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LEGISLATIVE FRONT

Long-Term Care Insurance

At its winter national meeting, the National Association of Insurance Commissioners (NAIC) adopted the following consumer safeguards as part of its Model Long-Term Care Insurance Regulation:

- If a group long-term care policy is replaced by another group policy, the replacing insurer must offer coverage to all persons covered under the previous policy.
- Agents must list on the application form for individual long-term care policies any other health insurance policies they have sold to the applicant that are either still in force or were sold within the past five years and are no longer in force.
- In situations involving replacement of a long-term care policy, the replacing insurer must notify the existing insurer of the proposed replacement.
- Insurers are required to maintain and report to state insurance departments information pertaining to replacement sales and lapses of long-term care policies, with amounts expressed as a percentage of total annual sales. Insurers must report this information on a company-wide basis and for the 10 percent of its agents with the greatest percentages of lapses and replacements. The regulation expressly states that reported replacement and lapse rates do not, in and of themselves, constitute a violation of any insurance law or imply any wrongdoing.
- If a state in which a policy is to be delivered or issued has a Senior Citizens Health Insurance Counseling (SCHIC) program, the insurer must provide written notice to the applicant of the name, address and telephone number of any such program.
- Any insurer or agent who is found to have violated any state requirement pertaining to long-term care insurance or the marketing of such insurance is subject to a fine of up to three times the amount of any commissions paid for the policy, or, up to $10,000.

The initial exposure draft of the consumer protection amendments issued by the NAIC last August had included a provision restricting agent commissions. This provision was identical to the one adopted by the NAIC in December 1989 as part of the NAIC Model Medicare Supplement Insurance Regulation. This proposal was not adopted. Instead, the NAIC took a more moderate position, addressing the commission issue by means of an "optional provision" and an accompanying drafting note to be inserted at the end of the model regulation.

By H. James Douds, NALU Senior Vice President and General Counsel

The drafting note states that the NAIC recognizes that the long-term care market is still in its developmental stages, and that further market development is necessary in order for the product to be responsive to consumer needs. This note advises states to recognize that not all replacements are improper, and advises state insurance departments that if there is evidence of abuse in the long-term care market in the state, the commissioner may wish to consider adopting the agent compensation language set forth in the optional provision.

This language is identical to Section 12 of the NAIC Model Medigap Regulation which, among other things, limits first year commissions on initial policy sales to 200 percent of the renewal commission. The optional provision and drafting note are intended to provide guidance to commissioners who find evidence of long-term care insurance marketing abuse in their states and wish to take additional action in response to such evidence.

The National Association of Life Underwriters (NALU) remains opposed to unnecessary commission regulation. Insurance is sold, not bought, and if the salesperson is denied adequate compensation, the conclusion is inescapable that people simply will not have vitally necessary coverage when they need it.

The compromise adopted by the NAIC seems to hold the promise of meeting regulatory problems while avoiding unnecessary infringement on the opportunities for agents to receive adequate compensation for their services. In other words, under the optional provision in the model regulation, commission restrictions will not be visited upon the marketplace by draconian fiat, but will only be called upon in a given state after the marketplace has been given reasonable opportunity to demonstrate the absence of widespread abuse.

Even then, commission restrictions will be imposed only where the evidence shows that a state's regulatory problems cannot be solved without resorting to commission regulation. It is the hope and belief of NALU that experience will show that agents will serve the long-term health insurance market so as to leave no question that they are well worthy of their hire. ■

LEGAL SIDE

Medigap Changes Focus on Consumer Protection

By David E. Hebert, NALU Counsel, Government Affairs, and Gary A. Sanders, NALU Counsel

Influential health policymakers on Capitol Hill decided that 1990 would be the year for medigap reform and one such target of reform would include health insurance agents.

At its Winter National Meeting held in December 1989, the National Association of Insurance Commissioners (NAIC) adopted significant amendments to its Medicare Supplement Insurance Minimum Standards Model Act and Regulation. These revisions, referred to as the consumer protection amendments, were adopted partially in response to a desire to further regulate marketing and claims practices pertaining to so-called medigap policies.

Of particular concern to agents was an amendment to the model regulation requiring that first year commissions on initial sales of medigap policies be no more than 200 percent of the renewal commission paid on the policy, and that the renewal commission must be paid for a "reasonable" number of years.

When replacing an existing policy, first year compensation cannot exceed the amount of renewal compensation paid by the replacing insurer on renewal policies unless the benefits under the new policy are "clearly and substantially greater" than the benefits under the policy being replaced.

In addition to the commission provision discussed above, the NAIC also adopted several other amendments to the model regulation that were designed to enhance policyholder protection. These revisions included the following:

- Agents must make reasonable efforts to determine whether a proposed policy is appropriate for the consumer;
- Marketers of medigap policies must establish marketing procedures to assure a fair and accurate comparison of policies and to prevent the sale of excessive insurance;
- The first page of the policy must prominently notify consumers that the policy may not cover all expenses incurred;
- Agents must make reasonable efforts to determine whether the applicant already has health or disability insurance, and if so, the types and amounts;
- Applications for medigap policies must include a series of questions regarding coverage under Medicaid and whether the applicant already owns a medigap policy;
- A prohibition on making misleading presentations and incomplete or fraudulent comparisons of policies;
- A prohibition on high-pressure sales tactics and cold lead advertising.

To date, over 30 states have adopted the NAIC's consumer protection amendments, including the provision on agent commissions. Several of these states have adopted commission restrictions that are more stringent than those contained in the NAIC model, including the following:

- Delaware and Minnesota—level commissions must be paid during the first four years of all Medigap policies.
- Michigan—Commissions paid in the first policy year can be no more than commissions paid in each of the two subsequent consecutive annual renewal periods.
- Washington State—commissions paid may not exceed an insurer's renewal commission on existing policies in cases where an existing policy is replaced by another policy issued by another insurer and the benefits under the new policy are substantially similar to the benefits under the policy being replaced.
- Wisconsin—requirements are similar to those contained in the NAIC model, except that first year commissions can be no more than 150 percent of renewal commissions.

As the states continue to move toward nationwide adoption of the NAIC's 1989 consumer protection amendments, the NAIC has begun the process of drafting further revisions to the NAIC Medicare Supplement Insurance Model Act and Regulation. New medigap standards contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA) now require the nationwide standardization of medigap policies.

The NAIC has until August 1991 to design the standard benefit packages meeting the requirements of the federal legislation. If the NAIC fails to act

by this deadline, the Secretary of Health and Human Services (HHS) is required to design the standardized benefit packages.

In light of the strict time deadline, the NAIC's Medicare Supplement and Other Limited Benefit Plans Task Force is working on an accelerated schedule to meet the OBRA requirements. The Task Force expects to have an exposure draft of the standardization requirements prepared in time for discussion at the NAIC's April 1991 spring meeting; a final version of the standardization amendments is expected to be ready for adoption by the NAIC at the June 1991 NAIC Summer National Meeting. The states will then have one year from the date of adoption by the NAIC to make the necessary changes to their own regulatory programs.

CONGRESSIONAL ACTION

On March 9, 1987, then Secretary of Health and Human Services Otis Bowen sent a report to Congress entitled "Study of Health Insurance Designed to Supplement Medicare and Other Limited Benefit Health Insurance Sold to Medicare Beneficiaries." The study was conducted pursuant to a congressional mandate in order to determine the extent of abuses in the sale of Medicare supplemental insurance and the possible need for mandatory federal minimum standards.

In a letter to then Speaker of the House Jim Wright, Dr. Bowen remarked that "a review of State insurance regulations relating to Medicare supplements and other types of health insurance sold to Medicare beneficiaries was done to determine how

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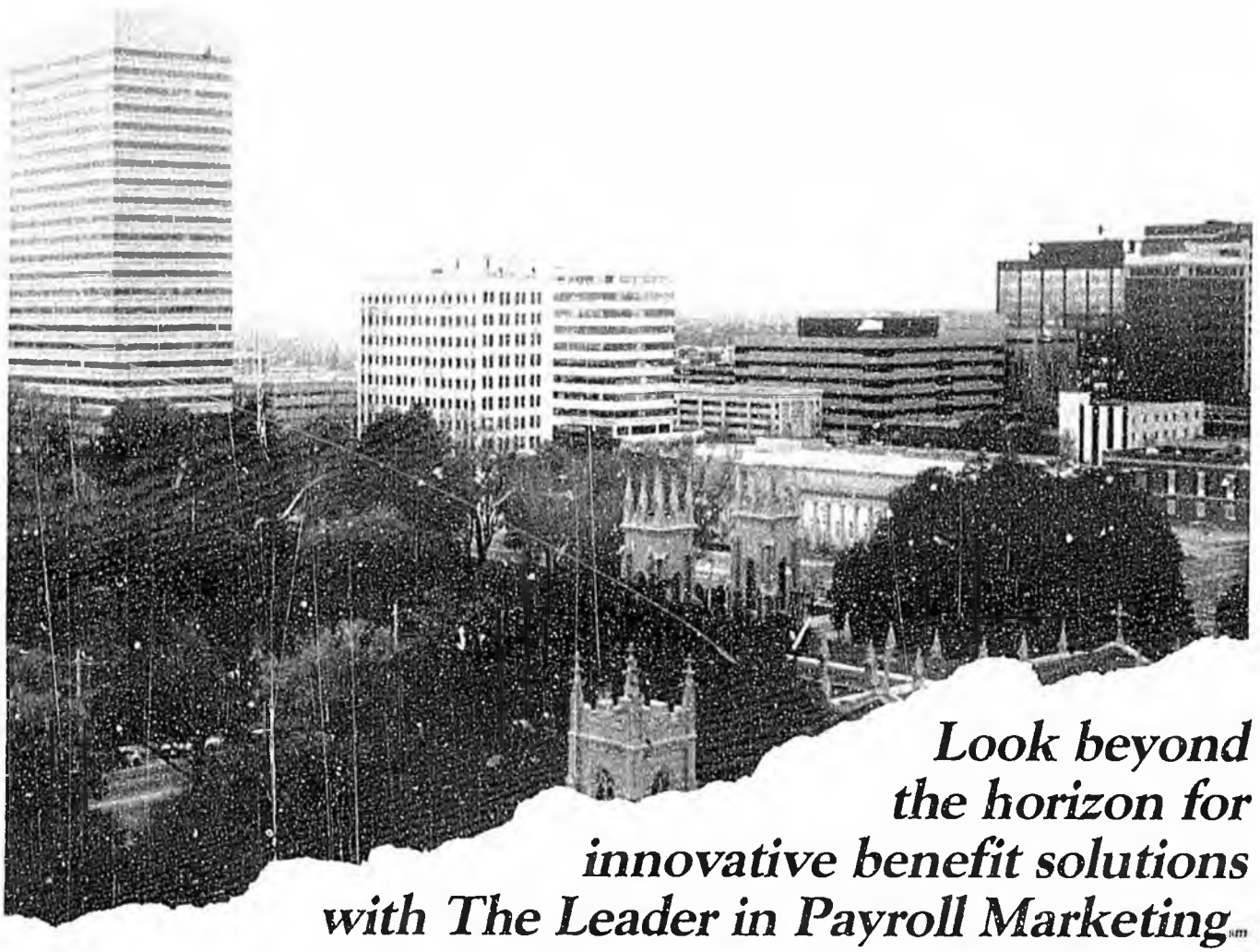

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many states have adopted the regulations found to be effective in dealing with the problems. Based on this review and other findings in this report, we concluded that there is no need for a federal mandatory program for Medicare supplement policies because all but four states meet or exceed the standards in P.L. 96-265" (Federal Voluntary Certification Program).

Bowen concluded by noting that "in summary, the Department believes that the states have dealt adequately with many of the past problems with Medicare supplement policies and encourage all states to consider some changes for other types of health insurance sold to Medicare beneficiaries."

Needless to say, Congress was singularly unimpressed with the Bowen/HHS Study. Dictated by either political expediency or genuine disagreement about the Reagan administration's findings, many influential health policymakers on Capitol Hill decided that 1990 would be the year for medigap reform and one such target of reform would include health insurance agents.

Stung by harsh criticism of its handling of the Medicare Catastrophic issue—an unpopular senior citizen program that was ultimately repealed—Congress seemed eager to placate an angry senior citizen constituency. A series of congressional hearings brought forth numerous elderly witnesses who claimed that zealous agents pressured them into purchasing several duplicative Medigap policies. Senior citizen organizations, flanked by self-styled consumer groups, joined in the chorus for reform.

Notwithstanding the lack of empirical evidence to document the allegation of abusive practices, members of Congress on both sides of the aisle introduced a plethora of bills in an attempt to respond to a growing public outcry.

Although the insurance community was unconvinced that widespread abuses had in fact occurred, NALU and other insurance groups

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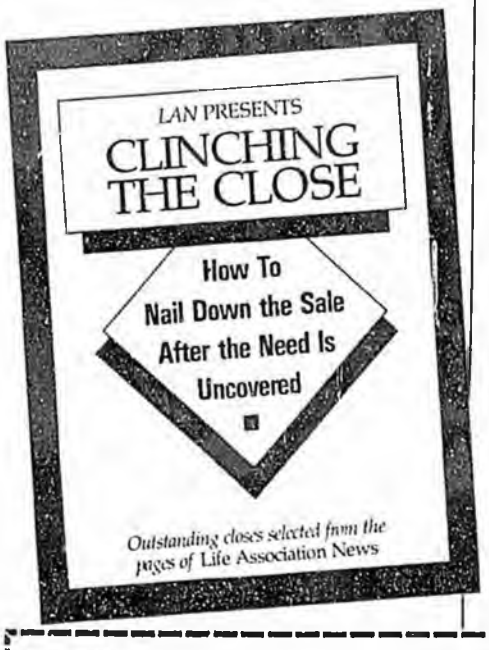

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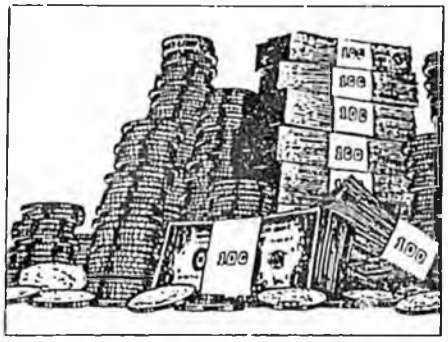

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worked with Congress to draft legislation in the hope that the final product would not unduly restrict either the ability or desirability of the industry to market and sell medigap policies. Congress focused on five main issues of concern: curbing agent abuse through commission restrictions, standardization or simplification of products, increasing individual and group loss ratios so that more premium dollars would be returned to the consumer, prohibiting the sale of duplicate coverage and agent/company liability for non-compliance.

■ *Agent Commissions.* Despite initial concerns that Congress would move to level commissions, the battle turned quickly to an initiative to adopt a more restrictive standard than that imposed by the NAIC Model, proposed by Sen. Tom Daschle (D-S.D.) and Rep. Ron Wyden (D-Ore.).

Under this proposal (S. 2640/H.R. 4840), first-year commissions could be no greater than 150 percent of renewals. Ultimately, Congress chose to remain silent on the issue. However, by making the voluntary Baucus federal certification standards mandatory Congress avoided direct regulation, but in effect mandated that states adhere to the NAIC standard on commissions or face the requirement that medigap policies be individually submitted to HHS for approval.

