ANALYSIS CONTINUATION

Alaska Health Fund

This bill establishes the Alaska Health Care Fund as a separate trust fund consisting of state and federal appropriations, employer & individual contributions, premiums, and interest. Individual and employer contributions can be designated to a particular person who receives an Alaska Health Care Voucher in that amount to purchase an insurance plan. Employer contributions also come from employers with 10 or more employees that provide coverage to fewer than 25% of employees or pay less than 33% of the employee premiums. Employers with 10-20 employees contribute 1% of the employer's gross payroll. Employers with more than 20 employees contribute 2%.

•We assume the Fund will be comprised of 1% employer contributions in the form of receipt supported services (RSS) and 99% general fund. Massachusetts recently implemented a universal health program partially funded by employer contributions. Massachusetts estimated that less than 2% of their revenue would be come from these contributions. Of the $24 million expected they are now expecting just $5 million.

Other Costs

•Alaska Health Care Board = $940.0 GF/yr including four State positions (350.0), travel (200.0), supplies (120.0), contractual (250.0), commodities/equipment (20.0), and one-time costs (67.0). Eff. immediately.

•Alaska Health Care Clearinghouse = $3,530.0 GF/yr including 21 positions (2,018.0), travel (220.0), contractual (1,000.0), supplies (250.0), commodities/equipment (42.0), and one-time costs (287.5). Eff. immediately.

•The contractual costs are for a premium collection system. The department does not currently have a system to handle premium collections. The Medicaid program collects premiums only from a few hundred persons. The estimated cost to develop this system is $2,000.0. The cost to maintain is $1,000.0/yr.

•There is no known database of employers who provide insurance and to what level they provide it to determine if an employer must contribute to the Fund. This fiscal note does not include the cost of creating or maintaining such a database, which most likely would be under the Department of Labor and Workforce Development.

Alternate Low-Premium Scenario

An alternate premium scenario was prepared assuming a low premium of $3,600 annual per capita (if similar to Arizona's plan). The cost for medical benefits remains $3,000 per person per year. The annual per capita cost to the individual would range from $400 (10%) to $2,900 (80%) for an average of $1,600.

Total the State pays: $172,000.0 (15,000.0 fed/15,000 GF/142,000.0 Fund)
Total individuals pay: $201,200.0
Grand total: $343,200.0

NFIB
The Voice of Small Business®

Alaska

January 25, 2008

The Honorable Hollis French
Alaska State Senate
State Capitol Building
Juneau, Alaska 99801-1182

RE: Senate Bill 160

Dear Senator French,

On behalf of the National Federation of Independent Business/Alaska, I wish to express our opposition to Senate Bill 160. The National Federation of Independent Business is the largest small-business advocacy group in the Alaska.

Health-care costs have been the No. 1 issue facing small-business owners since 1986, and those concerns are growing, according to NFIB's members. As health-care costs go through the roof, small-business owners have very few choices when selecting insurance coverage for their employees. The tipping point is here, and small businesses are begging for solutions to rising health-care costs, lack of access and other issues.

We're reminded weekly, if not daily, that 47 million Americans are uninsured. This hits especially close to home for small businesses, since approximately 27 million of those uninsured are the self-employed and small-business owners, their employees and their families. Many of those are in Alaska. Insurance premiums for small groups or single coverage have increased by more than 82 percent since 2000, a jaw-dropping statistic. This is completely unsustainable over the long-term.

National Federation of Independent Business – ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

Unfortunately, SB 160 mandates that small employers bear the cost of fixing the problem through mandated tax on a percentage of their gross payroll. It also creates mandated coverage design that will increase the cost of basic coverage that might be offered by small employers.

The NFIB has adopted **Small Business Principles for Health Care Reform**. I have enclosed a copy for your review. NFIB knows that no one solution will help all the uninsured Alaskans cover health-care costs, but a multi-faceted approach will allow many more to find health care at costs they can afford. This approach should include health-insurance purchasing pools for small businesses, tax-based incentives to assist with the purchase of health insurance and implementing cost-containment measures.

Sincerely Yours

Dennis L. DeWitt
Alaska State Director

Enclosure

cc: Senator Bettye Davis, Chair, Senate Health, Education, and Social Services Committee
Senator Joe Thomas
Senator John Cowdery
Senator Kim Elton
Senator Fred Dyson

Small Business Principles for Health Care Reform

Release Date: 12 / 12 / 2007

Our current system of health insurance and health care is financially unsustainable and threatens the health and financial security of the American people. Small-business owners and their employees are especially vulnerable to the weaknesses of our current system. NFIB supports policy reforms to balance the competing goals of access to quality care, affordability, and predictability and consumer choice. The resulting health care system would be:

Universal: All Americans should have access to quality care and protection against catastrophic costs. A government safety net should enable the neediest to obtain coverage.

Several reasons underlie our support for universal access to care. First, lack of insurance is especially problematic for small businesses and their employees. Second, having millions of uninsured Americans distracts us from focusing on affordability, quality and comprehensiveness of care and coverage. Third, laws already provide some level of insurance for everyone, but coverage is expensive, inefficient and often inadequate – guaranteed access to emergency rooms is one example. Under this piecemeal coverage, costs fall arbitrarily and inequitably on individuals, providers, governments and businesses.

Private: To the greatest extent possible, Americans should receive their health insurance and health care through the private sector. Care must be taken to minimize the extent to which governmental safety nets crowd out private insurance and care.

One-size-fits-all insurance and care are not wise options in a nation of 300 million people. Restoring and invigorating America's health care system requires rapid innovation; history shows that such rapid advances rarely come from government and more often come from private enterprises. America's health care system is far from perfect, but the world's single-payer systems have deep problems of their own. We need better health care delivery models, financial-management systems and risk-sharing arrangements. America remains the world's engine of health care innovation, and entrepreneurship is the key to that innovation. Given the current financial path of health care, governments ought to be wary of taking on the entire burden.

Affordable: Health care costs to individuals, providers, governments and businesses must be reasonable, predictable and controllable.

America's health care costs are high and growing more rapidly than earnings. The burden of costs often falls arbitrarily on individuals, businesses, providers and governments. Wages stagnate as health care costs eat further into take-home pay. Employers and governments struggle to balance budgets as health care costs rise. Health care uncertainties paralyze long-term financial planning. Through excessive malpractice judgments, we penalize good doctors practicing good medicine when their patients happen to experience bad outcomes.

Unbiased: Health care and tax laws should not push Americans into employer-provided or government-provided insurance programs and hobble the market for individually purchased policies. Small employers should be treated the same as large employers, who can already pool across state lines. A health care system built on employer mandates or on play-or-pay taxes is unacceptable.

Today, our tax and insurance laws riddle the health insurance market with inefficiencies. An employer who buys insurance for employees can write off the cost on its taxes. But if employees wish to purchase different policies on their own, they receive no tax benefit. Thus, an oddity of the tax code, not economic efficiency, artificially herds businesses and workers into the employer-based market. Current laws allow large employers to build large interstate risk pools and enjoy a reasonable level of regulatory oversight. Laws deny small employers the same opportunities, forcing them to offer insurance with inadequate risk pools. The result is to arbitrarily load a competitive disadvantage on the small firms that are an engine of America's productivity. Employer mandates compound the problem, penalizing the most vulnerable firms and workers, including cutting-edge startups, lower-income workers striving to rise and companies operating in economically disadvantaged markets. These mandates can force a promising enterprise out of business, sweeping away jobs and future economic growth.

Competitive: Consumers should have many choices among insurers and providers. Policymakers must alleviate the limitations that state boundaries and treatment mandates place on competitiveness.

In the next decades, America's capacity to deliver high-quality health care will face increased financial pressures. Maintaining or improving upon our current quality of care will depend critically upon our ability to develop newer and less expensive modes of treatment and delivery systems. Innovation is unlikely to come from a system where insurers or providers face little risk of competition. Under our current system, restrictions on interstate purchases of policies place powerful limits on choice. Some states are left with close to monopoly control on the issue of insurance as fewer and fewer insurers offer coverage in the small-group market. A cautionary note is in order: Any competitive system must guard against adverse selection—a situation in which some individuals purchase policies only after learning that they are likely to face high medical costs. Adverse selection can render insurance too expensive for healthier individuals. (In property insurance, an example would be someone who buys fire insurance only after he moves dangerous, combustible materials into his house.)

Portable: Americans should be able to move throughout the United States and change jobs without losing their health insurance.

Our current health-insurance system locks people into jobs and localities. An existing health problem may make it impossible for an individual to change jobs. Employer-based health insurance and restrictions on purchasing insurance across state lines limit a worker's ability to seek higher pay, greater opportunity, or a better locality for his or her family. This phenomenon of

job lock is not only a tragedy for the locked-in worker. It harms the overall economy by preventing workers from discovering their own entrepreneurial talents or accepting more productive jobs. It creates a significant impediment to those who wish to leave positions as employees and start small businesses of their own. Health care reform must maximize the mobility of American workers by eliminating health insurance as an impediment to changes in job and residence.

Transparent: Information technology should enable all parties to access accurate, user-friendly information on costs, quality and outcomes. Providers must be able to obtain relatively complete medical histories of patients. At the same time, patients' privacy must be guarded zealously. The private sector must play a vital role in developing the new technologies.

In any market, buyers and sellers need accurate and useful information on costs, quality and performance of the product. Health care is no different in this respect. Well-functioning health insurance and health care markets require information that is easy for consumers, providers and insurers to obtain and that is comprehensible to all. Today, information is often difficult to obtain and incomprehensible to consumers and providers alike. This is a function of the system we have, and not an inherent characteristic of health care data. Governments will have a role in the development of new and better information technologies, but many of the breakthroughs can come only from the private sector.

Efficient: Health care policy should encourage an appropriate level of spending on health care. Laws, regulations and insurance arrangements should direct health care spending to those goods and services that will maximize health. Adequate risk pools throughout the health care system are vital to accomplishing these goals.

Today's health care system encourages misallocation of resources. All parties lack access to vital information for making medical decisions. Providers can give too little guidance on cost-effective treatments because they lack access to accurate, comprehensible, comparable cost data that provide true "apples-to-apples" comparisons of services and treatments. Reimbursement systems encourage excessive spending on health care and poor spending choices within health care. Medical delivery systems are poorly structured. American health care is on an impossible path, with costs rising much more rapidly than the country's real economic output. To avoid catastrophe, incentive structures across the system need to be reconfigured to give consumers, providers and insurers the educational tools and the motives to use their dollars wisely and efficiently.

Evidence-based: The health care system must encourage consumers and providers to accumulate evidence and to use that evidence to improve health. Appropriate treatment choices and better wellness and preventive care should be key outcomes.

Current information and decision systems make it difficult to accumulate, interpret and use evidence affecting treatment decisions. One result is overspending on treatments and underspending on prevention. Decision-makers must understand the impact of their decisions on both costs and outcomes. Such an understanding must be based on solid clinical and economic evidence.

Realistic: Health care reform should proceed as rapidly as possible, but not so quickly that firms and individuals cannot adjust prudently. It is important to assure that no one's quality of care suffers as we move to provide coverage for all Americans.

Reform is a delicate balancing act. Moving too slowly will allow costs to rise too far and too fast. In the process, the health of Americans will suffer, and the financial security of some will be disastrously impacted. But excessive speed is also risky. Thus, we must assure that reform does not allow some Americans to slip through the cracks—to lose coverage or see their costs rise too rapidly. Somewhere in between is a seamless transition from the status quo to a more efficient and equitable system.

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR ALASKA
P.O. Box 240976, Douglas, AK 99824
Phone: (907) 789-1544 Fax: (907) 364-2468 Email: bevsmith@gci.net

January 2008

Amendments to Sponsor Substitute For SB160
Universal Health Care - Spiritual Care Amendment

To meet the health care needs of Alaska residents, health care reform legislation should include coverage for spiritual care similar to other state and federal government plans that currently do so. To accomplish this, we request that the following amendments be incorporated into such legislation to provide for consideration of spiritual care benefits as follows:

Amend Section 2 of the bill, "Sec. 21.54.250. Essential health care services", to read as follows:

> "Sec. 21.54.250. Essential health care services. For purposes of AS 21.54.200 - 21.54.310, essential health care services means ~~medical~~ services performed for an individual covered by a health care plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury. The ~~medical~~ services that must be performed for an individual covered by a health care plan include, as a minimum,
> . . . (5) prescription drug coverage; ~~and~~
> (6) mental health services~~.~~ ; and
> (7) spiritual care services."

Explanation

Access to effective health care is a vital issue for us all. As our society is reaching out for solutions to the problem of effective, affordable health care, access to spiritual care and treatment can serve as one of the solutions to that problem and can benefit everyone.

Alaska has an opportunity to shape health care reform for the future, and set the bar on access to health care, including recognition that a spiritual approach to health care has been, and remains, both practical and beneficial to the public. Spiritual care already meets the health care needs of many Alaskans. This care is both reliable and effective, and makes bodies -- and communities -- healthier. If people are achieving complete healing through spiritual care without incurring large medical bills, society is benefited.

The goal of any mandated universal health care system should be to provide access to care that meets the needs of the entire community that is being asked to support it, encourages participation, and seeks to minimize the costs associated with such care. Spiritual care and treatment can do just that. If a health insurance mandate is imposed on Alaskans, it is crucial for the mandate to embrace access to the diversity of approaches to health care, including spiritual care, and not just a medical approach.

We applaud you for your efforts in bringing solutions to the health care challenges in Alaska and appreciate the desire to make humanity safer and healthier. We respectfully request that the inclusion of spiritual care as a covered benefit be expressed clearly within this legislation, so that legislative guidance is provided concerning the inclusion of coverage for spiritual care.

Don Burrell

From: Russell Sherfick [rusdeb@mtaonline.net]
Sent: Wednesday, January 30, 2008 9:02 AM
To: Sen. Bettye Davis
Subject: SB 160

I am interested in SB 160, the "Universal Health Care" bill, because I, like many others, want to be assured that "universal" includes coverage for, not only health care provided by the AMA, but alternative methods of healing also... methods that have been proven effective and affordable for many people around the country and the world.

Personally, I am a Christian Scientist and have enjoyed a healthy life through the care and treatment of Christian Science Practitioners and Christian Science Nurses. I hope that coverage for these services, and other alternative methods of treatment and healing, will be included in this bill as well.

Debbie Sherfick
Willow, AK

AARP Alaska

January 30, 2008

The Honorable Bettye Davis, Chair
Senate Health, Education and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

RE: SB 160 (French)

Dear Chair Davis:

On behalf of the 93,000 members of AARP in Alaska, we ask that you and your colleagues on the Senate Health, Education and Social Services Committee welcome SB 160, authored by Senator Hollis French and co-sponsored by Senators Wielechowski and Ellis.

