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Hearing on Labor Force Health Care Coverage

Senate Committee on Industrial Relations

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SENATE COMMITTEE ON INDUSTRIAL RELATIONS

SENATOR BILL GREENE, CHAIRMAN

Hearing on

LABOR FORCE HEALTH CARE COVERAGE

October 20, 1988
Sacramento, California

RECORD OF
SENATE COMMITTEE ON INDUSTRIAL RELATIONS
HEARING ON

LABOR FORCE HEALTH CARE COVERAGE

State Capitol -- Room 4203
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Senator Bill Greene, Chairman

TABLE OF CONTENTS

		Page
1.	Hearing transcript	
	(a) Senator Bill Greene	1
	(b) Mr. Bert Seidman, AFL-CIO	2
	(c) Dr. Gary Krieger, California Medical Association	7
	(d) Dr. E. Richard Brown, UCLA School of Public Health	14
	(e) Ms. Pat Powers, Bay Area Health Task Force	20
	(f) Mr. Steve Zatkin, Kaiser Foundation Health Plan, Inc.	25
	(g) Ms. Leah Morris, State Council of Service Employees	27
	(h) Ms. Lois Salisbury, Health Access	29
	(i) Mr. Brent Barnhart, Association of California Life Insurance Companies	45
	(j) Mr. Gary DuQuette, California Association of Life Underwriters	49
2.	Written testimony of Mr. Bert Seidman, Director AFL-CIO Department of Occupational Safety, Health and Social Security	54
3.	Written testimony of E. Richard Brown, Ph.D. School of Public Health, UCLA	61
4.	Written testimony of Ms. Patricia E. Powers, Bay Area Health Task Force	76
5.	Written testimony of Mr. Steve Zatkin, General Counsel, Kaiser Foundation Health Plan	99
6.	Written testimony of Ms. Leah Morris Service Employees International Union	108
7.	Written testimony submitted by Michael Dimmitt, Ph.D. Director of Management Information Services California Association Hospital and Health Systems	116
8.	Letter from National Multiple Sclerosis Society, Southern California Chapter	122
9.	Additional material provided by Ms. Lois Salisbury of Health Access dated December 9, 1988	124
10.	Background Materials:	
	(a) Notice of Hearing	140
	(b) Excerpts from an American Hospital Association publication describing current situation of labor force health care in the United States	142

(c) An article from the Western Journal of Medicine by Dr. John Kitzhaber, President of the Oregon State Senate 162

(d) September 26, 1988, article from Fortune Magazine about health insurance coverage issues, which includes a description of Massachusetts program 168

(e) An analysis of Senate Bill 2260 (Keene), the recently enacted small business health care coverage tax credit bill 172

(f) Senate Office of Research report on the Massachusetts Health Care Program 176

CHAIRMAN BILL GREENE: We're going to get started. This is a meeting of the Senate Committee on Industrial Relations, being held in the State Capitol in 4203 on October the 20th, 1988.

The purpose of the hearing today is to provide information to this committee on the extent to which workers and their dependents are uninsured, the consequences of a growing population of uninsured workers, and of course, the options for increasing the availability of health insurance coverage to the uninsured part of the labor force.

Let me begin by saying that I, as the chair of the committee, am aware of the many problems created by uncompensated medical care in our society. I would also indicate that I also chair the Senate Budget and Fiscal Review Subcommittee on Health, Human Services, and Labor. We have spent countless hours in hearings and meetings with numerous people, some of whom will testify here today, in an effort to find a resolution to the problems of publicly financed Medi-Cal, medically indigent services, county health services, and categorical grant health programs. But it is not the purpose of this hearing to dwell on the state's responsibility for caring for the medically in need.

What we intend to focus on today is the private sector financing of health care for employees and the self-employed, which we know has a significant impact on the public cost of health care. Many of the public health care concerns brought to the Legislature have to do with the health care of working people.

One example of this was last Tuesday's statement by the United States Surgeon General, Dr. C. Everett Koop. Dr. Koop called for businesses to increase health care benefits for employees, saying that corporate America is in part responsible for the shockingly high infant mortality rate in this country.

I expect much of today's testimony to be about private sector financing of Medicare -- what is provided, what is not provided, and what should be provided for working people of this state. We have no preconceived proposals for expanding labor force health care to offer at this hearing. We do not even imagine that we will have, after we come out of this hearing, but we should be better educated from a foundation point of view. The committee today desires to listen and to learn from others who have assessed the problem and have some types of proposed solutions.

We are not, however, without a point of view. As a legislator and committee chair, the uppermost concern in my mind and that of many of the members -- well, all the members of the committee -- is that uninsured and uncompensated medical care leads to inadequate medical care. Lack of adequate care causes mothers to have sick babies, children to have their full potential needlessly endangered by disease, and productive workers from all walks of life to be wastefully removed from the labor force, and that is the most pressing problem which I would argue that this society and certainly this economy could not afford.

I hope that the witnesses today will also bear these concerns in mind as they make their facts and information and ideas known to us today, and we will commence our hearing with Mr. Bert

Seidman from the National American Federation of Labor -- AFL-CIO. We welcome you to Sacramento and to this first hearing on this subject, Mr. Seidman. Mr. Rankin, you may go first and make the introduction, the formal introduction, if you wish.

MR. TOM RANKIN: I'd just like to introduce Bert Seidman from the national AFL-CIO. He is the director of the AFL-CIO Department of Occupational Safety, Health, and Social Security, and has spent many years working on the issues regarding social insurance and he will share his expertise with you today. Thank you.

CHAIRMAN BILL GREENE: Thank you very much. Mr. Seidman, let me welcome you once again. I might indicate, I don't know if you recall the last time I was in your company was in Washington and you were quite profound and provocative then and we're looking forward to the same here now.

MR. BERT SEIDMAN: Thank you very much, Mr. Chairman. The AFL-CIO is pleased to have this opportunity to comment on ways in which the State of California might expand health insurance coverage.

To begin with, Mr. Chairman, I would like to commend you and the members of the committee for moving expeditiously to address this issue. With the number of people who are without protection reaching staggering levels nationally and statewide, no state can afford the high social and economic price of inaction.

At the national level, organized labor and many other groups concerned with widespread denial of access to health care have endorsed legislation introduced by Senator Edward Kennedy and California Congressman Henry Waxman (S. 1265 and H.R. 2508) which would require all employers to provide health insurance to employees and their families as a condition of doing business. We believe that such an employer mandate is long overdue and urgently needed in light of the growing number of employees who are falling through the cracks of the so-called private sector safety net and are not offered health insurance protection through their employer.

We intend to work very hard for passage of this bill, but in the meantime, the crisis is too severe for states to wait for Congress to act; and therefore, we encourage you to develop legislation requiring employers in your state to provide health care to their workers. As you know, Mr. Chairman, every industrialized country, except the United States and South Africa, has a national policy guaranteeing all citizens access to health care services through an organized system of public and private coverage, but in our country, employers have been allowed to voluntarily decide whether or not they would offer protection.

Recent structural changes in the economy have dramatized the inequities of the current system. As you know, employment has declined in manufacturing and other basic industries where health care coverage was an integral part of employee benefit plans, and at the same time, new jobs have been created in the service sector where health care coverage historically has been less comprehensive or, in many cases, not offered at all. In addition, the number of part-time workers has increased and so-called contractual employment has expanded. Some employers have even cut off coverage of children and other dependents previously covered. The net effect of these economic

shifts has been to leave millions of workers and their families without health insurance.

Since 1980, across the country the number of workers without protection has grown by 40%, leaving at least 37 million people without coverage (or 16% of the population). In California, the situation, if anything, appears to be even worse. In 1985, the last year for which state data are available, California had an astounding 21.4% of its population uninsured. In California, you have, as I understand it, over 5 million men, women, and children who are not covered for health insurance by any program, public or private -- almost one-seventh of the uncovered in the United States. Alaska, the state with the next most severe problem in the Pacific region, was far behind with 17.4% of its population uninsured.

Although we do not know how the uninsured population breaks down in California, it probably corresponds to national trends. As a matter of fact, Mr. Chairman, I know more now than when I wrote this because I read, coming out on the plane yesterday, an excellent study that was done by Professor Richard Brown of the University of California at Los Angeles who does have an analysis of how the uninsured population breaks down in California, and by and large, it does correspond to national trends with one exception; and that is that in California, a disproportionately large number of Latinos are uncovered for health care. For the country as a whole, approximately 52% of the uninsured are full-time workers and their families, 8% are steadily employed part-time workers and their families, and 17.2% are workers who were unemployed briefly during the year and their dependents. Taken together, three-quarters of the uninsured live in families with a strong link to the workplace, and if I recall the figure correctly, in California, that figure is even higher. I believe it is 88% of the uninsured live in families with a strong link to the workplace.