■ *Standardization/Simplification.* NALU supported Rep. Pete Stark's (D-Calif.) bill (H.R. 5626), which would have restricted the number of medigap policies companies could offer. Believing that if senior citizens are having difficulty sifting through the myriad of policies, NALU felt that perhaps imposing some limitations might ultimately assist seniors. While Congress found it difficult to agree on exactly how many different products should be available from any one company, the conferees agreed that companies may offer a core benefit package and up to nine alternatives.

■ *Loss Ratios.* Much to the chagrin of the industry, Congress quickly became enamored with the idea of raising loss

ratios for both individual and group medigap policies. For insurance companies, an increase meant a diminished ability to sell the product. For insurance agents, a hike in ratios translated to a likely decline in commissions as companies searched for methods with which to cut costs in order to return more premium dollars to the consumer. In the final analysis, Congress increased only individual ratios from 60 percent to 65 percent and left group ratios at 75 percent.

■ *Duplicate coverage.* NALU strongly supported efforts to stop the sale of duplicative policies. According to the new law, insurance agents and companies will be required to obtain a written statement from the client that indicates they do not have another medigap policy and they are not entitled to Medicaid. Insurance agents would not be liable for non-compliance if the statement is signed, answered completely, reflects non-duplication and indicates that state counseling may be available.

■ *Penalties for non-compliance.* NALU believed that while appropriate penalties would be worthwhile to discourage those who might take advantage of senior citizens, severe penalties that result from strict liability might have a chilling effect that could dissuade agents from selling the product. House and Senate conferees settled on $15,000 fines for agents and $25,000 fines for companies that fail to obtain the appropriate written statement or otherwise sell a policy to individuals who acknowledge that they have other policies.

Clearly, agents will be in the spotlight again in 1991 as Congress focuses on efforts to inhibit so-called abuses in the long-term care market. Once again, agents face a major battle with legislators who want to appear responsive to their constituents. Agents must handle the monumental task of convincing Congress that imposing ceilings on commissions will not only dissuade agents from selling time-intensive policies, but also that such restrictions will ultimately diminish the availability of a still evolving product in an increasingly older society. ■

February 15, 1991

HEALTH MATTERS

PRESIDENT'S MESSAGE

AHIA working toward solutions in health care crisis

By Karl E. Hansen, CLU, ChFC, LUTCF

In a recent NALU local association member survey, there was strong support for the need to focus on health care, health insurance and the interests of the individual health underwriter. A whopping 91 percent of you said there is a health care crisis in the United States. Almost 87 percent of you said that NALU should become a more active player in helping to shape today's health care issues. In short, over 80 percent of you sent us the same message: "Get involved." That's why AHIA was formed--to develop solutions to the crisis and to preserve the role of the health and employee benefits agent.

To those of you who have become charter

Continued on Page 2

STAT OF THE MONTH

	Life Underwriters Responding Yes
NALU should increase its efforts to influence federal and state government health care decisions	86%
NALU should serve the interests of its members by having a stronger voice on health insurance issues	85%
The individual health insurance underwriter needs a stronger voice on health care issues	78%

Source: National Association of Life Underwriters 1990 Local Association Membership Survey

THE WATCH LIST

What's hot in the statehouse

FEDERAL

Congress is expected to consider regulating agent commissions on the sale of long-term care (LTC) policies in 1991. Congress may wish to level commissions or impose restrictions similar to those adopted by the NAIC on medigap. This is in addition to LTC action taken by the NAIC at its winter convention.

VIRGINIA

Enacted legislation that allows insurers to issue basic, limited benefit policies that are exempt from existing state-mandated benefits. The policies may be offered to certain individuals, families or groups of less than 50 members.

KANSAS AND HAWAII

Among the states enacting legislation requiring that an assessment be made of the social and financial effects of any proposed mandated benefit **prior to** the adoption of any bill mandating a new health insurance coverage.

COLORADO, WYOMING, LOUISIANA, UTAH AND SOUTH CAROLINA

Recently enacted legislation establishing state health insurance high-risk pools.

CONNECTICUT

Adopted comprehensive legislation which, among other measures, includes small group market reforms designed to increase affordability and accessibility of insurance through the use of reinsurance pools and limits on premiums and pre-existing conditions.

The material in this special section was developed by the staff of the Association of Health Insurance Agents. For more information about AHIA, call (202) 331-2161.

Written by the Association of Health Insurance Agents AHIA

PRESIDENT'S MESSAGE

Continued from Page 1

members, I welcome you. To those of you who haven't, I ask you to consider it.

The past investment in the health arena by the NALU volunteers and staff members has been second to none. In recent years, we have represented the 138,000 NALU local association members in numerous key health issues. In fact, Congress has called on us to testify in such important areas as:

- IRC Section 89 Reform;
- Small Group Underwriting and Pricing Reforms;
- The Pepper Commission; and
- Medigap Reform.

NALU and its locals have also had a dramatic effect within the NAIC and during critical state regulatory campaigns.

Obviously, the tasks before us are imposing and may even seem insurmountable to some.

That's why the NALU Board of Trustees and National Council, responding to a call from its members for intensified involvement, voted in September to establish a new national health conference: the Association of Health Insurance Agents (AHIA). Since then, membership in this new and vital association has grown to more than 3,000 charter members.

The past investment in the health arena by the NALU volunteers and staff members has been second to none.

The members of the AHIA Board of Directors and standing committees have dedicated themselves to better identifying, enhancing and expanding the health-related benefits currently being offered to members by NALU. AHIA will provide members with an expanded variety of benefits, from public relations tools to consumer information brochures; from this monthly newsletter to regional seminars and annual meetings. A partial list of these benefits appears on page 3.

Karl Hansen

Obviously, your greatest benefit in AHIA will be the opportunity to expand your knowledge and enhance your capacity to serve your clientele. The $50 annual dues brings you all of this **and** creates the opportunity for dedicated professionals to have a voice in Washington and in state capitals across the nation.

If you are a professional involved in the sale and service of group or individual medical insurance, disability income protection, medigap coverage or long-term care plans, we at AHIA need your supporting membership. Your investment in this health conference will raise our flag higher and better guarantee the association's forward path as we prepare ourselves to battle the health insurance storms that lie ahead and to protect the vital role of the health insurance agent within the delivery system.

QUICK HITS

Selling disability income protection

By Robert J. Heller, FICF, LUTCF

Robert J. Heller, FICF, LUTCF, has been a district representative with Lutheran Brotherhood Financial Services in Dale City, Virginia for the past eight years. He has qualified for the NQA seven times, the NSAA seven times, the HIQA four times, and his company's prestigious President's Club for the past six years.

The sale of disability income (DI) protection is not as difficult as you might think. The main key to selling disability is to "talk about it." I have made it a rule for myself to mention the word "disability" in my presentation at least three times. While most people realize that they are going to die and need life insurance, you have to make clients appreciate the need for DI. They need to know that a person's most valuable asset is their ability to get up in the morning, get dressed and go to work to provide an income for their family's everyday expenses. So, even though it's difficult for prospects to visualize themselves as disabled, you must keep going back to it to make them realize the high chance of disability (see page 4) and the devastating effects of it. Here are my suggestions:

- Mention disability at least three times during the interview and continue to go back to the need and importance of DI protection.
- Don't be afraid to mention and sell disability protection because it seems confusing. Use the health marketing specialists in your home office to help you understand the provisions and make you more comfortable with the product.
- Keep in mind that you are putting your client's welfare in jeopardy if you don't propose DI protection.
- When you make a proposal for the need for life insurance, automatically include a proposal for the disability protection also. Sell it as a package.

By following these few simple steps, I think you'll find selling disability income protection isn't as difficult as you thought.

ASSOCIATION NEWS

AHIA's four standing committees met at AHIA headquarters in Washington, D.C. recently and continued to develop programs for health and employee benefits agents. Here's a breakdown of committee activities.

MEETINGS COMMITTEE

The Meetings Committee is charged with the task of "providing informative, educational and sales-oriented programs for those engaged in the health insurance industry." One of the major benefits of being an AHIA member is the opportunity to attend and participate in a variety of seminars, luncheons, meetings and workshops to enhance one's knowledge and professionalism, often while earning continuing education credits.

The first scheduled AHIA regional seminar will be in Phoenix on February 25th. AHIA is co-sponsoring the seminar with the highly-respected Columbia Institute. The seminar, which will be chaired by Arizona Senator John McCain, will feature Health and Human Services Secretary Louis W. Sullivan as the keynote speaker. Titled "The Arizona Forum on Health Care: A Focus on Our Needs and Goals," the meeting will last from 8:30 a.m. to 2:00 p.m. The only cost to AHIA members is the price of the luncheon. More information will be mailed to AHIA members.

Senator John McCain

LEGISLATION COMMITTEE

Task forces were created by the Legislation Committee to address issues of particular importance. The task forces address the following issues:

- Access to health care;
- Long-term care (LTC); and
- Small group reform.

The task force on access to health care will analyze current studies done by other organizations and develop working solutions to the access crisis.

The Long-Term Care Task Force will analyze congressional treatment of long-term care policies and review such issues as agent commissions, taxation of LTC product benefits and minimum policy standards.

The Small Group Plans Task Force will examine issues surrounding groups with 25 or fewer employees. How these groups are affected by issues such as medical underwriting, pre-existing conditions, mandated benefits and taxation will be evaluated.

Public policy position statements outlining AHIA's stand on health issues are also being revised and developed.

COMMUNICATIONS/ MEMBER SERVICES

This committee is in charge of creating and developing the vast resources and benefits available to the member-agent. As AHIA works to establish itself, the Communications/Member Services Committee is racing to develop these resources:

- Health Legislative Reports;
- Three "Underwriter's Update" education programs;
- A monthly newsletter;
- Local program modules;
- Consumer brochures;
- Speeches; and
- Increased access to information.

MEMBERSHIP

The Membership Committee is responsible for attracting new members and is building AHIA into a large, powerful agents group.

GET INVOLVED

Progress to date by all four committees has been extensive, but much is to be done. As an association of agents, AHIA is always interested in hearing from members who would like to become involved. To inform AHIA of your interest, simply drop a note to: AHIA Involvement, 1922 F Street N.W., Washington, DC 20006-4387, or call (202) 331-2161.

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Jim Tobin
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Health Matters *is written by the staff of the Association of Health Insurance Agents (AHIA). For questions or more information, please write, AHIA, 1922 F Street, N.W., Washington, DC 20006-4387 or call (202) 331-2161.*

TROUBLE SELLING DISABILITY INCOME INSURANCE?

- See the Disability Income (DI) sales piece on page 4. Photocopy and use with clients any way you wish.
- Read Dr. Bruning's article on page 4 and order his video where he talks directly to clients about DI insurance. He demonstrates the need, you make the sale.

AHIA members only can get this video at a special discount, just $64.50 (N.C. residents add 5%). One agent reports that in his first four months of using the video, he increased DI sales by 60 percent for the whole year!

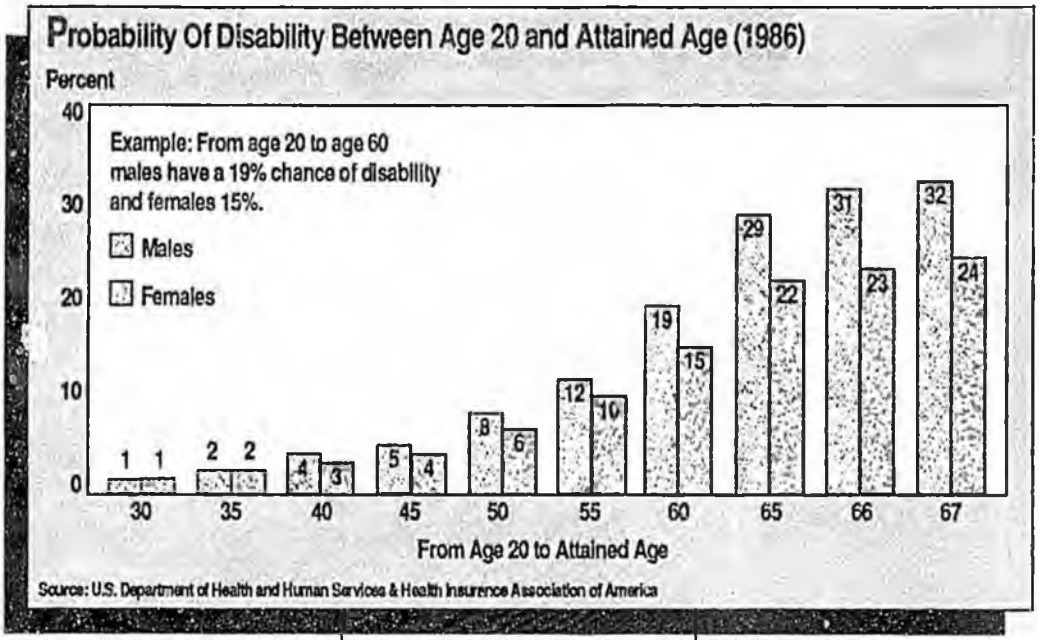
AHIA members, mail your check, made payable to Mary M. Bruning, to AHIA, 1922 F Street, N.W., Washington, D.C. 20006-4387, for verification of your membership. Non-AHIA members may get the video by mailing $69.50 (N.C. residents add 5%) directly to Mary M. Bruning, 642 N. Race St., Statesville, N.C. 28677.

WHAT YOU SHOULD KNOW ABOUT DISABILITY INCOME INSURANCE

If someone told you that you had a one in five chance of winning the lottery, you'd play, wouldn't you? Well, those are the odds of you becoming temporarily or permanently disabled between the ages of 20 and 60 (64 for women). And that number shoots even higher as you get older (see chart). In fact, you are up to six times more likely to be disabled than die at any age up to age 65.

What if suddenly, tomorrow, you couldn't work? What would happen to your house, your college fund, you? How long could you maintain your current lifestyle without an income? Especially if, while your income stopped, hospital bills began. According to a recent survey, 48 percent of all home foreclosures in the United States are the result of a disability in the family, while only 3 percent are caused by a death.

Disability income insurance can protect your income and investments. If you don't have it, you're playing a lottery with very good odds, but it's one you don't want to win.



DISABILITY INCOME INSURANCE: THE BENEFITS SPEAK FOR THEMSELVES

Dr. James Bruning, now 42, was a young dentist in his second year of practice in Statesville, N.C., in 1979 when he suffered a crippling injury in a diving accident. Dr. Bruning had purchased a disability income (DI) insurance policy shortly before his accident and now discusses what that policy means to him and his family.

"I had been swimming and diving in that same lake since 1963. I was a certified water safety instructor and I didn't even think I was doing anything dangerous. Then a few things went wrong and I took a 30-foot dive into four feet of water. I was left a quadriplegic and I couldn't continue my dental practice. I had no source of income in sight.

"A NIGHTMARE"

The first few years were a nightmare, as the whole family's life changed. Family life revolved around my physical needs. But through it all, when we thought we were going to go insane, one thing didn't change: the financial picture. It was the rock we knew we could count on.

Now, 11 years later, my disability income (DI) insurance keeps us in the business of life. It allows me personally to do those things that I want to do, like provide for my family. My kid's college is paid, my mortgage is taken care of and we can get out and do things. It does wonders for my self-esteem.

