,058	68,058	291,765	218,99[illegible]	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,188	50,262	11,181	182,516	182,518	344,[illegible]	228,8[illegible]7	1,559,131	2,586
FLORIDA	9,375,203	6,218,476	1,396,780	322,[illegible]	878,583	1,125,484	8,083,[illegible]07	4,010,590	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,638	124,588	489,424	852,179	2,22[illegible]39	2,301,976	13,669,245	2,072
HAWAII	697,628	966,101	96,984	48,022	102,084	106,251	29[illegible]352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,196	28,238	40,178	109,063	238,416	305,267	1,748,435	1,726
ILLINOIS	8,208,698	10,348,102	1,806,653	532,709	1,231,633	1,231,633	6,719,023	519,434	30,597,883	2,619
INDIANA	3,382,637	3,988,394	816,531	228,318	481,451	813,468	2,204,733	447,133	12,362,662	2,201
IOWA	1,834,062	2,218,841	448,816	115,314	247,922	355,295	1,345,839	49,288	6,815,478	2,351
KANSAS	1,772,719	2,218,335	415,780	100,640	220,379	220,379	1,287,848	190,689	6,420,779	2,548
KENTUCKY	1,947,743	1,418,857	270,882	67,343	254,106	599,458	1,233,765	1,229,672	7,021,825	1,875
LOUISIANA	2,547,782	1,822,033	352,995	96,280	345,188	608,634	1,741,606	2,030,597	9,545,115	2,185
MAINE	689,728	882,374	149,985	29,898	128,635	284,450	480,731	62,124	2,687,920	2,175
MARYLAND	3,169,204	2,674,955	484,561	99,774	541,404	541,404	2,178,431	1,958,060	11,627,792	2,436
MASSACHUSETTS	4,443,792	8,173,324	748,868	195,223	1,239,474	1,239,474	3,827,313	280,008	17,947,477	3,031
MICHIGAN	6,085,410	7,977,976	1,391,031	372,097	1,001,888	1,316,760	5,159,240	570,371	23,874,761	2,569
MINNESOTA	3,032,352	4,004,588	872,128	180,038	659,661	758,225	1,408,019	144,050	10,857,061	2,480
MISSISSIPPI	1,319,923	849,242	177,033	51,154	111,948	408,809	827,081	895,339	4,638,528	1,751
MISSOURI	3,643,381	4,398,101	845,312	224,843	355,821	547,738	3,055,508	302,658	13,373,361	2,568
MONTANA	383,483	438,546	46,226	25,273	57,205	112,948	241,279	336,263	1,641,223	2,059
NEBRASKA	1,132,890	1,361,739	285,541	70,028	128,525	171,137	668,770	115,011	3,933,640	2,[illegible]52
NEVADA	807,751	1,033,508	98,602	58,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,660	107,811	33,381	87,620	118,939	370,959	48,364	2,258,658	1,981
NEW JERSEY	4,545,827	6,011,019	741,459	200,122	1,042,327	1,042,327	3,501,694	283,989	17,368,763	2,224
NEW MEXICO	705,891	728,428	82,220	49,890	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,881	14,346,795	2,020,835	569,890	5,280,300	5,288,330	10,274,890	825,078	50,354,750	2,818
NORTH CAROLINA	3,806,151	2,855,434	567,966	130,692	378,718	850,088	1,957,921	1,712,411	12,259,381	1,833
NORTH DAKOTA	442,809	540,478	111,059	26,699	86,967	108,809	350,419	85,946	1,751,185	2,661
OHIO	6,966,974	8,754,357	1,645,671	429,028	1,244,280	1,739,605	5,855,967	557,522	27,193,403	2,493
OKLAHOMA	2,026,546	1,379,606	288,712	78,027	204,847	400,883	1,278,850	1,081,298	6,824,669	2,139
OREGON	1,657,140	2,007,536	207,895	110,855	171,845	274,649	886,019	1,106,958	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	365,577	1,248,011	1,835,583	7,748,007	375,838	30,541,850	2,538
RHODE ISLAND	704,349	853,513	135,007	30,385	173,508	223,809	531,628	48,987	2,701,187	2,707
SOUTH CAROLINA	1,809,718	1,401,609	269,561	63,523	160,028	428,154	889,168	891,428	6,011,188	1,689
SOUTH DAKOTA	469,323	532,487	106,789	30,642	51,118	107,733	320,442	43,718	1,662,251	2,322
TENNESSEE	3,284,049	2,385,982	493,952	110,504	341,451	804,357	2,185,908	1,742,697	11,328,958	2,262
TEXAS	11,992,115	8,477,215	1,555,624	465,330	1,145,085	1,320,848	6,584,259	5,840,450	37,380,724	2,192
UTAH	777,209	1,095,590	80,021	51,752	65,018	172,449	318,184	525,181	3,085,385	1,784
VERMONT	323,043	381,043	64,236	13,292	47,486	96,873	172,612	18,629	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,548	469,473	532,390	2,061,361	2,160,846	12,931,845	2,076
WASHINGTON	2,613,828	3,348,969	321,777	188,957	587,419	508,783	1,558,885	1,918,178	11,084,596	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	280,771	720,922	743,573	3,848,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	168,823	528,448	713,420	2,258,999	379,584	11,980,357	2,449
WYOMING	206,156	269,578	26,328	13,994	18,865	19,865	107,370	158,705	821,858	1,758
TOTAL	$161,010,653	$174,125,101	$27,063,851	$8,308,703	$27,397,885	$34,258,738	$116,277,024	$58,730,394	$605,978,347	$2,425

a/ Includes personal health expenditures and administrative costs

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

SOURCE: Lewin/ICF estimates

Table 3c

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

(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	6,587,653	4,706,531	976,883	267,896	387,825	980,063	5,375,234	3,424,954	22,667,039	5,201
ALASKA	865,679	1,121,008	70,581	71,054	152,806	152,806	250,751	536,159	3,228,864	5,330
ARIZONA	5,810,602	6,764,398	606,598	438,907	610,678	1,008,299	4,621,770	3,565,831	23,306,882	5,031
ARKANSAS	3,349,186	2,060,831	460,622	149,517	231,246	652,384	2,720,302	1,472,984	11,097,073	4,423
CALIFORNIA	53,007,530	66,644,841	6,086,483	4,304,439	8,982,840	8,982,640	45,912,880	29,714,318	223,595,772	6,584
COLORADO	4,891,263	6,222,417	616,198	365,225	684,360	684,360	2,685,710	2,670,108	18,819,641	5,496
CONNECTICUT	5,271,870	7,637,346	1,003,744	241,508	1,148,658	1,148,658	4,340,830	203,993	20,999,403	8,139
DELAWARE	1,195,017	959,790	184,826	43,011	167,503	167,503	911,917	509,052	4,138,620	5,160
DISTRICT OF COLUMBIA	704,048	529,771	111,169	27,784	388,391	388,391	804,558	445,965	3,500,076	5,882
FLORIDA	28,031,662	17,254,594	3,886,487	1,006,793	2,351,978	3,012,935	26,673,673	9,842,004	90,060,126	5,520
GEORGIA	10,852,590	8,320,811	1,565,419	383,829	1,291,755	2,513,120	7,237,055	5,569,541	37,733,819	4,714
HAWAII	1,910,550	2,643,972	280,159	147,929	289,540	280,542	981,238	1,173,704	7,853,834	5,619
IDAHO	993,703	1,184,244	120,221	71,828	104,758	237,141	638,985	608,459	3,959,138	3,928
ILLINOIS	18,024,960	22,707,029	3,973,387	1,315,734	2,807,418	2,807,418	17,533,255	1,008,052	69,779,254	5,953
INDIANA	7,587,956	8,940,608	1,835,468	576,081	1,041,239	1,759,298	5,877,353	886,461	28,504,460	5,004
IOWA	3,643,891	4,405,316	893,501	257,698	474,894	680,566	3,177,848	86,542	13,620,316	5,343
KANSAS	3,916,623	4,897,773	920,558	250,103	489,432	489,432	3,381,372	372,350	14,877,843	5,792
KENTUCKY	4,324,250	3,147,873	602,648	160,169	543,908	1,283,120	3,255,128	2,412,801	15,737,895	4,268
LOUISIANA	5,456,366	3,899,393	757,558	231,930	712,733	1,258,887	4,432,487	3,843,422	20,590,574	4,972
MAINE	1,663,097	2,126,142	362,405	81,089	299,039	661,265	1,320,211	132,390	6,645,638	4,945
MARYLAND	8,357,708	7,049,413	1,227,679	295,958	1,378,538	1,378,538	6,827,112	4,563,688	31,074,029	5,541
MASSACHUSETTS	10,176,490	14,127,420	1,718,518	502,868	2,738,599	2,738,599	8,871,559	566,719	42,438,773	6,890
MICHIGAN	13,152,128	17,623,528	3,081,357	925,199	2,135,251	2,808,318	13,553,224	1,114,322	54,891,321	5,840
MINNESOTA	7,051,420	9,305,818	1,568,223	470,911	1,478,930	1,695,420	3,891,005	296,049	25,755,773	5,641
MISSISSIPPI	3,116,442	2,003,742	418,860	135,852	254,833	826,041	2,320,679	1,868,319	11,044,767	3,984
MISSOURI	8,368,592	10,095,144	1,945,672	580,908	787,968	1,212,866	8,340,413	814,402	31,946,084	5,837
MONTANA	813,087	929,192	98,218	60,273	118,938	230,688	607,947	630,119	3,486,857	4,689
NEBRASKA	2,403,068	2,887,461	607,149	187,138	282,930	350,103	1,886,381	215,683	8,580,707	5,578
NEVADA	2,264,610	2,895,540	277,018	179,109	193,513	193,513	1,827,012	1,206,717	8,837,119	6,272
NEW HAMPSHIRE	1,867,766	2,188,757	295,910	102,842	257,810	314,084	1,207,467	117,076	8,351,711	4,505
NEW JERSEY	10,737,775	14,188,913	1,755,065	531,709	2,373,749	2,373,749	9,829,803	592,888	42,383,428	5,058
NEW MEXICO	1,814,472	1,871,107	211,785	144,284	218,600	480,760	1,053,827	1,283,266	7,076,082	4,078
NEW YORK	28,052,821	31,813,339	4,493,114	1,422,407	11,313,588	11,313,588	27,094,850	1,618,092	115,121,884	6,408
NORTH CAROLINA	9,878,126	7,405,800	1,477,120	381,519	847,619	2,127,070	8,038,653	3,927,803	32,183,511	4,170
NORTH DAKOTA	885,467	1,080,024	222,543	60,052	167,663	205,918	832,722	151,892	3,606,280	6,051
OHIO	15,316,195	19,232,268	3,825,387	1,080,889	2,837,287	3,887,115	15,298,854	1,083,233	61,941,308	5,887
OKLAHOMA	4,165,518	2,833,788	590,559	175,778	584,502	794,040	3,123,838	1,964,314	14,232,334	4,867
OREGON	3,848,838	4,657,015	483,608	289,452	384,153	614,885	2,722,592	2,271,062	15,269,405	5,260
PENNSYLVANIA	17,430,559	20,877,038	3,490,750	896,713	2,823,883	3,438,693	20,073,886	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,360	499,858	1,462,851	100,253	6,448,659	6,153
SOUTH CAROLINA	4,553,474	3,524,182	679,663	179,781	388,200	1,033,778	2,858,719	2,204,679	15,222,478	3,842
SOUTH DAKOTA	1,032,399	1,170,535	235,401	75,818	108,414	228,484	837,887	84,893	3,773,731	5,278
TENNESSEE	7,962,737	5,732,759	1,200,168	301,378	788,197	1,880,317	8,298,723	3,734,453	27,900,735	5,145
TEXAS	28,125,731	19,868,305	3,656,095	1,227,572	2,589,258	2,988,233	18,351,490	12,106,189	88,910,873	4,987
UTAH	1,889,913	2,662,266	194,991	141,549	152,431	404,292	819,418	1,128,669	7,493,528	4,062
VERMONT	777,694	918,691	154,965	35,892	110,215	224,379	493,830	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	362,799	1,192,047	1,351,801	6,451,550	5,029,566	34,364,026	4,724
WASHINGTON	6,406,052	8,197,810	790,328	520,941	1,340,850	1,344,072	4,540,641	4,155,168	27,295,859	5,258
WEST VIRGINIA	2,216,108	1,441,469	344,513	78,170	201,945	507,382	1,728,884	1,328,244	7,844,814	4,752
WISCONSIN	6,803,691	8,886,593	1,653,258	409,690	1,109,502	1,503,550	5,808,345	733,339	25,987,967	5,587
WYOMING	409,029	534,489	52,348	31,230	37,999	37,999	253,181	278,293	1,634,548	3,998
TOTAL	$385,931,868	$412,369,109	$63,755,912	$22,248,107	$62,147,543	$77,766,648	$328,079,658	$124,210,355	$1,476,507,197	$5,515