We understand this is a "work in progress" and that you will be dealing with a Committee Substitute today.

We applaud Senator French's efforts to develop a health care plan that works toward access to adequate coverage for all residents of all ages.

AARP pledges that we will work with Senator French and your colleagues in the Legislature to support efforts to provide high quality, accessible and affordable health care that offers reasonable choices for all Alaskans.

Let the discussion begin!

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Senator Joe Thomas, Senator Kim Elton, Senator Hollis French, Senator John Cowdery, Senator Fred Dyson

Don Burrell

From: Patricia Wilder [pcwilder@gci.net]
Sent: Tuesday, January 29, 2008 5:30 PM
To: Sen. Bettye Davis
Subject: Re: SB 160

Dear Senator Davis,

I understand that the above Bill regarding mandatory health insurance for Alaskans will be the subject of a hearing tomorrow, Wednesday.

As one of a number of practicing Christian Scientists in the State, I would want to be sure that language is included in the Bill that allows coverage for spiritual treatment and care. This would mean treatment by a Christian Science practitioner and care by a Christian Science nurse. During my lifetime, I have found that such spiritual care services have been very effective as well as affordable for myself, my husband, and our children.

So, my hope and request is that the final form of the healthcare plan will include coverage for spiritual care services in recognition of the rights of many members of the public to receive this effective, special form of health care treatment.

Thank you for your work for the public welfare.

Sincerely,
Patricia Wilder
Attorney at Law

[redacted]

3200 Providence Drive
P.O. Box 196604
Anchorage, Alaska
99519-6604

Tel 907.562.2211

April 23, 2007

The Honorable Hollis French
Alaska State Senate
State Capitol, Room 417
Juneau, AK 99801-1182

Dear Senator French:

I write today in support of the concepts contained in your legislation establishing the framework to ensure affordable health coverage for all Alaska. I applaud your leadership, and that of the Senate, for bringing this critical issue to the forefront.

Providence Health System remains deeply concerned about the increasing problem of access to affordable, quality health care for the uninsured and the under-insured, as do I personally. As this problem continues to grow, it results in cost increases for medical care. Escalating health care costs are creating great difficulties for Alaska's employers, as I know you are aware.

I believe it is crucial for Alaskans to engage in a public policy debate on this important issue and this legislation provides an excellent forum around which this discussion can be held. Providence stands ready to assist in any effort that stands to improve the quality of health care delivery in our state, improves access to that quality care, and strives to make health care delivery more affordable.

Again, thank you for your willingness to begin a serious debate on this vitally important issue.

Sincerely,

Al Parrish
VP/Chief Executive

Comments on SB 160

Lawrence D. Weiss PhD MS

Executive Director, Alaska Center for Public Policy
Editor, Alaska Health Policy Review

February 18, 2008

First, I want to congratulate the senators who have introduced Senate Bill 160: Senators French, Ellis, and Wielechowski. By introducing this bill, these legislators have shown serious interest in a very difficult problem, and they have put the whole question of access to health care for all Alaskans on the table for wide discussion. In light of that, I wanted to say a few words about the process of health policy formation. A sound, comparative, fact-based assessment of policy alternatives is more likely to lead to a policy that is actually effective and efficient. Policy driven by ideology and expedience is not.

Effective Public Policy

Based on the lack of any documented analysis, it appears that SB 160 was developed entirely in the absence of systematic comparison with other health reform approaches that might be less expensive, more effective, better able to meet the policy goals, and perhaps more likely to engender political support.

A few years ago, for example, the state of California was considering significant health care reform and state policy analysts invited nine different organizations to submit comprehensive proposals. On one side of the spectrum, were proposals that recommended minor tinkering around the edges of the health-care industry. On the other end of the spectrum, was a proposal that would create the California Health Service, a health plan in which all health care facilities would be publicly owned, and all health care providers would be civil servants. Here is a summary of the process and the criteria:

A competitive process was used to identify a contractor with experience in

microsimulation modeling to conduct an economic analysis of the reform options developed by health policy experts. The State selected the Lewin Group from among the bidders. Their final report provides a detailed discussion of the cost and coverage implications of each of the proposals. To assist readers in comparing reform options, each option is modeled as if it were fully implemented in 2002. A ten-year budget for each proposal also is presented. Substantial additional analysis also is provided in the report, including information about changes in individual out-of-pocket costs (by demographic category), changes in costs to employers (by size), and changes in costs for safety-net programs. The final report, including separate appendices providing additional analysis of each option, can be found at the HCOP website, [http://www.healthcareforall.org/studies.html] www.healthcareoptions.ca.gov.

The State selected a second contractor, AZA Consulting, to conduct a more qualitative analysis of the reform options. The report looked at potential impacts of the reform options in four areas: access, utilization and continuity of care; quality and appropriateness of care; safety net; and vulnerable groups. In performing the analysis, the contractor identified key questions and issues in each area of interest and reviewed how each proposal addressed the questions and issues identified.
[Source: Report by The Health Resources and Services Administration, U.S. Department of Health and Human Services on the state of the uninsured, the overall health care environment, the Healthcare Options Project, and recommendations for a federally run healthcare program.]

Senator French has stated in public that the SB 160 proposal was specifically designed by the bill sponsors to minimize political opposition to a substantial health reform proposal, and it was based on a similar plan in another state. I will leave the discussion to others about the assessment of political opposition to various approaches to health reform. However, I question the wisdom of basing health care reform in Alaska on the Massachusetts plan. The Massachusetts plan itself appears to have several serious structural problems and to be underperforming in terms of its goals. It also appears to be far more expensive than projected. This requires serious review because it may very well be that the Massachusetts plan is not a

good health plan; and therefore, basing the Alaska plan on the Massachusetts plan would likewise not be a good idea.

Alternative Approaches to Consider

Finally, there is the question of what alternative approaches to health reform in Alaska could and should be compared with SB 160? In light of the costs to the state and the social consequences for Alaska families, a systematic and comprehensive analysis of various health policy alternatives is crucial to the development of good health reform policy. I suggest an approach that, in and of itself, could have a huge impact on the real issues of access to health care for tens of thousands of Alaskans—and I suspect would cost a fraction of what SB 160 is going to cost. In short, I suggest taking a serious look at the expansion of programs that we already have, that we know work, that we know are cost effective, and that have some quality of care elements built in:

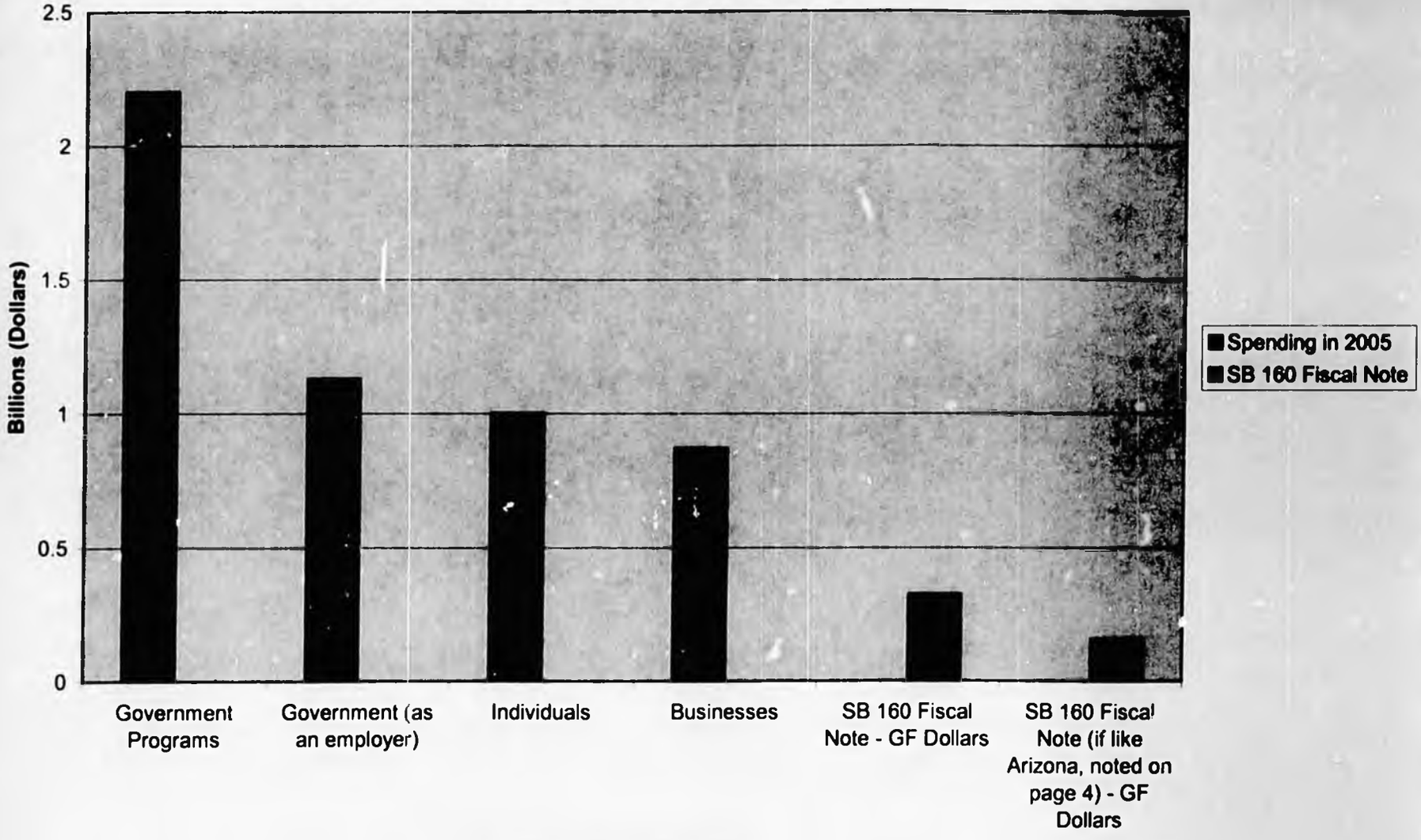
- Expand Medicaid to the maximum extent possible to serve Alaskans. A Medicaid insurance policy is much less expensive for the state than a comparable private health insurance policy, it costs the recipient nothing, co-payments and deductibles are minimal, and the federal government pays at least half of all the state's Medicaid costs.
- Expand Denali KidCare to the maximum extent possible, to serve as many Alaska children as possible. This has all the benefits of expanding Medicaid as noted above. In addition, recruitment for Denali KidCare was seriously hampered under the Murkowski administration by the firing of all five state recruiters for the program. As a result, there are perhaps 10,000 children who qualify for Denali KidCare but remain uninsured because they are not in the program. Hire back the recruiters.
- Develop a comprehensive package of funding for the 130 community health clinics scattered across Alaska to enable these nonprofit, federally-subsidized clinics to recruit and retain staff, and to directly serve those who need health care. This approach would completely eliminate the unnecessary administrative and other costs of private health insurance, and at the same time directly provide medical care to those in need. Patient care costs have been documented to be far below those in a for-profit health care setting.

Additional Supplementary Approaches

- Require all commercial health insurers to submit documents for public review and to attend public hearings justifying premium raises.
- Require all health care providers, all pharmacists, all medical implement providers, and others in related health industries to publicly post prices.
- Sponsor a website that aggregates all available quality of care data for the public to evaluate.
- To the greatest extent justified, coordinate and support the training and recruitment of health care providers and public health professionals in the state of Alaska.
- To the greatest extent justified, support and expand the traditional preventive public health programs such as clean air, clean water, food inspections, job safety and health, etc.

There is available factual information, and often formal research on all these proposals. It makes sense to spend a million dollars on health policy evaluation alternatives rather than hundreds of millions of dollars on a program that may prove to be expensive, inept, and unworkable.

Health Care Spending in Alaska during 2005 - $5.3 Billion
(Source: ISER 2006)



Shown By Dollar Source

DHCFP

Health Care in Massachusetts: Key Indicators

January 2008

Deval Patrick, Governor
Commonwealth of Massachusetts

Timothy P. Murray
Lieutenant Governor

JudyAnn Bigby, Secretary
Executive Office of Health and Human Services

Sarah Iselin, Commissioner
Division of Health Care Finance and Policy

About this Report

Health Care in Massachusetts: Key Indicators is a new quarterly report from the Division of Health Care Finance and Policy. *Key Indicators* provides an overview of the Massachusetts health care landscape through data reported by providers, health plans. government, and through surveys of Massachusetts residents and employers.

This report reviews the progress of statewide efforts to expand health insurance coverage, the financial performance of hospitals, community health centers and health plans, health insurance costs, and consumer access to health care. These indicators provide an important framework for measuring our progress as we continue implementation of health reform in 2008. A common baseline provides an opportunity to reflect on our course so far and to consider the opportunities and challenges that lie ahead.

The indicators in this report draw on data from many different sources. Notes at the bottom of each page describe the data source, methodology, and time period. We want to make this report as useful as possible and welcome your feedback on *Health Care in Massachusetts: Key Indicators*.

The Division would like to thank Nancy Turnbull of the Harvard School of Public Health for her strategic and analytic support in the conception and development of this report, and staff at the Department of Public Health, including Monica Valdes Lupi, Bruce B. Cohen, Gerald O'Keefe and Zi Zhang for their significant contributions to the health care access section. We also thank Robin Callahan and Ben Walker in the Office of the Medicaid Director; Bob Carey at the Commonwealth Health Insurance Connector Authority; and Catherine Moore at the Group Insurance Commission for their support and review of the data. Finally, we thank the staff at the health plans for their timely responses to our requests for enrollment data.

About DHCFP

The Mission of the Division of Health Care Finance and Policy (DHCFP) in the Executive Office of Health and Human Services is to improve the delivery and financing of health care by providing information, developing policies, and promoting efficiencies that benefit the people of Massachusetts.