The refusal of some employers to offer health care protection forces many workers and their families to postpone seeking needed medical care. Last year, the Robert Wood Johnson Foundation published the results of a comprehensive survey showing that the proportion of Americans without health care coverage who had not visited a doctor's office in a 12-month period jumped from 19% in 1982 to 33% in 1986. A disturbing 30% of pregnant women with low incomes received no health care during their first trimester of pregnancy, and 20% of those with hypertension had not had their blood pressure checked within a 12-month period.

Just this week, the Wall Street Journal, not the most liberal -- I'll use that "L" word -- liberal publication in America, had a front-page story on the lack of health care for pregnant women, beginning with the tragic death of a premature infant that took place in Los Angeles when that mother, who was uninsured, received no care until she went into the hospital. That article also has a very, very revealing chart which shows that the United States has, of all industrialized countries, the highest infant mortality rate.

The last and, in many cases, the only resort of the uninsured is to be treated in a hospital emergency room, which is the most expensive health care setting, placing the burden of financing care for the working uninsured disproportionately on companies which provide protection and facilities that provide coverage. This is what is known as cost-shifting. In 1986, uncompensated care accounted for 6% of total charges in California hospitals. Approximately 15% of all uncompensated

care provided in California is borne by public hospitals, and these are the very hospitals on which the burden of coping with the AIDS epidemic has clearly fallen most heavily.

Organized labor urges this committee to develop legislation based on the only equitable solution, and that is requiring employers to provide protection and covering the remaining uninsured through public programs.

Under the leadership of Governor Michael Dukakis, Massachusetts has led the way for the nation. In that state, a comprehensive program has been designed to meet the diverse needs of the state's entire uninsured population. This goal will be accomplished through a series of initiatives phased in beginning in 1989. By 1992, all Massachusetts residents are expected to have coverage. There are five major components to this legislation:

Next year, a statewide insurance pool will be established for small firms with six or fewer employees. Individuals in such firms could purchase protection through this pool or their employers could purchase protection on their behalf.

Beginning September 1989, all students studying at least three-quarters time will have health insurance coverage offered through their schools.

In 1990, a two-year tax credit (20% in year one and 10% in year two) will be offered to businesses with 50 or fewer employees and which have not offered health insurance in the previous three years.

In 1990, persons receiving unemployment compensation will be eligible for employer-subsidized health insurance. Employers will be required to contribute 0.12% of the first $14,000 in yearly wages per employee to finance health insurance for the unemployed.

In 1992, employers will be required to contribute 12% of the first $14,000 in yearly wages per employee. However, the great majority of employers who presently provide health care coverage will receive an offsetting credit so they will not have to pay this amount.

The Massachusetts program will make affordable insurance available to employers by establishing an insurance pool for small business. This will minimize any adverse selection one firm might face because of the demographic makeup or health status of its workforce. By requiring all employers to have health insurance for their employees, the legislation will eliminate the competitive disadvantage that employers providing insurance now face.

The Massachusetts employer mandate applies to all employers except those with five or fewer employees, the self-employed, and new businesses in their first year of operation. All other employers must make contributions for all full-time employees and all part-time employees working at least 20 hours per week after 180 days, or after 90 days if they are heads of households. Employers with 50 or fewer employees who are severely impacted by the 12% contribution will be eligible for financial assistance.

The Massachusetts program will also improve access for those who would not be covered by the employer mandate. Its goal is to expand Medicaid to cover poor families who have no permanent ties

to the workplace and to allow early retirees and other individuals with relatively higher incomes to purchase insurance protection from the state pool.

Let me now turn to your situation here in California about which I am, of course, admittedly not an expert. Therefore, I wish to make some general observations based on experience across the nation that you might wish to consider. I'm starting with the premise, which I hope you accept, that your aim should be to assure health care coverage to every resident of California just as Massachusetts has done. That does not mean, of course, that your legislation would have to be exactly the same.

National studies have shown that three-fourths of all workers without health insurance protection have incomes under $10,000 per year, and 93% earn less than $20,000. It is crucial, therefore, in developing your situation, that you consider the burden on employees that premium-sharing and heavy out-of-pocket costs would impose. Our view is that any premium sharing should not exceed 20% and that deductibles and co-insurance should be as modest as possible. In addition, it is crucial that the state explicitly require that insurance sold to employees through state pools include cost containment features, particularly managed care, to minimize total premium costs and out-of-pocket requirements imposed at the point of treatment.

Currently we are seeing a great many initiatives of states and local communities attempting to grapple with the access problem. Many have been aided by demonstration grants from the Robert Wood Johnson Foundation. Unfortunately, since these initiatives are new, little data are available about what works. Generally, the fifteen Johnson-supported initiatives break down as follows:

- 12 are developing modest, low-cost insurance products.
- 5 are developing mechanisms to pool risk by fostering the formation of multiple employer groups.
- 5 are subsidizing the purchase of insurance for individuals.
- 11 are attempting to reduce insurance costs through managed care.

As you know, Hawaii was the pioneer, enacting mandated employer health insurance in 1974. According to all accounts, that program has been quite successful. A number of other state initiatives are worth noting.

This year the State of Oregon began offering a five-year tax credit to employers with 25 or fewer employees who offer health care protection. In addition, to encourage broad participation in the program, coverage is being offered through a state pool.

In July of this year, the State of Washington began making available a basic health care plan to families with incomes under 200% of the federal poverty level. The state has negotiated preferred provider relationships and will subsidize the purchase of coverage on a sliding scale related to family income.

In 1986 the Wisconsin State Legislature developed an ambitious plan that would have gone into effect in 1988. Unfortunately, last year, the initiative was vetoed by the new governor. The proposed plan had five components: It would have offered subsidized coverage to individuals who were unemployed for the previous six months or not offered coverage through their employers; it

would have subsidized the cost of protection for employees who were offered a plan by their employers but could not afford to purchase it; it would have provided high risk individuals access to a pool for medically uninsurables; it would have made short-term loans to the temporarily uninsured; and it would have provided for the development of insurance products for the disabled.

Essentially, these three states illustrate the range of choices available to the California Legislature should it decide to move forward. Our view, however, is that none of these options would be as effective in solving the access problem as an employer mandate. The AFL-CIO believes that the Massachusetts model offers an efficient and effective approach for California to consider, and we hope that the Legislature will move ahead in this direction.

In cooperation with the California Labor Federation, AFL-CIO, we at the national AFL-CIO stand ready to provide whatever support we can in the process of developing legislation and implementing a program.

Thank you, Mr. Chairman. I'll be glad to answer any questions you or the members of the committee may have.

CHAIRMAN BILL GREENE: Thank you very much, Mr. Seidman. Let me ask you, the Massachusetts law, the federal law, are they similar or identical, or what?

MR. SEIDMAN: They are not identical but they are similar in this respect: that -- when you say the federal law, you mean the bill that has been introduced by...

CHAIRMAN BILL GREENE: Right.

MR. SEIDMAN: ...Senator Kennedy and Congressman Waxman.

CHAIRMAN BILL GREENE: Well, the proposed federal law.

MR. SEIDMAN: The proposed federal law. They are similar in this respect: that they both rest on the basic foundation that every employer should provide health care for the employees of that firm. The difference is that that is all that is in the Kennedy-Waxman bill. The Massachusetts bill is more comprehensive in that it tries to fill in the gaps that would still remain even with a mandated employer requirement. Since roughly two-thirds of those who are uninsured are employed, that would still leave some people who are not employed or employed, in the case of the Kennedy bill, less than 17½ hours a week who would not be covered without additional legislation. And so, of course, we support in the Congress additional legislation to do everything possible to fill in those gaps. But the Kennedy-Waxman bill itself doesn't do so. The Massachusetts program does attempt to do so.

CHAIRMAN BILL GREENE: Do you understand whether or not the Kennedy bill looks to the states to fill in those gaps, or is it that they just felt that they could not deal with that at this point in time?

MR. SEIDMAN: The Kennedy bill does not place any requirements on the states at all. The requirements are placed on employers throughout the country.

CHAIRMAN BILL GREENE: All right, now, in the Massachusetts plan, I was trying to follow you here, you indicate that there's a state pool which is established in that they require the state schools, then the other businesses, and then the people of UI and -- is there any segment of the Massachusetts population which is not covered in the Massachusetts law?