a/ Includes personal health expenditures and administrative costs.

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

SOURCE: Lewin/ICF estimates

Table 4

ESTIMATED NUMBER OF UNINSURED PERSONS

STATE	1980 NUMBER a/	1980 % OF STATE POP	1980 RANK b/	1988 NUMBER c/	1988 % OF STATE POP	1988 RANK b/	PERCENT CHANGE
ALABAMA	560,052	14.4%	9	615,680	15.1%	15	9.9%
ALASKA	54,655	13.6%	11	85,903	15.8%	13	57.2%
ARIZONA	449,151	16.5%	2	608,444	17.7%	7	35.5%
ARKANSAS	372,852	16.3%	3	519,163	21.8%	2	39.2%
CALIFORNIA	3,004,160	12.7%	14	4,737,675	17.2%	10	57.7%
COLORADO	371,701	12.9%	13	428,555	13.0%	22	15.3%
CONNECTICUT	193,401	6.2%	50	186,011	5.8%	51	-3.8%
DELAWARE	53,621	9.0%	36	65,178	10.2%	34	21.6%
DISTRICT OF COLUMBIA	97,916	15.3%	6	97,659	15.7%	14	-0.3%
FLORIDA	1,358,123	13.9%	10	2,199,960	18.4%	4	62.0%
GEORGIA	672,080	12.3%	17	788,513	12.6%	25	17.3%
HAWAII	78,539	8.1%	43	87,669	8.1%	42	11.6%
IDAHO	115,174	12.2%	18	165,419	16.4%	11	43.6%
ILLINOIS	1,078,105	9.4%	32	1,164,471	10.1%	35	8.0%
INDIANA	538,413	9.8%	30	751,116	13.6%	21	39.5%
IOWA	244,302	8.4%	41	222,017	7.9%	44	-9.1%
KANSAS	172,575	7.3%	48	257,374	10.4%	33	49.1%
KENTUCKY	328,638	9.0%	37	555,113	14.9%	16	68.9%
LOUISIANA	522,790	12.4%	16	778,919	17.3%	9	49.0%
MAINE	127,156	11.3%	22	92,123	7.8%	45	-27.6%
MARYLAND	382,164	9.1%	35	430,254	9.5%	38	12.6%
MASSACHUSETTS	493,906	8.6%	39	424,868	7.3%	48	-14.0%
MICHIGAN	604,488	6.5%	49	756,414	8.2%	41	25.1%
MINNESOTA	350,485	8.6%	40	282,003	6.6%	50	-19.5%
MISSISSIPPI	378,740	15.0%	8	472,365	17.9%	6	24.7%
MISSOURI	511,424	10.4%	26	533,342	10.5%	32	4.3%
MONTANA	120,046	15.3%	7	129,258	15.9%	12	7.7%
NEBRASKA	147,733	9.4%	33	168,268	10.5%	31	13.9%
NEVADA	92,188	11.5%	20	172,097	17.3%	8	86.7%
NEW HAMPSHIRE	70,854	7.7%	46	105,203	9.9%	36	48.5%
NEW JERSEY	688,699	9.4%	34	638,403	8.3%	40	-7.3%
NEW MEXICO	245,114	18.8%	1	345,509	22.8%	1	41.0%
NEW YORK	1,656,634	9.4%	31	2,049,755	11.5%	28	23.7%
NORTH CAROLINA	668,728	11.4%	21	883,308	13.8%	20	32.1%
NORTH DAKOTA	52,615	8.1%	45	50,447	7.5%	47	-4.1%
OHIO	872,119	8.1%	44	1,031,230	9.6%	37	18.2%
OKLAHOMA	399,994	13.2%	12	592,995	18.0%	5	48.3%
OREGON	260,217	9.9%	29	397,160	14.6%	18	52.6%
PENNSYLVANIA	981,113	8.3%	42	949,608	8.0%	43	-3.2%
RHODE ISLAND	72,422	7.6%	47	71,051	7.2%	49	-1.9%
SOUTH CAROLINA	493,006	15.8%	5	406,552	11.9%	26	-17.5%
SOUTH DAKOTA	86,842	12.6%	15	104,051	14.7%	17	19.8%
TENNESSEE	536,142	11.7%	19	687,400	14.2%	19	28.2%
TEXAS	2,270,337	16.0%	4	3,621,720	21.4%	3	59.5%
UTAH	146,561	10.0%	28	198,706	11.7%	27	35.6%
VERMONT	52,373	10.2%	27	50,256	9.2%	39	-4.0%
VIRGINIA	473,667	8.9%	38	637,029	10.8%	30	34.5%
WASHINGTON	457,440	11.1%	24	579,781	12.8%	24	26.7%
WEST VIRGINIA	217,640	11.2%	23	245,160	12.9%	23	12.6%
WISCONSIN	273,431	5.9%	51	361,781	7.6%	46	32.3%
WYOMING	50,687	10.8%	25	54,968	10.9%	29	8.4%
TOTAL	24,501,212	10.8%		31,837,904	13.1%		29.9%

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

b/ Based upon percent uninsured

c/ Based upon March 1988 CPS data

SOURCE Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

By:

Lewin/ICF
a division of Health & Sciences International, Inc.

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

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

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1986 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