"THE OTHER GUY"

"When my agent approached me about getting DI insurance, I gave him all the textbook reasons why I didn't need it. Even after I bought it, I really thought it could only happen to the other guy. Then suddenly, I was the other guy. I've never sold insurance to anybody, but I'm hard-pressed to think of a more satisfying feeling than being able to walk into the hospital room of one of your clients, someone who's been paralyzed, who thinks his world is crumbling, and say, 'I've got it covered. Your business is taken care of, your house is taken care of and your kids can go to college. The cavalry is here.'

"A LIFESAVER"

"And now, when my kid grows up, he'll have the same memories as other kids. He'll say, I hope, that 'Dad might have been in a wheelchair, but he did all right for us anyway.'

"My DI policy has been, quite simply, a lifesaver."

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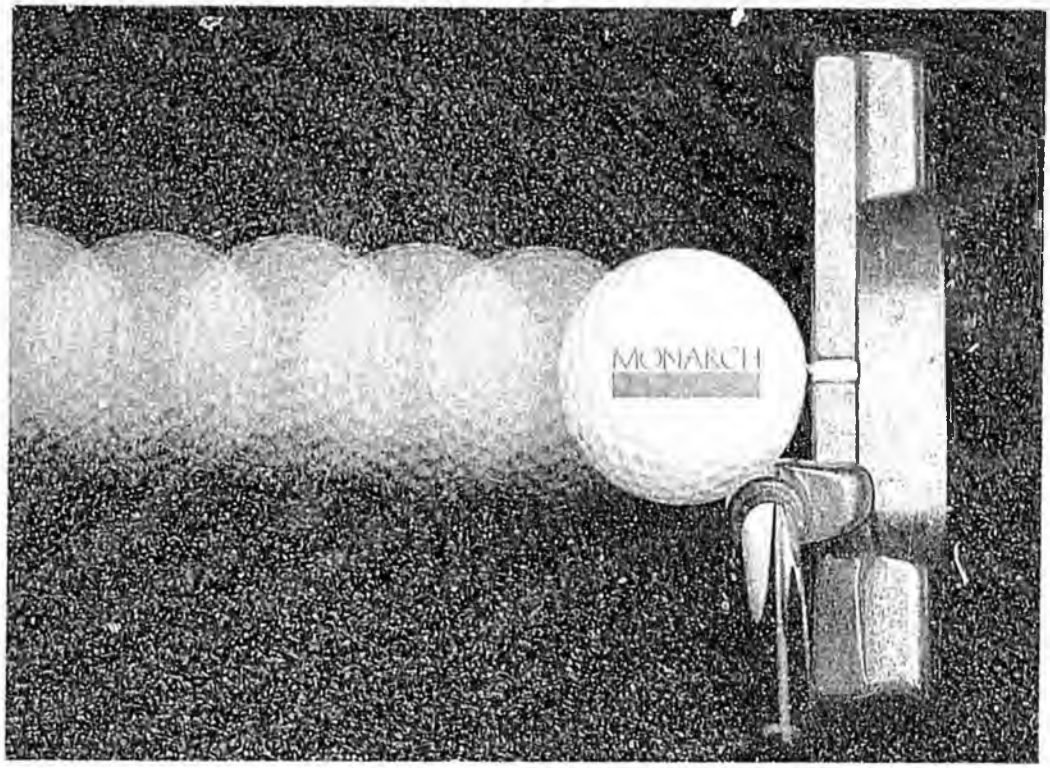

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Toward Solving America's Health Cost Crisis

A report by
Families USA Foundation

in cooperation with
Citizen Action

November 1990

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

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

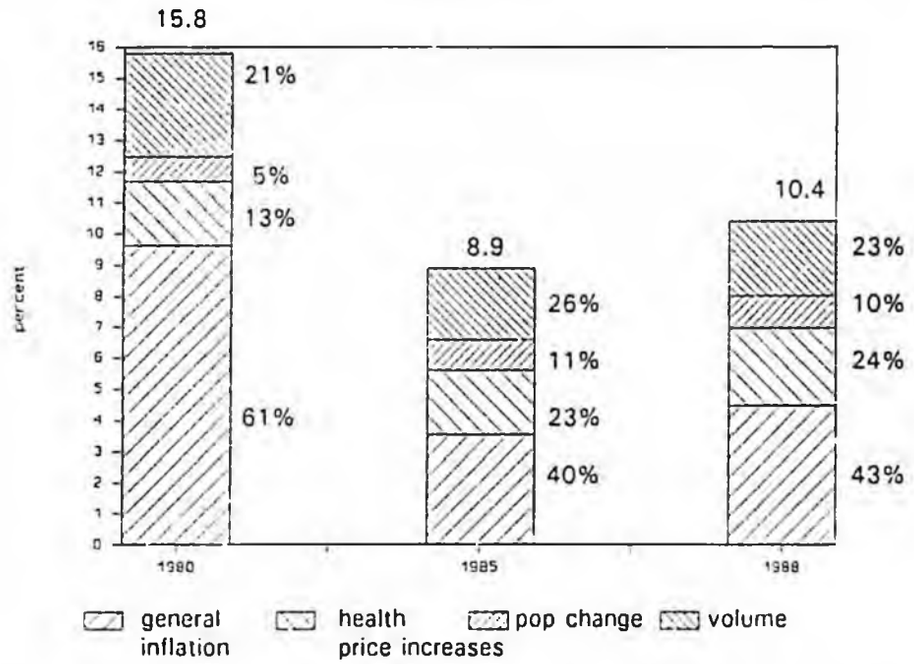
Health care spending has increased at more than twice the rate of general inflation during the last decade and, absent reform, this trend is expected to continue during the 1990s. An analysis of the components of health care inflation reveals areas that can be controlled without affecting quality.

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 <u>not</u> 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 <u>above</u> 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]

HEALTH INFLATION COMPONENTS



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.

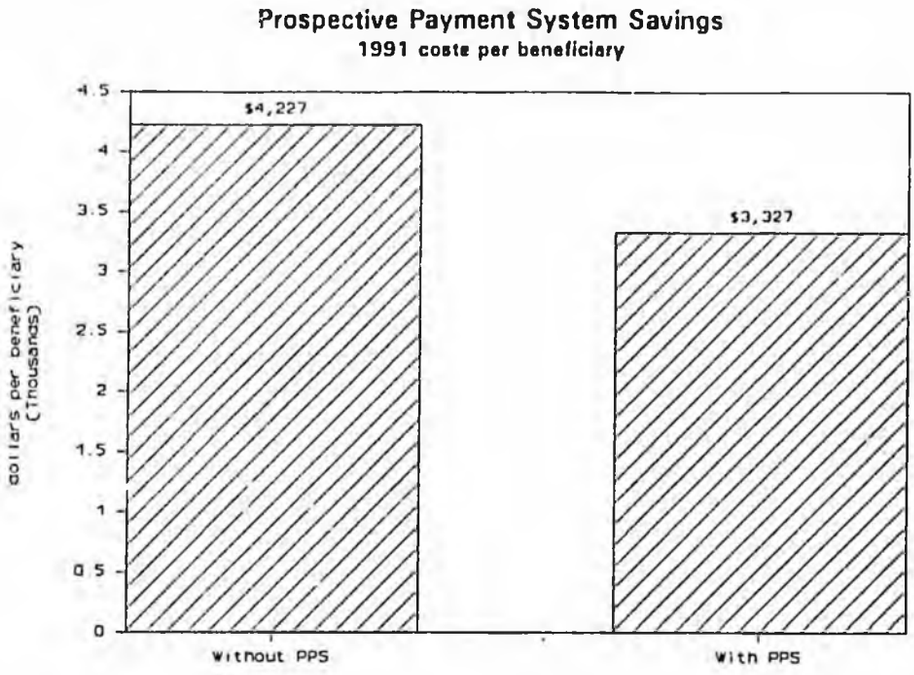
Although both public and private health care plans have initiated a variety of cost containment efforts in the last decade, these piecemeal approaches have failed to control costs system-wide. The fragmented nature of our multiple-payer approach has been a major barrier to effective cost containment. 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.

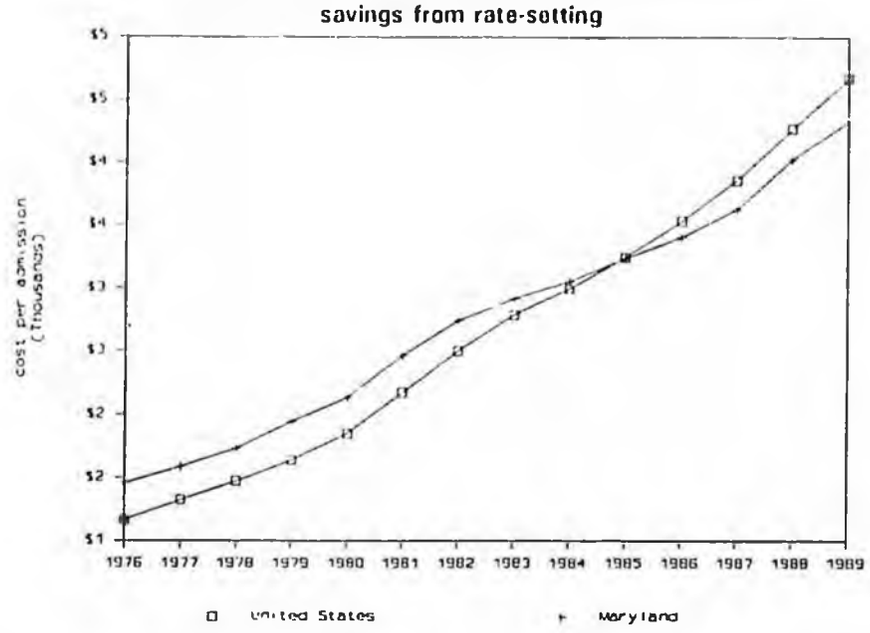


Source: Committee on Ways & Means, *1990 Green Book*, p. 238

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]

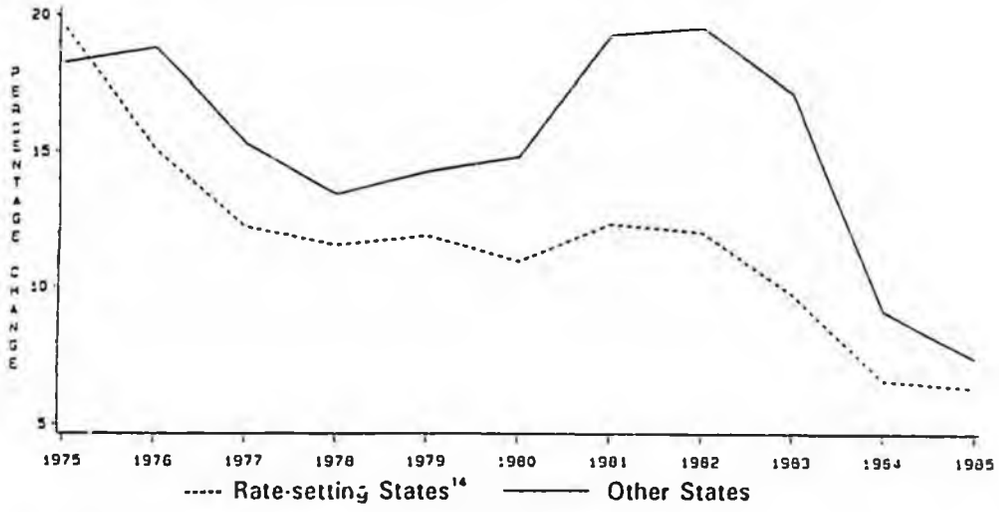
Several states have controlled hospital costs by establishing rates for all payers, public and private, large and small. The rate of increase in individual hospital expenses was reduced 4% in these states. Hospital charges per admission were 3.8% lower in the experimental states compared to other states.[12] 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]

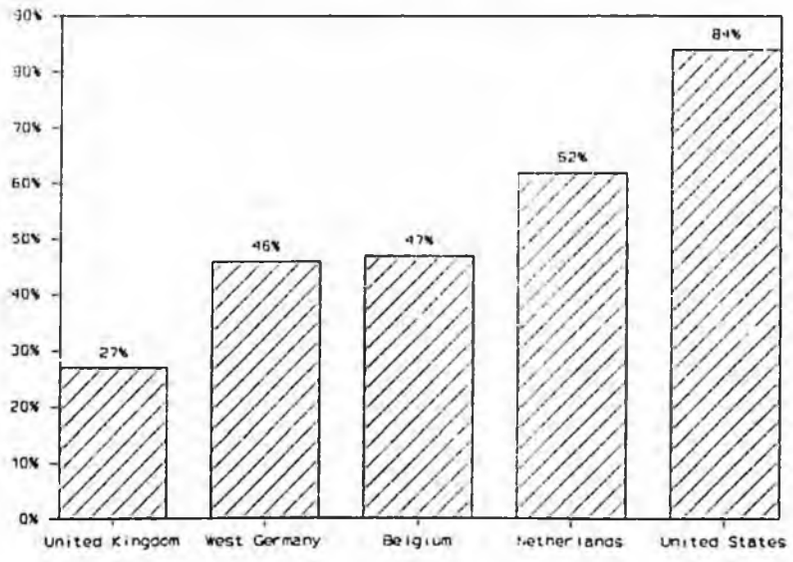
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes. 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



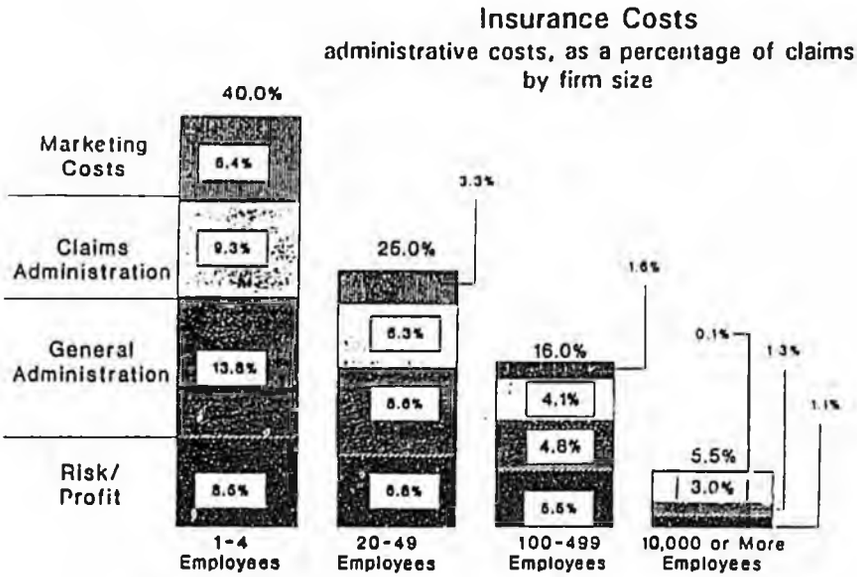
Source: *Journal of the American Medical Association*