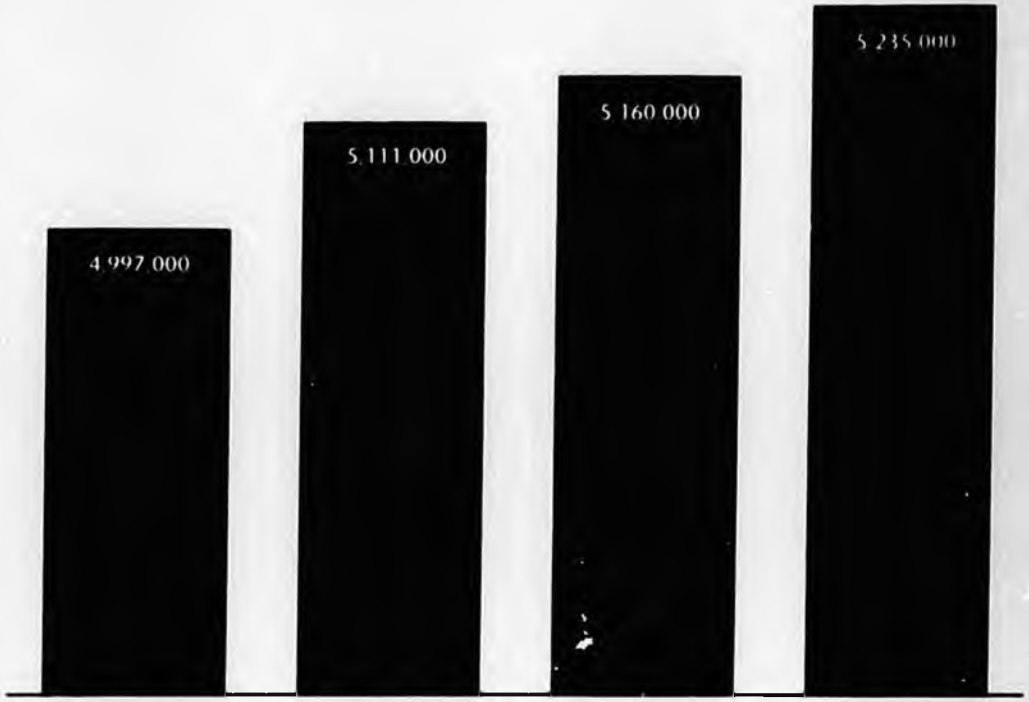
The goals of the Division are to assure the availability of relevant health care delivery system data to meet the needs of health care purchasers, providers, consumers, and policy-makers; advise and inform decision-makers in the development of health care policies; develop health care pricing policies that support the cost-effective procurement of high-quality services for public beneficiaries; and improve access to health care for low-income uninsured and underinsured residents.

Contributing Staff: Han Huang, Rebecca Balder, Linda Green, Caroline Minkin, Kate Nordahl, Beth Perry, and Meenakshi Verma Agrawal
Design, Editing, Layout, and Distribution: Shelley Fortier, Harry O. Lohr, Jr., Emily O'Brien, Heather Shannon, and Rick Vogel

Table of Contents

People with Health Insurance

Excludes Medicare Enrollees Ages 65+



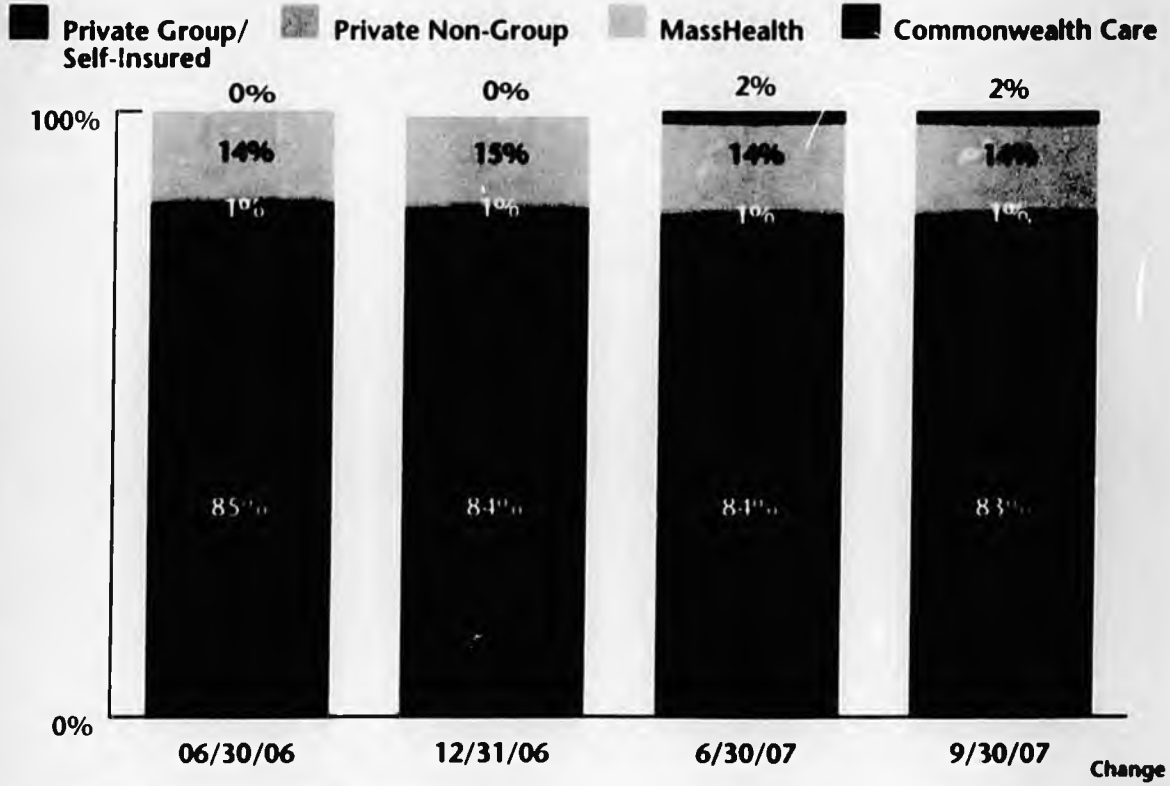
6/30/06	12/31/06	6/30/07	9/30/07
Change since 6/30/06:	+ 114,000	+163,000	+ 256,000

The number of people enrolled in private or subsidized health insurance products has increased by 256,000 people since health care reform began to be implemented.

Note: Data reflect total enrollment, rounded to the nearest thousand, as of the specified date. These data do not include approximately 18,000 people insured through small employers who purchase coverage from health plans that are not required to report quarterly enrollment statistics to the Division of Insurance. DHCFP intends to track enrollment in these plans in future versions of this report. Recent public announcements on new enrollments includes enrollment that took place after September 30, 2007.
Source: Membership reported to DHCFP by health plans, MassHealth, and the Group Insurance Commission; Commonwealth Care enrollment data are from the Connector.

Insured Population by Type of Insurance

Excludes Medicare Enrollees Ages 65+



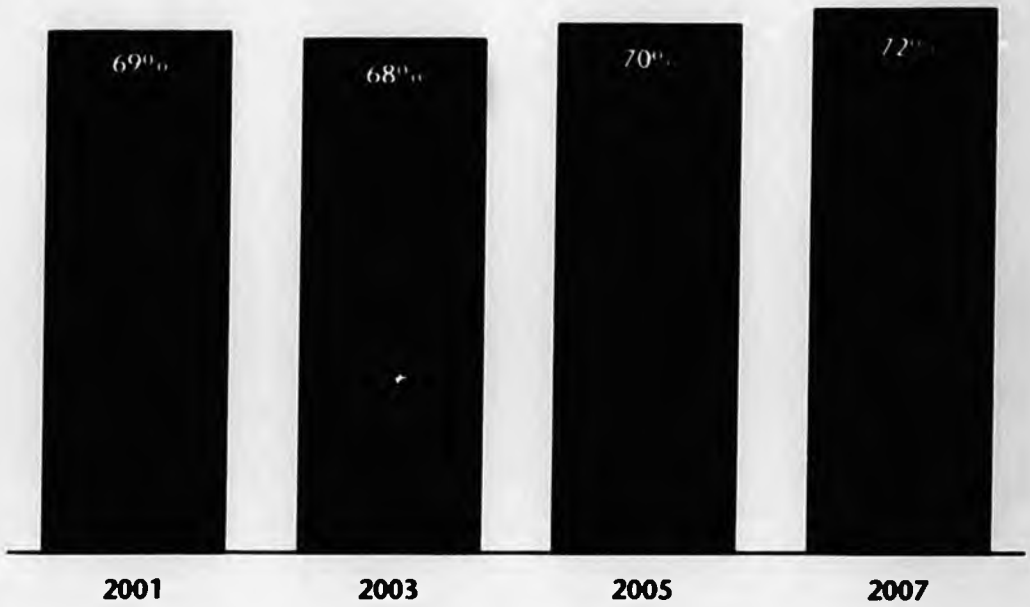
Number of Members (rounded to the nearest 1,000):	06/30/06	12/31/06	6/30/07	9/30/07	Change Since 6/30/06:
Private Group	4,235,000	4,297,000	4,297,000	4,341,000	+ 106,000
Private Non-Group	57,000	55,000	51,000	43,000	- 14,000
MassHealth	705,000	741,000	732,000	753,000	+ 48,000
Commonwealth Care	0	18,000	80,000	115,000	+ 115,000
Members under Age 65	4,997,000	5,111,000	5,160,000	5,253,000	+ 256,000

Note: Data reflect total enrollment, rounded to the nearest thousand, as of the specified date, excluding Medicare enrollees over age 65. Private Group includes group, small group, Commonwealth Choice, self-insured, and GIC members. Private Non-Group includes individual members. MassHealth includes members with comprehensive coverage and excludes those with partial coverage or premium assistance, such as Seniors, MassHealth Limited, individuals with third party liability (e.g. disabled with Medicare), and Family Assistance/Insurance Partnership. Commonwealth Care includes all private plans. These data do not include approximately 18,000 people insured through small employers who purchase coverage from health plans that are not required to report quarterly enrollment statistics to the Division of Insurance. Recent public announcements on new enrollments includes enrollment that took place after September 30, 2007.
Source: Data reflect membership reported to DHCFP by health plans, MassHealth, and the Group Insurance Commission; Commonwealth Care enrollment data are from the Connector.

The distribution of the insured population by source of insurance has not changed significantly since health reform began to be implemented. However, private group insurance has grown by more than 100,000 enrollees.

Employers Offering Health Insurance

Percent of Employers

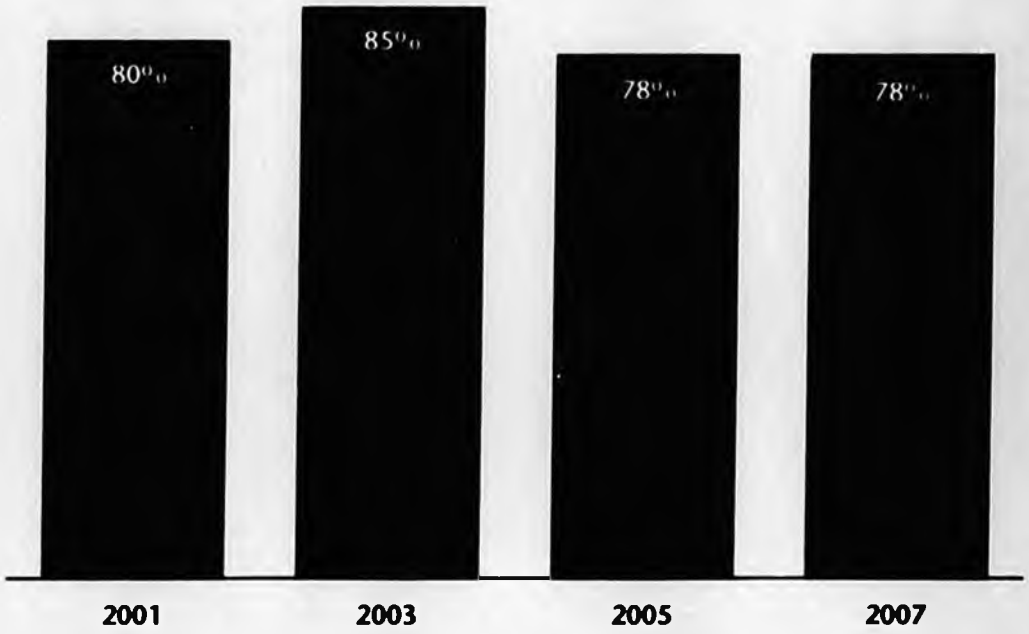


Nearly three-quarters of Massachusetts employers offer health insurance to their employees. The Massachusetts employer offer rate has held steady, even as the employer offer rate nationally declined from 68% to 60% between 2001 and 2007, as reported in the Kaiser/ HRET survey.

Note: The changes from year-to-year are not statistically significant.
Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

Employees Enrolled in Health Insurance

Percent of Eligible Employees

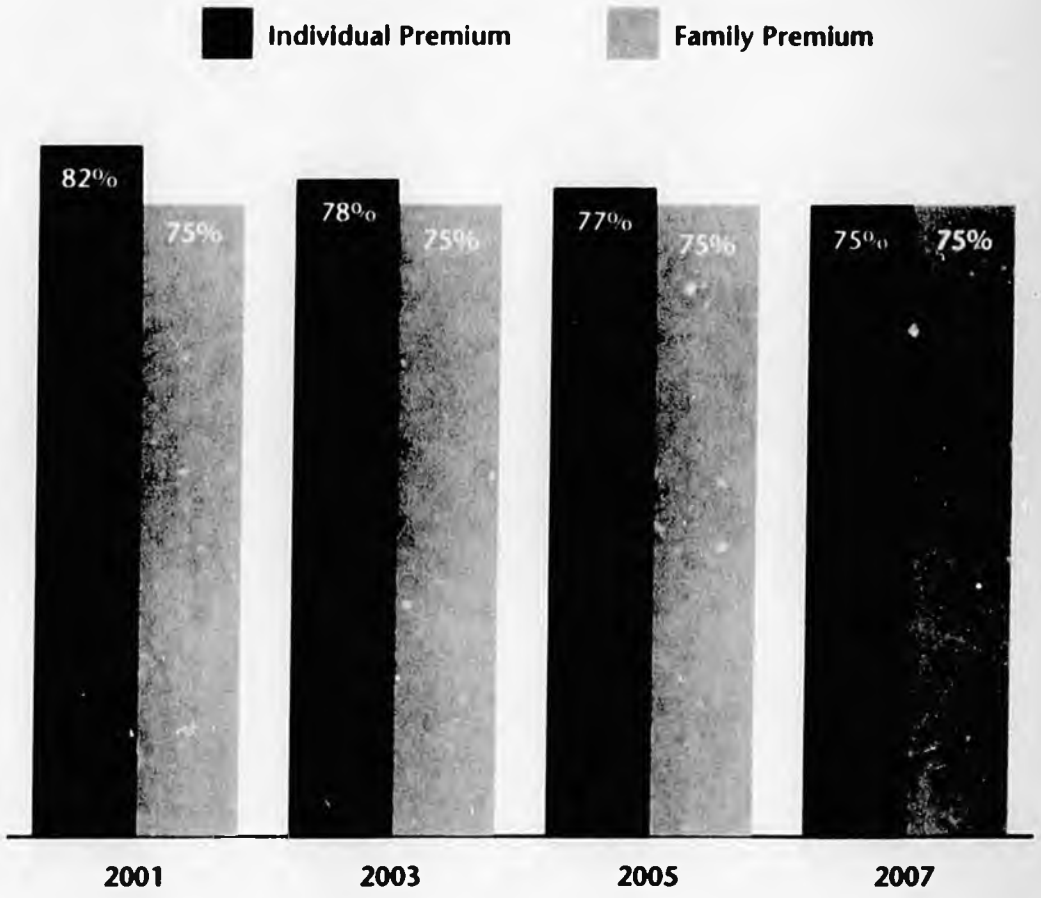


Note: Data reflect medians.
Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

More than three-quarters of employees eligible for health insurance enrolled in their employer's health plan in 2007. Nationally, the take-up rate for employees eligible for health insurance was 82% in 2007 as reported in the Kaiser/HRET survey. While Massachusetts employers are more likely to offer coverage than employers nationwide, employees are less likely to enroll.