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

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

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

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

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

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

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

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

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

Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

ADDITIONAL TABLES

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

Percentage Distribution

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	31.0 %	21.0 %	5.2 %	1.2 %	2.2 %	5.4 %	15.3 %	18.1 %	100.0 %
ALASKA	24.0	32.8	2.0	1.7	3.7	3.7	4.8	27.3	100.0
ARIZONA	25.3	30.3	3.2	1.8	0.0	0.0	14.3	25.4	100.0
ARKANSAS	30.2	19.1	4.5	1.2	3.4	9.1	15.6	16.9	100.0
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.8	23.6	100.0
COLORADO	24.2	32.4	2.6	1.5	3.0	3.4	10.5	22.3	100.0
CONNECTICUT	28.8	34.5	6.7	1.2	5.0	5.0	17.1	1.6	100.0
DELAWARE	29.5	24.0	5.0	1.0	4.1	4.1	15.4	17.0	100.0
DISTRICT OF COLUMBIA	21.3	15.6	3.6	0.8	10.9	10.8	18.8	18.0	100.0
FLORIDA	30.0	10.0	5.1	1.0	1.8	2.5	23.0	17.6	100.0
GEORGIA	31.1	23.5	4.8	1.1	3.3	6.6	12.8	16.9	100.0
HAWAII	22.7	29.0	2.6	1.3	5.2	5.2	9.6	24.5	100.0
IDAHO	23.6	28.8	2.8	1.4	2.7	5.3	9.8	25.8	100.0
ILLINOIS	27.2	33.6	7.3	1.6	4.9	4.9	18.7	1.6	100.0
INDIANA	29.7	35.6	8.2	1.9	3.1	4.1	15.0	2.3	100.0
IOWA	28.2	33.8	8.2	1.8	3.5	4.6	16.8	3.0	100.0
KANSAS	27.0	31.9	8.2	1.7	3.9	4.4	17.7	5.2	100.0
KENTUCKY	32.0	25.0	5.5	1.1	3.3	7.0	13.5	12.7	100.0
LOUISIANA	30.3	22.3	5.0	1.0	3.4	7.4	11.9	18.8	100.0
MAINE	29.1	28.7	7.9	1.4	4.2	9.6	18.3	0.9	100.0
MARYLAND	29.3	26.2	4.6	1.1	3.7	3.7	15.9	15.2	100.0
MASSACHUSETTS	26.6	30.0	5.9	1.2	6.8	7.3	20.6	1.4	100.0
MICHIGAN	26.1	33.9	7.1	1.6	5.4	5.4	17.4	3.1	100.0
MINNESOTA	27.5	33.1	8.0	1.8	5.9	7.5	15.6	0.6	100.0
MISSISSIPPI	32.3	21.5	0.0	1.2	2.5	8.8	14.7	13.7	100.0
MISSOURI	29.2	32.5	8.6	1.9	2.4	3.6	19.6	2.0	100.0
MONTANA	23.5	27.0	2.8	1.4	3.4	6.1	10.9	25.0	100.0
NEBRASKA	29.4	33.4	8.4	1.9	3.0	4.0	16.3	3.5	100.0
NEVADA	22.8	29.4	2.6	1.4	2.8	2.0	12.7	25.9	100.0
NEW HAMPSHIRE	30.3	34.8	7.2	1.3	3.8	6.0	14.4	2.1	100.0
NEW JERSEY	27.9	34.6	8.7	1.3	5.7	5.7	16.7	1.4	100.0
NEW MEXICO	24.7	26.0	2.8	1.6	2.4	5.4	9.8	26.8	100.0
NEW YORK	24.9	27.4	5.9	1.1	10.6	10.6	16.2	1.3	100.0
NORTH CAROLINA	31.7	24.3	5.0	1.2	2.9	6.1	12.7	16.0	100.0
NORTH DAKOTA	28.6	32.2	8.6	2.0	2.7	4.3	17.4	4.3	100.0
OHIO	28.7	35.6	8.5	1.7	3.3	4.1	16.2	1.7	100.0
OKLAHOMA	30.7	21.2	3.1	1.0	3.6	6.3	15.8	16.2	100.0
OREGON	22.6	26.5	2.8	1.4	3.3	4.1	12.9	24.4	100.0
PENNSYLVANIA	28.8	32.7	7.1	1.3	4.0	4.9	19.7	1.4	100.0
RHODE ISLAND	28.0	32.0	6.4	1.1	6.2	6.5	18.2	1.6	100.0
SOUTH CAROLINA	30.1	19.9	4.3	1.1	3.5	8.6	10.5	22.0	100.0
SOUTH DAKOTA	30.6	30.3	8.9	2.4	2.7	5.9	15.1	3.9	100.0
TENNESSEE	31.5	23.7	5.2	1.1	2.7	8.2	14.4	15.2	100.0
TEXAS	32.6	23.6	4.0	1.2	3.2	4.5	14.4	15.5	100.0
UTAH	24.2	32.1	2.7	1.4	2.4	5.1	7.3	24.8	100.0
VERMONT	26.7	32.0	7.1	1.3	4.6	10.0	15.3	1.0	100.0
VIRGINIA	30.4	24.4	5.1	1.0	3.5	4.5	12.9	18.3	100.0
WASHINGTON	22.2	27.3	2.6	1.4	4.4	4.4	10.4	26.7	100.0
WEST VIRGINIA	33.5	24.1	5.5	1.1	2.1	4.4	15.4	14.0	100.0
WISCONSIN	26.1	34.2	7.6	1.5	5.7	7.0	15.9	1.0	100.0
WYOMING	23.3	32.4	2.5	1.5	2.2	2.2	9.7	26.2	100.0
TOTAL	27.4 %	28.5 %	5.8 %	1.4 %	4.6 %	5.7 %	16.2 %	10.5 %	100.0 %

a/ Includes personal health expenditures and administrative costs.

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

SOURCE: Lewin/ICF estimates

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	29.6 %	21.1 %	4.4 %	1.1 %	1.7 %	4.5 %	20.3 %	17.4 %	100.0%
ALASKA	28.5	34.4	2.4	1.9	4.9	4.9	6.5	16.6	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	16.9	17.5	100.0
ARKANSAS	30.6	19.0	4.2	1.2	2.2	6.2	21.0	15.3	100.0
CALIFORNIA	24.0	30.3	2.8	1.7	4.2	4.2	17.5	15.3	100.0
COLORADO	26.1	33.2	3.3	1.7	3.6	3.6	12.0	16.1	100.0
CONNECTICUT	25.8	37.5	4.9	1.1	5.6	5.6	17.9	1.1	100.0
DELAWARE	29.4	23.0	4.5	0.9	4.3	4.3	18.8	14.2	100.0
DISTRICT OF COLUMBIA	20.5	15.4	3.2	0.7	11.7	11.7	22.1	14.7	100.0
FLORIDA	28.8	19.8	4.4	1.0	2.8	3.6	25.7	12.8	100.0
GEORGIA	29.0	22.3	4.2	0.9	3.6	7.0	16.3	16.6	100.0
HAWAII	24.9	34.5	3.5	1.7	3.6	3.6	10.6	17.3	100.0
IDAHO	25.2	30.1	3.0	1.6	2.8	6.2	13.6	17.5	100.0
ILLINOIS	28.6	33.8	5.9	1.7	4.0	4.0	22.0	1.7	100.0
INDIANA	27.4	32.3	6.6	1.8	3.9	6.6	17.6	3.6	100.0
IOWA	27.7	33.5	6.6	1.7	3.7	5.4	20.3	0.7	100.0
KANSAS	27.6	34.5	6.5	1.6	3.4	3.4	20.0	3.0	100.0
KENTUCKY	27.7	20.2	3.9	1.0	3.6	8.5	17.6	17.5	100.0
LOUISIANA	26.7	19.1	3.7	1.0	3.6	8.4	16.2	21.3	100.0
MAINE	25.7	32.8	5.6	1.1	4.8	10.6	17.1	2.3	100.0
MARYLAND	27.3	23.0	4.0	0.9	4.7	4.7	16.7	16.6	100.0
MASSACHUSETTS	24.8	34.4	4.2	1.1	6.9	6.9	20.2	1.6	100.0
MICHIGAN	25.5	33.4	5.6	1.6	4.2	5.5	21.6	2.4	100.0
MINNESOTA	27.9	36.9	6.2	1.7	6.1	7.0	13.0	1.3	100.0
MISSISSIPPI	28.5	16.3	3.8	1.1	2.4	6.6	17.8	19.3	100.0
MISSOURI	27.2	32.9	6.3	1.7	2.7	4.1	22.8	2.3	100.0
MONTANA	23.4	26.7	2.6	1.5	3.5	6.9	14.7	20.5	100.0
NEBRASKA	28.6	34.6	7.3	1.8	3.3	4.4	17.0	2.9	100.0
NEVADA	25.9	33.2	3.2	1.8	2.3	2.3	15.7	15.6	100.0
NEW HAMPSHIRE	30.2	35.4	4.8	1.5	4.3	5.3	16.4	2.1	100.0
NEW JERSEY	26.2	34.6	4.3	1.2	6.0	6.0	20.2	1.6	100.0
NEW MEXICO	25.6	26.4	3.0	1.8	3.2	7.0	12.5	20.5	100.0
NEW YORK	23.3	26.5	4.0	1.1	10.5	10.5	20.4	1.6	100.0
NORTH CAROLINA	31.0	23.3	4.6	1.1	3.1	6.9	16.0	14.0	100.0
NORTH DAKOTA	25.3	30.9	6.3	1.5	5.0	6.1	20.0	4.9	100.0
OHIO	25.6	32.2	6.1	1.6	4.6	6.4	21.5	2.1	100.0
OKLAHOMA	29.7	20.2	4.2	1.1	4.3	5.9	16.7	15.8	100.0
OREGON	25.4	30.8	3.2	1.7	2.6	4.2	15.1	17.0	100.0
PENNSYLVANIA	26.2	31.4	5.2	1.2	4.1	5.4	25.4	1.2	100.0
RHODE ISLAND	26.1	31.6	5.0	1.1	6.4	8.3	19.7	1.8	100.0
SOUTH CAROLINA	30.1	23.3	4.5	1.1	2.7	7.1	14.8	16.5	100.0
SOUTH DAKOTA	28.2	32.0	6.4	1.8	3.1	6.5	19.3	2.6	100.0
TENNESSEE	29.0	20.9	4.4	1.0	3.0	7.1	19.3	15.4	100.0
TEXAS	32.1	22.7	4.2	1.2	3.1	3.5	17.6	15.6	100.0
UTAH	25.2	35.5	2.6	1.7	2.1	5.6	10.3	17.0	100.0
VERMONT	28.9	34.1	5.8	1.2	4.3	6.7	15.5	1.7	100.0
VIRGINIA	30.1	24.1	4.4	1.0	3.6	4.1	15.0	16.7	100.0
WASHINGTON	23.6	30.2	2.9	1.7	5.1	5.1	14.1	17.3	100.0
WEST VIRGINIA	28.5	16.6	4.4	0.9	2.7	6.8	18.7	19.3	100.0
WISCONSIN	26.0	34.0	6.3	1.4	4.4	6.0	18.9	3.2	100.0
WYOMING	25.1	32.8	3.2	1.7	2.4	2.4	13.1	19.3	100.0
TOTAL	26.7 %	28.7 %	4.5 %	1.4 %	4.3 %	5.7 %	19.2 %	9.4 %	100.0%

a/ Includes personal health expenditures and administrative costs.