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

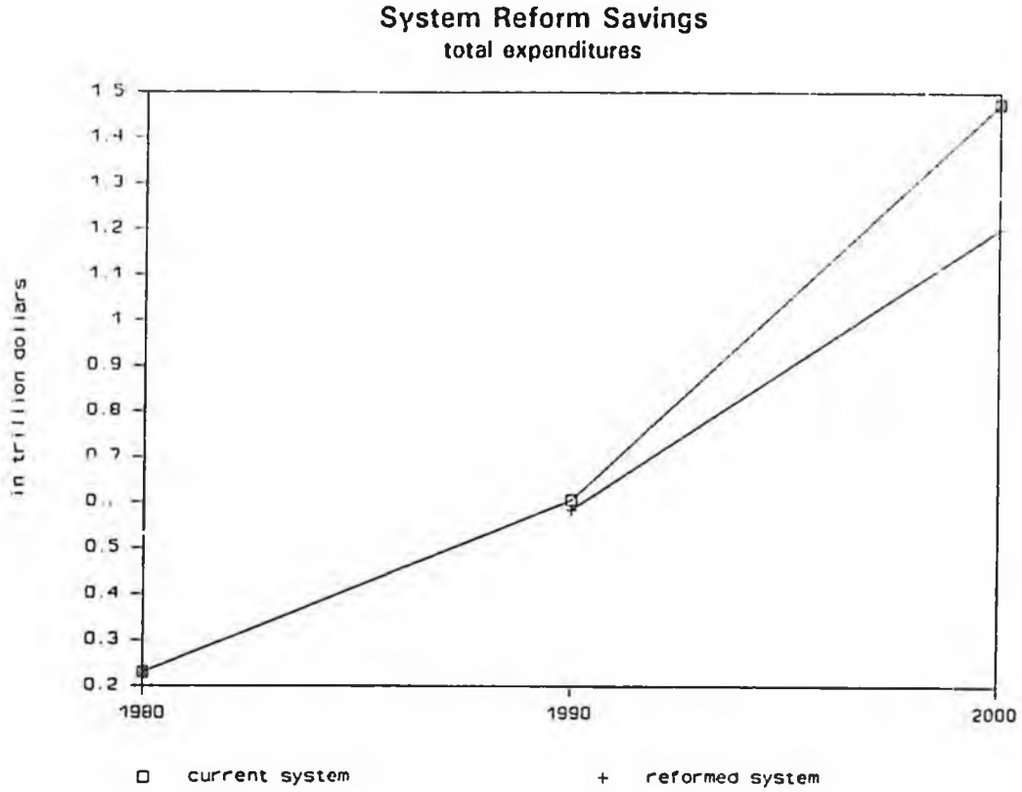
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

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

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

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

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	22,667,039	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	354,138	(3,463,197)	(940,296)	16,947,048	(4,049,355)
DELAWARE	4,138,620	60,393	(691,154)	(125,720)	3,382,140	(756,480)
DISTRICT OF COLUMBIA	3,500,076	67,223	(593,286)	(70,790)	2,903,224	(596,852)
FLORIDA	90,060,126	1,210,959	(15,089,001)	(2,344,533)	73,837,551	(16,222,576)
GEORGIA	37,733,919	538,227	(6,309,527)	(1,087,148)	30,875,471	(6,858,448)
HAWAII	7,653,634	109,434	(1,262,304)	(323,721)	6,177,043	(1,476,590)
IDAHO	3,959,138	71,591	(659,214)	(145,671)	3,225,845	(733,294)
ILLINOIS	69,779,254	1,240,749	(11,547,728)	(2,963,833)	56,508,442	(13,270,812)
INDIANA	28,504,460	497,770	(4,717,173)	(1,201,718)	23,083,338	(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	7,493,526	123,948	(1,238,664)	(317,448)	6,061,352	(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	26,967,967	480,209	(4,460,714)	(1,159,098)	21,828,364	(5,139,603)
WYOMING	1,634,546	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	(152,020)	(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)	1,593,908	(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)	(33,603)	791,062	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(21,376,038)	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 increased? One of the major reasons is a reduction in the number of individuals and their families covered by employment-

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

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

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

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

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

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

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

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

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

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

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

ENDNOTES

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

2. The estimates in this report are based on the most recent data from the Census Bureau. These estimates, 31.8 million persons nationally, are lower than previous estimates of approximately 37 million uninsured persons because the Census Bureau now asks if uninsured persons are covered by insurance 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	5,541	432.5%
MASSACHUSETTS	1,284	3,031	136.0%	38	6,890	436.5%
MICHIGAN	1,097	2,569	134.3%	41	5,840	432.5%
MINNESOTA	1,110	2,480	123.4%	49	5,641	408.1%
MISSISSIPPI	759	1,751	130.6%	45	3,984	424.6%
MISSOURI	1,033	2,568	148.6%	8	5,837	465.1%
MONTANA	859	2,059	139.7%	27	4,686	445.6%
NEBRASKA	1,016	2,452	141.4%	21	5,576	448.8%
NEVADA	1,109	2,757	148.5%	10	6,272	465.3%
NEW HAMPSHIRE	813	1,981	143.6%	19	4,505	453.8%
NEW JERSEY	930	2,224	139.2%	32	5,056	443.8%
NEW MEXICO	711	1,792	152.2%	4	4,078	473.9%
NEW YORK	1,257	2,818	124.2%	48	6,408	409.8%
NORTH CAROLINA	773	1,833	137.1%	34	4,170	439.5%
NORTH DAKOTA	1,066	2,661	149.7%	6	6,051	467.6%
OHIO	1,039	2,493	140.0%	26	5,667	445.6%
OKLAHOMA	906	2,139	136.2%	37	4,867	437.3%
OREGON	940	2,312	146.0%	15	5,260	459.8%
PENNSYLVANIA	1,021	2,536	148.3%	11	5,763	464.2%
RHODE ISLAND	1,184	2,707	128.6%	47	6,153	419.7%
SOUTH CAROLINA	706	1,689	139.2%	31	3,842	444.4%
SOUTH DAKOTA	952	2,322	144.0%	16	5,278	454.7%
TENNESSEE	952	2,262	137.7%	33	5,145	440.3%
TEXAS	915	2,192	139.7%	28	4,987	445.3%
UTAH	741	1,784	140.8%	23	4,062	448.0%
VERMONT	815	1,956	140.1%	25	4,448	445.9%
VIRGINIA	863	2,076	140.5%	24	4,724	447.2%
WASHINGTON	929	2,311	148.7%	7	5,258	466.0%
WEST VIRGINIA	843	2,088	147.6%	12	4,752	463.4%
WISCONSIN	1,097	2,449	123.2%	50	5,567	407.3%
WYOMING	714	1,756	146.1%	14	3,998	460.0%
TOTAL	$1,016	$2,425	138.7%		$5,515	442.8%

SOURCE: Lewin/ICF estimates

Table 2

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

STATE	1980	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	3,226,864	772.5%
ARIZONA	2,305,619	8,105,810	251.6%	1	23,306,832	910.9%
ARKANSAS	1,929,340	4,706,750	144.0%	37	11,097,073	475.2%
CALIFORNIA	28,080,581	84,754,469	201.8%	5	223,595,772	696.3%
COLORADO	2,878,913	8,045,268	179.5%	14	18,819,641	553.7%
CONNECTICUT	3,566,669	8,815,808	147.2%	32	20,996,403	488.7%
DELAWARE	570,197	1,547,100	171.3%	17	4,138,620	625.8%
DISTRICT OF COLUMBIA	791,551	1,559,131	97.0%	51	3,500,076	342.2%
FLORIDA	9,376,859	31,411,102	235.0%	4	90,060,126	860.5%
GEORGIA	4,822,254	13,669,245	183.5%	12	37,733,919	682.5%
HAWAII	958,674	2,797,343	191.8%	8	7,653,634	698.4%
IDAHO	668,050	1,748,435	161.7%	24	3,959,138	492.6%
ILLINOIS	12,489,958	30,597,883	145.0%	35	69,779,254	458.7%
INDIANA	5,047,369	12,362,662	144.9%	36	28,504,460	464.7%
IOWA	2,894,898	6,615,476	128.5%	49	13,620,316	370.5%
KANSAS	2,498,938	6,426,779	157.2%	26	14,677,643	487.4%
KENTUCKY	2,951,766	7,021,825	137.9%	45	15,737,895	433.2%
LOUISIANA	3,954,402	9,545,115	141.4%	42	20,590,574	420.7%
MAINE	978,536	2,687,926	174.7%	15	6,645,638	579.1%
MARYLAND	4,388,016	11,627,792	165.0%	20	31,074,629	608.2%
MASSACHUSETTS	7,367,870	17,947,477	143.6%	38	42,436,773	476.0%
MICHIGAN	10,158,071	23,874,781	135.0%	46	54,691,321	438.4%
MINNESOTA	4,525,259	10,857,061	139.9%	44	25,755,773	469.2%
MISSISSIPPI	1,914,580	4,638,528	142.3%	41	11,044,767	476.9%
MISSOURI	5,079,283	13,373,361	163.3%	23	31,946,064	528.9%
MONTANA	676,015	1,641,223	142.8%	39	3,486,657	415.8%
NEBRASKA	1,595,143	3,933,640	146.6%	33	8,580,707	437.9%
NEVADA	887,542	3,115,213	251.0%	2	8,837,119	895.7%
NEW HAMPSHIRE	749,188	2,258,658	201.5%	6	6,351,711	747.8%
NEW JERSEY	6,848,103	17,368,763	153.6%	27	42,383,428	518.9%
NEW MEXICO	925,932	2,757,688	197.8%	7	7,076,082	664.2%
NEW YORK	22,066,936	50,354,750	128.2%	50	115,121,894	421.7%
NORTH CAROLINA	4,546,873	12,259,381	169.6%	18	32,183,511	607.8%
NORTH DAKOTA	696,115	1,751,185	151.6%	30	3,606,280	418.1%
OHIO	11,215,407	27,193,403	142.5%	40	61,941,308	452.3%
OKLAHOMA	2,740,188	6,824,669	149.1%	31	14,232,334	419.4%
OREGON	2,474,037	6,523,595	163.7%	22	15,269,405	517.2%
PENNSYLVANIA	12,117,790	30,541,650	152.0%	29	69,555,852	474.0%
RHODE ISLAND	1,121,337	2,701,187	140.9%	43	6,448,659	475.1%
SOUTH CAROLINA	2,203,405	6,011,186	172.8%	16	15,222,478	590.9%
SOUTH DAKOTA	657,535	1,662,251	152.8%	28	3,773,731	473.9%
TENNESSEE	4,368,396	11,328,956	159.3%	25	27,908,735	538.9%
TEXAS	13,012,429	37,380,724	187.3%	10	88,910,873	583.3%
UTAH	1,082,735	3,085,385	185.0%	11	7,493,526	592.1%
VERMONT	416,395	1,117,014	168.3%	19	2,753,403	561.2%
VIRGINIA	4,615,580	12,931,845	180.2%	13	34,364,026	644.5%
WASHINGTON	3,838,548	11,084,596	188.8%	9	27,295,859	611.1%
WEST VIRGINIA	1,644,557	3,846,712	133.9%	47	7,844,814	377.0%
WISCONSIN	5,164,568	11,980,357	132.0%	48	26,967,967	422.2%
WYOMING	335,414	821,658	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	7,266	6,155	13,720	13,720	17,773	101,013	370,062	921
ARIZONA	582,995	698,587	72,743	36,635	NA	NA	328,804	585,855	2,305,619	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	7,201,598	710,178	370,271	1,401,953	1,401,953	4,164,002	6,839,211	28,080,581	1,186
COLORADO	695,272	933,532	74,685	43,390	87,470	99,272	302,454	642,638	2,878,913	996
CONNECTICUT	1,026,949	1,220,813	238,910	43,829	179,702	179,702	611,034	57,729	3,566,669	1,148
DELAWARE	168,160	130,750	28,466	5,707	23,279	23,279	87,529	98,949	570,197	960
DISTRICT OF COLUMBIA	168,707	123,705	28,275	6,661	86,588	86,588	148,816	142,410	791,551	1,241
FLORIDA	2,814,989	1,770,637	478,802	98,866	165,422	237,450	2,153,010	1,851,597	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	668,050	708
ILLINOIS	3,400,815	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	411,838	97,491	155,513	208,516	754,790	115,419	5,047,369	919
IOWA	817,145	979,140	230,551	51,428	102,750	133,838	486,426	85,621	2,894,898	993
KANSAS	674,088	790,112	204,462	42,979	86,399	111,000	443,405	130,491	2,498,938	1,057
KENTUCKY	945,732	738,292	181,140	31,508	97,004	208,798	397,702	373,522	2,951,700	809
LOUISIANA	1,198,552	880,118	196,340	40,451	133,052	293,670	470,671	741,550	3,954,402	940
MAINE	284,843	280,438	77,439	13,382	41,117	93,828	179,001	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	536,007	1,529,777	104,800	7,367,870	1,284
MICHIGAN	2,648,828	3,441,020	710,157	159,462	550,719	550,719	1,771,076	317,690	10,158,071	1,097
MINNESOTA	1,243,181	1,498,322	381,198	83,258	269,169	337,814	704,635	27,881	4,525,259	1,110
MISSISSIPPI	619,332	410,589	0	23,326	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	19,060	9,501	22,871	41,158	73,442	168,847	676,015	859
NEBRASKA	469,733	532,375	134,404	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	9,908	28,738	45,157	107,879	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,168	450,150	85,935	388,438	388,438	1,146,073	92,675	6,848,103	930
NEW MEXICO	228,563	248,079	25,501	14,411	22,378	49,875	91,184	247,833	925,932	711
NEW YORK	5,502,085	8,045,460	1,304,202	248,347	2,334,327	2,334,327	4,012,129	285,980	22,066,936	1,257
NORTH CAROLINA	1,443,006	1,108,169	227,200	52,418	133,398	278,833	576,692	729,155	4,546,873	773
NORTH DAKOTA	199,350	223,808	59,960	13,989	18,628	29,678	120,845	29,759	696,115	1,066
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	3,486,617	3,967,694	860,052	161,365	487,881	599,683	2,385,775	168,722	12,117,790	1,021
RHODE ISLAND	291,136	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	1,036,809	228,360	45,904	119,232	270,798	629,946	662,156	4,368,396	952
TEXAS	4,244,744	3,070,355	632,707	159,455	419,882	588,238	1,878,289	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	26,122	55,687	79,516	268,814	1,082,735	741
VERMONT	119,592	133,426	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	391,282	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	$63,149,984	$65,626,952	$12,946,686	$3,123,818	$10,687,198	$13,147,309	$37,248,701	$24,228,100	$230,166,741	$1,016