MR. SEIDMAN: It's my understanding that when the program is fully operational, it will cover, in one way or another, every resident of the State of Massachusetts.

CHAIRMAN BILL GREENE: The others that it would not cover it would then cover with the expansion of Medicare, is that correct?

MR. SEIDMAN: Well, one way that it would do this is by expanding Medicaid.

CHAIRMAN BILL GREENE: Okay. So that would take care of those businesses who employ five or less people.

MR. SEIDMAN: Yes. This would be done through a state pool which would permit them to buy health insurance at a much lower cost than is available to them now. The problem that small employers face now is that the premiums tend to be higher for small employers than for large employers. It would also be done, as I understand it, by a declining subsidy that would be available to small employers -- a tax credit over a two-year period beginning in 1990.

CHAIRMAN BILL GREENE: The thought that comes to mind with me is that in most cases, at least here in this state, those employees of the smaller firm are also your poorest paid employees, and in many cases are not at a wage rate or a permanent wage rate that would afford them the opportunity to expand any of their financial obligations to any great degree. Now, how is that state pool established in the Massachusetts plan?

MR. SEIDMAN: The state pool is established by the legislature, and I don't know the exact details of that -- I have that information but I don't have it at my fingertips.

CHAIRMAN BILL GREENE: All right, if you would be kind enough to leave that with us. We had hoped that we would have somebody at these hearings that would be able to give us some understanding of the Massachusetts plan. We've failed in that. We haven't been able to get a complete view on our own. Of course, it's understandable that people back there are involved in other activities, but we had hoped that we would be able to have a clearer understanding of what is in the Massachusetts plan to date, but of course, any help you can give us in that regard with the information that you have, you do not have to present it now, but before you leave, and then of course we will be pursuing other opportunities to get more information about their plan.

Mr. Davenport, do you have any questions? (Portion of hearing omitted due to technical difficulties.)

DR. GARY KRIEGER: ...of health care. We have increased both the quality and the quantity of human life in ways that are absolutely unimaginable, and we have technologically increased our ability to do such marvelous things that were unimaginable just twenty short years ago.

But of course, this has a price, and that price is cost and the cost of health care has become a very significant part of our nation's economy today. Health care now consumes up to 12% of our gross national product, and most economists feel will easily be 15% before the beginning of the next century. Health care is now the third largest employer in our nation, behind retail sales and defense. Health care occupies 39% of our state budget here, and Medicare alone occupies 7½% of our federal budget.

So it is no longer simple for us to say we can change the program without significantly altering

the economy of our country. And as we delve for a solution to any of these problems, we must look into that particular aspect of it, that it affects all pieces of this.

And so the first question we must decide on is whether we wish to change the entire health care system, which has fostered such tremendous good but created a problem which we are facing today because there was a gap and that gap is widening; or whether we should just narrow it down to the problem of those who do not have health insurance. And then if you decide that you wish to change that, do you change it on a national basis or do you change it on a state basis? The State of California, the sixth largest economy in the world, is a unique place, and for us to be compared on a national basis and to do the same things as happened in other states across the country might very well be inappropriate and we must have solutions that are unique to us.

If, on the other hand, we decide that we want to deal just with this problem, the question is, how do you deal with this problem, recognizing the concerns of the business community, recognizing the concerns of labor, recognizing the concerns of government; and therefore, we must work to develop a solution that is equitable to all.

We also must recognize some very basic facts of what has happened in health insurance. These folks are poor but they are working, and we must recognize that they must contribute partly to the cost of care. We must have limits that are placed upon us in terms of how much care they can get.

One of the things that has occurred in the development of the Medicaid and the Medicare program is the unlimited benefit package. Unlimited benefits sound wonderful but they cost tremendous amounts and eventually they ratchet down a program so that in Medicaid today in this state, close to two-thirds of the physicians no longer will see people under Medicaid and they are all switched back to the county system which is seriously overburdened.

So when we create a program, we must be conscious of the needs of the state, conscious of the needs of the people, and conscious of how we can fiscally, fairly, and prudently afford this.

The California Medical Association is committed to participate in the dialogue and to develop and hopefully be part of the development of a program that will be fiscally sound, prudent, and fair to all individuals. We cannot hurt the economy of this state but we cannot allow what is becoming a tragedy in every county in this state to continue to go on. If we do, it will be dangerous for people to come into our state and we may indeed have to post warnings at our borders: danger to your health if you enter this particular state.

We look forward to working with all interested parties in developing and creating a solution to this problem. Thank you, Mr. Chairman.

CHAIRMAN BILL GREENE: Doctor, let me assure you that this committee would not consider anything which would in any sense do any damage to our economy, because even in terms of our own mission, if anything happens to that, there's no reason for this committee to exist. Let me assure you that we are mindful of the economy first and then the people who make that economy hum, which are the workers and the business side of it; and then all the other factors are attendant unto that, not that being attendant to those other factors. So let me assure everybody that our thinking and our searching and our research is rooted in that, and we can imagine no reason for that to change.

You offered the idea as to which was the best way to go, one which would reform the entire system or one which would take care of these specific problems. Which do you, with your breadth of knowledge, which do you see as the most advisable direction to look in?

DR. KRIEGER: We have a pluralistic system of delivery of health care in this state, many methodologies of ways in which people receive their care, both through government-sponsored programs, such as Medicare and obviously Medi-Cal, plus a whole variety of health insurance programs. We believe and are committed to the idea of maintaining that pluralistic system. We believe it is in the best interest of patient care; we believe it's in the best interest of physician involvement.

We also have -- and I've had the experience of talking to people, to physicians, from around the world who have been involved in national health systems, and the one thing I have received from them, which is disturbing to me, is the incentive, the lack of sometimes full caring without that incentive to be able to develop a pluralistic type of system.

We also have got to recognize the fact that it is going to be far more difficult, and perhaps far more costly, to develop some type of a national health system in which we eliminate basically private health insurance. I know there are those in the room who will advocate that, and I respect their point of view, but I believe that we can solve this problem without breaking the banks of our business community, without going to a national health system.

CHAIRMAN BILL GREENE: Well, I understand there are many different points of view, but I just don't see anything like that happening. I mean, you know, you'd have problems getting a person like myself to vote for something of that nature. So, I mean, I just don't see it, you know. I know of no major segment of the society whose thinking is rooted in that kind of approach. That's not to say there aren't individuals who think along those lines, but I find that thinking prevalent in no segment of the society, not even among the poor, and I represent a larger percentage of poor than any member of the Senate. I don't find that kind of thinking prevalent in my own constituency. This is not to challenge anyone who does think along those lines, but they don't have a constituency that could move anything at this pont in time, and I don't see it happening, at least in my lifetime here in the Legislature.

What is your reaction to a plan which would somewhat bring about an -- well, you said you believe in the pluralistic approach so I guess you've already answered that.

Are there any specifics that you and your committee are honing in on now that you feel that might be a part of what you end up with eventually? And of course I recognize and understand that you're in the process of your work, and what have you, and that also we should be cautious as to take nothing as absolute at this stage, but just to give us a feel for it because, you see, we're going to have, and already have, people running an awful lot of ideas by us; not that we'd settle on any of them, but we need to have some kind of a measurement in how we privately and personally consider many of these proposals that are run by us.

For example, we had legislation before us this last session where persons wanted to draw upon the disability fund which we rejected out of hand. Number one, we weren't prepared to deal with it.

We knew nothing about the potential effects of it, what it would do on the other side of the coin, and we basically looked at it as a -- not that the people were not acting in good faith, but we really looked at it as an opportunistic move rather than one that was borne from a lot of thought, a lot of examination, and a lot of research, which of course, as I said, we were not prepared to examine because we had not undergone that research ourselves; so we rejected it. That was a great impetus in the calling of this meeting because, as I determined then, I said this is only the beginning, we're going to be faced with this over and over again and it is an issue, although we're not a health committee per se inasmuch as it involves workers, it is an issue that will come before this committee for some kind of judgment. So I thought it was best that we begin to learn as much as we could about it from individuals out there in the world who are far, far more expert than we probably ever will be but who at least can educate us to the point where we would intelligently examine any proposal brought before us.

So, after all of that, are there any little offshoots of roads that might be a part of your major plan or that are of such a nature that they're going to be a part of -- have to be a part of any plan that anyone comes up with? Just so we have kind of a sense of what's real and what might not be as real, and what is doable and what might not be as doable, and what have you.