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

SOURCE: Lewin/ICF estimates.

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

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID		MEDICARE	OTHER PUBLIC	TOTAL
					STATE	FEDERAL			
ALABAMA	29.1 %	20.8 %	4.3 %	1.2 %	1.6 %	4.2 %	23.7 %	15.1 %	100.0%
ALASKA	26.8	34.7	2.4	2.2	4.7	4.7	7.8	1* 8	100.0
ARIZONA	24.1	29.0	2.9	1.9	2.6	4.3	19.6	15.3	100.0
ARKANSAS	30.2	18.6	4.2	1.3	2.1	5.8	24.5	13.3	100.0
CALIFORNIA	23.7	29.8	2.7	1.9	4.0	4.0	20.5	13.3	100.0
COLORADO	28.0	33.1	3.3	1.9	3.6	3.6	14.3	14.2	100.0
CONNECTICUT	25.1	36.4	4.8	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	28.9	23.2	4.5	1.0	4.0	4.0	22.0	12.3	100.0
DISTRICT OF COLUMBIA	20.1	15.1	3.2	0.8	11.1	11.1	25.8	12.7	100.0
FLORIDA	28.9	19.2	4.3	1.1	2.6	3.3	29.6	10.9	100.0
GEORGIA	28.8	22.1	4.1	1.0	3.4	8.7	19.2	14.8	100.0
HAWAII	25.0	34.5	3.5	1.9	3.5	3.7	12.6	15.3	100.0
IDAHO	25.1	29.9	3.0	1.8	2.6	8.0	18.1	15.4	100.0
ILLINOIS	25.8	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	28.6	31.4	6.4	2.0	3.7	8.2	20.0	3.1	100.0
IOWA	26.8	32.3	6.6	1.9	3.5	5.0	23.3	0.6	100.0
KANSAS	26.7	33.4	6.3	1.7	3.2	3.2	23.0	2.5	100.0
KENTUCKY	27.5	20.0	3.8	1.1	3.5	8.2	20.7	15.3	100.0
LOUISIANA	26.5	18.9	3.7	1.1	3.5	8.1	21.5	18.7	100.0
MAINE	25.0	32.0	5.5	1.2	4.5	10.0	19.9	2.0	100.0
MARYLAND	28.9	22.7	4.0	1.0	4.4	4.4	22.0	14.7	100.0
MASSACHUSETTS	24.0	33.3	4.0	1.2	8.4	8.4	23.3	1.3	100.0
MICHIGAN	24.6	32.2	5.6	1.7	3.9	5.1	24.8	2.0	100.0
MINNESOTA	27.4	36.1	6.1	1.8	5.7	6.6	15.1	1.1	100.0
MISSISSIPPI	28.2	18.1	3.8	1.2	2.3	8.4	21.0	16.9	100.0
MISSOURI	28.2	31.6	6.1	1.8	2.5	3.8	28.1	1.9	100.0
MONTANA	23.3	26.6	2.8	1.7	3.4	6.8	17.4	18.1	100.0
NEBRASKA	28.0	33.7	7.1	1.9	3.1	4.1	19.7	2.5	100.0
NEVADA	25.6	32.8	3.1	2.0	2.2	2.2	18.4	13.7	100.0
NEW HAMPSHIRE	29.4	34.5	4.7	1.6	4.1	4.9	19.0	1.8	100.0
NEW JERSEY	25.3	33.5	4.1	1.3	5.6	5.6	23.2	1.4	100.0
NEW MEXICO	25.6	28.4	3.0	2.0	3.1	8.8	14.9	18.1	100.0
NEW YORK	22.8	27.6	3.9	1.2	9.8	9.8	23.5	1.4	100.0
NORTH CAROLINA	30.7	23.0	4.6	1.2	2.9	6.6	18.8	12.2	100.0
NORTH DAKOTA	24.6	29.9	6.2	1.7	4.8	5.7	23.1	4.2	100.0
OHIO	24.7	31.0	5.9	1.7	4.3	6.0	24.7	1.7	100.0
OKLAHOMA	29.3	19.9	4.1	1.2	4.1	5.8	21.9	13.8	100.0
OREGON	25.2	30.5	3.2	1.9	2.5	4.0	17.8	14.9	100.0
PENNSYLVANIA	25.1	30.0	5.0	1.3	3.8	4.9	28.9	1.0	100.0
RHODE ISLAND	25.3	30.6	4.9	1.2	6.0	7.7	22.7	1.6	100.0
SOUTH CAROLINA	29.9	23.2	4.5	1.2	2.8	6.8	17.5	14.5	100.0
SOUTH DAKOTA	27.4	31.0	6.2	2.0	2.9	6.1	22.2	2.3	100.0
TENNESSEE	28.5	20.5	4.3	1.1	2.9	6.7	22.6	13.4	100.0
TEXAS	31.6	22.3	4.1	1.4	2.9	3.4	20.6	13.6	100.0
UTAH	25.2	35.5	2.6	1.9	2.0	5.4	12.3	15.1	100.0
VERMONT	28.2	33.3	5.6	1.3	4.0	8.1	17.9	1.4	100.0
VIRGINIA	29.8	23.9	4.4	1.1	3.5	3.9	18.6	14.8	100.0
WASHINGTON	23.5	30.0	2.9	1.9	4.9	4.9	16.6	15.2	100.0
WEST VIRGINIA	28.2	18.4	4.4	1.0	2.6	8.5	22.0	16.9	100.0
WISCONSIN	25.2	33.0	6.1	1.5	4.1	5.8	21.8	2.7	100.0
WYOMING	25.0	32.7	3.2	1.9	2.3	2.3	15.5	17.0	100.0
TOTAL	28.1 %	27.9 %	4.3 %	1.5 %	4.2 %	5.3 %	22.2 %	8.4 %	100.0%

a/ Includes personal health expenditures and administrative costs

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

SOURCE: Lewin/ICF estimates.

Jack Lindberg → Oct 11 – New Eng. Journal of Medicine

For the Health of a Nation

by Henry Simmons, M.D., from the Report of the National Leadership Commission on Health Care

The National Leadership Commission on Health Care identified four major problems in our health care system and proposed a major restructuring of the nation's health care system to resolve them. The commission's proposal provides universal access to a basic level of health services; it controls escalating costs through use of economic leverage in the purchase of care, financing and systems reforms, economic incentives including cost sharing, and practice guidelines to encourage appropriate care and eliminate unnecessary care. The commission believes that reducing unnecessary procedures will help contain costs and improve the quality of health care. Its malpractice reform recommendations will also help contain costs and improve quality.

The commission agreed on a vision of a better health care system in the twenty-first century, one that promotes preventive care and healthy lifestyles, and established an innovative, efficient health care system. The system would encourage personal responsibility for choosing good health and appropriate treatment, support a strong doctor-patient relationship, and establish and utilize a public-private partnership to control costs, assure universal access, and improve the quality of care.

Problems with the Current Health Care System

America's health care system is in crisis. Costs are out of control, millions of Americans face difficulty gaining access to needed care, there is a malpractice crisis, and there are serious problems in the quality and appropriateness of much of the medical care being rendered. These problems are interrelated, systemic, and growing worse. It seems clear that they cannot be solved without a long-term, comprehensive strategy. Awareness of these problems has led to a strong shift in public attitudes to broad dissatisfaction with our health care system.

The rate of health care cost escalation is of major concern to both government and the private sector. Unless we act soon to change America's health care system, by the year 2000 the United States could be spending a quarter of the GNP—$2.5 trillion—on health care. That number is more than double the federal government's entire budget for 1990. It is also $1 trillion more than recent estimates for U.S. spending on health care at the turn of the century. National health care spending of $2.5 trillion translates to almost $10,000 per year for every man, woman, and child in this country.

Government is concerned because it is increasingly clear that the federal deficit and rising health care costs are inextricably intertwined. Business and labor are concerned because rising health care costs are now considered a major threat to industry's economic viability and its ability to compete and to provide jobs. The American people are concerned because more and more of the costs are borne directly by individuals, and there is no end in sight.

A systemic problem of this magnitude cannot be solved with a piecemeal strategy. Nor can it be solved by any one segment of society, including government, alone. We all share some of the blame for this complex societal problem, and therefore we share the responsibility for resolving the problem. Costs must be contained, quality and access must be assured, the malpractice problem must be resolved, and, to the extent possible, the American system of freedom of choice, "pluralism," and competition must be preserved. But this will not be possible without comprehensive, long-term structural reform. Such reforms will require creation of a new public-private partnership and a coordinated effort of business, labor, government, providers, insurers, and consumers. Otherwise, costs and problems will only be shifted, and our situation will grow more severe, to the detriment of all.

The growing seriousness of the problems and public concerns have combined to create a new opportunity and need for effecting major change in our health care system. There is now a clear and compelling case for comprehensive reform.

Summary of the Commission's Proposal

The National Leadership Commission on Health Care's final report, *For the Health of a Nation: A Shared Responsibility*, proposes a major restructuring of the nation's health care system. The central feature of the commission's proposal is the notion that none of the problems besetting the nation's health care system—lack of access for millions, poor quality, inefficiency, soaring costs, and a malpractice insurance crisis—can be solved in isolation. The problems are interconnected; the solution must also be. The plan is based on seven fundamental principles and has four interrelated parts—a universal access proposal, a national quality improvement initiative, a cost containment strategy, and a malpractice reform package.

Fundamental Principles of the Commission's Proposal

The commission's proposal is based on seven fundamental principles.