a/ Includes personal health expenditures and administrative costs

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

SOURCE: Lewin/ICF estimates

Table 3b

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 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	101,705	183,013	425,482	1,932,643	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	240,860	137,174	222,669	367,852	1,367,192	1,418,278	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	12,926,177	84,754,469	2,894
COLORADO	2,097,807	2,670,571	263,730	139,260	304,439	304,439	969,276	1,295,747	8,045,268	2,415
CONNECTICUT	2,278,555	3,303,221	432,925	92,800	514,939	514,939	1,578,669	99,760	8,815,808	2,699
DELAWARE	454,368	365,183	70,128	14,539	66,058	66,058	291,705	218,999	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,188	50,262	11,191	182,516	182,516	344,880	228,617	1,559,131	2,586
FLORIDA	9,375,203	6,218,476	1,396,790	322,360	878,583	1,125,484	6,083,607	4,010,599	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,638	124,588	489,424	852,179	2,224,539	2,301,976	13,669,245	2,072
HAWAII	697,628	966,101	96,984	48,022	102,084	108,251	295,352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,186	28,238	48,178	109,063	238,416	305,267	1,748,435	1,726
ILLINOIS	8,208,698	10,348,102	1,806,653	532,708	1,231,633	1,231,633	6,719,023	519,434	30,597,883	2,819
INDIANA	3,382,637	3,988,394	818,531	228,316	481,451	813,468	2,204,733	447,133	12,362,682	2,201
IOWA	1,834,062	2,218,841	448,618	115,314	247,922	355,295	1,345,939	49,288	6,815,478	2,351
KANSAS	1,772,719	2,218,335	415,790	100,640	220,378	220,379	1,287,848	190,689	6,426,779	2,548
KENTUCKY	1,947,743	1,418,857	270,882	67,343	254,108	599,458	1,233,765	1,229,672	7,021,825	1,675
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	128,835	284,450	460,731	62,124	2,687,928	2,175
MARYLAND	3,169,204	2,674,955	484,581	99,774	541,404	541,404	2,178,431	1,958,060	11,627,792	2,436
MASSACHUSETTS	4,443,792	6,173,324	748,868	185,223	1,239,474	1,239,474	3,827,313	280,008	17,947,477	3,031
MICHIGAN	6,085,418	7,977,876	1,391,031	372,097	1,001,088	1,316,760	5,159,240	570,371	23,874,781	2,569
MINNESOTA	3,032,352	4,004,588	672,128	180,038	659,881	758,225	1,408,019	144,050	10,857,061	2,480
MISSISSIPPI	1,318,923	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	383,463	438,546	46,226	25,273	57,205	112,948	241,279	336,263	1,641,223	2,059
NEBRASKA	1,132,690	1,381,739	285,541	70,028	128,525	171,137	668,770	115,011	3,933,640	2,452
NEVADA	807,751	1,033,508	98,602	58,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,660	107,811	33,381	87,829	118,839	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	49,698	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,861	14,346,785	2,020,835	569,890	5,288,300	5,288,300	10,274,890	825,078	50,354,750	2,818
NORTH CAROLINA	3,808,151	2,855,434	587,966	130,692	378,718	850,088	1,957,921	1,712,411	12,250,381	1 833
NORTH DAKOTA	442,809	540,478	111,059	26,699	66,967	108,809	350,419	85,946	1,751,185	2,661
OHIO	6,966,974	8,754,357	1,645,871	420,028	1,244,280	1,739,605	5,655,987	557,522	27,193,403	2,493
OKLAHOMA	2,026,546	1,379,606	288,712	76,027	294,947	400,683	1,278,650	1,081,298	6,824,669	2,139
OREGON	1,657,140	2,007,536	207,895	110,855	171,645	274,649	988,819	1,106,958	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	385,577	1,248,011	1,835,583	7,748,007	375,838	30,541,650	2,536
RHODE ISLAND	704,349	853,513	135,007	30,385	173,508	223,809	531,629	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	991,426	6,011,188	1,689
SOUTH DAKOTA	469,323	532,487	106,789	30,642	51,119	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	2,185,968	1,742,697	11,328,958	2,282
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	85,019	172,448	318,184	525,181	3,085,385	1,784
VERMONT	323,043	381,043	64,236	13,292	47,488	96,673	172,612	18,629	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,548	469,473	532,390	2,061,301	2,160,846	12,931,845	2,076
WASHINGTON	2,613,628	3,346,969	321,777	188,957	587,419	588,783	1,558,885	1,518,178	11,084,596	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	260,771	720,922	743,573	3,846,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	166,623	528,448	713,420	2,258,899	379,584	11,980,357	2,449
WYOMING	206,156	269,576	26,328	13,994	18,865	19,865	107,370	158,705	821,858	1,758
TOTAL	$161,818,653	$174,125,101	$27,063,851	$8,308,703	$27,397,885	$34,256,738	$116,277,024	$56,730,394	$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	267,898	387,825	960,063	5,375,234	3,424,054	22,667,039	5,201
ALASKA	865,699	1,121,008	78,581	71,054	152,806	152,806	250,751	536,159	3,228,864	5,390
ARIZONA	5,610,602	6,764,390	606,598	438,907	610,878	1,008,299	4,621,770	3,565,631	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	66,844,841	6,086,483	4,304,439	8,982,840	8,982,840	45,912,860	29,714,318	223,595,772	6,364
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	1,148,656	1,148,656	4,340,630	203,993	20,998,403	6,136
DELAWARE	1,195,017	959,780	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	904,558	445,965	3,500,076	5,882
FLORIDA	26,031,662	17,254,594	3,886,487	1,008,793	2,351,978	3,012,935	28,673,673	9,842,004	90,060,126	5,520
GEORGIA	10,852,590	8,320,811	1,565,419	383,620	1,291,755	2,513,120	7,237,055	5,569,541	37,733,919	4,714
HAWAII	1,910,550	2,643,972	266,159	147,929	269,540	280,542	961,238	1,173,704	7,653,634	6,619
IDAHO	993,703	1,184,244	120,221	71,028	104,758	237,141	638,985	608,459	3,959,138	3,928
ILLINOIS	18,024,960	22,707,029	3,975,387	1,315,734	2,607,418	2,607,418	17,533,255	1,008,052	69,779,254	5,953
INDIANA	7,587,956	8,940,606	1,835,468	570,081	1,041,239	1,759,200	5,877,353	888,461	28,504,460	5,004
IOWA	3,643,891	4,405,316	893,561	257,698	474,894	680,588	3,177,648	86,542	13,620,316	5,343
KANSAS	3,916,623	4,897,775	920,558	250,103	469,432	469,432	3,381,372	372,350	14,677,643	5,792
KENTUCKY	4,324,250	3,147,873	602,648	168,169	543,908	1,283,120	3,255,128	2,412,801	15,737,895	4,288
LOUISIANA	5,456,366	3,899,393	757,556	231,930	712,733	1,256,887	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	1,378,536	1,378,536	6,827,112	4,563,688	31,074,829	5,541
MASSACHUSETTS	10,176,490	14,127,420	1,718,518	502,668	2,736,599	2,736,599	9,871,559	566,719	42,436,773	6,890
MICHIGAN	13,452,128	17,623,526	3,081,357	925,199	2,135,251	2,806,316	13,553,224	1,114,322	54,691,321	5 840
MINNESOTA	7,051,420	9,305,818	1,568,223	470,911	1,478,930	1,695,420	3,891,005	298,049	25 755,773	5,641
MISSISSIPPI	3,116,442	2,003,742	418,860	135,852	254,033	926,041	2,320,679	1,868,319	11,044,767	3,984
MISSOURI	8,368,592	10,095,144	1,945,872	580,906	787,968	1,212,968	8,340,413	814,402	31,946,084	5,837
MONTANA	813,087	929,192	98,216	80,273	116,938	230,888	607,947	630,119	3,486,657	4,686
NEBRASKA	2,403,868	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	277,016	179,199	193,513	193,513	1,627,012	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	117,078	6,351,711	4,505
NEW JERSEY	10,737,775	14,188,913	1,755,065	531,709	2,373,749	2,373,749	9,829,603	592,868	42,383,428	5,056
NEW MEXICO	1,814,472	1,871,107	211,785	144,264	216,600	480,760	1,053,827	1,283,268	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	1,018,092	115,121,894	6,408
NORTH CAROLINA	9,878,128	7,405,600	1,477,120	361,519	947,618	2,127,070	8,038,653	3,927,803	32,163,511	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	19,232,288	3,625,387	1,080,689	2,637,287	3,087,115	15,298,854	1,063,233	61,941,308	5,887
OKLAHOMA	4,165,518	2,833,788	590,559	175,778	584,502	794,040	3,123,838	1,984,314	14,232,334	4,867
OREGON	3,848,838	4,657,015	483,608	289,452	384,153	814,885	2,722,592	2,271,062	15,269,405	5,260
PENNSYLVANIA	17,430,559	20,877,036	3,490,750	898,713	2,823,883	3,438,893	20,073,868	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,360	499,858	1,462,951	100,253	6,448,859	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	226,484	837,887	84,893	3,773,731	5,278
TENNESSEE	7,962,737	5,732,759	1,200,168	301,378	788,187	1,800,317	6,298,723	3,734,459	27,908,735	5,145
TEXAS	28,125,731	19,869,305	3,656,095	1,227,572	2,589,258	2,888,233	10,351,490	12,106,189	86,910,873	4,887
UTAH	1,889,913	2,682,266	194,991	141,549	152,431	404,292	919,416	1,128,869	7,493,528	4,082
VERMONT	777,694	916,691	154,965	35,992	110,215	224,378	493,630	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	380,799	1,192,047	1,351,801	8,451,550	5,029,566	34,364,026	4,724
WASHINGTON	6,406,052	8,197,810	700,326	520,941	1,340,650	1,344,072	4,540,641	4,155,168	27,295,859	5,258
WEST VIRGINIA	2,215,108	1,441,469	344,513	78,170	201,945	507,382	1,728,984	1,326,244	7,844,814	4,752
WISCONSIN	6,803,891	8,886,593	1,653,258	409,690	1,109,502	1,503,550	5,868,345	733,039	26,967,967	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	$412,389,109	$63,755,912	$22,248,107	$62,147,543	$77,766,846	$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	5.8%	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, wa 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 1980 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	31.6 %	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	1.0	0.0	0.0	14.3	25.4	100.0
ARKANSAS	30.2	19.1	4.5	1.2	3.4	8.1	15.6	18.9	100.0
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.8	23.8	100.0
COLORADO	24.2	32.4	2.0	1.5	3.0	3.4	10.5	22.3	100.0
CONNECTICUT	28.0	34.5	0.7	1.2	5.0	5.0	17.1	1.6	100.0
DELAWARE	28.5	24.0	5.0	1.0	4.1	4.1	15.4	17.0	100.0
DISTRICT OF COLUMBIA	21.3	15.6	3.0	0.8	10.9	10.8	18.6	18.0	100.0
FLORIDA	30.0	19.0	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	8.6	24.5	100.0
IDAHO	23.6	28.6	2.6	1.4	2.7	5.3	9.8	25.6	100.0
ILLINOIS	27.2	33.6	7.3	1.8	4.9	4.9	16.7	1.6	100.0
INDIANA	29.7	35.6	8.2	1.0	3.1	4.1	15.0	2.3	100.0
IOWA	28.2	33.6	8.2	1.6	3.5	4.6	16.6	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	18.6	100.0
MAINE	29.1	28.7	7.9	1.4	4.2	9.6	16.3	0.9	100.0
MARYLAND	29.3	26.2	4.8	1.1	3.7	3.7	15.9	15.2	100.0
MASSACHUSETTS	26.6	30.0	5.9	1.2	6.6	7.3	20.8	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	1.6	5.9	7.5	15.6	0.6	100.0
MISSISSIPPI	32.3	21.5	0.0	1.2	2.5	6.6	14.7	13.7	100.0
MISSOURI	28.2	32.5	6.6	1.9	2.4	3.6	18.6	2.0	100.0
MONTANA	23.5	27.0	2.6	1.4	3.4	6.1	10.9	25.0	100.0
NEBRASKA	29.4	33.4	6.4	1.9	3.0	4.0	18.3	3.5	100.0
NEVADA	22.6	29.4	2.6	1.4	2.6	2.6	12.7	25.9	100.0
NEW HAMPSHIRE	30.3	34.6	7.2	1.3	3.6	6.0	14.4	2.1	100.0
NEW JERSEY	27.9	34.6	6.7	1.3	5.7	5.7	16.7	1.4	100.0
NEW MEXICO	24.7	26.6	2.6	1.6	2.4	5.4	0.6	26.6	100.0
NEW YORK	24.9	27.4	5.9	1.1	10.6	10.6	18.2	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	26.6	32.2	6.6	2.0	2.7	4.3	17.4	4.3	100.0
OHIO	26.7	35.6	6.5	1.7	3.3	4.1	16.2	1.7	100.0
OKLAHOMA	30.7	21.2	5.1	1.0	3.6	6.3	15.6	16.2	100.0
OREGON	22.6	28.5	2.6	1.4	3.3	4.1	12.9	24.4	100.0
PENNSYLVANIA	26.6	32.7	7.1	1.3	4.0	4.9	19.7	1.4	100.0
RHODE ISLAND	26.0	32.0	6.4	1.1	6.2	6.5	16.2	1.6	100.0
SOUTH CAROLINA	30.1	19.9	4.3	1.1	3.5	6.6	10.5	22.0	100.0
SOUTH DAKOTA	30.6	30.3	6.9	2.4	2.7	5.9	15.1	3.9	100.0
TENNESSEE	31.5	23.7	5.2	1.1	2.7	6.2	14.4	15.2	100.0
TEXAS	32.6	23.6	4.9	1.2	3.2	4.5	14.4	15.5	100.0
UTAH	24.2	32.1	2.7	1.4	2.4	5.1	7.3	24.8	100.0
VERMONT	28.7	32.0	7.1	1.3	4.6	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	27.9	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	7.9	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 %	5.6 %	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 STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	29.6 %	21.1 %	4.4 %	1.1 %	1.7 %	4.5 %	20.3 %	17.4 %	100.0%
ALASKA	26.5	34.4	2.4	1.9	4.0	4.9	6.5	18.6	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	16.9	17.5	100.0
ARKANSAS	30.8	19.0	4.2	1.2	2.2	6.2	21.0	15.3	100.0
CALIFORNIA	24.0	30.3	2.6	1.7	4.2	4.2	17.5	15.3	100.0
COLORADO	26.1	33.2	3.3	1.7	3.8	3.8	12.0	16.1	100.0
CONNECTICUT	25.6	37.5	4.9	1.1	5.6	5.6	17.9	1.1	100.0
DELAWARE	29.4	23.6	4.5	0.9	4.3	4.3	18.6	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	29.6	19.6	4.4	1.0	2.6	3.6	25.7	12.6	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	3.3	1.7	3.6	3.6	10.6	17.3	100.0
IDAHO	25.2	30.1	3.0	1.6	2.6	6.2	13.6	17.5	100.0
ILLINOIS	26.6	33.6	5.9	1.7	4.0	4.0	22.0	1.7	100.0
INDIANA	27.4	32.3	6.6	1.6	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
KENYUCKY	27.7	20.2	3.9	1.0	3.6	6.5	17.6	17.5	100.0
LOUISIANA	26.7	19.1	3.7	1.0	3.6	6.4	16.2	21.3	100.0
MAINE	25.7	32.6	5.6	1.1	4.6	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	24.0	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	26.5	16.3	3.6	1.1	2.4	6.6	17.6	19.3	100.0
MISSOURI	27.2	32.9	6.3	1.7	2.7	4.1	22.6	2.3	100.0
MONTANA	23.4	26.7	2.6	1.3	3.5	6.9	14.7	20.5	100.0
NEBRASKA	26.6	34.6	7.3	1.5	3.3	4.4	17.0	2.9	100.0
NEVADA	25.9	33.2	3.2	1.6	2.3	2.3	15.7	15.6	100.0
NEW HAMPSHIRE	30.2	35.4	4.6	1.5	4.0	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	1.6	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	30.6	6.3	1.5	5.0	6.1	20.0	4.6	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	15.6	100.0
OREGON	25.4	30.6	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	6.3	19.7	1.6	100.0
SOUTH CAROLINA	30.1	23.3	4.5	1.1	2.7	7.1	14.6	16.5	100.0
SOUTH DAKOTA	26.2	32.0	6.4	1.6	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	26.9	34.1	5.6	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	15.9	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	26.5	16.6	4.4	0.9	2.7	6.6	18.7	18.3	100.0
WISCONSIN	26.0	34.0	6.3	1.4	4.4	6.0	16.9	3.2	100.0
WYOMING	25.1	32.6	3.2	1.7	2.4	2.4	13.1	19.3	100.0
TOTAL	28.7 %	28.7 %	4.5 %	1.4 %	4.5 %	5.7 %	19.2 %	9.4 %	100.0%