Employer Contributions to Health Insurance

Percent of Individual and Family Premiums

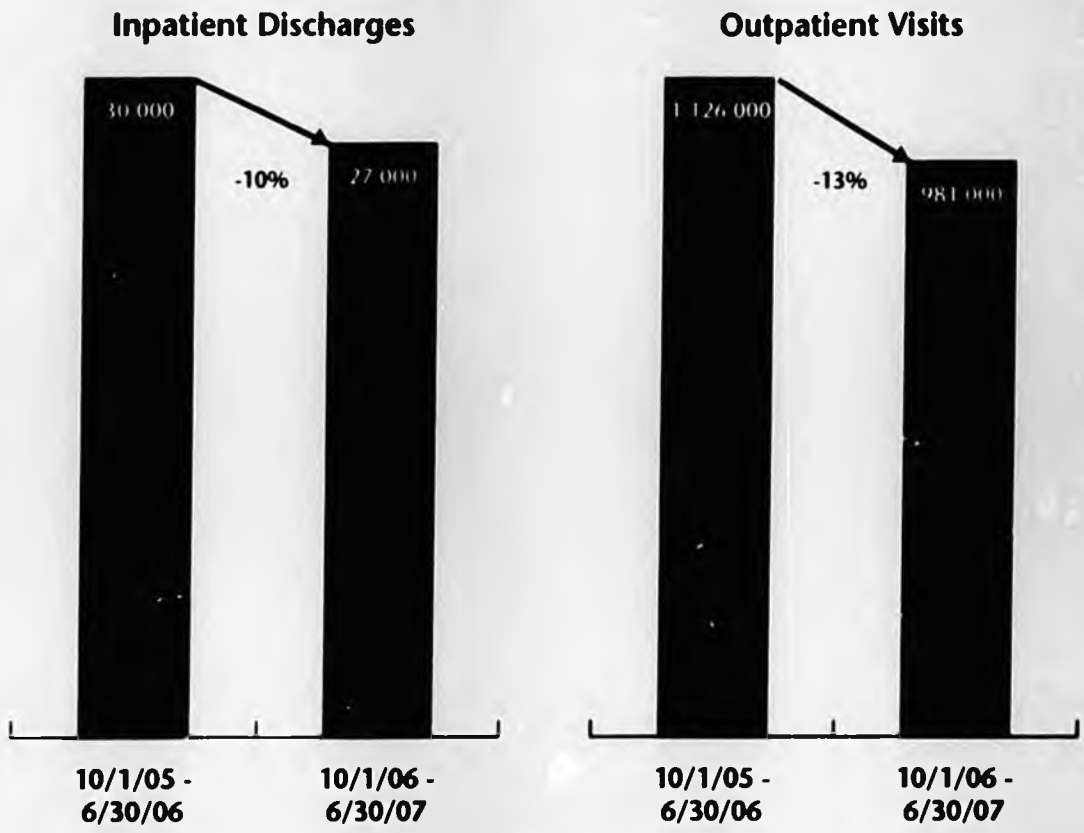


Note: Data reflect medians.
Source: DHCFP Employer Survey for 2001, 2003, 2005, and 2007. National data from the Henry J. Kaiser Family Foundation/Health Research and Educational Trust Employer Benefits Survey, 2001-2007.

Most Massachusetts employers contribute at least 75% toward their employees' health insurance premiums. While Massachusetts employers' contributions are comparable to employers nationwide for family plans (75% in Massachusetts versus 73% nationally as reported in the 2007 Kaiser/HRET survey), contributions are significantly lower for individual plans (75% in Massachusetts versus 85% nationally).

Hospital Volume

Inpatient Discharges and Outpatient Visits

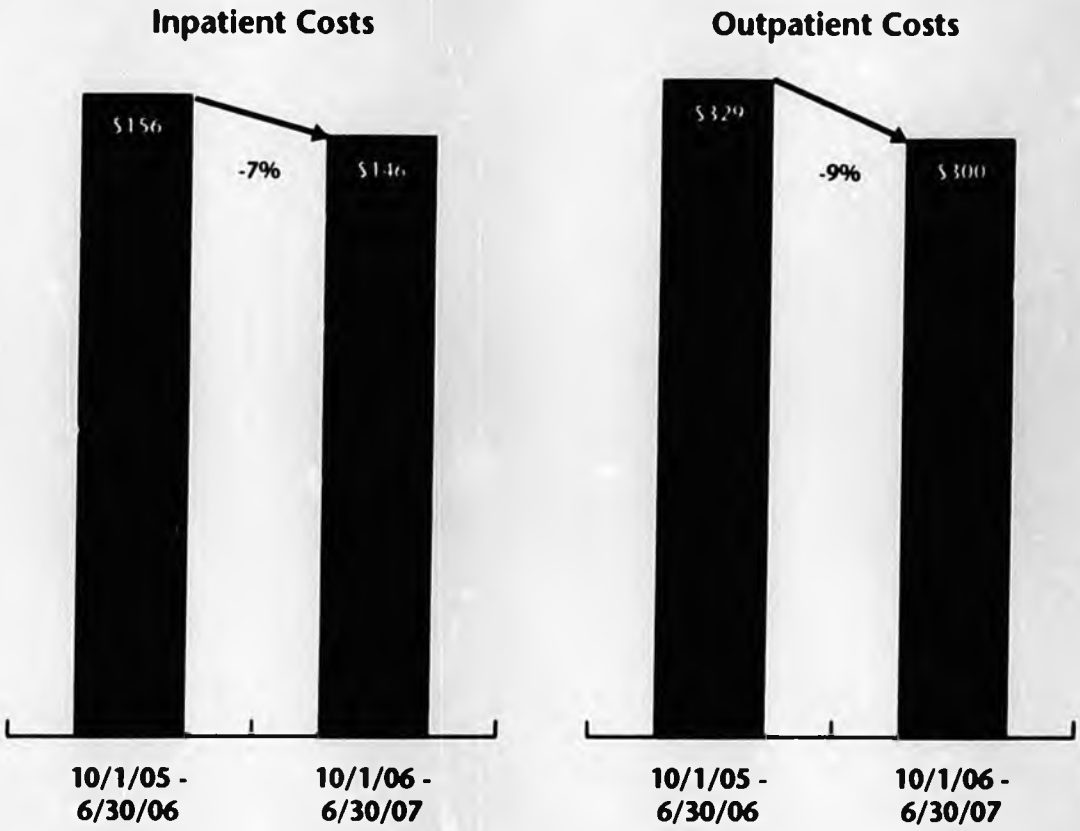


The number of hospital inpatient discharges and outpatient visit claims submitted to the Uncompensated Care Pool declined by approximately 13% overall during the first nine months of Pool fiscal year 2007 (October 1 through June 30) compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06. Numbers are rounded to the nearest thousand.
Source: DHCFP UCP Claims Database, data reported as of 11/27/07.

Hospital Costs

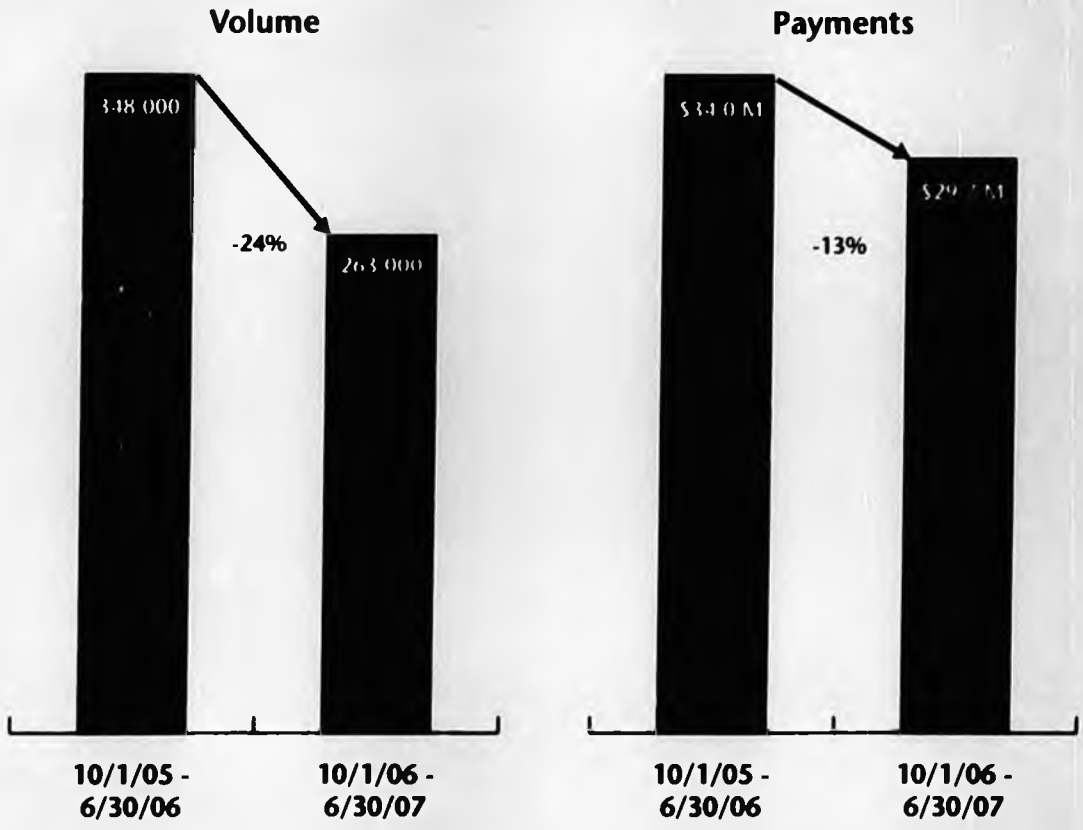
Inpatient and Outpatient (in millions)



The cost of acute hospital claims submitted to the Uncompensated Care Pool declined by 8% overall during the first nine months of Pool fiscal year 2007 (October 1 through June 30) compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06.
Source: DHCFP UCP Claims Database, data reported as of 11/27/07.

CHC Volume and Payments

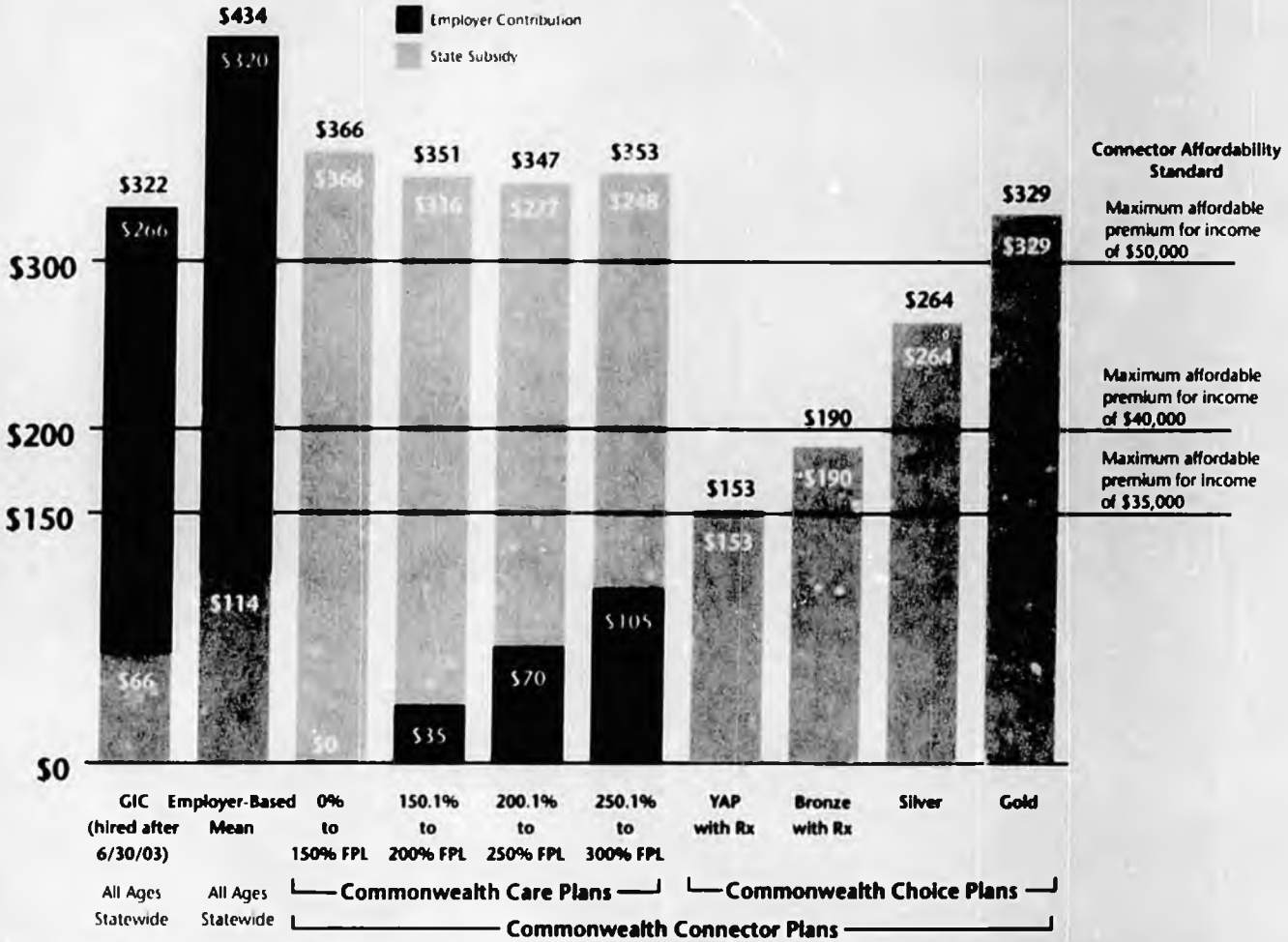


Community health center (CHC) Uncompensated Care Pool visit volume and payments decreased by 24% and 13%, respectively, for the first nine months of Pool fiscal year 2007 compared to the same period in Pool fiscal year 2006.