DR. KRIEGER: Thank you, Mr. Chairman. I appreciate the delicacy of the way you made your remarks. The California Medical Association is committed to, right now, develop a coalition of interest groups to see if we can, together, develop something that will involve all of us. Rather than being specific of the names of the interest groups, I think it would be fair to say that you have to involve the business community, you have to involve other providers, intermediaries who will administer health care, and beneficiaries of health care. And we are in the process right now of hopefully trying to slowly identify those groups, meet with them, and see what their needs are rather than presenting a proposal just from doctors.

Doctors alone, who are the major providers of health care admittedly, cannot solve this problem, because this is a societal problem and must be solved by all groups, recognizing that everybody has different interests involved here.

As you look at the problem, if you're not going to go into some kind of a general national/statewide national health insurance, obviously you're going to have some employer requirements, because we're focusing on the employee who does not have health insurance. How that will ferret out I can't answer. There has to be some employee requirements because there are individuals out there who certainly can afford to purchase health insurance who do not, and when they access the system, they access it in ways that are extremely costly. Indeed, one of the most astounding figures I came of is of those medically indigent adults who access the county health system. They spend the exhorbitant amount of $512 per beneficiary per month, which is two to three times greater than what the average citizen puts in per beneficiary per month. So they use the system inefficiently and it certainly can be used better.

And obviously with the large numbers, and we're talking about a number of people who are greater than the combined numbers of those who are on Medi-Cal and Medicare in this state, you're

going to have to have some government funded parts of this. We are concerned about having to deal with the budgetary process every year. You have to have obviously specific funds which will be geared toward the development of this plan, and how it will be administered will be based upon what the legislatures will decide working with those who are interested in the program.

We have to obviously cover the uninsurables -- something that the Governor just vetoed a bill on that, and that has to be put into it; and it's difficult actuarily to find a reason how to handle this particular part.

We have to cover a dreadful problem -- maternal benefits, prenatal care. I'm not saying it will be in this but somehow it has to be dealt with, because we know that for every dollar we spend on prenatal care, we save $3 in that difficult baby that comes along.

And so all these pieces will have to be put together with the providers, the beneficiaries, the payers of care, and the administrators of care looking at this together and hopefully, collectively, coming out with something that will be of the best interest of the people of this state.

CHAIRMAN BILL GREENE: As the one who handles the health budget in the Senate here, have since '77, I get a little uneasy about that piece of it, taking into consideration the stops and starts, peaks and valleys we've had consistently in terms of dealing with that budget brought on by the factors out there and this Legislature's reaction to it and then of course the Administration's reaction to it. We, in my opinion, would be subjecting such a program to an uncertain future. We have many areas of the health budget that are mandated. We do not meet -- the MIA's program, for example, is an ideal example of that. We don't even do it in welfare. So, you know, what we're seeing going in then, to the degree that we rely on government participation taxpayer dollars, and it isn't because this is the way I believe or feel but I'm factual in my accounting of what the potential results will be, we would be subjecting it to an uncertain, unstable, highly chaotic future.

DR. KRIEGER: Mr. Chairman, I would submit that we do not want to create what has happened to the Medicaid program, and I would agree with you in your previous comments that to expand Medicaid to solve this problem is not the answer. But we do not want to create another program that becomes a "Medicaid" program as we have today ten or fifteen years down the line. We need to have a program so that the citizens who are eligible for this program will know they have the assurance that they can get the health care that they are entitled to under the insurance plan that's devolved and that each year it's not changed so they get a little bit less, a little bit less, a little bit less and their access to care fails in a period of time. So whatever program we devise has to have something so the citizens can be assured that the program will be available to them, and that is one of the tragedies that has happened today under the Medi-Cal program.

CHAIRMAN BILL GREENE: And that would mean we would be talking about participation by employees, participation by the individual, participation by the employer because, as I said at the moment, we bring us into it, you bring uncertainty into it. I've been here for 22 years. I was on Ways and Means in the Assembly. I've handled that budget over here since 1977 and I speak from my experience. Even when we had money under the Brown Administration when we were running a surplus, we still had that same situation in terms of where the votes were in the area of health.

DR. KRIEGER: I believe, sir, that we can develop some creative solutions working with all the elements of the people of California to develop something that is equitable and fair. I think it's going to take some innovative thinking on all our parts, and no one group is going to come out ahead on this...

CHAIRMAN BILL GREENE: Oh no, I didn't imagine that.

DR. KRIEGER: All of us are going to have to participate in some difficult solutions, but unless we do that, I think the health care system as we know it, and indeed the economy as we know it, can be significantly affected by what's going on.

CHAIRMAN BILL GREENE: All right, then taking that into account, we're talking several years down the line for that constituency to come together. I don't see that constituency coming together anytime soon. Maybe I'm incorrect. Anything short of three years.

DR. KRIEGER: I would hope, sir, that realistic, well-thinking people could work together, and I certainly would not put a time frame on anything that's coming down the line. But I would hope and I think by looking at the people you have testifying here tonight and in my personal conversations with them that I think there is a concern among all elements to develop something that can help this particular situation now.

CHAIRMAN BILL GREENE: Okay. Well, I'm, you know, looking at it from a practical, practicing, pragmatic politician point of view, and part of the ability to do that hinges on remarks of persons such as yourself. The other persons that we have here, the people who are knowledgeable in this -- in fact, that's one thing we hope that we can contribute to by virtue of holding this hearing and having a transcript that we can make available to the world, if necessary. It's for them to be able to have before them the facts and the findings and recommendations and suggestions and the things to look at from persons such as yourself and the others who will be here. So we hope that in our small way we will contribute to developing that constituency and educating people a little bit more finely on all the points surrounding this.

DR. KRIEGER: I certainly agree with that and appreciate your comments, sir.

CHAIRMAN BILL GREENE: Any questions from Mr. Davenport? Mr. Young? Mr. Davenport, you have no questions? You should have at least one, if not two or three.

MR. ALLEN DAVENPORT: Dr. Krieger, you started out your testimony by indicating that we have a superior and highly technological and expensive kind of medical care system that has provided us with a healthier and older population over the last few years. On the other hand, you indicated that along with cost-sharing you felt that another component of a health care system that would work better would be one that limited care in some way, if I understood you correctly. Could you tell me how those two concepts would work together?

DR. KRIEGER: Well, one of the things that I think has become apparent is that when we give (quote/unquote) "free care" and we pay for it, we have an increased utilization of care and we give unlimited benefits of care. It's difficult to define care and I realize this is a controversial issue as to what is basic, what is minimal, what is necessary care, but we're going to have to define that out because our country is kind of to the point where it cannot afford everything that we would wish to

have. Indeed, right now in Oregon they are wrestling with the concept of transplants and how to fund transplants, and every week they change the rules and the game there because the public wants them to have the transplants yet the state can't afford it; and they've tried a bunch of innovative schemes, none of which I think has been resolved yet.

So I think we have got to recognize the fact that the responsibility of our society to provide everything in terms of health care may not be there. We only have limited resources available. I know that you have to build roads and educate kids and do all the other things that's necessary in government, and so government cannot allow, as some economists have said, that our GNP, 40% of it will occupy health care by the mid-21st century. That obviously is not going to occur. There are too many other priorities. So we have to define what our society can give to maintain the health of our citizens and what is not necessary. That's going to be a difficult decision and I think we have to allude to that, and that's why I brought that up in terms of how we define Medi-Cal and Medicare. We gave unlimited benefits, and I'm not saying it's wrong but whether we can realistically afford it, and as we develop a new program for a population that is perhaps greater than either of those two populations, or the size of them combined, we have to think about what we can give in terms of what we can realistically afford, and that's what I was alluding to.

CHAIRMAN BILL GREENE: Your comment there raises a question in my mind which is part of conversations I've had with persons on this subject not only here in California but some other locations of the country through the National Conference of State Legislatures and then through the Congressional Black Caucus, and that is that part of the thinking might have to be the requirement of some regiment of wellness before people are brought into a plan or maybe before even some people are employed. For example, a person like Bill Greene who smokes just wouldn't cut the mustard, wouldn't make it, because you're buying problems when I walk through the door. Is that part of the thinking of any measure of people, to the best of your knowledge? Not that they've settled on this or not that this is likely, but is that being discussed, or am I talking with people who have some ideas of their own which might be out in some field -- I won't say right or left, or what have you.