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employer 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 STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	29.1 %	20.6 %	4.3 %	1.2 %	1.8 %	4.2 %	23.7 %	15.1 %	100.0%
ALASKA	20.8	34.7	2.4	2.2	4.7	4.7	7.8	16.6	100.0
ARIZONA	24.1	29.0	2.9	1.9	2.8	4.3	19.8	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	26.0	33.1	3.3	1.0	3.6	3.6	14.3	14.2	100.0
CONNECTICUT	25.1	30.4	4.8	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	20.9	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	28.8	19.2	4.3	1.1	2.8	3.3	29.6	10.9	100.0
GEORGIA	28.8	22.1	4.1	1.0	3.4	6.7	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	2.8	8.0	10.1	15.4	100.0
ILLINOIS	25.8	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	20.6	31.4	6.4	2.0	3.7	6.2	20.6	3.1	100.0
IOWA	26.6	32.3	6.0	1.8	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	6.1	21.5	18.7	100.0
MAINE	25.0	32.0	5.5	1.2	4.5	10.0	19.8	2.0	100.0
MARYLAND	20.9	22.7	4.0	1.0	4.4	4.4	22.0	14.7	100.0
MASSACHUSETTS	24.0	33.3	4.0	1.2	6.4	6.4	23.3	1.3	100.0
MICHIGAN	24.6	32.2	5.6	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	26.2	31.6	6.1	1.8	2.5	3.8	26.1	1.9	100.0
MONTANA	23.3	26.0	2.8	1.7	3.4	6.6	17.4	18.1	100.0
NEBRASKA	26.0	33.7	7.1	1.9	3.1	4.1	19.7	2.5	100.0
NEVADA	25.6	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	5.8	5.8	23.2	1.4	100.0
NEW MEXICO	25.6	26.4	3.0	2.0	3.1	6.8	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	24.8	29.9	6.2	1.7	4.6	5.7	23.1	4.2	100.0
OHIO	24.7	31.0	5.9	1.7	4.3	6.0	24.7	1.7	100.0
OKLAHOMA	29.3	19.9	4.1	1.2	4.1	5.6	21.9	13.8	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	30.8	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	1.3	100.0
VIRGINIA	29.8	23.9	4.4	1.1	3.5	3.9	18.8	14.6	100.0
WASHINGTON	23.5	30.0	2.9	1.9	4.9	4.9	16.6	15.2	100.0
WEST VIRGINIA	28.2	18.4	4.4	1.0	2.6	6.5	22.0	16.9	100.0
WISCONSIN	25.2	33.0	6.1	1.5	4.1	5.6	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	26.1 %	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 th gh 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

While the benefits of effective health treatment are often viewed from the point of view of the patient and his or her family, it should not be forgotten that there is much to be gained for the patient's employer as well.

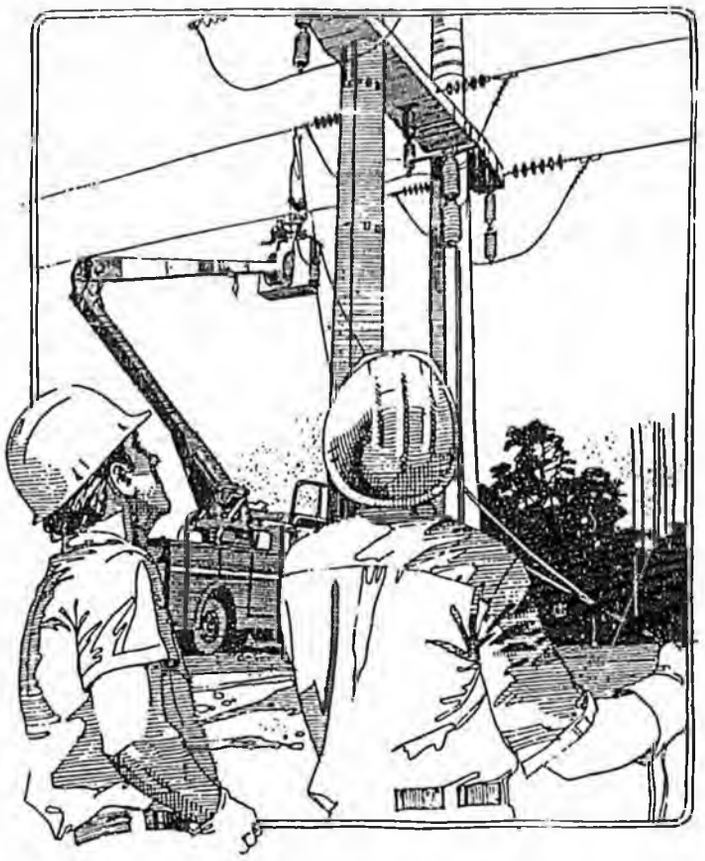
If the employee can be kept healthy, the employee can be kept productive. If timeoff for sickness and injury can be reduced, Workers' Compensation and insurance costs can be saved.

Numerous time loss studies of industrial back injury show conclusively that under chiropractic care, work days lost and total treatment cost is significantly less than with medical treatment. The facts attest the advantages of including chiropractic in any health plan designed for industry.

Comparative Cost Studies of Industrial Back Injuries

The studies cited here are presented to demonstrate to Industrial and Union health planners, HMO directors, federal officials, Congressional staffs, third-party payors, and other health care professionals the direct cost-effectiveness abilities of chiropractic treatment. However, the studies show chiropractic to be not only cost-effective, but quite efficacious as well. Measures of time loss at work, employee disability, and duration of treatment all point to the advantages of chiropractic care in the treatment of certain major categories of back and neck injuries. The fact that back injuries are a major cause of work-time loss and various degrees of disability, are two of the main reasons that chiropractic care is growing in usage and is an important part of the health care system.

Although these studies focus upon Workers' Compensation expenses, there is some indication that chiropractic treatment reduces overall costs in several hard to quantify areas. It is difficult to measure the overall savings to society in getting working people back to their job as promptly as possible. Also, chiropractic care does not rely upon the use of any pharmaceuticals or in the hospitalization of patients, which enables additional savings.



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[5]American Chiropractic Association, Chiropractic State of the Art, ACA. (Des Moines, Iowa), 1979, pp. 31-33.

[6]Martin, R. A., M.D., "A Study of Time-Loss Back Claims: Workmen's Compensation Board, Medical Directors Report, State of Oregon", Archives of the California Chiropractic Association. Vol. 4, No. 1, 1975, pp. 91-95.

[7]Cichoke, Anthony, D.C., and West, Henry, D.C., "A Comparative Study of Time-Loss Back Claims", The ACA Journal of Chiropractic. December, 1978, pp. 17-18.

[8]American Chiropractic Association, "Comparison of Chiropractic and Medical Treatments of Non-Operative Back and Neck Injuries in Iowa 1976-1978", Statistical information from the Iowa Industrial Commission, tabulated by the Department of Research and Statistics, ACA. (Des Moines, Iowa), 1978.

CALIFORNIA STUDY

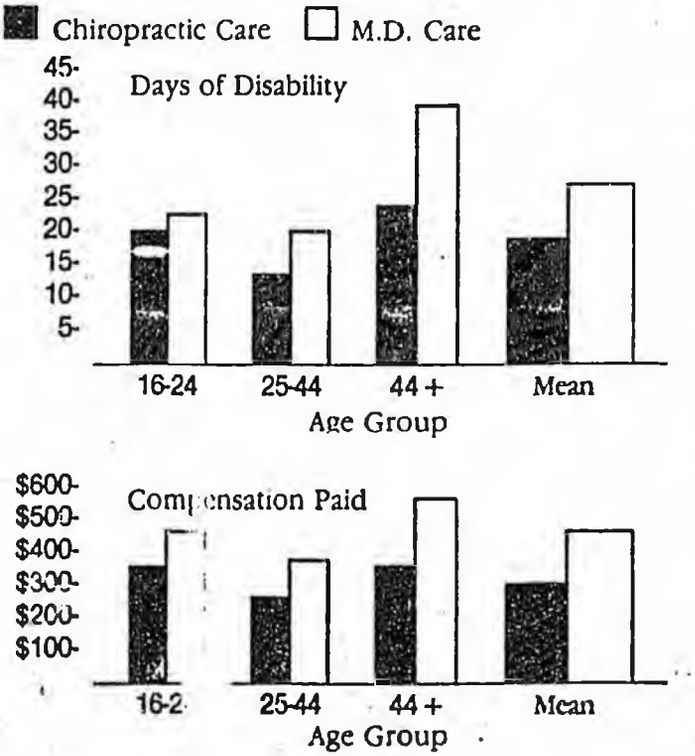
This study was conducted by C. Richard Wolfe, M.D., utilizing records provided by the California Division of Labor Statistics and Research, in 1972. Dr. Wolfe's independent study was designed to compare cases of time loss due to industrial back injury when treated by a medical doctor and when treated by a doctor of chiropractic. The study was structured to report on the next arriving 500 cases of back injuries treated by M.D.'s and the next 500 cases under chiropractic care. Each of the patients was contacted by mail and asked three questions regarding the treatment they had received. 1,000 patients were queried, and 629 replied. Following are the results of the study.[1]

	Aver. No. Work Days Lost	% Reporting Complete Recovery	% Reporting No Lost Work Time	% Losing Over 60 Work Days
Chiropractor	15.6	51	47.9	6.7
Medical Doctor	32	34.8	21	13.2

MONTANA STUDY

An American Chiropractic Association sponsored study of Montana's workers' compensation claims from 1975-1978[2] demonstrated substantial savings to patients using chiropractic services versus M.D. services. Of special note is that the period of disability resulting from an industrial back injury and the treatment costs were considerably less when a doctor of chiropractic was utilized.

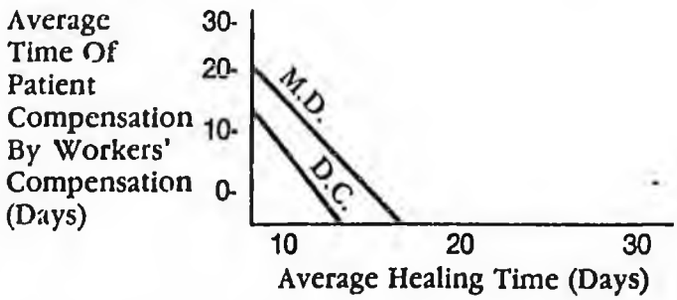
The bar graph below clearly highlights the above statement concerning costs and the length of disability.



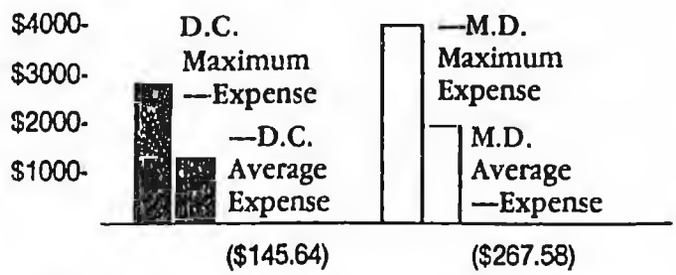
WISCONSIN STUDY

In March, 1979, the Wisconsin Chiropractic Association commissioned researchers at The University of Wisconsin to perform a study of persons having strained or sprained backs.[3] The study excluded back fractures, and cases that resulted in permanent total disability. The research revealed that those patients treated by chiropractic recovered faster, returned to their workplaces more promptly and had lower overall health care costs.

The study was based upon documented cases filed with the State Department of Industry, Labor and Human Relations during 1977. Also, the cases were covered by the State's Workers' Compensation Laws. The two charts presented next show the quicker healing time and lower cost of chiropractic care.



Expense Range For M.D. And D.C. Care Per Back Injury



OREGON STUDY

In 1971, a detailed back injury study[6] was performed using the records of the Workers' Compensation Board of the State of Oregon. This study revealed that all of claimants under chiropractic care, 82% returned to work after one week of time lost. This compares to 41% who resumed work after one week under the care of M.D.'s.

A separate study using the Oregon records[5] compared the costs of rendering care for strains and sprains. The results of this study are briefly outlined below. Note that chiropractic care costs were less than 25% of the M.D. costs.

	Strains and Sprains Treated By M.D.'s	Strains and Sprains Treated By D.C.'s
Average Total Cost of Care	$298.52	$72.92

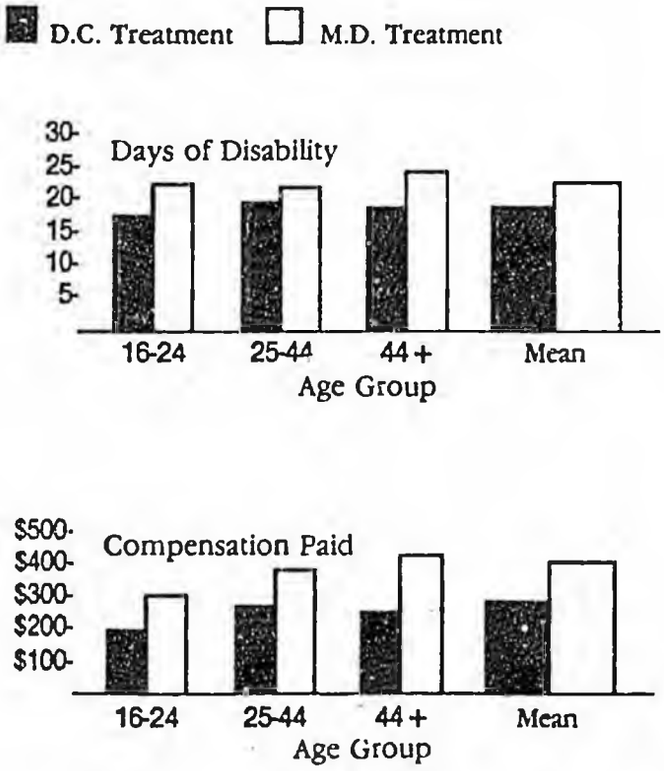
A follow-up study, completed in 1975[7], again using the workers' compensation data, further reinforced the efficacy of chiropractic care in Oregon. This study revealed that twice as many patients treated by medical physicians received temporary disability awards than those treated by chiropractic physicians. Additionally, 13% of the M.D. treated patients were awarded permanent disability awards while only 6% of the D.C. treated patients received permanent disability awards.

IOWA STUDIES

Two studies utilizing Iowa back injury data have been undertaken. The original study used cases for the years 1966 and 1969.[5] The statistical information was provided by the Iowa Workers' Compensation Authority.

	Back Injuries Treated By M.D.'s	Back Injuries Treated By D.C.'s
Cost Per Case 1966	$118.74	$68.25
Cost Per Case 1969	$210.06	$79.28

In 1978, an analysis of nonoperative back and neck injuries claims processed by the Iowa Office of the Industrial Commission[8] revealed a number of interesting conclusions. Both the average period of disability and the average amount of compensation awarded were lower for chiropractic patients than for non-chiropractic patients.



FLORIDA STUDY

Based on Florida statistics, a 1960 study by the First Research Corporation[4] also demonstrated the cost-effectiveness of chiropractic treatment. The comparison between chiropractic and other types of professional treatment for similar nonoperable injuries is shown in the chart below. Note the difference in both cost and average work days lost per employee.