1. *Principle of Universal Access.* There should be no financial barrier separating Americans in need of health care from access to care.
2. *Principle of Fair Compensation.* Every provider of health services in America should be adequately compensated for services rendered to patients.
3. *Principle of Clinical and Economic Freedom.* To the maximum extent possible, without unduly compromising other important principles, health policy ought to restore clinical freedom in rendering health services and economic freedom in financing these services, within the context of adequate countervailing market power from those who ultimately pay for health care in America.
4. *Principle of Shared Responsibility.* Financial responsibility for health care for those too poor to afford it should be shared by government, individuals, and employers.
5. *Principle of Individual Responsibility.* To help achieve the goal of universal access to health care, the individual has a duty to have adequate insurance coverage for himself or herself and dependents.
6. *Principle of Basic Benefits Guarantee.* The design of a basic package of health service benefits to which all Americans should have reliable access is ultimately a federal responsibility.
7. *Principle of a Strong Doctor-Patient Relationship.* Any health care system should foster the goal of protecting the integrity of the doctor-patient relationship.

In light of the federal deficit, the commission proposes building upon the American tradition of providing private health insurance through the workplace. The proposal is designed to encourage continued extensive reliance on that approach, without mandating that employers provide such coverage. The commission also noted that universal access could be funded out of general revenues.

The Commission's Proposal

The Universal Access (UNAC) Plan. UNAC would provide universal access to basic health care for all Americans without insurance. Medicaid recipients would become part of this program. There would be an incentive for more employers to offer health insurance to employees, since both would pay a fee to UNAC if employees were not offered insurance. Financing for this public program would be paid for through a health insurance premium of 0.6 percent of income up to the social security maximum, paid by everyone with incomes over 150 percent of the federal poverty level and their employers, with special provisions for new and small businesses and part-time workers. The funds would be collected nationally; the UNAC program would be administered in a decentralized fashion by the states.

A National Quality Improvement Initiative. This provision would improve the quality, appropriateness, and efficiency of care by establishing a national program of increased technology assessment and outcomes research that would result in national practice guidelines for all the major procedures. Since seventy major procedures account for about half of our total national health expenditures, this is an important way to eliminate unnecessary care. Up to $500 million a year from the UNAC funds would support this ongoing program, designed to assess technology, develop guidelines and standards, and compare new procedures, as they become available, with those already in use.

A Cost Containment Strategy. The elimination of much unnecessary care could potentially cut back up to 20 percent to 30 percent of all procedures performed today. UNAC will have economic leverage, because it will negotiate payment rates for 60 million to 70 million people. Under UNAC, cost shifting of charity care will end and there will be greater inter-employer equity. UNAC will also encourage intervention. The new ability through research and guidelines to make more informed purchasing decisions, combined with cost sharing, will increase individual responsibility. The commission called for increased use of organized systems of care, such as PPOs, by private employers and for physician payment reform with expenditure targets.

A Malpractice Reform Package. This six-part proposal, based on successful programs in some states, calls for strict criteria for expert witnesses; strengthened standards of negligence; punitive damages limited to a grave dereliction of professional responsibility with damages going to the state; limited contingency fees; a fast track through the court system for malpractice cases; and increased use of arbitration. If the states do not move expeditiously to make these changes, there should be consideration of federal preemption of state malpractice laws.

NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

AT&T
Amalgamated Clothing and Textile Workers Union
American Academy of Pediatrics
American Association of Retired Persons
American College of Physicians
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Nurses' Association, Inc.
Ameritech
Association of Academic Health Centers
Association of Minority Health Professional Schools
Bell Atlantic
BellSouth
Bethlehem Steel
Chrysler Motors Corporation
Communications Workers of America
DuPont
Eastman Kodak
Equifax
Families USA Foundation
Ford Motor Company
General Electric
Georgia-Pacific Corporation
W.R.Grace & Co.
International Association of Machinists and Aerospace Workers
International Brotherhood of Electrical Workers
International Union of Electrical Workers
Lincoln Telephone & Telegraph Co.
Lockheed Corporation
Meredith Corporation
National Leadership Commission on Health Care
National Small Business United
Northern Telecom Limited
Northwest Airlines
NYNEX Corporation
Pacific Gas & Electric
Pacific Telesis Group
Pioneer Seed
Rochester Telephone Corporation
Rubbermaid
Service Employees International Union
W.C.Smith Inc.
Southern California Edison Company
Southwestern Bell Telephone
3M
Time Warner Inc.
U S WEST
United Steelworkers of America
United Way of America
Westinghouse Electric Corporation
Weyerhaeuser Company
Xerox Corporation

September 21, 1990

SCR

11

No. 1

STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION Bill Version: SCR 11
PUBLISH DATE (S) Publish Date: 3/6/91

FISCAL NOTE

REQUEST:
Revision Date:
Title: "TAKE PRIDE IN SOBRIETY"
Sponsor: HOFFMAN

Affected Agency: LEGISLATURE
BRU:
Components:

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services							
Travel							
Contractual							
Supplies							
Equipment							
Land & Structures							
Grants, Claims							
Miscellaneous							
TOTAL OPERATING		0					
CAPITAL		0					
REVENUE		0					

FUNDING: (THOUSANDS OF DOLLARS)

		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
General Fund		0					
Federal Fund							
Other							
TOTAL		0					

POSITIONS:

		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Full-Time							
Part-Time							
Temporary		0					

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY)

Prepared By: SENATE HESS COMMITTEE
Phone: 465-3818
Division:
Date: 05MAR91

Approved By: [signature]
Agency:
Date: 05MAR91

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

Senator Lyman F. Hoffman

Alaska State Senate
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4453

M E M O R A N D U M

TO: Ms. Nancy Quinto
Senate Secretary

FROM: Senator Lyman Hoffman L.H. by M.R.

DATE: February 19th, 1991

RE: " Take Pride in Sobriety " Resolution

Please add the following Senators as Co-Sponsors to the above mentioned resolution;

Senator Sturgulewski, Adams, Pearce, Frank, Menard, Collins, Zharoff, Shultz, and Eliason

As well as the following Representatives as cross-sponsors;

Representative Ivan, Lincoln, B. Davis, Taylor, Larson, Zawacki, Koponen, Ulmer, Sharp, Leman, Brown, Parnell, Hudson, Foster, KUBINA, Jacko

If there are any questions feel free to contact my office at your earliest opportunity.

P.O. Box 763 • Bethel, Alaska 99559 • (907) 543-3543

STATE OF ALASKA

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF ALCOHOLISM AND DRUG ABUSE

P.O. BOX H
JUNEAU, ALASKA 99811-0607
PHONE: (907) 586-6201
FAX: (907) 586-1061

March 1, 1991

MAR 05 1991

Lyman Hoffman
Alaska State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Hoffman:

We would like to take this opportunity to express our support of Senate Concurrent Resolution No. 11, urging all Alaskans to "Take Pride in Sobriety."

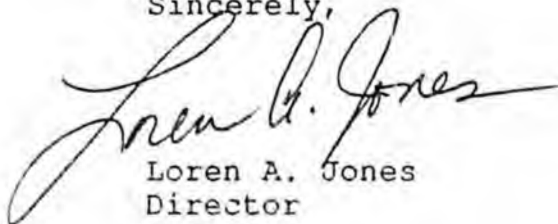
It is truly exciting and gratifying to see Alaskan organizations and communities take the initiative to promote sobriety. The Alaska Federation of Natives has been an active leader in this movement.

Legislative support and recognition of Alaskan's efforts as found in SCR 11 is appreciated. Such support will help promote and foster local sobriety efforts.

The timing of the "Take Pride in Sobriety Weekend" will tie in nicely with the annual "Red Ribbon" campaign scheduled for October 19 - 27, 1991 which is coordinated by Alaskan's For Drug Free Youth. These two events will focus local efforts in a positive direction early in the school year and as the busy holiday season begins.

Thank you for your concern and support in this area.

Sincerely,



Loren A. Jones
Director

lj/scr11

06-F74LH

EXECUTIVE SUMMARY

The devastating effects of alcohol on individuals, families, and whole communities in Alaska is well known and documented. Various factors including Alaska's lower median age, higher proportion of men, and higher proportion of Native Americans all suggest a larger problem than that revealed by national statistics.

The Division's mission, as clearly defined by legislation, is to create and maintain a comprehensive program of prevention, intervention, and treatment for all Alaskans that may be affected by alcohol, drug, and inhalant abuse.

A principal method used by the Division in carrying out its mission is the grant-in-aid. Grant proposals submitted by applicants define their areas' needs and priorities and describe their approach to meeting those needs. This process allows local communities to have input into what services are provided within their region.

The Division is also responsible for conducting reviews and issuing certificates of approval for private alcohol and other drug abuse treatment agencies. In recent years there has been significant growth in the number and location of such private agencies. The Division encourages the development of these programs which provide high quality treatment services to those who can afford to pay the full cost of care.

While the Division of Alcoholism and Drug Abuse (ADA) works to implement strategies that will reduce the incidence of alcohol and other drug abuse there is a constant need for treatment services. These treatment services must continue to address the varying needs of alcohol, drug, and inhalant abusers.

Alaska's substance abuse programs have been growing and changing to meet the changing needs of the communities that they serve. They have proved flexible enough to respond to these needs and maintain basic services while state funding has fluctuated over the years. Entering the 1990s the substance abuse programs and the Division of Alcoholism and Drug Abuse have established a broad range of services and are challenged to preserve that service system while continuing to respond to diverse community needs.

Over the six years from FY 85 to FY 90, total funding for the Division of Alcoholism and Drug Abuse declined steadily until FY 89. This drop was due to declining state funds, which decreased over seventeen per cent (17%) from FY 85 to FY 89. State funding remained 8 per cent lower (8%) in FY 90 than in FY 85, even with an increase of $1.3 million over FY 89 funding.

While state funding for the Division has fluctuated with oil revenues, federal funding has steadily increased. Federal funding to the Division during the last six years has grown from $1.5 million to $2.6 million in FY 90. These funding increases may be attributed to growing national concern with drug addiction and have resulted in increased programs for drug abuse treatment and prevention.