DR. KRIEGER: All of us, and certainly physicians, heartily endorse wellness in the development of healthy habits from day one. Indeed, I'm now looking at my kids from a standpoint of watching them towards their diet when they're young because they teach us that down the line it may have a significant effect of what happens to them when they're adults. So the idea of preventive health care is something that not only I support, I embrace fully. That's part of why I became a pediatrician. However, for us to turn the door down to an individual because he happened to have smoked or drank too much or ate too much, whatever the answer was, would be something that I don't think our profession could do. I mean, we believe that we have to supply basic health care for the citizens of our country, because you then get into the definitions of what is or is not a healthy system and I think we can exclude some very, very fine people. We subscribe to preventive care, but indeed, we have never looked at that as a barrier to people having an interest to the health care system.

CHAIRMAN BILL GREENE: Okay. Doctor, thank you so very much. You've been very helpful to us, at least in terms of giving us a feel for where the people here at home would be going or might

be going, and we will be in communication with you. We hope that you will stay in communication with us. Whatever we can do to assist in this regard, we'd be happy to do so. Let me be very candid with you. You're going to have to give us instructions because -- and we follow instructions quite well -- because we have no original thinking of our own in this regard.

DR. KRIEGER: Thank you, Mr. Chairman. The California Medical Association is not known for its shyness, and I can assure you, we will be back before you.

CHAIRMAN BILL GREENE: Thank you very much. All right, our next witness will be Dr. E. Richard Brown of the UCLA School of Public Health and a witness that we are very happy to receive and to have appear before us. Doctor, you of course know that you are -- everyone is talking about you now and we are among those persons who are talking about you for the fine work you've done, your study and your research, and what have you, so we're looking forward to hanging onto every word that you have to give us, and welcome to our committee meeting.

DR. E. RICHARD BROWN: Thank you very much, Senator Greene. And I appreciate the invitation to present a summary of some of my research findings as well as some of my views on possible solutions that the committee might look at.

CHAIRMAN BILL GREENE: We welcome anything you would be willing to share with us.

DR. BROWN: Thank you. Much of my work on health insurance coverage has been done with colleagues of mine at the UCLA School of Public Health -- Dr. Robert Valdez and Dr. Hal Morgenstern. We have been using data from the Current Population Surveys conducted by the U.S. Census Bureau, particularly those for 1979 to 1986, to try to understand who is uninsured in California and what the characteristics of that population are.

Compared to a decade ago, of course, a far greater proportion of the U.S. population is without any health insurance coverage -- no private insurance, no Medicare and no Medicaid coverage. Our study has found that in California the problem is considerably more severe than across the country as a whole. In 1979, 17% of California's population under 65 years of age was uninsured when the U.S. average was 15%. But by 1986, 21% of non-elderly Californians were uninsured compared to 18% for the U.S. as a whole. Between those two points, 1979 and 1986, the number of uninsured Californians increased from 3½ million to more than 5.1 million.

Los Angeles, and some other parts of California, have an even more severe problem of people being uninsured. In 1986, 26% of Los Angeles County's non-elderly population was without any coverage all year long, up from 20% in 1979. Among the twenty largest metropolitan areas in the United States, the three with the highest proportions of non-elderly population who are uninsured are in California -- Los Angeles, Orange, and San Diego counties.

The 1.6 million increase in the number of uninsured Californians was due partly to the growth in the state's population. In fact, I have provided some figures with my written testimony; Figure 1 shows the change in the number of uninsured that is due to the growth in the state's population and that which is due to the change in the rate at which people are uninsured. In fact, what we found was that half of the growth was due to population increase, but half, some 800,000 people added to the ranks of the uninsured since 1979, has been due to an increasing rate at which people have no

insurance.

The proportion of uninsured children and adults increased in all age groups, but the percentage of young adults without health insurance increased most dramatically -- from 22% in 1979 to 30% in 1986.

Near-poor children (those living in families with incomes between the federal poverty level and 150% of the poverty level, or up to $16,800 a year for a family of four) experienced a massive increase -- from 27% to 40% in 1986, a rate that is nearly twice that of all non-elderly Californians.

The proportion of uninsured poor adults increased from their already very high rate of 41% in 1979 to 46% in 1986. The increase for the near-poor was the most dramatic -- from 29% to 39%. Poor and near-poor children and adults now constitute 45% of all uninsured Californians, up from 38% in 1979, as is illustrated in Figure 2.

Nevertheless, a large proportion of the uninsured in California are not poor at all. We found that 27% of all uninsured Californians had family incomes at least three times the poverty level -- about $33,600 a year for a family of four in 1986.

One in three Latino children and adults were uninsured in 1986, up from one in four in 1979, the highest rate among all ethnic groups. The proportions of uninsured Blacks, Asians, and other ethnic groups are also higher than the rates for non-Latino whites. However, the problem of uninsured Californians is not just a minority group problem. Although non-Latino whites consistently have had the lowest rates of being uninsured among all ethnic groups within California, as within the U.S. as a whole, their rates in California have averaged about 2 percentage points higher than the rates for non-Latino whites in the U.S. as a whole.

Of greater concern to this committee, however, is the fact that the uninsured in California, as in the rest of the country, are predominently workers and their families. Working people themselves constitute more than half the uninsured. The number of Californians, ages 16 to 64, who work for a living but have no health insurance rose from 1.7 million in 1979 to 2.7 million in 1986. Uninsured workers have increased faster than the number of uninsured persons not in the labor force and faster than uninsured children.

As Figure 3 illustrates, in 1986 uninsured workers represented 53% of the uninsured population. The number of uninsured workers grew rapidly because of the steadily rising rate at which they were uninsured, as is shown in Figure 4 -- from 15% in 1979 to 20% in 1986. And throughout this period, California's rates were about one-third higher than for the U.S. as a whole.

Although the proportion of government employees who are uninsured hovered between 6 and 8 percent during this period, the rate for self-employed workers increased sharply from 30% to 37%. However, private sector employees had the largest absolute impact on the uninsured problem. The percentage of employees of private sector firms who were uninsured increased steadily from 15% in 1979 to 20% in 1986, as is illustrated in Figure 5. They alone constitute 43% of all uninsured Californians.

The probability of being uninsured increased sharply among full-time and part-time workers. Among full-time, full-year employees (those who worked at least 35 hours a week for at least 50

weeks a year), the uninsured rate rose from 9% to 12% in 1986. The uninsured rates for full-time, part-year and part-time employees were more than twice the rates for full-time, full-year employees. But full-time, full-year workers, who represent a very large part of the workforce, are now a larger share of all uninsured employees, up from 34% in 1979 to 42% in 1986, as is shown in Figure 6.

Low-income employees are far more likely to be uninsured than are more affluent employees. Among all full-time employees in California in 1986, 48% of those with family incomes below 150% of the poverty level (just under $17,000 a year for a family of four) were uninsured -- four times the rate of 12% for those with family incomes above that level. And I believe that speaks strongly to the issue of whether the uninsured population can be expected to contribute to the costs of health insurance coverage for themselves and their families.

Because most people still get their health insurance through their employment, it is not surprising that increases in the proportion of employees who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers. Among full-time, full-year employees, as Figure 7 illustrates, 78% were covered by their employer's health plan and 9% were uninsured in 1979, compared with 75% covered by their own fringe benefit and 12% uninsured in 1986.

Far fewer full-time, part-year employees receive health insurance as a fringe benefit, and their proportion has been falling even more rapidly. In 1979, as shown in Figure 8, 51% of full-time, part-year employees were covered by their employer's health plan, and 21% were uninsured, compared with 45% who received this fringe benefit and 28% who were uninsured in 1986.

The ranks of the uninsured would have been even greater in 1986 if full-time, full-year employees had not increased as a proportion of all employees in the workforce -- from 55% to 62% over this period of time.

As is now well known, the proportion of employees who are covered by their employer's health plan is much lower in some industries than in others. Even looking only at full-time, full-year employees, excluding those who work part year or part time, the proportion with this fringe benefit was lower in the personal services sector (in which 41% had health benefits), agriculture, forestry, and fisheries (44%), the retail sector (61%), and construction (66%) than in, for example, transportation (at 81%), professions (at 81%), and durable goods manufacturing (at 86%).

Why is the growing lack of health insurance a problem? First, as Dr. Krieger and Mr. Seidman so eloquently pointed out, compared to people with health insurance coverage, the uninsured have much less access to necessary medical care, and this has been documented in a number of national studies.

Second, reduced access to medical care due to lack of insurance coverage may contribute to a severe decline in individuals' health status. This issue has not been very well studied, but it has been well documented in a couple of cases -- that is, in a couple of studies which have been rather small in character. It's a difficult type of study to undertake.