Note: The Pool Fiscal Year (PFY) runs from 10/1 through 9/30 of the following year, e.g., PFY06 ran from 10/1/05 through 9/30/06. CHC volume is rounded to the nearest thousand.
Source: DHCFP UCP Claims Database, data extracted 11/27/07

Lowest Monthly Cost of Health Insurance

Employer and Connector Plans for Individuals



Note: The calculation of mean premiums for private employer-based insurance does not include those paid by government employees. Premium for Commonwealth Choice YAP with Rx plan calculated for a 22 year old unemployed individual living in Boston. Premiums for Commonwealth Choice Bronze with Rx, Silver, and Gold plans calculated for a 37 year old unemployed individual living in Boston. Data were rounded to the nearest whole dollar.

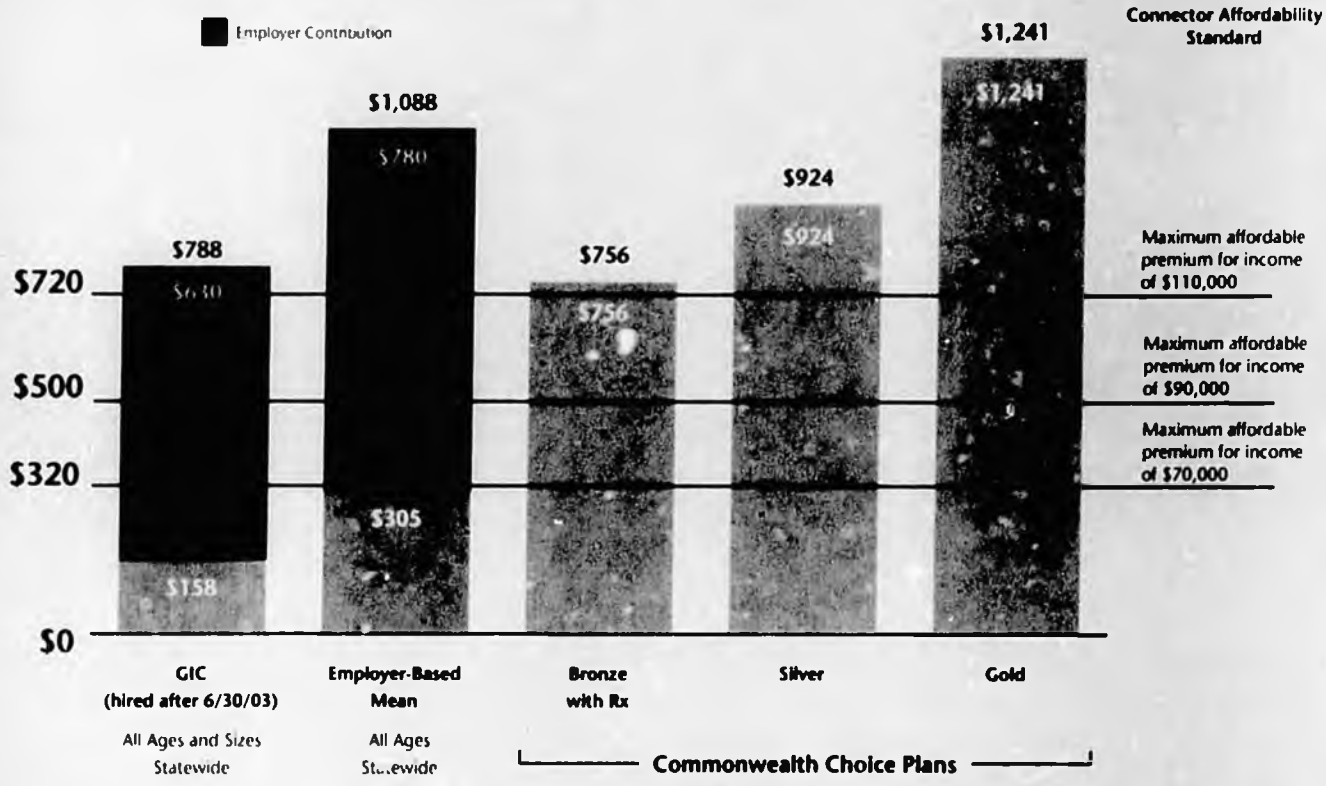
Source: *2007-2008 GIC Benefit Decision Guide*; 2007 DHCFP Employer Survey; Connector Affordability Schedule, Commonwealth Connector website www.mahealthconnector.org. All data reported as of 10/2/07. These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for calendar year 2007. Please visit www.mahealthconnector.org for more details.

Commonwealth Care premiums for individuals compare favorably to the average employee contribution for employer-based coverage.

These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for the calendar year 2007. Please visit www.mahealthconnector.org for more details.

Lowest Monthly Cost of Health Insurance

Employer and Connector Plans for Families



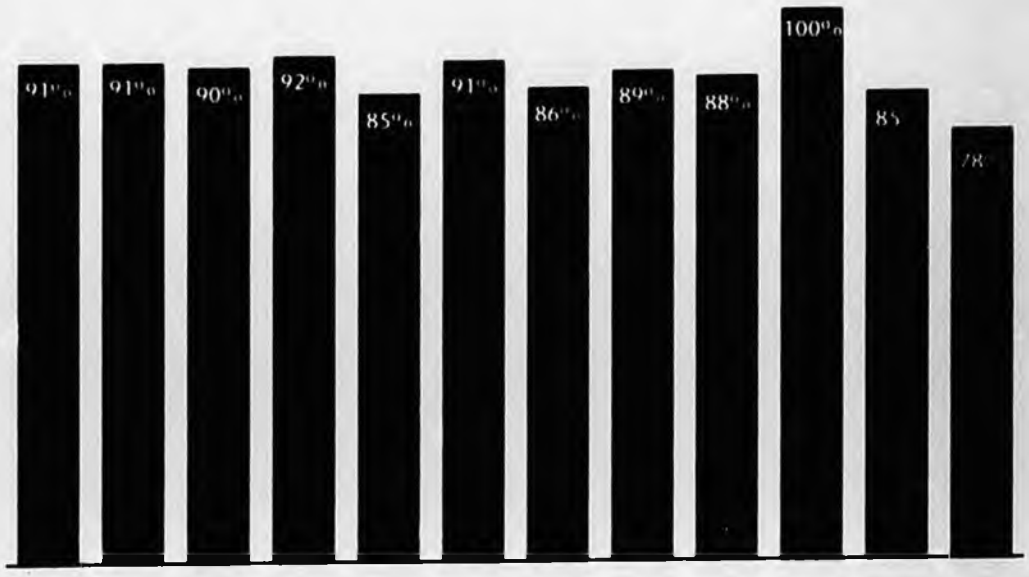
Note: Commonwealth Care plans provide coverage for adult individuals only, and therefore, do not have family plans. The calculation of mean premiums for private employer-based insurance does not include those paid by government employees. Premiums for Commonwealth Choice Bronze with Rx, Silver, and Gold plans calculated for a family of four, with two 37 year old unemployed parents and two children, living in Boston. Data were rounded to the nearest whole dollar.
Source: *2007-2008 GIC Benefit Decision Guide*; 2007 DHCFP Employer Survey; Connector Affordability Schedule, Commonwealth Connector website www.mahealthconnector.org. All data reported as of 10/2/07. These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for calendar year 2007. Please visit www.mahealthconnector.org for more details.

Commonwealth Choice premium contributions for families are higher than the average employee contribution for employer-based family coverage.

These premiums were compared to the affordability schedule that was established by the Commonwealth Health Insurance Connector Authority on 6/27/07 for the calendar year 2007. Please visit www.mahealthconnector.org for more details.

Medical Expense Ratio

by Health Plan for the First Six Months of 2007



Aetna	BMC HealthNet	BCBS of MA	CIGNA	Connecti-Care	Fallon	HPHC	HNE	NHP	Network Health	Tufts	United Health
Enrollment Data (total Massachusetts members in thousands):											
7	190	3,041	5	9	165	638	101	148	117	645	13

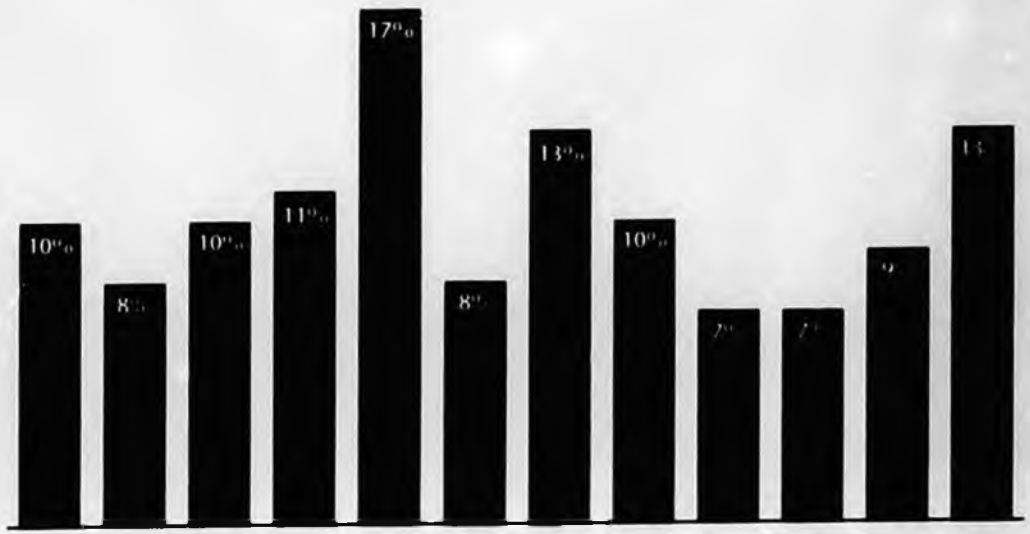
The four largest Massachusetts health plans spent between 85% and 91% of their total revenue dollar on medical services provided to members in the first six months of 2007.

Note: Medical expense ratio is calculated by dividing total hospital and medical expenses by total revenue (including investment gain/loss). Blue Cross Blue Shield of Massachusetts (BCBSMA) includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.

Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 4B and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Administrative Expense Ratio

by Health Plan for the First Six Months of 2007



Enrollment Data (total Massachusetts members in thousands):											
7	181	3,041	5	9	165	638	101	148	108	645	13

The four largest health plans spent between 8% and 13% of their total revenue on administrative expenses including staff, claims processing, rent and clinical oversight.

Note: Administrative expense ratio is calculated by dividing total administrative expenses (including claims adjustment and general administrative expenses) by total revenue (including investment gain/loss). BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.
Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 1B and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Profit Margin

by Health Plan for the First Six Months of 2007

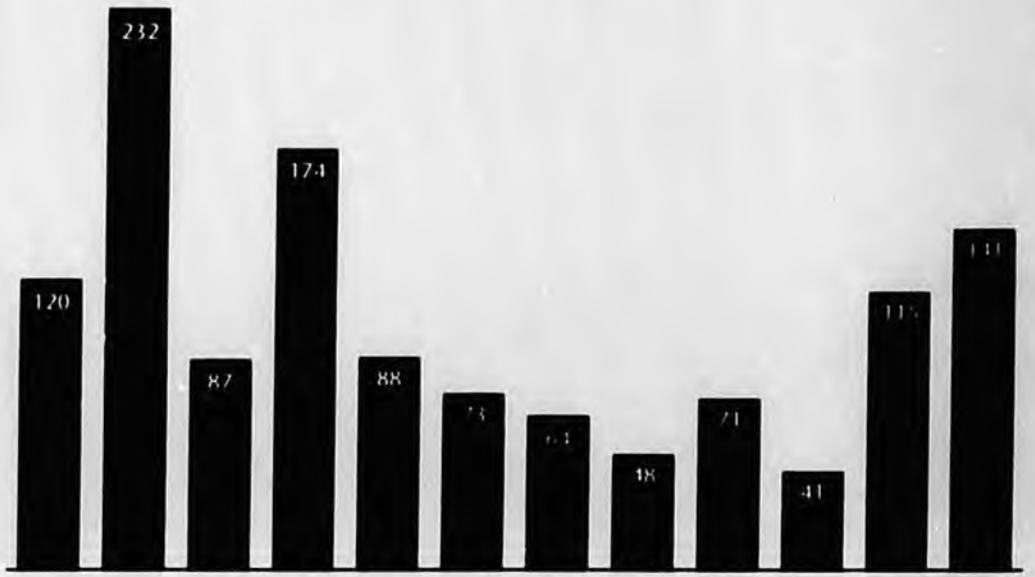
Aetna	BMC HealthNet	BCBS of MA	CIGNA	Connecti-Care	Fallon	HPHC	HNE	NHP	Network Health	Tufts	United Health
Enrollment Data (total members in Massachusetts in thousands):											
7	181	3,041	5	9	165	638	101	148	108	645	13

Note: Profit margin is calculated by dividing net income by total revenue (including investment gain/loss). BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.
Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 48 and insolvency reports from 6/30/07, with a "paid through" date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Profit margin represents the net margin available to the plan for other purposes after paying medical claims and administrative costs. Profit margins for the four largest health plans ranged from less than 1% to nearly 6% in the first six months of 2007.