In FY 90 the Division of Alcoholism and Drug Abuse funded more than 40 separate alcohol and other drug abuse treatment and prevention agencies throughout Alaska. Treatment programs included 400 residential care beds and more than 1700 outpatient treatment "slots." Almost eight thousand (7,998) individuals were admitted as clients to ADA funded programs during this year.

Agencies funded by the Division in FY 90 also provided substance abuse prevention programs throughout the state. These programs most often focused on youth as the most appropriate target for their prevention activities. These activities ranged from peer counseling and "natural helpers" training to summer camps for high risk youth.

The Division of Alcoholism and Drug Abuse recognizes that there will always be unmet needs and that the problems of alcoholism and drug abuse will not be eliminated by the actions of a single state agency. There are numerous local, state and federal programs that address some aspects of the alcohol and other drug abuse problem in Alaska. It is the intended role of the Division to coordinate these efforts and provide leadership in finding solutions to these problems.

An important part of that leadership role is balancing the need to monitor and regulate programs with the need to foster new ideas and new approaches to a complex problem. The Division will strive to balance these roles and seek support for decisions through an on going dialogue with providers of service, clients, and advocacy groups.

OLDER PERSONS ACTION GROUP, Inc.

325 E. Third Avenue, Suite 300
Anchorage, AK 99501
(907) 276-1059 (Toll free 800-478-1059)

March 11, 1991

Senator Arliss Sturgulewski
Alaska State Legislature
P. O. Box V
Juneau, Alaska 99811-3100

Dear Senator Sturgulewski:

Thank you for heading a movement to encourage sobriety in Alaska.

Older Persons Action Group, Inc. (OPAG) endorses and supports the resolution urging Alaskans to "Take Pride in Sobriety." Designating 1991 the year for schools, health care organizations and practioners, public and private agencies and individuals to pay particular attention to the problem will increase awareness and challenge us all to work toward this common goal.

Sincerely,

ROSE PALMQUIST
President

RP:bja

Alaska State Legislature

SENATOR
ARLISS STURGULEWSKI

3111 C STREET, SUITE 550
ANCHORAGE, ALASKA 99503
(907) 561-7615

While in Juneau
P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3818

Senate

March 13, 1991

John Schaeffer, Chairman
Alaska Native Blue Ribbon Commission
on Alcohol and Drugs
1577 C Street, Suite 100
Anchorage, Alaska 99501

Dear John:

Thank you for your message of support for SCR 11 "Take Pride in Sobriety." I am a co-sponsor of this resolution and as chairman of the Senate Health, Education and Social Services Committee scheduled the bill for a committee hearing on March 6. I am pleased to report that the resolution passed out of the committee with a unanimous "do pass" recommendation.

Senate Concurrent Resolution 11 is now in the Senate Rules Committee and it is my hope that it will be scheduled for floor action soon. You can count on my continued support!

Kindest regards,

Arliss

Arliss Sturgulewski
Alaska State Senator

PUBLIC OPINION MESSAGE

DEAR: SENATOR STURGULEWSKI

NAME: THERESA DEVLIN
TITLE: AK NATIVE BLUE RIBBON COMMISSION
ADDRESS: 1577 C STREET, SUITE 100
CITY: ANCHORAGE ZIP: 99501
PHONE: 274-3611
BILL NO: SCR 11
SUBJECT:
MESSAGE: WE STRONGLY URGE YOU TO SUPPORT "TAKE PRIDE IN SOBRIETY." PLEASE PASS THIS RESOLUTION AS A MESSAGE FOR ALL ALASKANS. SIGNED: JOHN SCHAEFFER, CHAIRMAN, ALASKA NATIVE BLUE RIBBON COMMISSION ON ALCOHOL AND DRUGS. EOM/MJ

POMID: 07111142
DATE: 91/03/11
TIME: 11:11:42
LIONAME: FAIRBANKS LIO

COPIES:

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3/6 3DP

Yukon-Kuskokwim Health Corporation

"Fostering Native Self-Determination in Primary Care, Prevention and Health Promotion"

Yukon Kuskokwim Health Corporation
P.O. Box 528
Bethel, Alaska 99559

Our Mission is to achieve the greatest possible improvement in the health status of the people of the Yukon Kuskokwim Delta Region. We are committed to the development of culturally relevant programs for primary care, prevention and health promotion in a setting that fosters Native self-determination in the control and management of health delivery.

We are proud to dedicate 1991 to:

"Take Pride In Sobriety"

Since our young people are our most valuable resource, YKHC is proud to unite with the people of the State of Alaska in the war on drugs and alcohol.

YKHC sincerely hopes that all residents of Alaska join us in honoring those who practice sobriety.

P.O. Box 528 Bethel, Alaska 99559 (907) 543-3321

SCR

15

STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION SCR 15
PUBLISH DATE 23 April 1991

FISCAL NOTE

REQUEST: Senate HESS Committee
Revision Date:
Affected Agency: Office of the Governor
Title: SCR 15: Requesting the Alaska Comm Children & Youth-special attention to adolescents.
BRU: AK Comm Children & Youth
Sponsor: Pearce
Components:

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING	FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services	0.00					
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.00	0.00	0.00	0.00	0.00	0.00

CAPITAL						

REVENUE						

FUNDING: (THOUSANDS OF DOLLARS)

General Fund						
Federal Fund						
Other						
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00

POSITIONS:

Full-Time						
Part-Time						
Temporary						

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY)

Prepared By: Senate HESS Committee
Phone: 465-3818
Division:
Date: 23-Apr-91

Approved By: Senator Arliss Sturgulewski
Agency: Senate HESS Committee
Date: 23 April 1991

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

WALTER J. HICKEL
GOVERNOR

P.O. Box A
Juneau, Alaska 99801
(907) 465-3155

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

ALASKA COMMISSION ON CHILDREN AND YOUTH

POSITION PAPER - SCR 15

In the 1988 report by the Governor's Interim Commission on Children and Youth, Our Greatest Natural Resource, Investing in the Future of Alaska's Children, the Commission documented the growing problem of increased teenage pregnancy rates in Alaska and made recommendations.

SCR 15 asks the Alaska Commission on Children and Youth to focus increased attention on the needs of adolescents to avoid early pregnancy and achieve their full potential. The Commission is well aware of the responsibilities mandated by Statute, and they would like to go on record as being in full support of this resolution.

With the creation of the Alaska Commission on Children and Youth came Statute which requires the development of a comprehensive statewide plan that identifies the needs of children and youth and provides recommendations to enhance their quality of life. Our responsibilities are many and our commitment is real. In developing our statewide plan we will look to the work of groups like the Teen Pregnancy Task Force for insight into the problems facing adolescents and children alike.

We understand what this resolution asks of us. We thank those individuals who gave their hearts and time on the Teen Pregnancy Task Force, and we look forward to working with them as we develop our comprehensive statewide plan.

RECOMMENDATION:

Encourage the Governor's Commission on Children and Youth to give more consideration to the needs of adolescents than has been given in the past.

Issue

The Task Force commends the Governor's Commission on Children and Youth for the efforts they have made in addressing the problems of pre-adolescent children. However, probably because the Commission feels the needs of younger children are more urgent, a proportionate amount of effort has not been given to the problems of adolescents. The Task Force encourages the Governor's Commission to go to the source of many of the problems they are having to deal with in addressing the needs of younger children. Many of these children are the product of adolescent parents. A significant number of adolescent mothers give birth to infants of lower birth weight and with more developmental problems than children of older parents. These offspring frequently suffer more from child abuse, neglect, lack of good nutrition, and financial instability. In addition, these children of adolescents are frequently more at risk of repeating the cycle of early pregnancy, of having lower self-esteem, and of having a higher school drop out rate.

Implementation

Replace retiring members of the Governor's Commission on Children and Youth with individuals having the problems of adolescents as their primary interest and/or expertise.

Cost

This recommendation should have no additional cost. It merely requests a more equal distribution of effort from the Governor's Commission on Children and Youth. That commission is already mandated to deal with the problems of all children, including adolescents.

Benefits

The Task Force believes that with more attention paid to the problems of adolescents in all areas of prevention and prenatal and parenting services, the greater the benefits to society. Alaska can reduce the $51 million a year it spends annually to support needy families of Alaska mothers who had children when they were teenagers and the $4 million a year spent to support parents who are still teenagers. While these figures cover only the costs of AFDC, Food Stamps and Medicaid, other costs such as those for child care, protective services for abused adolescent mothers and their children, housing and counselling can also be reduced.

RECOMMENDATION:

Identify the Governor's Commission on Children and Youth as the oversight body for implementation of the Adolescent Pregnancy and Parenthood Task Force recommendations.

Issue

The Task Force recommendations were designed to help Alaska's adolescents avoid pregnancy, as well as to help adolescents who do become pregnant to receive prenatal care and help in improving their parenting skills. However, simply making recommendations will not bring about the desired goals. If we stop here, without some organization pushing the recommendations through the legislature and through their implementation and follow up stages, the Task Force's efforts will have been wasted. Adolescents will continue to become pregnant, and the rate of adolescent pregnancy will continue to escalate.

Not all programs suggested here will be perfect, and none will be effective over night. Minor adjustments to programs will be necessary to assure their maximum effectiveness, and some organization must be responsible to see that these programs are both implemented and adjusted accordingly.

The Governor's Commission on Children and Youth was set up to deal with the problems of all of Alaska'a children, including adolescents; and as such, is the logical organization to follow up on the Task Force recommendations.

Cost

The Governor's Commission on Children and Youth has already set up a network to address problems of children in Alaska. Making use of this network and experience would be the most efficient means of assuring the effectiveness of the Adolescent Pregnancy and Parenthood Task Force recommendations. No additional cost to the State is anticipated.