Finally, everyone pays for the care that the uninsured do receive. Uncompensated care (bad debts and charity care) cost California hospitals $827 million in 1984-85. Taxpayers shoulder the

financial burden of uncompensated care provided by the state's county hospitals -- $345 million in 1984-85. And this problem is likely to worsen as the number of AIDS patients, including those who are medically indigent, increases over the next few years.

Private hospitals provided the other $481 million of uncompensated care in that year, and as was pointed out, they traditionally have shifted their costs of this kind of uncompensated care to privately insured patients with employers, for the most part, paying the costs through higher insurance premiums. But as cost-shifting has become more difficult over the last few years, more and more private hospitals have found ways to keep out uninsured patients. Many in the state have closed their trauma centers and shut their emergency room doors to 911 rescue ambulances. Eleven hospitals in the downtown Los Angeles area are now threatening to downgrade their emergency rooms in this way, an area that would create a black hole for emergency care that could directly affect hundreds of thousands of people. The fact that two million residents in Los Angeles County are uninsured helps explain why so many hospitals in that area have experienced severe financial burdens of uncompensated care.

The problem of the uninsured has already reached crisis proportions and it urgently requires public action. But what solution strategies would be appropriate? One solution that has been twice approved by the California Legislature and twice vetoed by the Governor is a risk pool for people who have been denied health insurance because of preexisting medical conditions. This approach has a lot of appeal because it targets people whose desperate need for coverage is obvious even to the most skeptical observer. However, one study estimated that of the 5.1 million uninsured people in California, 244,000 are medically uinsurable and about 15,000 would be likely to participate in even a heavily subsidized risk pool. Although such risk pools are helpful to some people, they do not benefit very many of the uninsured and are expensive for the state to maintain.

Because most of the uninsured are workers and their families, it is logical to look to employers as one solution to this problem. One approach recently enacted in California (S.B. 2260) will provide tax credits to small employers who offer their employees health insurance coverage. It is difficult to estimate how many uninsured workers and their families will benefit from this or similar tax credit proposals because this approach relies on voluntary efforts by employers. Their participation rate is likely to be influenced by the costs of health insurance plans that are available to them, the market for their own products or services (that is, would adding insurance premiums to their labor costs make them less competitive?), and the labor market (can they get and keep workers if they don't provide health insurance?). However, if we assume that 200,000 workers and dependents were covered under this program in plans that cost not more than $100 per month per person, foregone tax revenues would cost the state $60 million a year. If one million people were eligible for this subsidy — one-fifth of all uninsured Californians — the cost to the state would be $300 million. That is a substantial cost in state revenues that would grow by $300 million for every one million additional eligible people, and it could be much more if insurance premiums exceed $100 per month.

The high cost of such programs has encouraged many legislators and members of the Congress to propose legislation that would mandate employers to provide health insurance to their employees

and dependents. This strategy would place the full cost of such health insurance on employers and their workers, unlike the tax-credit approach in which the state would absorb 25% of the cost. This has obvious advantages for the state, but it has some equally obvious disadvantages for employers.

The effectiveness of this strategy depends on what cut-points are adopted: how many hours per week would an employee have to work to be covered by this provision? would small employers be exempted, as in Massachusetts, and if so, how small is small? If we make a few assumptions about the provision of such a bill, we can examine how this approach would affect the uninsured population in California. Our data analysis thus far considers part-time workers as those who work less than 35 hours a week. To illustrate the effect of one type of employer mandate, I will assume that the proposal would cover all employees who work at least 35 hours a week or more and their dependents, regardless of the size of the firm in which the employee works. If it is 100% effective, then 1.7 million employees would receive health insurance together with about 860,000 children and another 250,000 homemakers, for a total of about 2.8 million people, or 55% of all the uninsured in California. Of course, extending eligibility downward to employees who work 17½ hours a week or more, as the Kennedy-Waxman and Stark bills propose, would include a greater proportion of the uninsured. However, employers might respond by reducing the number of working hours for many part-time employees to keep them below the insurance threshold. Excluding employees who work less than, say, two months for one employer and excluding small employers would substantially reduce the effectiveness of the mandate.

An employer mandate certainly would be a welcome relief to the uninsured who are covered by it and to public and private providers who now care for them. But it also would impose substantial burdens on low-wage paying employers. For example, the Kennedy-Waxman bill would raise labor costs of employers who pay very low wages by as much as 20%, according to the Congressional Budget Office. Moreover, an employer mandate would not solve numerous other systemic problems, such as continually rising health care costs and the fragmentation of health programs and plans.

Incremental strategies, such as risk pools, tax-credit programs, and employer mandates, can help small to large numbers of uninsured people depending on how they are structured. However, for the most part, in my view they would add new patches to what is already a badly frayed crazy quilt. Specifically targeted solutions, even those that are as broad in scope as the recently enacted Massachusetts legislation, would add more fragments to an already fragmented, increasingly confusing, and ever more costly system of health care.

Another broad alternative would be a universal and comprehensive health insurance system, particularly one that would overhaul the way we finance and pay for care. A state or national health insurance system could promote equitable access to quality care, help allocate resources more effectively and efficiently, and control the amount of money that we as a society spend on health care.

There is strong popular support for public policy interventions, including national health insurance, to address these problems. Recent national public opinion polls have found support for national health insurance among two-thirds of adult respondents, and support is even stronger in

California where we have a higher rate of our population who are uninsured. In a poll in Orange County, California, an area not known for its "L" word political views, 75% of respondents favored national health insurance, including 67% of Republicans. I believe that this strong public support should encourage legislators and policymakers to propose and enact the most effective solutions to this pressing problem.

And I thank you, Mr. Chairman, for considering my views.

CHAIRMAN BILL GREENE: Doctor, in consideration of your letter, comments, and the surveys and research in that these people envision national health insurance differently from national health insurance as is represented with what knowledge we have of other nations, am I correct or incorrect on that?

DR. BROWN: Well, there are a number of...

CHAIRMAN BILL GREENE: Because the reason I ask the question, I find, as I stated earlier, even in my own constituency, national health insurance which appears to be developed more along welfare program lines, I find a rejection of that. Now, when you say national health insurance and the kind of responses we get here, you're talking about something separate and apart and different from...

DR. BROWN: From a welfare program.

CHAIRMAN BILL GREENE: Right. Okay. All right.

DR. BROWN: Yes, very definitely. In fact, many people...

CHAIRMAN BILL GREENE: And that's very important to make that differentiation because most of us, the only view we have in our minds is as we know it in other nations or as has been represented to us for what exists in other nations. And that goes more along the lines of something that's closer to a public assistance program to provide health care. We won't use the word welfare. But we're talking about something -- in fact, much of the thinking that I hear from people in this nation, when they speak of national health insurance, the idea is something far different from what we know exists in other nations.

DR. BROWN: If I may, Senator, I agree with your point that much of what we know about other national health insurance programs stems from the information provided to us by parties in this country who have a particular bias in presenting that information. In fact, most countries that have national health insurance programs do not operate them as welfare programs but rather as universal entitlement programs -- some of them through the workplace, through health plans, through something like an employer mandate but where they regulate very strictly and tightly both the costs and payment for health care and the health plans that operate. Others, like the Canadian system, which many people look to as a very useful model that we could learn from, actually operate a fee-for-service system in the payment of physicians who are all paid according to a fee schedule negotiated by the provincial health insurance program and the medical society. These national health insurance programs are universal (that is, for all the people in the society), not welfare programs, and are immensely popular institutions in virtually every country in which they exist. As you know, among the industrialized nations, only the United States and South Africa do not have national health

programs to assure that all people -- rich and poor alike -- get necessary medical care. And despite the fact that the United States spends more money per capita and more of its gross national product on medical care than any other country in the world, many of our citizens cannot get the necessary health care that would be their right in other industrialized countries.

(Ms. Powers' introduction inaudible.)

MS. PATRICIA E. POWERS: Mr. Chairman and members of the committee, I am pleased to be a part of this hearing on business and health care. My name is Patricia Powers. I work for the Bay Area Health Task Force, a coalition of policymakers, purchasers, and health care providers convened by United Way of the Bay Area. Last year, the task force conducted an in-depth study of San Francisco's working uninsured population. Based on these data, we are initiating a Health Benefits Information and Referral Service for uninsured small firms in the Bay Area. The Service will provide health care information and link employers with brokers and health maintenance organizations dedicated to finding them coverage.