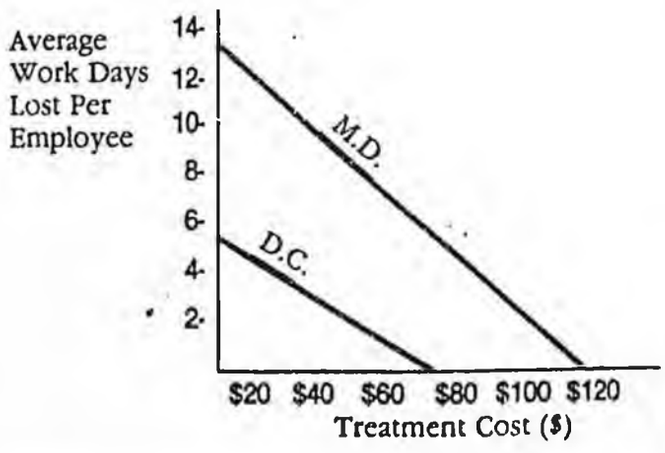
	Cases Treated By M.D.'s	Cases Treated By D.C.'s
Average Work Days Lost Per Employee	9 Days	3 Days
Average Total Treatment Cost	$102.00	$60.00
Average Number Of Visits	6	9

A similar comparison was made on nonoperable injury cases treated by M.D. specialists, such as orthopedists, and neurologists.

	Cases Treated By M.D. Specialists	Cases Treated By D.C.'s
Average Work Days Lost Per Employee	30 Days	2.5 Days
Average Total Treatment Cost	$299.00	$30.00
Average Number Of Visits	18.1	8.6

KANSAS STUDY

A study of 1972, Kansas Workers' Compensation[5] records concerning the comparison between chiropractic and medical treatment for nonoperable injuries, is graphically presented below. Please observe that the average D.C. treatment cost was $68.43 as compared to $117.61 for the M.D. This is approximately 40% less than the M.D. cost. D.C. treatment also resulted in an average workday loss per employee of 5.8 versus 13.1 days for non-D.C. physician treatment.



DRAFT

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

Submitted to:

The American Association for Retired Persons

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August, 1990

CHAPTER ONE:
Background and Purpose of this Document

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
U.S. TOTAL	214,660	134,072	15,984	16,958	10,619	34,112	15.9
ALABAMA	3,478	2,069	202	311	134 *	695	20.0
ALASKA	453	212	27	63	58	90	19.7
ARIZONA	3,053	1,837	191	142	179	662	21.7
ARKANSAS	2,146	1,160	148	204	120	484	22.5
CALIFORNIA	24,907	13,740	1,780	2,615	1,399	5,080	20.4
COLORADO	2,802	1,731	231	183	202	428	15.3
CONNECTICUT	2,794	2,109	211	89	58 *	294	10.5
DELAWARE	589	409	29	42	40	64	10.9
DIST. OF COL.	507	294	36	47	18	101	20.0
FLORIDA	10,420	5,674	904	574	782	2,336	22.4
GEORGIA	5,564	3,286	395	421	316	1,049	18.9
HAWAII	920	549	60	47	145	111	12.1
IDAHO	879	511	114	47	39	159	18.1
ILLINOIS	10,094	6,838	695	891	313	1,219	12.1
INDIANA	4,849	3,404	373	190	211	617	12.7
IOWA	2,416	1,603	412	117	52	219	9.1
KANSAS	2,072	1,419	217	77	102	232	11.2
KENTUCKY	3,116	1,894	173	255	174	573	18.4
LOUISIANA	3,847	1,839	256	482	204	1,012	26.3
MAINE	1,038	669	82	100	50	121	11.6
MARYLAND	4,152	2,657	193	276	338	440	10.6
MASSACHUSETTS	5,164	3,651	377	388	178	510	9.9
MICHIGAN	8,205	5,532	553	948	316	719	8.8
MINNESOTA	3,908	2,498	523	349	66 *	451	11.5
MISSISSIPPI	2,282	1,126	186	273	138	516	22.6

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

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

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

THE CRISIS IN HEALTH INSURANCE

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

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

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

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

"If the employed population knew how vulnerable they were, they'd be up in arms demanding national health insurance," says Bonnie Burns, a counselor with California's insurance counseling program. "Most of these people are three paychecks away from disaster."

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

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

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

WHO LOSES IT? WHAT HAPPENS?

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

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

Two-thirds of all people with hypertension fail to have their disease controlled, largely because they can't afford medications. Half of those with hypertension haven't seen a doctor within the past year. A Roper poll has found that the proportion of Americans going to doctors in any one month has fallen to a 15-year low.

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

Crisis: Delayed care

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

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

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

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

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

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

Shifting the cost

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

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

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

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

Unaffordable premiums

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

Even when employers do offer coverage, not all their employees take it. The Service Employees International Union, whose members are hospital workers, janitors, and government employees, found that 49 percent of its low-wage members were offered insurance but turned it down because they could not afford the premiums. In 1987, 25 percent of the uninsured worked for very large employers, most of whom offered health insurance.

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

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

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

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

Less coverage for many

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

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

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

Losing coverage

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

Crisis: Benefits end, costs don't

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

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

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

Eventually the carrier paid most of Curnow's bills, which totaled nearly $250,000. But he is still waiting to be reimbursed for the services of the home-health aide he needs every day. The third-party administrator handling his case told him those services were covered, but so far, the cost—some $1500 each month—comes out of his pocket.

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

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

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

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

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

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

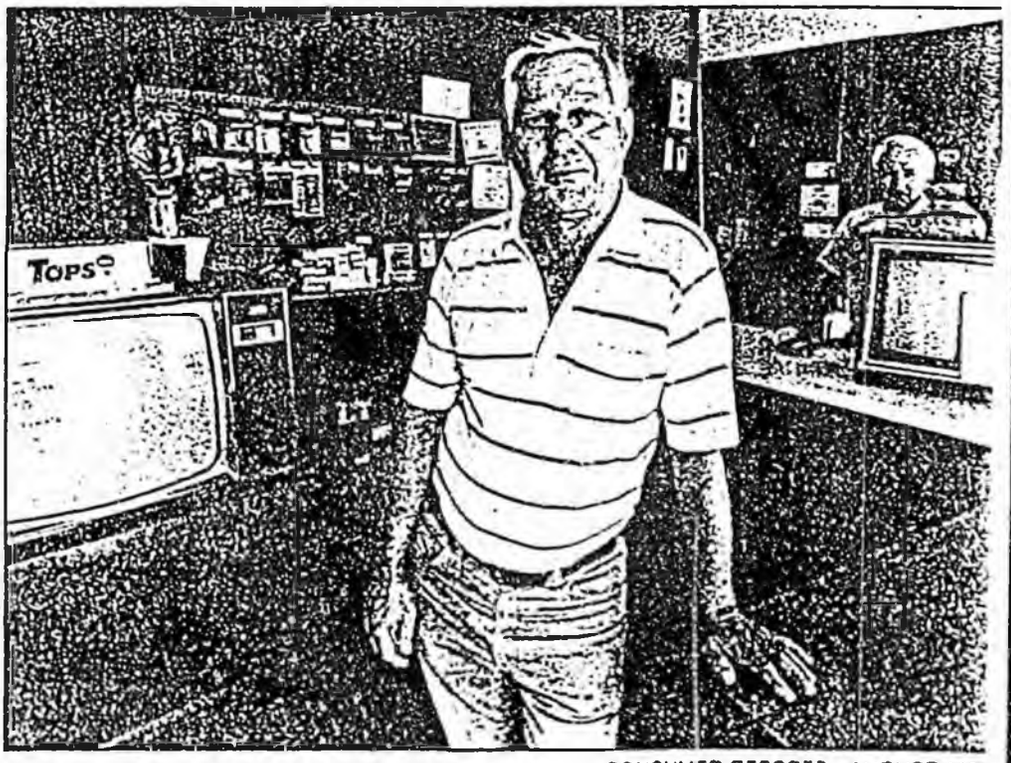
Crisis: Unaffordable premiums

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

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

When his present carrier, American Western Life, sent a renewal notice last summer, Pudiwitr's monthly premium had jumped from $272 to $543, and the premium for Sutherland doubled from $421 to $642.

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



The woes at HMOs

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

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

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

Consider what happened to Samuel Stroup. A former home-improvement salesman in Akron, Ohio, Stroup underwent a liver transplant at the same time that Maxicare, his HMO, was going bankrupt. Stroup went ahead with the transplant because the firm handling Maxicare's affairs approved the procedure and agreed to pay for the antirejection drugs he would need following the operation.

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

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

Clinging to coverage

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

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

Crisis: Locked in

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

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

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

Nichols is 38.

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

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

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

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

No coverage for the sick

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

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

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

Susan Turner (not her real name) knows how vulnerable a person can be. Turner, who asked us not to identify her, earns $19,000 as a secretary for a small accounting firm in Texas. Her daughter, who's now 20, was born with an immune deficiency disease that makes her susceptible to infections. Every four to five weeks, she needs a lifesaving infusion of antibodies that costs about $2400.

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

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

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

Continued

THE CRISIS IN HEALTH INSURANCE

WHICH POLICIES ARE BEST?

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

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

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

Types of policies

There are three basic kinds of health-insurance coverage:

☐ **Major-medical policies.** These are the most comprehensive, covering both hospital stays and physicians' services in and out of the hospital.

☐ **Hospital-surgical policies.** These cover hospital services and surgical procedures only.

☐ **Hospital-indemnity and dread-disease policies.** These policies are vastly inferior to the other two types and offer very limited benefits. They are discussed in the box on page 539.

What's covered

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

Some policies, however, don't pay for assistant surgeons or for standby surgeons. Others won't cover emergency treatment unless the policyholder is admitted directly to the hospital. (That's to discourage the use of emergency rooms for routine treatment.) Still others limit the number of times they'll pay for doctors' visits in the hospital. Even a comprehensive policy may pay for only one visit each day.

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

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

Maternity benefits

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

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

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

Another drawback is that companies don't pay the full benefit during the first two years the policy is in force. A policyholder who becomes pregnant may receive only 50 or 60 percent of the benefit in the first year and 75 percent in the second year. Not until the third year are full benefits paid.

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

What's not covered

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

How policies pay

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

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

What portion the company considers differs among insurers. Each company sets its reimbursement level based on physicians' charges for services and procedures in your area. One company might choose to reimburse policyholders based on the charge that represents the 90th percentile for a given procedure or service. Another might choose the 75th percentile. (For hospital services, companies pay either the

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

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

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

Amounts paid by hospital-surgical policies usually fall far short of the actual charges. For example, Metropolitan's policy will pay a surgeon who performs an appendectomy as little as $260 or as much as $480, depending on the schedule the policyholder picks; in 1989, the average surgeon's charge was $846 for an appendectomy. The policy pays as little as $390 or as much as $720 for a hysterectomy; but a hysterectomy cost an average of $1737 in 1989.

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

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

Suppose a physician charges $3000 for an angioplasty (a cardiac procedure), but the carrier considers only $2610 as an eligible expense. If the insurer pays 80 percent, the policyholder will receive $2088 (80 percent of $2610). He or she will then have to pay the remaining 20 percent, or $522, plus the $390 that's not eligible for reimbursement.

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

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

Pay by the Day? By the Disease?

THE WORST TYPES OF INSURANCE

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

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

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

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

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

Dread-disease policies offer similarly inadequate benefits. We measured two cancer policies against a $19,774 claim for colon-cancer surgery and follow-up chemotherapy that we also used to rate the policies in our survey. A policy from American Family Life, a large seller of this type of insurance, would pay a maximum of $4100; a policy from American Fidelity Assurance would cover as much as $6210—but only if the policyholder had purchased some optional coverage. (These policies may also pay an additional benefit based on the number of months you own the policy before you contract cancer.)

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

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

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

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

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

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

holder pays the first $5000 of covered expenses.

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

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

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

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

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

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

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

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

Some companies no longer offer low deductibles. "If somebody can afford to buy our product, he can afford a $1000 deductible," says John Hartnedy, the chief actuary at Golden Rule. "You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill."

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

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

Can you renew?

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

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

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

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

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

Are you insurable?

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

Virtually no commercial carriers and only a handful of Blue Cross and Blue Shield plans will sell policies to anyone who has had heart disease, internal cancer, diabetes, strokes, adrenal disorders, epilepsy, or ulcerative colitis. Treatment for alcohol and substance abuse, depression, or even visits to a marriage counselor can also mean a rejection.

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

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

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

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

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

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

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

Truth will out

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

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

Better off at the Blues?

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

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

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

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

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

Preexisting conditions

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

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

THE LAST RESORT

HIGH-RISK POOLS

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

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

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

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

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

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

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

Long waiting lists

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

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

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

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

THE CRISIS IN HEALTH INSURANCE

To encourage applicants to reveal all their medical conditions, some companies waive their usual waiting periods *if* you have disclosed all your health problems (providing the company is willing to accept you and not exclude coverage for those conditions).

What policies cost

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

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

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

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

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

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

The wrong job

Occupations some insurance companies consider unacceptable for health coverage:

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

Pricing tricks

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

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

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

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

Managed care and PPOs

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

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

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

How we rated the policies

Most Blue Cross and Blue Shield organizations and a handful of commercial carriers sell individual health coverage. Twenty of the 29 Blue Cross and Blue Shield plans we approached for information refused to cooperate with our study, forcing us to turn to state regulators to obtain necessary information on their policies, premiums, and rate histories. (Surprisingly, some regulators made it difficult to obtain the information, even though data filed with public agencies is usually available to the public.) The Blue plans that refused to answer our questionnaire are noted in the Ratings with an asterisk.

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

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

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

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

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

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

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

A good policy is useless if the company can cancel it, or if rate increases are so steep you can't pay the premiums. Therefore, we gave weight to each policy's renewability features and rate-increase history. A policy scored highest in these factors if it was guaranteed renewable and if the company's rate increases over a five-year period were less than the medical consumer price index.

We also looked at a policy's lifetime benefit maximum, its preexisting conditions clause, and coverage provided by the maternity rider.

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

Blue Cross and Blue Shield

ABANDONING THE MISSION

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

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

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

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

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

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

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

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

Blue Cross and Blue Shield of Kentucky, for example, receives only a 7 percent discount from the hospitals. And it does not subsidize individual health coverage (other than conversion policies) out of the profits from other lines of business. At the suggestion of insurance regulators, it abandoned community rating a few years ago in favor of the kind of pricing used by its commercial competitors.

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

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

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

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

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

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

Hospital-surgical plans cost less than major-medical policies, but they generally provide much less coverage. At Bankers Life and Casualty, a 45-year-old man living in Chicago would pay $806 a year for a hospital-surgical plan, compared with $1245 for the company's major-medical policy. But as you can see from the column labeled "Payout," the coverage offered by these policies is, for the most part, decidedly inferior to that provided by major-medical policies.

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

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

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

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

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

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

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

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

Ratings begin on page 544

Catastrophic Claims

PERCENTAGE GAMES

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

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

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

The treatment for the heart-attack patient came to $49,767. It included an angioplasty (a procedure to open blocked arteries) that cost $8730 in surgical fees, and a 21-day hospital stay that piled up bills of $34,107.