Days in Reserve

by Health Plan for the First Six Months of 2007



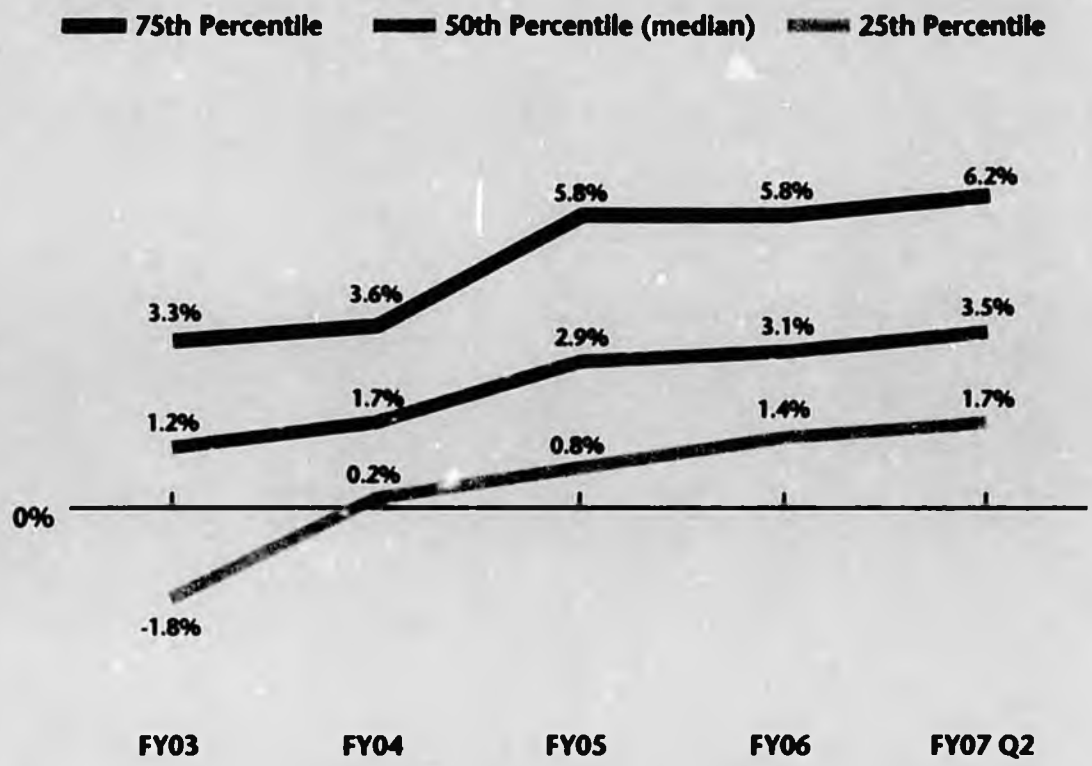
Aetna	BMC HealthNet	BCBS of MA	CIGNA	Connecti-Care	Fallon	HPHC	HNE	NHP	Network Health	Tufts	United Health
Enrollment Data (total Massachusetts members in thousands):											
7	181	3,041	5	9	165	638	101	148	108	645	13

Note: Days in reserve is calculated by dividing net worth (including total capital and surplus) by the result of dividing total hospital and medical expenses by the number of days in the YTD period. BCBSMA includes the combined performance of BCBSMA and HMO Blue. Fallon includes the combined performance of Fallon Community Health Plan and Fallon Life and Health Assurance Company. Ratios may not sum to 100% due to rounding.

Source: Division of Insurance quarterly financial statements. BMC HealthNet and CHA Network Health data from MassHealth 4B and insolvency reports from 6/30/07, with a paid through date of 7/31/07. In addition, insurers were asked to provide enrollment statistics for MA residents only, including self-insured members; data above was reported by the plans.

Days in reserve is a measure of financial solvency. It reflects the number of days of medical expenses a plan could fund from its net worth. Performance on this measure varies widely, but nearly every plan has at least two months days in reserve and the majority have close to three months.

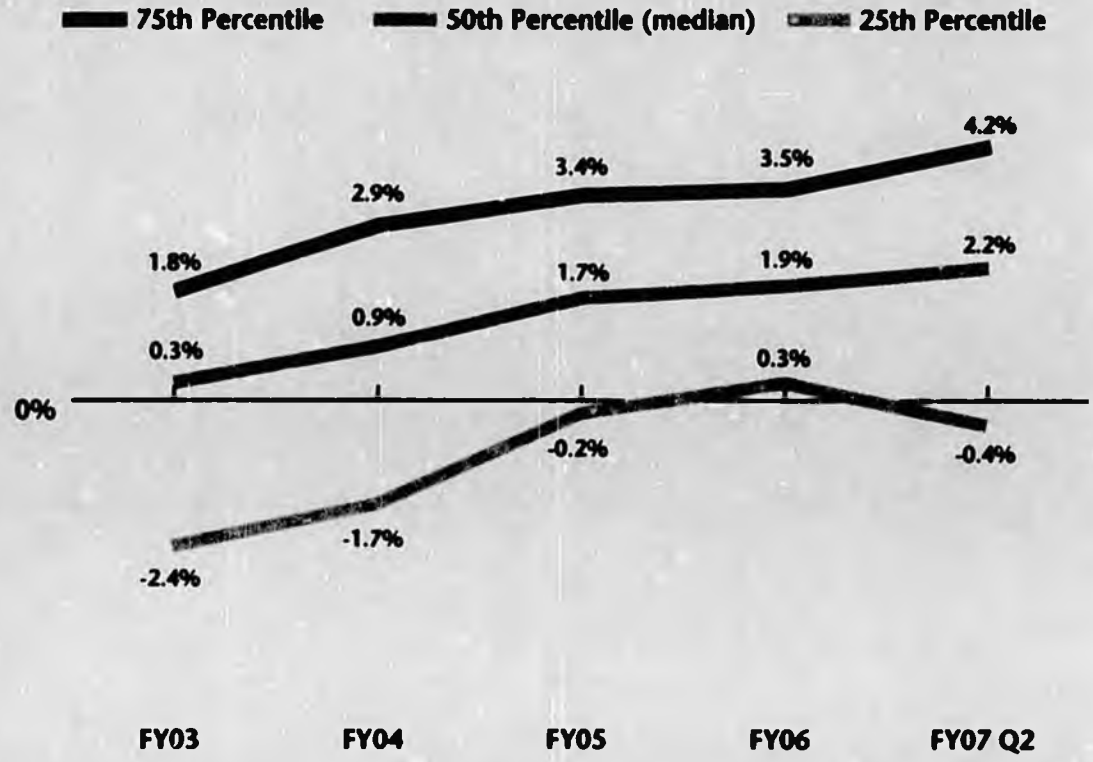
Total Margin Trend
by Year



The overall financial performance of acute hospitals has improved steadily over the past four years.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 10/2/07.

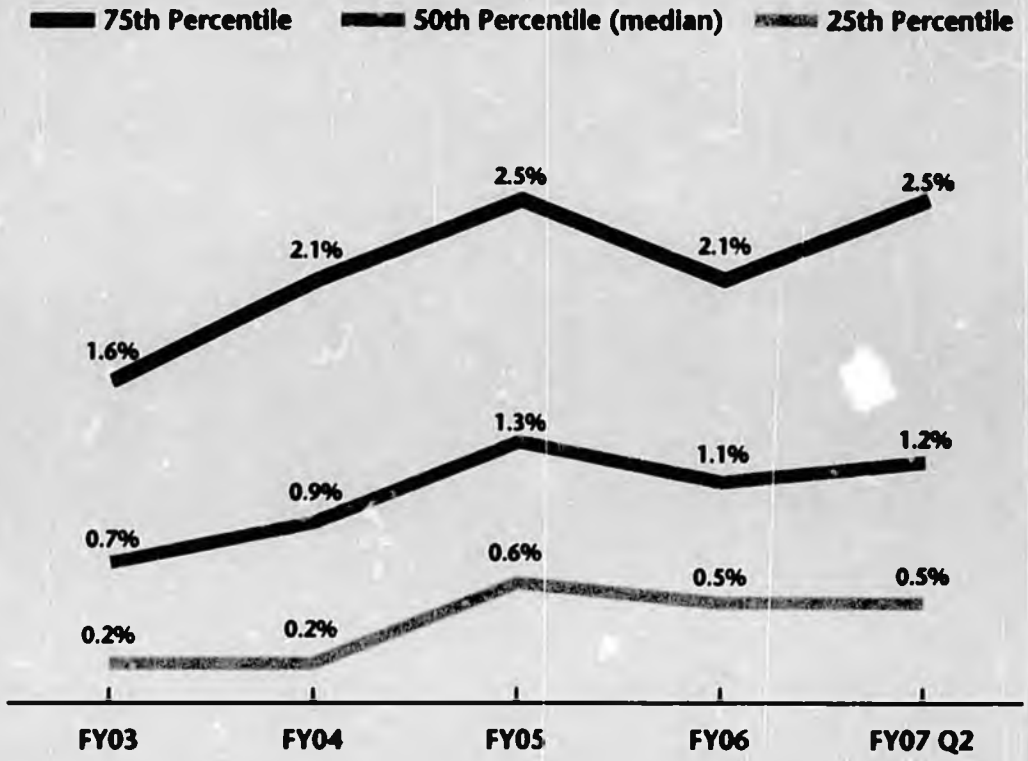
Operating Margin Trend
by Year



Most acute hospitals experienced positive operating margins in the past year. However, a significant gap remains between the highest and lowest performing acute hospitals.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 10/2/07.

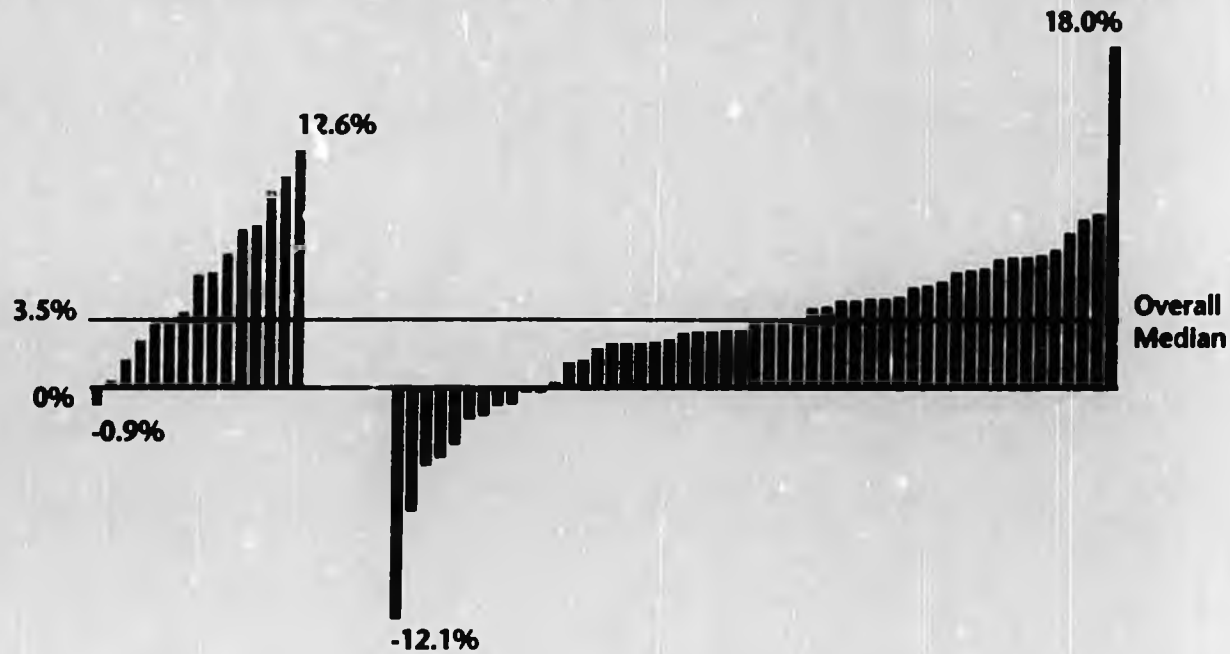
Non-Operating Margin Trend
by Year



Note: Non-operating margin is calculated by dividing non-operating income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 10/2/07.

Non-operating margins for acute hospitals have improved over the past four years. However, the highest performing hospitals have experienced much greater gains than the lowest performing group of hospitals.

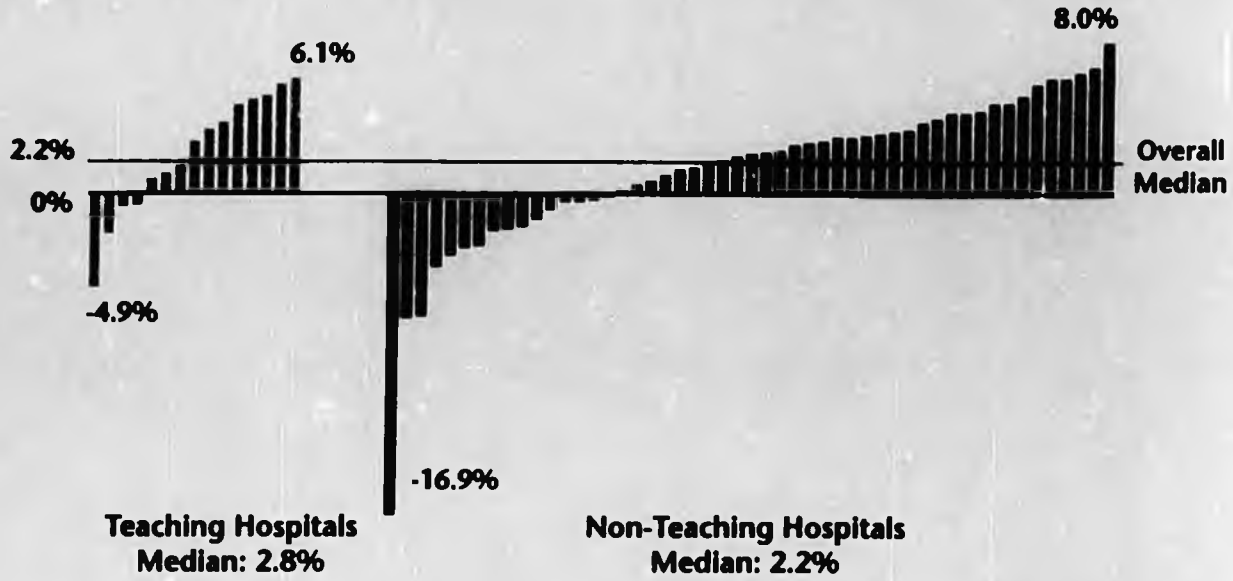
Total Margin
by Teaching Status for FY07 Q2



The overall financial performance of acute hospitals varies widely by teaching status. The median total margin for teaching hospitals was 6% through the second quarter of fiscal year 2007 while the median total margin for non-teaching hospitals was 3.4%.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 9/18/07.

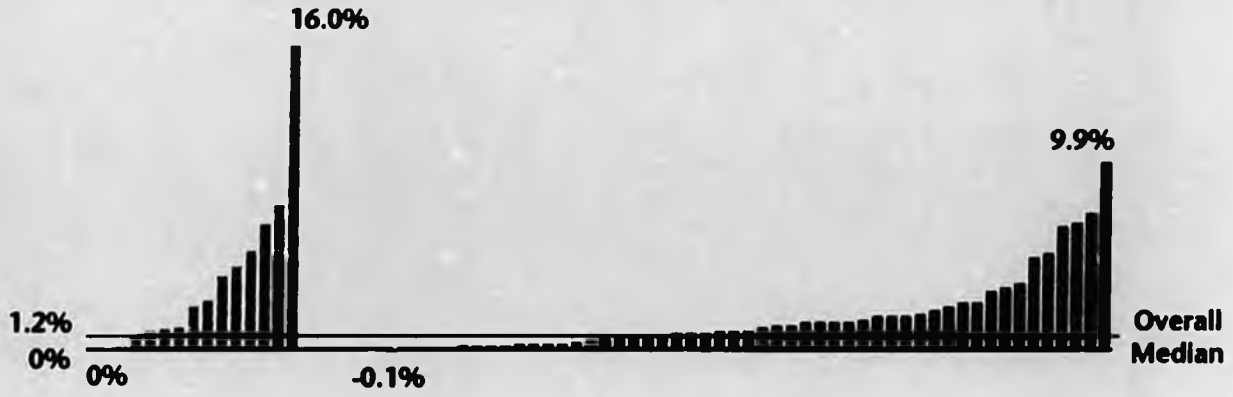
Operating Margin
by Teaching Status for FY07 Q2



Teaching hospitals reported a higher operating margin than non-teaching hospitals in FY07 Q2.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Dat., data reported as of 9/18/07.