Benefits

With an oversight agency such as the Governor's Commission on Children and Youth, all of the recommendations of the Adolescent Pregnancy and Parenthood Task Force can be coordinated. This will help assure that the duplication of services is minimized and those areas where services are lacking are covered. Since our recommendations include programs run at all levels of government, and involve private agencies and organizations as well as state agencies, the Chidren's Commission would be best qualified to coordinate the implementation of our recommendations. The Children's Commission was designed to represent all sectors.

SCR

16

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SCR 16

Revision Date:
Department Affected: University of Alaska
Title: Requesting the University of Alaska to compile certain types of information relating to adolescent pregnancy & Parenthooc
BRU: UAA/Organized Research
Component:
Sponsor: Pearce, Uehling, Zharoff, Collins
Requestor: Pearce
Component Serial No.

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY92	FY93	FY94	FY95	FY96	FY97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	75.0	75.0	75.0	75.0	75.0	75.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	75.0	75.0	75.0	75.0	75.0	75.0

CAPITAL						

REVENUE						

FUNDING: (Thousands of Dollars)						
GENERAL FUND	75.0	75.0	75.0	75.0	75.0	75.0
FEDERAL FUNDS						
OTHER						
TOTAL	75.0	75.0	75.0	75.0	75.0	75.0

POSITIONS:						
FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year impact: ____________________

ANALYSIS: (Attach a separate page if necessary.)

Cost to establish data base and provide analysis for public policy review

Prepared by: Marsha A. Hubbard
Phone: 474-7593
Division: Statewide Budget Office
Date: 4/11/91

Approved by: Wendy Redman, Vice President for University Relations
Agency: University of Alaska
Date: 4/11/91

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

Rev 10/90

Alaska State Legislature

3111 C Street, Suite 150
Anchorage, Alaska 99503
(907) 561-2038

During Session:
P.O. Box V
Juneau, Alaska 99811
(907) 465-4993

Senator Drue Pearce
District G

MEMORANDUM

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

FROM: Senator Drue Pearce DP

DATE: April 12, 1991

RE: Sponsor Statement for SCR 16

The purpose of this legislation is to create a source of continued and compiled information about the problem of teen pregnancy. This will serve as an aid to public policy makers as to the progress or problem areas in the adolescent pregnancy problem in our state.

In this resolution, ISER is requested to maintain this data as they are uniquely suited for this task.

With this data, combating the crises of adolescent pregnancy and the problems associate with it, our battle will be much more effective.

RECOMMENDATION:

Develop a report on the costs of supporting adolescents and their offspring as compared to the costs of preventing adolescent pregnancies.

Issue

Both the causes and effects of adolescent pregnancy and parenting are complex and far reaching. The state must examine not only the costs of preventing adolescent pregnancy and supporting adolescent parents, but must also examine the costs of not preventing these pregnancies and the generational cycle of poverty thus created.

Implementation

1) Request that the Institute of Social and Economic Research (ISER) establish and maintain a body of statistical information assessing the costs to the state of adolescent pregnancies in Alaska compared to the estimated cost of preventing these pregnancies and of promoting healthy life-styles in existent adolescent parent families.

2) Request that ISER prepare an initial report which projects comparative financial costs and social implications into the next century (at least a 10 year projection). Data should be maintained in such a way as to allow for the timely update of reports.

Cost

ISER estimates that the cost of this report would be approximately $75,000.

Benefits

The development of a comparative costs report would: 1) provide justification for state expenditures; 2) provide standards for the measurement of program effectiveness; and 3) provide data for public information and support of programs.

SCR

17

STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION CS SCR 7 (HESS)
PUBLISH DATE 10-Apr-91

FISCAL NOTE

REQUEST: SENATE HESS COMMITTEE
Revision Date:
Title: Amend Uniform Rules, Create Educat
Sponsor: Kerttula

Affected Agency: Legislative Affairs Agency
BRU: Legislative Council
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
	0.00	0.00	0.00	0.00	0.00	
CAPITAL	0.00	0.00	0.00	0.00	0.00	
	0.00	0.00	0.00	0.00	0.00	
REVENUE	0.00	0.00	0.00	0.00	0.00	
	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
	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
Division:
Phone: 465-3818
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)

FISCAL NOTE

No. 1
Bill Version: HCR 3
(H) Publish Date: 4/8/91

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date:
Title: Proposing an amendment to... Uniform Rules... relating to Education comm... & H&SS comm...
Sponsor: Representative Carney
Requestor: House HESS

Department Affected: Legislative Affairs Agency
BRU: Legislative Council
Component: Session Expenses

COMPONENT SERIAL NO: 782

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0

REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

Zero fiscal impact.

Prepared By: Pamela A. Stoops, Director — Phone: 465-3850
Division: Administrative Services — Date: 3/7/91

Approved By: Warren W. Endicott, Executive Director
Agency: Legislative Affairs Agency — Date: 3/7/91

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

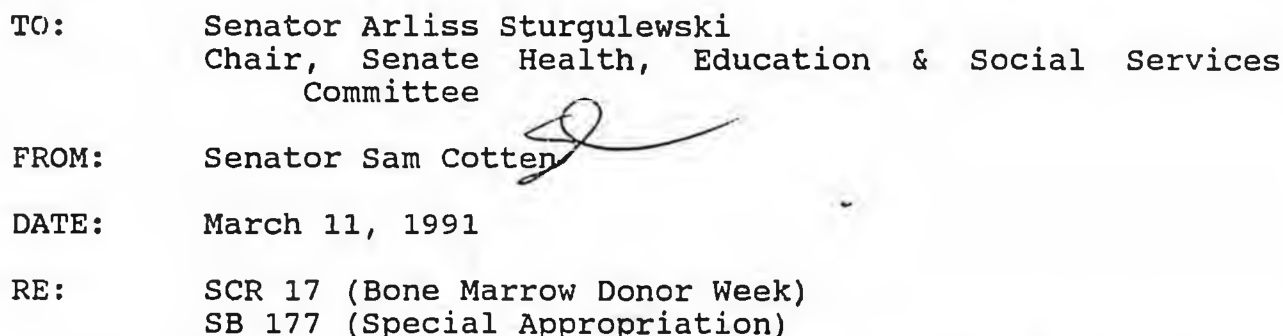
Alaska State Legislature

SENATE

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM



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

FROM: Senator Sam Cotten

DATE: March 11, 1991

RE: SCR 17 (Bone Marrow Donor Week)
SB 177 (Special Appropriation)

I have introduced SCR 17 and SB 177 in an effort to educate persons regarding bone marrow transplants and to provide funding for efforts to increase enrollment in the donor program.

SCR 17 designates the week of April 14-20 as "Bone Marrow Donor Week". The resolution asks that efforts be made, in conjunction with the work being done by the Blood Bank of Alaska, to educate and inform Alaskans about the bone marrow donor program.

SB 177 requests an appropriation of $222,000 as a grant to the Blood Bank of Alaska to assist in increasing enrollment of bone marrow donors in Alaska.

For the committee's review, I have attached information concerning bone marrow transplants and the bone marrow donor program.

Dale Goodloe testimony (summary)

BLOOD BANK OF ALASKA, INC.
4000 LAUREL STREET • ANCHORAGE ALASKA 99508
907/563-3110

March 12, 1991

Senate HESS Committee
Senator Arliss Sturgulewski, Chair
P.o. Box V
Juneau, Alaska 99811

TESTIMONY BEFORE THE SENATE HESS COMMITTEE

Prepared by: Dale V. Goodloe, Operations Manager
Blood Bank Of Alaska, Inc.

- An estimated 16,000 children and adults are stricken each year with leukemia, aplastic anemia, or other blood related diseases that can be successfully treated with bone marrow transplants.

- More than two thirds of these people can not find a suitable marrow donor match with in their own family.

- The National Marrow Donor Program was established in 1987, to assist patients in locating a suitable unrelated marrow donor with an identical tissue type.

- Finding a suitable marrow donor can be as high as one in a million based on the rarity of the tissue type and the availability of donors with the same racial background as the patient.

- Currently the National Marrow Donor Program registry is made up of 91% Caucasian.

- The Blood Bank of Alaska, Inc. became a recruitment center for National Marror Donor Program in July 1989 and remains the only recruitment center in the State.

- The Blood Bank of Alaska has become aware of people throughout Alaska in need of marrow transplants.

- As we became aware of Alaskans in need of marrow transplants, we stepped up our efforts to enroll as many donors as possible into the National Marrow Donor Program; without a marrow transplant these people cannot survive.

- We have been working with volunteers and family fundraising efforts to recruit, test and enroll donors into the National Marrow Donor Program.

- With the interest and support expressed by individuals and communities throughout Alaska, we have come to realize the potential of recruiting thousands of Alaskans into the National Marrow Donor Program.

- Alaskans have already stepped forward to enroll as donors but we can only enroll as many as we have funds for.

- The State of Alaska's support of the resolution and funding is critical in not only the overall success of the National Marrow Donor Program, but to the people of Alaska in dire need of marrow transplants.

- The Blood Bank of Alaska, Inc. respectfully urges the Senate HESS Committee's support for Senate Bill 177 and Senate Concurrent Resolution 17.

Respectfully submitted,

Dale V. Goodloe

BLOOD BANK OF ALASKA, INC.
REQUEST FOR STATE OF ALASKA FUNDING

The Blood Bank of Alaska, Inc., is a not-for-profit corporation serving the blood needs of Alaskans for over 29 years. A year and one-half ago, the Blood Bank of Alaska became the only Alaskan recruitment center for the National Bone Marrow Donor Program (NMDP). The following explains the purpose and need of the NMDP and the Blood Bank of Alaska.

- There are close to 10,000 patients nationwide with leukemia and other related blood diseases who cannot find a donor and will not survive without a bone marrow transplant. One in 6,000 children alone will be diagnosed with fatal childhood leukemia. The diseases are not thought to be inherited and can happen to anyone, any age, anytime. Alaskans and thousands of others have already died for lack of a "miracle match" marrow donor. All of these numbers increase daily as new cases are diagnosed and time runs out for those who are searching for a matched donor.