In this case, the Blue Cross and Blue Shield of Minnesota plan would have paid about 97 percent of the $49,767 claim if the policyholder used all "preferred provider" doctors and up to 95 percent if the policyholder did not. American Republic's *UltraCare* policy with no coinsurance would have paid 97 percent. The major-medical plan from Washington National would have paid 90 percent of the claim. And Pyramid Life's marginal hospital-surgical policy would have paid only 44 percent, leaving the patient to recover from a $28,000 debt as well as the heart attack.

CONTINUING COVERAGE

WHEN YOU LEAVE A GROUP PLAN

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

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

COBRA: How it works

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

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

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

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

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

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

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

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

Some employers consider COBRA an administrative headache and may offer employees who leave a simpler alternative—insurance that covers them only for injuries caused in an accident. Accident-only policies may be tempting because they're cheap—a few hundred dollars a year, compared to a few thousand for COBRA coverage—but we don't recommend them. Unless you are very young, you're much more likely to need coverage for illnesses than for accidents.

Beyond COBRA

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

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

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

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

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

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

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

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

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

RATINGS

Health-insurance policies

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

1 Annual premiums. These are annual premiums for 45-year-old **men** and **women** living in Chicago. For a company not selling there, the premium is for the company's major operating territory. **Family** premiums assume a 40-year-old husband, a 35-year-old wife, and two children. Premiums are given for policies with $500 deductibles. If the company does not offer a $500 deductible, we show the premium for the closest deductible to $500; footnotes (on pages 548-549) state the deductible on which the price is based. Premiums for **maternity rider** show the cost of adding coverage for routine pregnancies.

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

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

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

Policy	Comments	1 Annual premiums: Men	Women	Family	Maternity rider
Major-medical					
Blue Cross and Blue Shield of Minnesota	Aware Gold (F2844) PPO	$1493 [1][2]	$1962 [1][2]	$5100 [1][2]	Included
Capital Blue Cross w/Penn. Blue Shield	Major Medical	1815 [3]	1815 [3]	3923 [2]	Included
American Republic	UltraCare, no coinsurance	1904 [4]	2240 [4]	5012 [4]	$608
Blue Cross and Blue Shield of New Jersey	Medallion	1843 [2][5]	1843 [2][5]	4759 [2][5]	Included
Benefit Trust Life	MMI	1794 [6]	2096 [6]	4319 [6]	Included
Empire Blue Cross Blue Shield	Tradition Plus Wraparound (LGL 3252)	2392 [7]	2392 [7]	6126 [7]	Included
Independence Blue Cross w/Penn. Blue Shield	Major Medical w/Plan 100	2192 [10]	2192 [10]	5159 [10]	Included
Blue Cross and Blue Shield of Minnesota	Aware Care (F2239)	658 [2]	882 [2]	2225 [2]	Included
American Republic	UltraComp	1632 [2]	1953 [2]	4333 [2]	536
American Republic	UltraCare, 20% coinsurance	1596 [4]	1877 [4]	4200 [4]	608
Blue Cross of Washington and Alaska*	Personal Prudent Buyer, Low Option 200, Wash.	1032 [2][8]	1092 [2][8]	2376 [2][8]	None
Blue Cross and Blue Shield of Alabama*	ALPHA Plan	1308 [2][9][10]	1308 [2][9][10]	3432 [2][9][10]	72
Blue Cross and Blue Shield of Illinois*	Non-Group PPO	1543	1932	4363	261
Blue Cross and Blue Shield of Montana*	Personal Choice Plan	1851	1851	4241	Included
Blue Cross and Blue Shield of Montana*	Healthy Montanan Plan	1553	1553	3554	Included
Blue Cross and Blue Shield of New Jersey	Direct Payment Supplemental Major Medical	3167 [10]	3167 [10]	6135 [10]	Included
Blue Cross and Blue Shield of Indiana*	Personal Security	1293	1374	2935	1164
Blue Cross and Blue Shield of Oklahoma*	Health Check	1764 [11]	1764 [11]	3780 [11]	Included
Blue Cross and Blue Shield of Maryland*	Personal Comp	1001	1001	2604	Included
Central States Health & Life	Individual Major Medical (569-570, 571-572)	1463 [2]	1300 [2]	3721 [2]	781
Time	24 Karat (502)	1580 [2]	1876 [2]	3854 [2]	490
Benefit Trust Life	Tele-Med	1443	1822	3878	1257
Bankers Life and Casualty	VIP V (CR-G002)	1245 [2]	1625 [2]	3382 [2]	None
Bankers Multiple Line	The Spectrum Plan (D-G002)	1245 [2]	1625 [2]	3382 [2]	None
Union Bankers	The Spectrum Plan (MM-89)	1245 [2]	1625 [2]	3382 [2]	None
Blue Shield of California*	Preferred	1952	1952	3299	None
Blue Cross and Blue Shield of New Jersey	Blue Care	1261 [2]	1261 [2]	3400 [2]	Included
Blue Cross of Washington and Alaska*	Traditional Individual in Alaska	1933	1933	4123	None
Blue Cross of California*	Personal Prudent Buyer	1680	1680	3858	3360
Blue Cross and Blue Shield of Illinois*	Non-Group Comprehensive	1838 [13]	1992 [13]	4886 [13]	None
Blue Cross and Blue Shield of Maine	Blue Alliance	1294 [12]	1294 [12]	2580 [12]	Included
Empire Blue Cross Blue Shield	Tradition Plus Comprehensive (LGL 3253)	1507 [14]	1507 [14]	3228 [14]	Included
Benefit Trust Life	MM2	1496	1751	3603	None
Blue Cross and Blue Shield of Arizona*	Preferred Care	716	716	1928	None
Aid Association for Lutherans	TotalMed II (4945)	1708 [2]	1724 [2]	4032 [2]	1860

● ◓ ○ ◒ ● Better ← → Worse

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

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

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

7 Renewability. **Guaranteed** means the policy is guaranteed renewable for the policyholder's life. **Conditional** means that the company can cancel it along with all similar policies. **Optional** means the company can cancel an individual policy.

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

9 Preexisting illness. The **waiting period** is the number of **months** a policyholder must wait before coverage begins for a preexisting illness not disclosed on the application. The waiting period may be shorter for disclosed illnesses. The **look-back period** is how far back in time the insurance company will investigate for preexisting illness.

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

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

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

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

	3 Payout					9 Preexisting illness									
	Quality index 2	Single	Family	4 Catastrophic claims	5 Lifetime maximum	6 Maternity coverage	7 Renewability	8 Rate history	Waiting period, mo.	Look-back period, mo.	10 Available to anyone	11 Exclusion riders	12 Higher rates	13 Other coverage	Comments	Telephone
	85	89%	89%	●	None	●	Conditional	●	24	3	No	Yes	Yes	a,b,c	A	800-382-2000
	83	84	87	●	None for basic policy	●	Conditional	◓	12	12	Yes	No	No	a,c,d	C	717-255-0820
	81	82	68	●	$1-million per condition	○	Guaranteed	●	24	24	No	Yes	Yes	a,d	B	800-247-2190
	80	88	88	●	None	●	Conditional	—	12	12	No	No	No	a,c,e	C	201-822-4500
	80	86	85	○	1-million	●	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	80	83	82	●	1-million	●	Conditional	—	11	24	No	No	No	a,d,h	C	212-490-4757
	80	83	83	●	None for basic policy	●	Conditional	○	12	12	Yes	No	No	a,c	C	215-564-2100
	79	76	72	●	None	◓	Conditional	●	24	3	No	Yes	Yes	a,c,h	—	800-382-2000
	78	74	60	●	2-million	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	D	800-247-2190
	77	75	61	●	1-million per condition	○	Guaranteed	—	24	24	No	Yes	Yes	a,d	—	800-247-2190
	75	82	67	—	1-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-752-6663
	75	75	60	—	None for hospital	○	Conditional	●	12	24	No	Yes	No	a	J	800-392-5705
	75	73	61	—	1-million	◓	Optional	●	12	12	No	No	No	a,c,h	E	312-938-7209
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	68	62	—	None	●	Conditional	—	12	12	No	No	No	a,c	F	406-444-8210
	74	74	74	●	None for basic policy	●	Conditional	—	12	12	Yes	No	No	a,e,f	C	201-822-4500
	74	82	68	—	1-million	○	Conditional	—	12	No limit	No	Yes	No	a	B,E	800-522-4075
	74	77	72	—	1-million	◒	Optional	●	12	6	No	Yes	No	a,c,h	K	918-560-2121
	74	73	72	—	1-million	●	Conditional	◓	9	No limit	No	Yes	No	a,c,d	—	800-992-2308
	73	73	60	●	1-million	○	Conditional	●	12	24	No	Yes	Yes	a	—	402-397-1111
	73	72	60	◓	2-million	○	Conditional	●	24	12	No	Yes	Yes	a	—	800-333-1203
	72	71	58	◓	2-million	○	Conditional	—	24	12	No	Yes	Yes	a	—	708-615-1500
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000
	71	75	64	●	None	◒	Conditional	●	24	24	No	Yes	Yes	a,g	—	214-939-0821
	71	73	60	—	2-million	◒	Conditional	—	12	12	No	Yes	No	a,c,d	E	800-624-5150
	71	70	70	◓	100,000 per year	●	Conditional	—	12	12	No	No	No	a,e	—	201-822-4500
	71	75	60	—	1-million	◒	Conditional	◓	12	12	No	Yes	No	a	—	800-752-6663
	71	68	55	—	2-million	◓	Conditional	—	6	6	No	Yes	No	a,c	E	800-777-9000
	71	70	56	—	1-million	◒	Optional	●	12	12	No	No	No	a	—	312-938-7209
	70	67	72	—	None for basic policy	◓	Conditional	●	12	No limit	Yes	Yes	No	a,f	C,G	800-482-0966
	70	61	59	●	500,000	●	Conditional	—	11	24	Yes	No	No	a,d,h	—	212-490-4757
	69	72	60	○	1-million	◒	Guaranteed	●	24	24	No	Yes	Yes	a	C,G	708-615-1500
	69	75	62	—	1-million	◒	Conditional	—	11	No limit	No	Yes	No	a,c,h	E	800-543-2944
	69	71	60	◓	2-million	○	Conditional	●	24	No limit	No	Yes	Yes	a,d	—	414-734-5721

Ratings
Continued

		Annual premiums			
	Policy	Men	Women	Family	
Blue Cross and Blue Shield of Indiana*	Comprehensive Value	$ 928	$ 987	$2108	$1164
Blue Cross and Blue Shield of Virginia*	Personal Health Care	2044 [12]	2044 [12]	4359 [12]	Incluc
Blue Cross and Blue Shield of Virginia*	Personal Health Care (Healthy Virginian)	1169 [12]	1169 [12]	2454 [12]	Incluc
Blue Cross and Blue Shield of Florida*	Preferred Patient	1882	2085	4558	None
Blue Cross of Washington and Alaska*	Traditional Individual in Washington	1320	1320	2844	None
Blue Cross and Blue Shield of South Carolina	Mark Four	963	1292	2312	671
Blue Cross and Blue Shield of Kansas*	Afforda-Care	1208	1208	2653	Incluc
Blue Cross and Blue Shield of Kentucky*	BCBS 3082	765	1123	1918	Incluc
Metropolitan Life	Major Medical Expense Plan (FAH 15-86)	1594 [14]	2042 [14]	4030 [14]	770
Certified Life	VIP Variable Individual Protection (CER-G002)	1245 [2]	1748 [2]	3382 [2]	None
First National Life	Major Medical (MM-286)	1005 [16]	1137 [16]	2142 [16]	748
Blue Shield of California*	Coronet	2941 [14]	2941 [14]	4229 [14]	None
Pyramid Life	G91	1501 [2]	1863 [2]	4015 [2]	645
Golden Rule	Inflation Guard GRI-H-1.4	1805	1990	3623	316
Blue Cross and Blue Shield of Arizona*	ExecuCare	940 [14]	940 [14]	1814 [14]	Non
Prudential	Pru-Med (PM-83)	1228 [2] [14] [17]	1584 [2] [14] [17]	3127 [2] [14] [17]	2640
Washington National	Classic Choice (AM2836)	1764 [2]	2205 [2]	3249 [2]	900
Hospital-surgical					
Capital Blue Cross w/Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1579 [16]	1579 [16]	3451 [16]	Incl
Independence Blue Cross w/ Penn. Blue Shield	Blue Cross Hospital and Blue Shield Plan 100	1968 [16]	1968 [16]	4729 [16]	Incl
Blue Cross and Blue Shield of Michigan*	Non-Group Option E	2004 [16]	2004 [16]	3742 [16]	Incl
Blue Cross and Blue Shield Rochester*	Non-Group Basic	1016 [16]	1250 [16]	2472 [16]	Incl
Blue Cross and Blue Shield of Alabama*	Non-Group	1216 [20]	1216 [20]	2966 [20]	Incl
Blue Cross and Blue Shield of Oklahoma*	Health Check Basic	756 [9]	756 [9]	1848 [9]	Incl
Metropolitan	Tower Hospital and Medical-Surgical Expense	1015 [16]	1162 [16]	2846 [16]	Non
Blue Cross and Blue Shield of Maine	Blue Cross with Blue Shield H	1033 [16]	1033 [16]	2058 [16]	Incl
Blue Cross and Blue Shield of Montana*	Essential Care Plan	814 [8]	814 [8]	1844 [8]	Incl
Blue Cross and Blue Shield of Ohio*	Non-Group Policy w/Catastrophic Rider	1266 [16]	1266 [16]	2683 [16]	51
Blue Cross and Blue Shield of New Jersey	Direct Payment Comprehensive Hospital and Series 14/20	1336 [16]	1336 [16]	2796 [16]	Incl
Blue Cross and Blue Shield of New Jersey	Co-op Protection Plan and Series 14/20	1992 [16]	1992 [16]	3439 [16]	Inc
Bankers Life and Casualty	Hospital Surgical Protection (CR-G020)	806 [2]	1043 [2]	2137 [2]	No
Bankers Multiple Line	Hospital Surgical Plan (D-G020)	806 [2]	1043 [2]	2137 [2]	No
Union Bankers	Major Hospital Surgical (HS-89)	806 [2]	1043 [2]	2137 [2]	No
State Farm Mutual Automobile	Basic Hospital-Surgical 97047IL	705 [4]	853 [4]	2177 [4]	No
Certified Life	Hospital Surgical Protection (CER-G020)	806 [2]	1043 [2]	2137 [2]	No
Pyramid Life	G95	1016 [3] [16]	1250 [2] [16]	2472 [2] [16]	64
Hospital-only					
Empire Blue Cross Blue Shield	Tradition Plus Hospital	839 [16]	839 [16]	1886 [16]	In

[1] *$500 deductible on hospital services only.*
[2] *Rates for nonsmokers.*
[3] *$350 deductible on nonhospital only.*
[4] *$500 deductible for each condition every 3 years.*
[5] *$300 deductible only for supplies and drugs.*
[6] *$250 for nonhospital services.*
[7] *$300 deductible.*
[8] *$200 deductible.*
[9] *$200 deductible for each hospital admission.*
[10] *$500 deductible on nonhospital only.*
[11] *$400 deductible.*
[12] *$750 deductible.*
[13] *$300 deductible for each hospital admission; $500 for all services.*
[14] *$1000 deductible.*
[15] *$200 deductible for nonhospital services.*
[16] *Atlanta rates, $500 deductible for each condition.*
[17] *$100 deductible for hospital inpatient stays only; $1000 for other services.*
[18] *No deductible required.*
[19] *$250 deductible.*
[20] *$60 deductible for each hospital admission.*

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