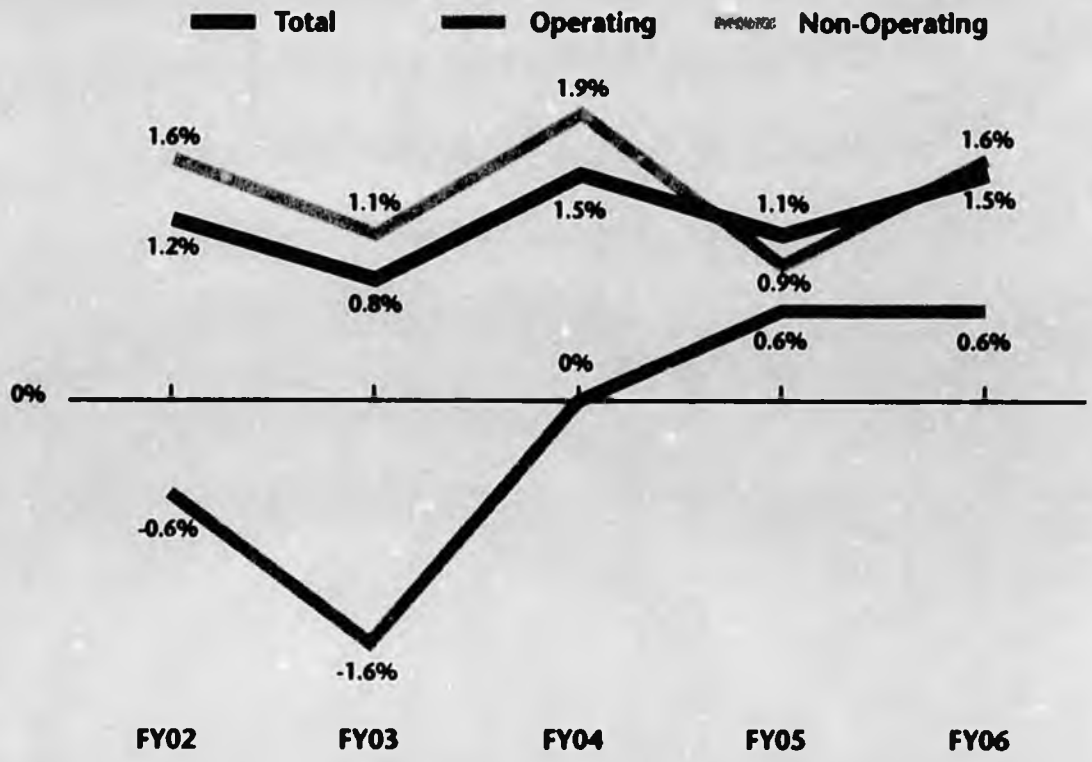
Non-Operating Margin
by Teaching Status for FY07 Q2



Non-operating margin performance varies widely by hospital teaching status. The median non-operating margin for teaching hospitals was 2.3% through the second quarter of fiscal year 2007, while the median for non-teaching hospitals was less than half that at 1.0%.

Note: Non-operating margin is calculated by dividing non-operating income by total revenue. Fiscal Year Ends (FYEs) vary across hospitals: of 66 hospitals, 3 hospitals have a 6/30 FYE, 1 hospital has a 3/31 FYE, and 1 hospital has a 12/31 FYE. The remaining 61 hospitals have a 9/30 FYE.
Source: DHCFP Acute Hospital Financial Data, data reported as of 9/18/07.

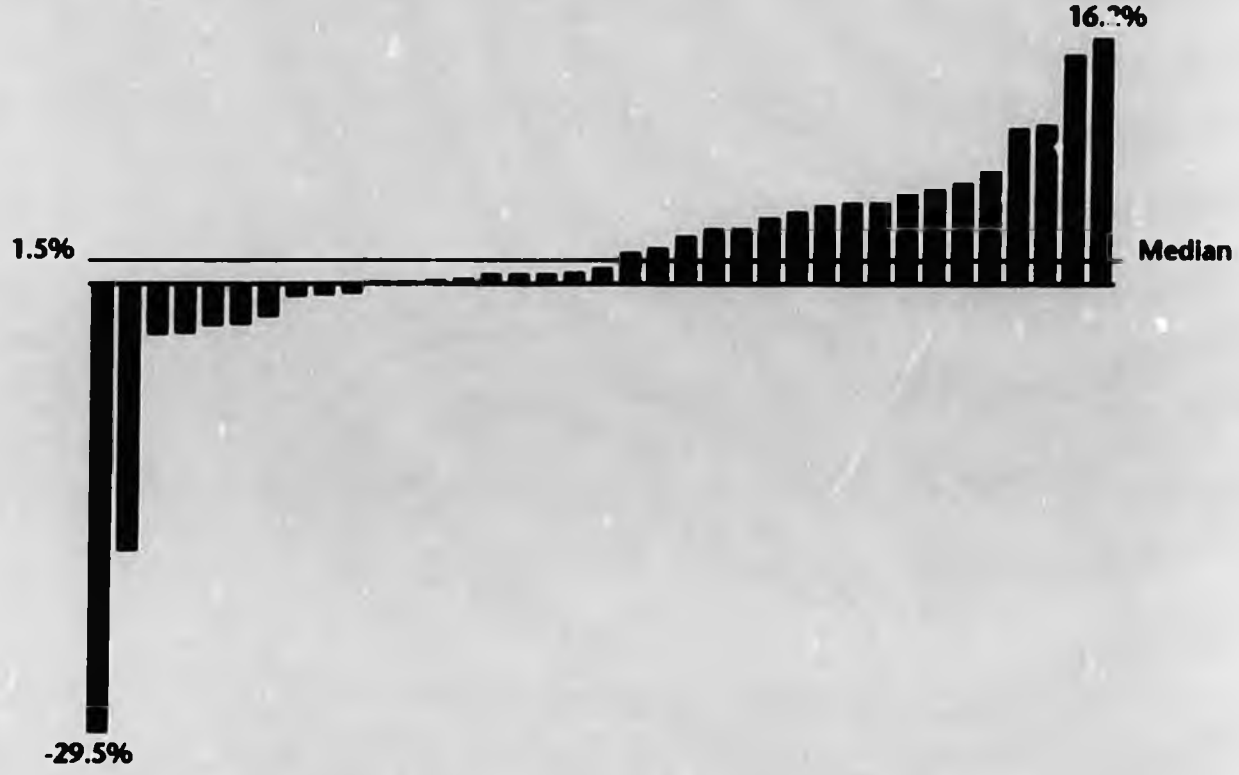
CHC Median Financial Margins
by Fiscal Year



Community health centers (CHCs) have experienced improved financial performance over the past five years through reduction of operating losses.

Note: Fiscal Year Ends (FYEs) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31 FYE, and 1 has a 7/31 FYE.
Source: Data were obtained from CHC audited financial statements, for free-standing CHCs from FY02 through FY06. For FY02, FY03, FY04, FY05, and FY06, 34, 35, 35, 37, and 37 CHCs, respectively, were included in this analysis.

CHC Total Margin
in FY06



The total margin for community health centers ranged from -30% to 16% in their 2006 fiscal year. Three-quarters of community health centers experienced positive total margins in their 2006 fiscal year, however one-quarter lost money overall.

Note: Total margin is calculated by dividing total income by total revenue. Fiscal Year Ends (FYEs) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31 FYE, and 1 has a 7/31 FYE.
Source: Data were obtained from CHC audited financial statements for free-standing CHCs in FY06. For FY06, 37 CHCs were included in this analysis.

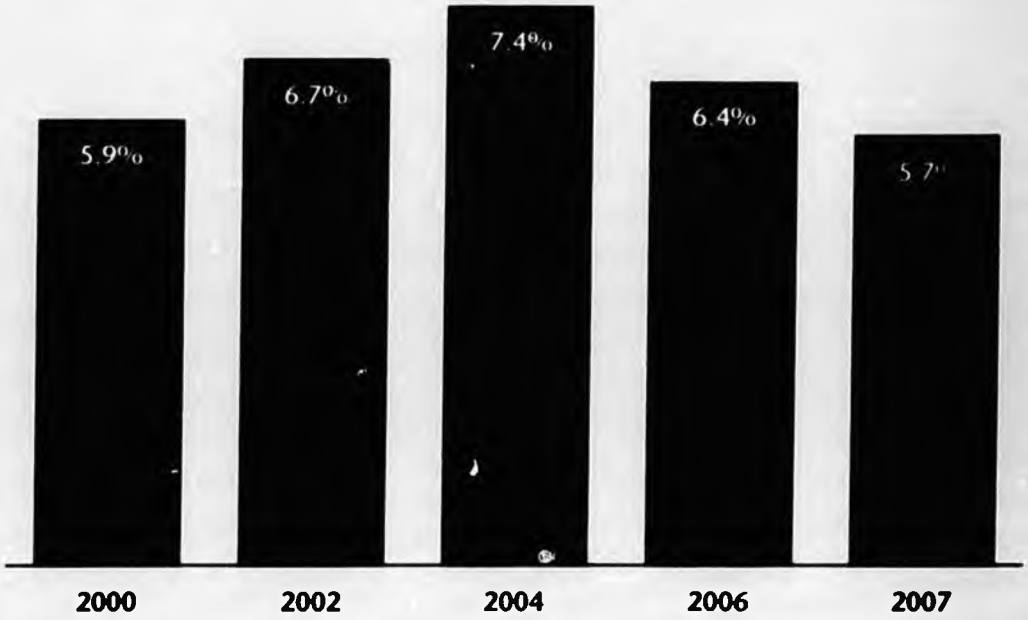
CHC Operating Margin
in FY06

Operating margins for community health centers ranged from -38% to 13% in their 2006 fiscal year. Just over one-half of community health centers experienced positive operating margins, while just under one-half of community health centers lost money on operations.

Note: Operating margin is calculated by dividing operating income by total revenue. Fiscal Year Ends (FYEs) vary across CHCs: of 37 CHCs, 30 have a 6/30 FYE, 4 have a 9/30 FYE, 2 have a 12/31, and 1 has a 7/31 FYE.
Source: Data were obtained from CHC Audited Financial Statements for free-standing CHCs in FY06. For FY06, there were 37 CHCs included in this analysis.

Don't Have Health Insurance

Percent of All Massachusetts Residents

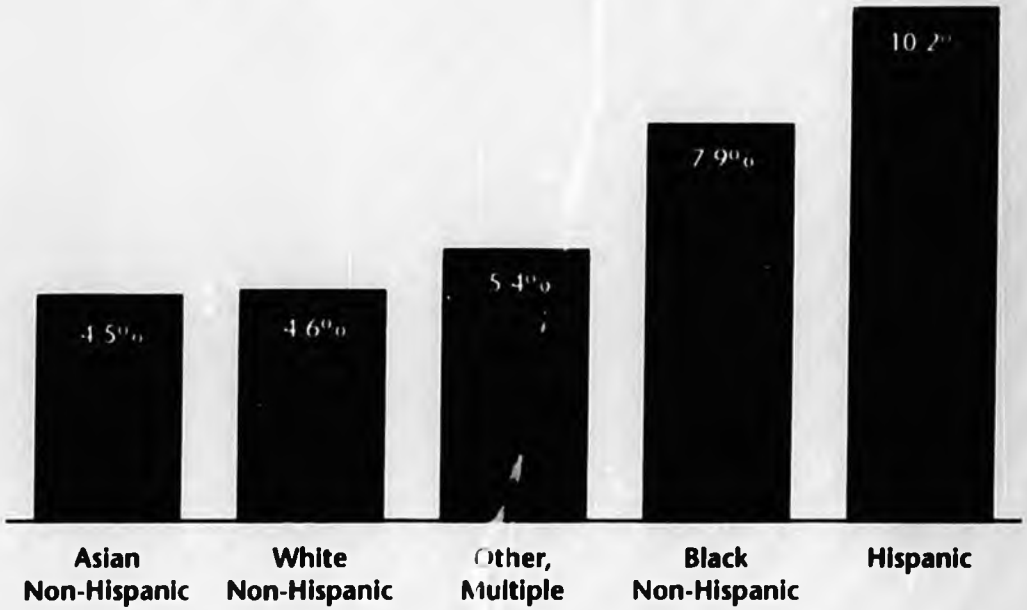


The overall uninsured rate for Massachusetts dropped from 6.4% to 5.7% from 2006 to 2007, and the number of people without coverage fell from 395,000 to 355,000, a 10% decrease reflecting the successful early implementation of health reform.

Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of 2007.