Prior to my work for the task force, I served as the advocate for Health Policy for the Chief Counsel of the U.S. Small Business Administration in Washington, D.C. I worked with congressional and administration staff to explore ways to provide health care coverage for the uninsured.

There is a growing amount of statistics on the uninsured and I defer to several knowledgeable witnesses who are here today to provide you with in-depth data. Instead, I will first briefly present some key characteristics of uninsured small businesses and their employees. These characteristics reveal that small firms' ability to sponsor health benefits differs from that of large businesses. Understanding these differences and the difficulties small employers face in sponsoring health benefits can provide insight into developing ways to assist them. Finally, I will discuss a range of federal, state, and local initiatives that focus on the expansion of health insurance among small firms.

Health care is second only to vacations among all fringe benefits provided by employers. Employer-sponsored plans have burgeoned since World War II, when they began to receive favorable tax treatment. Eighty-four percent of health insurance is now provided through the workplace. In order to attract and retain employees, employers strive to establish health care plans.

There are three trends that make health care an issue of highest concern for small firms. First, health expenditures in the United States have increased from $42 billion in 1965 to nearly $500 billion in 1987. Health care expenditures comprise almost 11% of the gross national product, and growth in health care costs continue to outpace the rate of inflation. In 1986 health care costs averaged 8% of payroll for an employer outlay of almost $1,500 per employee (The Wyatt Company, 1986). Small employers, who in general pay from 10 to 40 percent more for health care than large employers, are especially interested in keeping costs down while providing reasonable benefits.

Second, changing demographics will heighten the importance of affordable health plans to small business. An increasingly elderly population means that even greater efforts will be needed to check rising health costs. In addition, as growth of the labor supply slows and there are fewer workers available, health benefits will be an increasingly important tool in helping small employers compete

for the most qualified labor.

Third, there is much debate about the ramifications of the growth in the medically uninsured population in this country. In light of government fiscal constraints, policymakers are turning to employers as a vehicle for resolving a large portion of the problem. Small businesses are at the center of this focus because most of the working uninsured are found in small firms. Small employers in turn are concerned about mandated benefits and the trend toward increased regulation of welfare plans. Firms without plans fear that the result of mandated health insurance will be fewer jobs and lower wages. Firms with health benefits find it costly and administratively burdensome to keep up with new, complex requirements.

There are between 32 to 37 million non-elderly uninsured persons (17%) nationwide, 5.1 million uninsured persons in California (21.6%), and an estimated 189,000 adults (18.3%) and 80,000 children (26.8%) in San Francisco's MSA who are uninsured.

Nearly 80% of the uninsured across the country and across the state are employed or dependents of workers. National data indicate that about one-quarter, or 8.2 million, of the uninsured are private sector wage-and-salary workers. Of these working uninsured, 6 million are in firms with under 500 workers, with the majority (3.9 million) employed in firms of 1 to 24 employees. In addition, there are another 1.6 million uninsured business owners, primarily sole proprietors, and 1.6 million government, farming, and household workers without any source of insurance.

In California, there are an estimated 2.7 million uninsured non-elderly workers. Approximately 48,000 persons who live and work in San Francisco are uninsured. Among the working uninsured, self-employed persons, followed by private-sector workers, are at highest risk.

Not surprisingly, as is true for all fringe benefits, the prevalence of health care increases with firm size. Both national and San Francisco employer surveys indicate that only slightly more than half of employers in firms with 25 or fewer employees offer coverage, compared to almost 100% in larger companies. For businesses with ten or fewer employees, the figures are 46% nationally and 41% in San Francisco.

There are several key firm characteristics associated with lower health coverage, including industry, age, and legal form of business. Nationally and in California small business-dominated industries, notably certain services, retail trade, construction, and agriculture, forestry, and fishing, are more likely to lack health benefits. In San Francisco, the arts and health care industries also have significantly lower rates of coverage.

The older the firm, the more likely it is to provide health benefits. National data show that there is about a 15% difference between small businesses with fewer than 25 employees operating 10 years or less and those in operation more than 10 years. Similarly, a San Francisco employer survey revealed that 36% of firms in business less than five years offered health benefits compared to 57% of firms established for over five years.

There is also a significant gap between unincorporated businesses' (generally sole proprietors) and incorporated firms' coverage. Even for firms in the smallest size category of one to nine employees, unincorporated firms are about half as likely as corporations to provide coverage to

owners and workers.

SENATOR LEROY GREENE: How about where the employees are members of union groups -- union members as opposed to...

MS. POWERS: Union groups tend to have much higher rates of coverage because employees can go through their union. They have negotiated for that benefit, but there's also often a pooling arrangement in a particular industry that is similar to that of a large employer pool.

SENATOR LEROY GREENE: Do you find though that if the employer is a large employer that it doesn't make any difference whether it is or isn't a union shop in terms of health coverage?

MS. POWERS: Over 90% of firms with over 25 employees offer health coverage. In firms with over 100 employees, it's almost universal.

SENATOR LEROY GREENE: Okay. So that whether you are or are an employee, by way of organized labor, is not material if there's a large number of people working in that place -- that doesn't seem to make too much difference. If it's a small organization, one to ten or maybe twenty-five, it would rarely be a union operation, right? and it would rarely have the same kind of coverage you have in large organizations.

MS. POWERS: Right.

SENATOR LEROY GREENE: Okay.

MS. POWERS: That's correct.

SENATOR LEROY GREENE: Thank you. Go ahead.

MS. POWERS: About half of employers with fewer than 25 employees do offer health care coverage, and I can't give you the figures, but I'm sure that a good portion of those are unionized, or they may obtain coverage through a trade association...

SENATOR LEROY GREENE: But when you talk about health care coverage, that in itself is a tremendous variable, is it not?

MS. POWERS: Yes, it is.

SENATOR LEROY GREENE: As to what it is that you're covering. Is there any particular way of divining which kinds of firms are more likely to give a, let's say a full coverage as opposed to a partial or a minimum coverage?

MS. POWERS: Well, there are two points. First, data show that -- and it's surprising -- small firms are more likely to pay 100% of the health care costs of their employees than large employers.

SENATOR LEROY GREENE: They're also more likely to pay more per person, aren't they?

MS. POWERS: Yes. And if you're talking about benefits, small firms' benefits are probably not as generous as the larger firms. They probably have a standard benefit package which may be their only option.

What I'd like to do is go through three reasons why health insurance is less prevalent among small employers, and the first is the cost issue. It is from 10 to 40 percent more expensive for the small employer to purchase health care. If you compare self-insured firms, which most of the large companies are right now, the gap is probably even greater. If you're self-insured, you avoid state premium taxes, you avoid state-mandated benefit costs, you have an improved cash flow, and you

have better control over the administration and cost containment features of your plan. Small firms don't have those advantages.

Small firms experience higher turnover and employ relatively more part-time workers, which drives up the administrative costs even further. Insurance sales and marketing costs adds to this administrative cost. That's where the bulk of the difference is between the large and small firms.

Small business owners don't have the time to understand the complexities of health care, to shop around for a plan that might be best suited for their workers, or determine the best price. I think a lot of them don't understand an HMO, or PPO, or IPA and all the new arrangements. In California, or at least in San Francisco, there is a higher percentage of small firms in HMOs than there is nationwide; but across the country most small firms offer only traditional indemnity insurance.

There also has been a lot of federal regulation of health plans in recent years. This adds to the administrative burden, again, of the small employer who doesn't employ administration personnel to follow plans and comply with regulations.

The second reason why small businesses lack coverage is due to medical underwriting standards. This is essential to understand because large firms are a large enough risk pool that they are not subject to medical underwriting standards. Essentially, firms with fewer than ten and sometimes fewer then twenty employees must complete a health status questionnaire for each employee so that risk can be assessed. Based on that information, the insurer might carve out an individual or illness, or, more likely, turn down the entire firm.

This relates to the medically uninsured high-risk pool. If you can place some of the small firm, high-risk employees in that pool, then you're not only helping those individuals, you may also be helping the entire firm qualify for a health plan for which they might not otherwise qualify.

The prevalence of AIDS in San Francisco has led to even tighter medical underwriting restrictions. Some insurers have even refused to cover certain zip codes or industries perceived as likely to have a high incidence of AIDS. There's litigation going on right now over those concerns. One broker told me recently that for all single individuals applying for insurance and living in San Francisco, their medical records are requested. We've seen a tightening up in this market from the insurance side.

And then the third reason why health care is less prevalent among small employers is that it may not be affordable or desirable for small firm workers. A lot of witnesses have mentioned today that these people are low-income. They may prefer higher wages to health benefits, especially if they're young, and they don't view health care as a necessary expense.