- For a transplant to be successful, the donor and the patient must have the same immune system recognition signals, called Human Leukocyte Antigens or HLA. To be a perfect match, all six HLA locations on the donor's white blood cells must be identical to the patients. The odds that two unrelated individuals will match is one in 20,000.

- The NMDP was created to establish a national registry of individuals who could donate marrow to unrelated patients. The more donors enrolled into the registry, the greater the chance a patient has of finding a match.

The Blood Bank of Alaska has received numerous requests from groups and individuals throughout Alaska who are interested in enrolling into the NMDP Registry. As a combined effort, we can offer hope and life to thousands of people suffering from fatal, but now curable, leukemias and other blood related diseases.

The Blood Bank of Alaska is requesting funding from the State of Alaska in the amount of $222,000 in support of enrolling an additional 3,000 marrow donors into the national registry.

Additional Expense for Remote Locations	SUBTOTAL	$ 36,300
	TOTAL EXPENSES:	$ 221,800

BUDGET DETAIL

			ANNUAL
1. PERSONNEL			
Clerical Position:	20 Hours Per Week @ $9.50/Hr. 23% Fringe Benefits	$ 12,150	

Mailing out information packages, making appointments, reviewing medical history forms, typing labels & files, assembling information (consent forms, donor data forms, medical history forms, etc.), coordinating shipping, HLA data processing, data submission to National Bone Marrow Program (NBMP) representative, accounts receivable and payable, correspondence.

Phlebotomist:	8 Hrs./Wk. @ $13/Hr. 23% Fringe Benefits	6,650	

Draws blood specimen, labels tubes, prepares package for shipping.

Technical Coordinator:	12 Hrs./Wk @ $19.50/Hr. 23% Fringe Benfits	14,975	

Provides information session for potential donors, determines eligibility for program, oversees drawing and shipping of specimens, coordinates HLA data and enrollment in National Bone Marrow Program.

	TOTAL PERSONNEL		$ 33,775

2. TRAVEL			
Technical Coordinator:	2 Trips Wk./Avg. 20 Miles Roundtrip X 26 Cents/Mile	$ 550	
Phlebotomist:	1 Trip Wk./Avg. 14 Miles Roundtrip X 26 Cents/Mile	275	
	TOTAL TRAVEL		$ 825

5. OTHER EXPENSES	ANNUAL
Shipping (Federal Express Overnight Delivery Service); 32 specimens/shipment (4 boxes together) X 2600 donors, plus 50 individual shipments for additional testing	$ 6,600
Telephone/FAX Charges; long distance calls re: shipping information to lab, FAXing HLA data for enrollment in registry, miscellaneous related calls	525
Printing (excluding information packages); handouts to potential donors concerning future draw sites, miscellaneous information for donors	300
Miscellaneous; donor acknowledgements, etc.	150
TOTAL OTHER	**$ 7,570**

		ANNUAL
3. EQUIPMENT		
(One Time Purchase)		
Fireproof Locking File Cabinet	$ 800	
4 Each Blood Pressure Cuffs	300	
Off-Site Phlebotomy Carrying Cases	275	
TOTAL EQUIPMENT		$ 1,375
4. SUPPLIES		
Medical Supplies For Enrollment (test tubes, needles, gauze, etc.); $1.55 per sample X 2600 donors plus additional supplies for further typing (50/Yr.)	$ 4,100	
D.O.T. Approved Specimen Shipping Containers (double-insulated, foam-lined, plastic barrier); 8 specimens/box @ $4.40 X 325 donors, plus separate individual box for additional specimen for DR and MLC test (50/Yr.)	1,650	
HLA Typing Charge (performed by NBMP-certified lab (Alaska does not have an in-state HLA Lab); $50 X 2600 donors	130,000	
Office Supplies (files, labels, envelopes, etc.); 15 cents/donor, plus $300 in xerox paper	700	
Postage (mailing information/consent package = 75 cents/each; enrollment letter = 29 cents/each) X 2600 donors, plus miscellaneous correspondence of $100	2,700	
Infectious Disease Marker Testing (performed only on potential donor when additional HLA typing requested); 50 X $28 (portion not reimbursed by NBMP)	1,400	
Information Package (contains Q & A, consent form, medical history, donor data sheet, cover letter); copying charge X 54 cents/each X 2600 donors	1,400	
TOTAL SUPPLIES		$141,950

APPENDIX 1

Additional Expenses For Enrollment of Donors at Remote Locations

The following additional expenses are for the recruitment of donors at six remote locations. The figures are based on the following assumptions:

- o All coordinating site selection and organization for remote draws is done from Anchorage.
- o Volunteers are available at the remote site to coordinate activities and times.
- o A facility in which to perform information sessions and collect specimens is provided for BBA to use (a hospital room, school room, fire station, or office building).
- o The location of the site is no greater than two hours air travel time distant; and a roundtrip can be made in one working day (no overnight trips).
- o A minimum of 50 residents are interested in enrolling in the program, with a maximum of 100 per day.
- o A hospital, lab, clinic, or physician's office in the community is willing to draw any future specimens needed for additional HLA typing on a specific donor.

<u>PERSONNEL</u>

<u>Technical Coordinator</u>:	16 Hrs. Coordinating/Site; 12 Hrs. At Each Site; 6 Sites - 168 Hrs. X 19.50 + 23% Fringe Benefits	$ 4,040
<u>Clerical</u>:	12 Hrs./Site X 6 Sites - 72 Hrs. X $9.50 + 23% Fringe Benefits	850
<u>Phlebotomist</u>:	12 Hrs./Site X 6 Sites - 72 Hrs. X $13 + 23% Fringe Benefits	1,160
	ADDT'L PERSONNEL EXPENSE	$ 6,050

TRAVEL

2 Each Roundtrip Tickets, Coach; Average $333/Ticket X 2 Tickets/Site X 6 Sites

ADDT'L TRAVEL EXPENSE	$ 4,000

SUPPLIES

$55.40 Per Donor X 450 (includes HLA typing charge)

ADDT'L SUPPLIES EXPENSE	24,950

TELEPHONE/FAX

ADDT'L TELEPHONE/FAX EXPENSE	500

SHIPPING SPECIMENS TO BBA

ADDT'L SHIPPING EXPENSES	300
TOTAL ADDITIONAL EXPENSES	$ 36,300

March 12, 1991

Senate HESS Committee
Senator Arliss Sturgulewski, Chair
P.O. Box V
Juneau, Alaska 99811

Dear Senate HESS Committee Members:

I have leukemia and am searching for a compatible donor who may save my life through a bone marrow transplant. During my search, I have discovered that 9000-10,000 other individuals throughout Alaska and the United States share this need to find a compatible marrow donor. I have also found that as the public becomes aware of this urgent need, many of my fellow Alaskans are eager to step forward to become marrow donors, not just for myself, but for anyone who might need a bone marrow transplant. Many of these people have shared with me how their lives have also been touched by parents, children, siblings, friends, and co-workers with leukemia and other blood-related diseases that can be cured through bone marrow transplants.

What started as a local Eagle River community response to my personal need has become a rapidly-growing effort in Anchorage and the Matanuska-Susitna Valley to support the needs of other families in similar catastrophic situations. Through volunteer time, private donations, and collaboration with the Blood Bank of Alaska, my family and friends have enrolled 200 potential donors into the National Marrow Donor Program in the past six weeks. Attached is my "Gift of Life" letter which we are using in our recruitment efforts.

We need your help now. Senate Bill No. 177 and Senate Concurrent Resolution No. 17 provide funding for the Blood Bank of Alaska to recruit an additional 3000 Alaskan marrow donors. This funding will cover one-time start-up costs to expand the Blood Bank's public education and blood-testing of potential bone marrow donors from communities throughout our state. This effort will also begin to meet the needs of ethnic minorities such as Alaska Natives, who currently have little hope of finding compatible donors due to their under-representation in the donor registry.

I would appreciate the Senate HESS Committee's support for Senate Bill No. 177 and Senate Concurrent Resolution No. 17. Thank you for your consideration.

Sincerely,

Eileen L. Albert

Eileen L. Albert
17708 Kiloana Circle
Eagle River, Alaska 99577
(907) 694-5781

THE FOLLOWING PAGES
WERE TREATED AS A UNIT
IN THE ORIGINAL FILE

BLOOD BANK OF ALASKA, INC.

4000 Laurel Street
ANCHORAGE, ALASKA 99508
(907) 563-3110

Dale V. Goodloe
Operations Manager

March 11, 1991

Senator Arliss Sturgulewski
Senate
P.O. Box V Capitol, Room 427
Juneau, Alaska 99811

Dear Senator Sturgulewski:

Enclosed you will find information about our efforts to recruit Alaskans as bone marrow donors.

I have leukemia and am searching for a compatible donor who may save my life through a bone marrow transplant. During my search, I have discovered that 9000-10,000 other individuals throughout Alaska and the United States share this need to find a compatible marrow donor. I have also found that as the public becomes aware of this urgent need, many of my fellow Alaskans are eager to step forward to become marrow donors, not just for myself, but for anyone who might need a bone marrow transplant. Many of these people have shared with me how their lives have also been touched by parents, children, siblings, friends, and co-workers with leukemia and other blood-related diseases that can be cured through bone marrow transplants.

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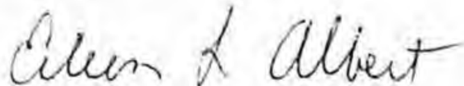
I would appreciate your support for Senate Bill No. 177 and Senate Concurrent Resolution No. 17. Thank you for your consideration.

Sincerely,



Eileen L. Albert
17708 Kiloana Circle
Eagle River, Alaska 99577
(907) 694-5781

Sample forms
used in our
donor drives