Uninsured by Race and Ethnicity

Percent of All Massachusetts Residents, 2007

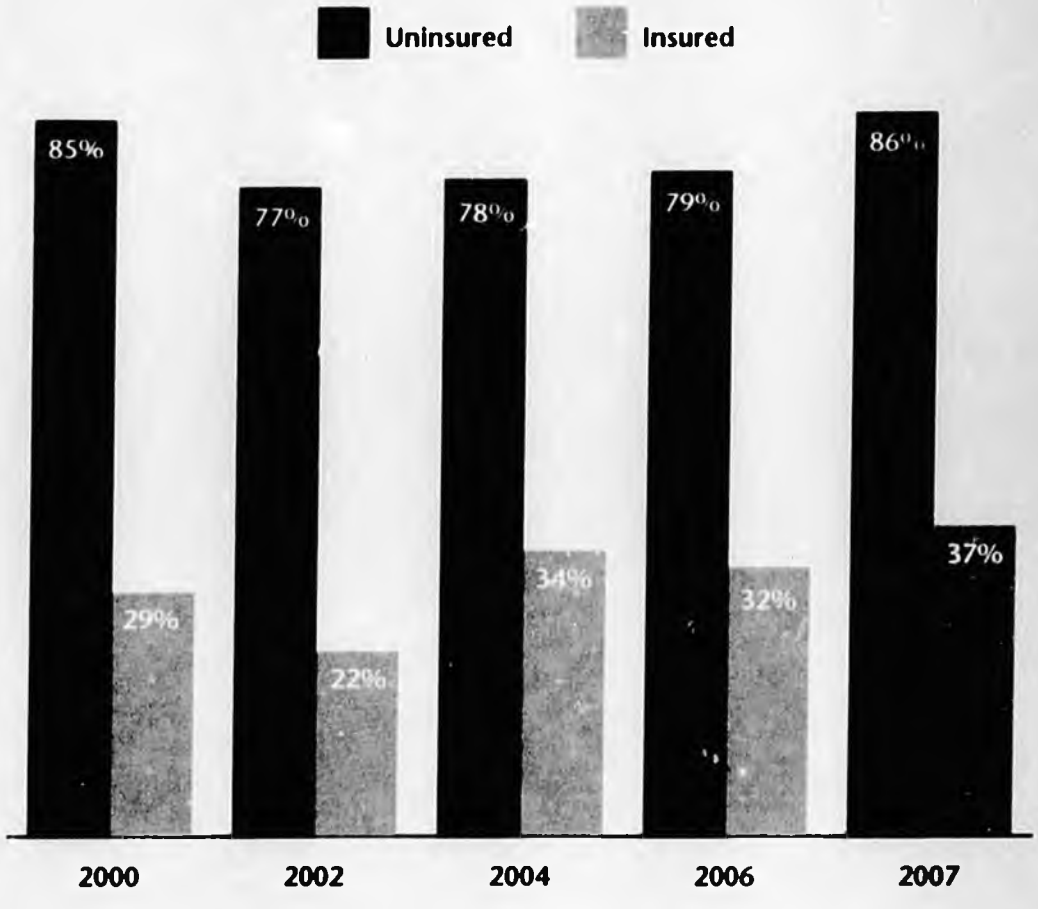


In 2007, 5.7% of all Massachusetts residents did not have health insurance. However, Hispanics and Black Non-Hispanic residents have higher rates of uninsurance when compared to other races and ethnicities.

Source: DHCFP Household Survey for 2007. The 2007 survey was conducted January through July of 2007.

Needed Care but Cost Was an Obstacle

Percent of Adults Ages 19 to 64

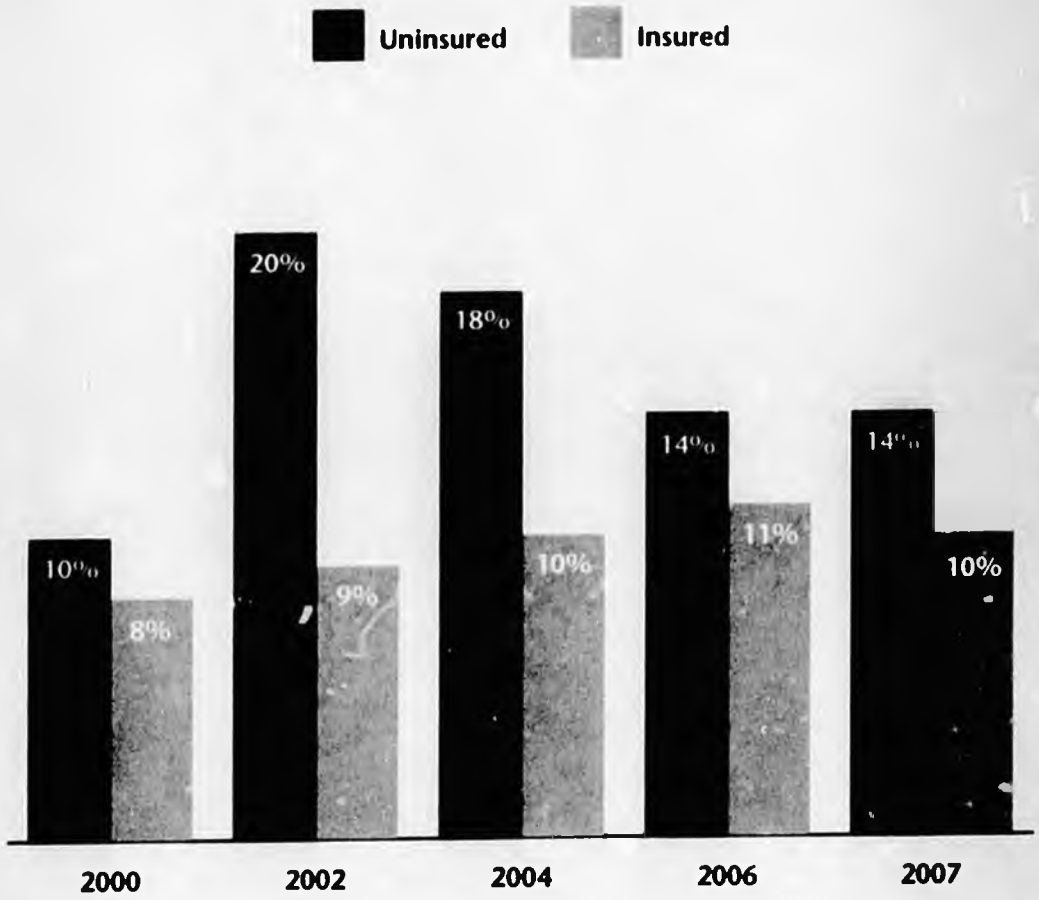


Note: In 2004 and 2006, the sample size doubled from survey years 2000 and 2002. In 2007, the sample size was about 16% smaller than in 2004 and 2006.
Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Cost appears to be a growing obstacle to accessing health care for Massachusetts residents and remains a significant barrier for most people without health coverage.

Reported Being in Fair or Poor Health

Percent of Adults Ages 19 to 64

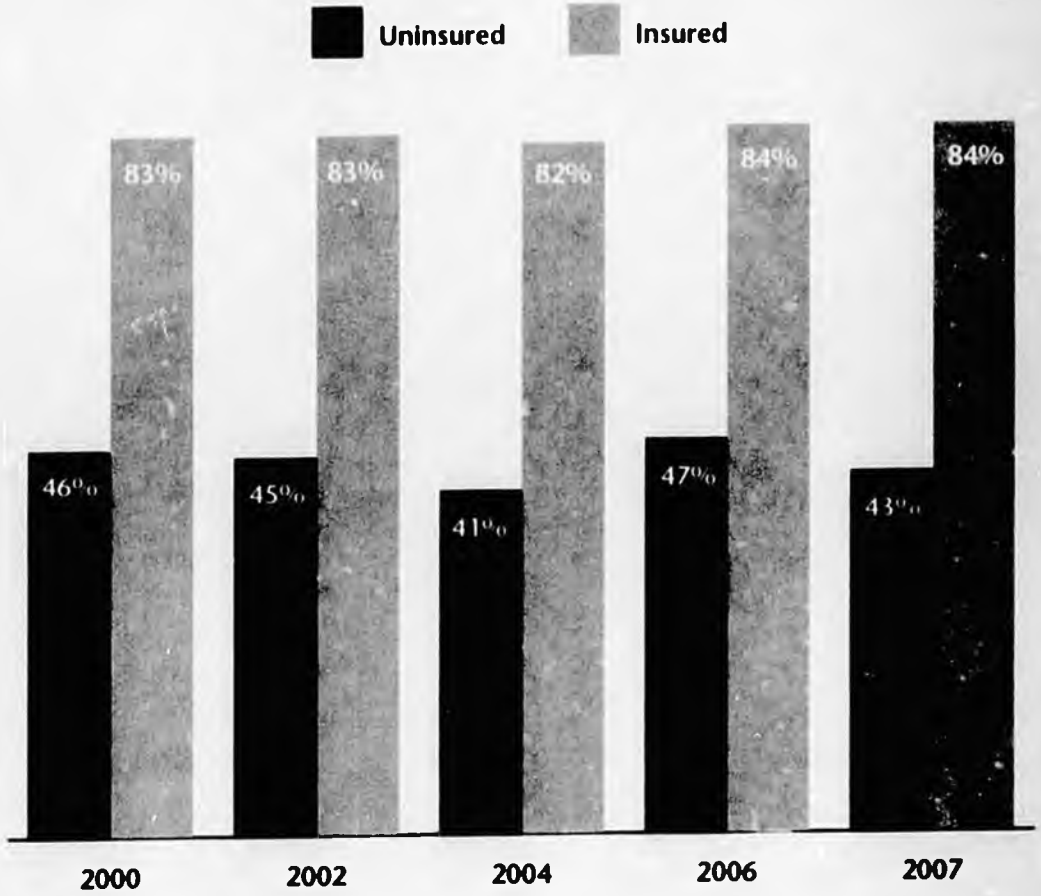


Note: The differences between insured and uninsured residents are statistically significant for 2002, 2004, and 2007.
Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Most Massachusetts residents surveyed, both insured and uninsured, reported being in good or excellent health.

Reported Having a Dental Visit

in the Past Year, Percent of Adults Ages 19 to 64

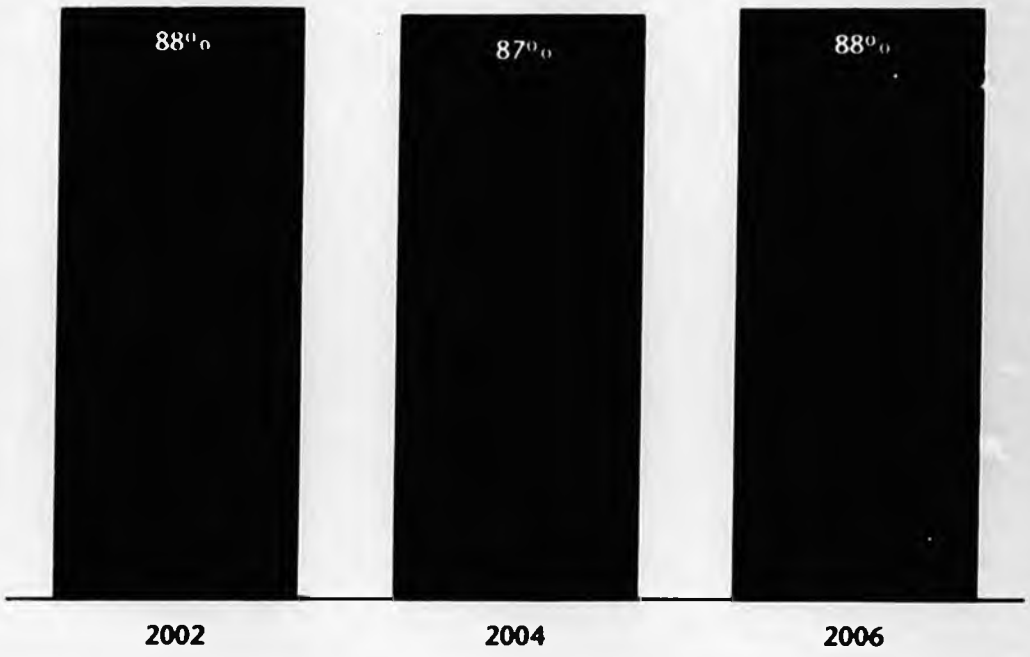


Source: DHCFP Household Survey for 2000, 2002, 2004, 2006, and 2007. The surveys from 2000 through 2006 are conducted between February through June of the survey years. The 2007 survey was conducted between January through July of the survey year.

Only 43% of uninsured Massachusetts residents reported getting dental care in the past year compared to 84% of those with insurance coverage.

Have a Personal Health Care Provider

Percent of Adults Ages 18+



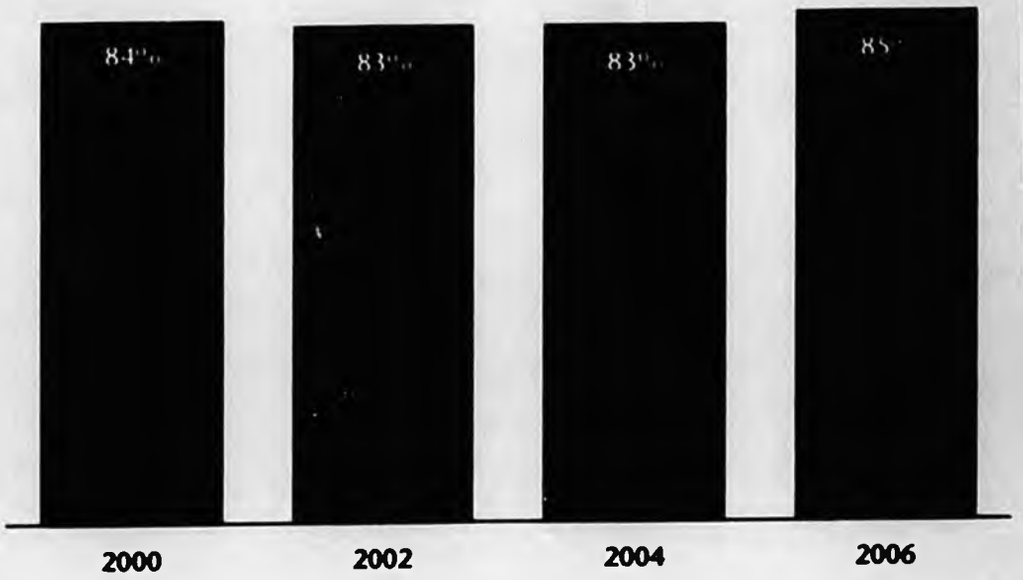
Percent of Adults Ages 18+ by Race/Ethnicity (Confidence Interval):			
White	90% (89% - 91%)	90% (88% - 91%)	90% (89% - 91%)
Black	82% (77% - 87%)	88% (83% - 93%)	87% (83% - 92%)
Hispanic	70% (65% - 75%)	66% (60% - 72%)	70% (65% - 76%)
Asian	78% (71% - 85%)	83% (77% - 90%)	80% (72% - 89%)

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.

The vast majority of Massachusetts residents surveyed reported having a personal physician, a percentage that has held steady over the past three survey periods. However, a significantly lower percentage of Hispanics and Asians reported having a personal physician compared to other racial and ethnic groups.

Had a Mammogram

in the Past 2 Years, Percent of Women Ages 40+



Most Massachusetts female residents ages 40 and over reported having a mammogram to screen for breast cancer.

Percent of Women Ages 40+ by Race/Ethnicity (Confidence Interval):				
White	84% (82% - 86%)	83% (81% - 85%)	82% (81% - 84%)	85% (84% - 87%)
Black	87% (80% - 95%)	82% (71% - 92%)	79% (64% - 95%)	80% (71% - 89%)
Hispanic	89% (84% - 94%)	86% (80% - 92%)	88% (82% - 93%)	87% (82% -92%)
Asian	Insufficient Data	Insufficient Data	Insufficient Data	Insufficient Data

Source: Massachusetts Department of Public Health (DPH) results from the Behavioral Risk Factor Surveillance System (BRFSS) for 2000, 2002, 2004, and 2006. The BRFSS survey is conducted throughout the year.