If you look at all these different factors, it is clear why small firms are less likely to have coverage.

As I mentioned, there is a shift from the federal government to states, localities, and employers to pay for health care costs. There have been a number of regulations that require employers with plans to continue offering this benefit to employees. Starting in January of '89, there are going to be very complicated, nondiscrimination rules that employers will have to follow. Health care, as a

benefit, is not becoming more attractive in terms of regulation for small employers.

State legislatures have enacted numerous health insurance mandates over time and are experimenting with different ways of covering the uninsured. I believe California has 23 types of mandated health benefits that small firms are subject to through group health insurance. Again, the large firms are not subject to these laws because they are self-insured and are covered by ERISA, the federal law.

As we discussed, only two states -- Hawaii and Massachusetts -- require all employers to establish and offer health benefits to their workers. Massachusetts does have an exemption for employers with five or fewer employees.

Outside of employer-mandated health insurance, there are a lot of projects going on around the country. Many states are either considering or enacting legislation. I think the tax credit for small business owners who are offering health insurance for the first time -- that was recently signed by the Governor here -- will be very helpful for small businesses. It lowers the cost for them, which is one of the key ways to expanding coverage.

There are two projects in California: one is in San Diego, and is one of the fifteen Robert Wood Johnson Foundation projects. The project is using community clinics to provide primary care for the working uninsured. The project in San Francisco that I'm working with is trying to provide information and link up brokers and HMOs with small employers.

I have five recommendations that I will just briefly run through. I am also happy to answer any questions. First, I've three principles that I think need to be addressed by any solution on this problem.

One is to spread the cost of the uninsured as widely as possible. I think small employers want to do their fair share but they don't want to be the only ones picking up the tab.

Second is to lower the cost, either the administrative cost or the actual plan cost for small businesses. That will help them obtain health insurance.

And third, as a number of people have said today, we need to build cost-containment features into any approach because, otherwise, health care costs will just continue to escalate.

My five recommendations are, first of all, to eliminate or curtail the growth of state-mandated benefits. The cost of state-mandated benefits adds 10 to 15 percent to a group health insurance plan. About five states have enacted legislation that requires a proponent of a new state-mandated benefit to conduct a cost-benefit analysis. I think this is very helpful because it indicates that there is a financial impact involved when you require a new provider, a new treatment, or a type of coverage to be included in group health insurance. Cost has to be recognized. The benefits may or may not outweigh the cost.

Second, I think that you have to try and help the small firms obtain the leverage that large employers have by creating some kind of a group pooling arrangement. A number of states and localities, and the Robert Wood Johnson projects, are experimenting with different ways to arrange pooling for small employers. Last year, Oregon enacted legislation to establish a state-administered health insurance pool for small firms. The Massachusetts comprehensive legislation includes a state

pooling arrangement for firms, I believe with ten or fewer employees. The pool will be administered by their new Department of Medical Security. In Arizona, there is a program where they're tying small employers into their Medicaid HMO provider system, which is unique. But it's an example of using state monies to help pay for the administrative costs for small firms.

Third, I know that a state risk pool for medically uninsurables has been considered here. I think that it is a good solution for a portion of the uninsured and will help the small firms that have high-risk individuals obtain coverage. It will go beyond covering just high-risk individuals.

Fourth, I would suggest scrutinizing insurance industry practices in medical underwriting, especially with respect to industry exclusions. Insurers have much discretion as to what firms they may or may not cover. They have a lot of employer requirements that go along with the risk assessment of the firm. And I also suggest that assessments that insurers are conducting with respect to AIDS be examined.

My last recommendation would be to educate the public on the crisis of the uninsured and the importance of health insurance. In San Francisco, the Bay Area Health Task Force is planning to conduct a community-wide education campaign, along with Health Access and some other community-based groups in the area.

I think that it's important from the demand side to have employees and individuals understand that the consequences of not having health insurance is catastrophic, and understand that the costs will be lower for everyone when they do purchase health care.

I think that county business and health coalitions, consumer groups, community clinics, and departments of public health are several sources that would be useful for information dissemination for an education campaign.

I appreciate the invitation to testify and am happy to answer any questions.

SENATOR LEROY GREENE: Thank you. Any questions? Staff?

MR. DAVENPORT: For either of you, I think I read something about, in some of the material I was reviewing that indicated that the tax advantages of providing health insurance to employees are a lot better for big businesses than small businesses. Is that correct?

MS. POWERS: Well, for unincorporated business owners, the 1986 Tax Reform Act now allows them to deduct 25% of their health premium. Prior to that, they couldn't deduct anything. But if you are a corporation and you are a business owner, you can deduct your full health premium. I think Congress recognizes the inequity, and I think over time the 25% for the unincorporated firm will be expanded to a hundred percent but it will be down the road. The tax deduction is an incentive. If you are a very small firm with one, five, six employees, that's an incentive for you to establish a plan because you personally will be benefiting from it.

SENATOR LEROY GREENE: Thank you. Thank you very much. Mr. Steve Zatkin, Kaiser Foundation Health Plan, Inc.

MR. STEVE ZATKIN: Senator, I'm Steve Zatkin, counsel to Kaiser Foundation Health Plan. We recognize the importance of the issue which the committee is considering -- the lack of health benefits coverage for a large number of Californians, many of whom are employed persons or their

dependents. My written comments address each of the five questions raised by the committee in its notice of hearing. I'm not going to read my testimony, I'll summarize it.

I think the options that are available have been well discussed. There is the Hawaii mandate, which would require an amendment to ERISA; the Massachusetts tax, which is a way of getting around ERISA by taxing and by providing a credit for employer health care expenses; the California and Oregon tax credit approaches; subsidized health benefits coverage, which Massachusetts relies on also; the technical assistance that the Robert Wood Johnson Foundation programs are designed to provide and which was alluded to earlier; risk pools for the medically uninsurable, which address a small part of the problem and have been vetoed in this state. So the three major approaches to the problem of the working uninsured are: employer mandates, employer taxes with forgiveness, and publicly subsidized health benefits coverage.

We would recommend that whatever approach you use in a publicly sponsored health benefits program for the working uninsured, you provide eligible beneficiaries with a reasonable choice of cost-effective health plans so that we could participate if such a program were appropriately structured. If public financing is used, it should be broadly based and equitable in impact.

Your second set of questions had to do with the impact of cost now for people who don't have coverage and I've summarized those. Employees pay now from their own funds if they don't have coverage, or they rely on the government. If they receive care from the counties, that's where they get their funding. Care also is received through Medicaid and, in some cases, through health care payers and providers who provide the coverage at below cost or for free.

Your third question had to do with why employer provided health insurance is less affordable and available for some employers. There are three factors that are involved in determining differences in what employers pay. First, the size of the group. A small group or a small employer result in higher administrative costs for carriers. Some carriers will charge a higher rate just for that reason, and all carriers will establish a minimum group size. For Kaiser in Northern California, the minimum group size is five. That's very low. Most carriers have a minimum of 25. Below those levels carriers won't write group coverage. One reason is that when you get to very small units, you're into family businesses where employers are aware of employee health status, and you don't have the same risk spread you do in larger units.

The Robert Wood Johnson projects are designed to pool the resources of smaller employers so that they can get the same advantages of large group rates. Our program rates small groups and the large groups under a community rated system. The rate is the same for members with the same coverage.

A second factor in the cost difference is the rating practices that the carrier uses. Experienced rating carriers charge different rates for groups depending upon how much the group utilizes health care services. That is not necessarily a matter of the size of the group; it's just a matter of whether a group has greater or fewer sick people.

Community-rated plans, like federally qualified HMOs, do not differentiate on that basis, although there is a change in federal law that will allow some variation in that regard.

The third factor in determining what groups pay has to do with how efficiently services are provided and how the carrier manages the health benefits program. Some carriers, principally indemnity carriers, are in less of a position to manage the costs of care; we've heard about the rate increases that are resulting. Managed care programs are in a better position to maintain cost containment; we think we do a reasonably good job of that.

Employer access to health care coverage can be improved by programs which provide technical assistance and financial assistance, and that's particularly the case with small employers.

You asked a question about limits and exclusions in group health insurance and what options excluded workers have to obtain health care coverage. Many carriers and health self-insured employers impose restrictions. There are preexisting condition restrictions which don't allow coverage of a condition until a period of time has passed, or exclude it entirely. Federal law prohibits our doing that.

Another approach to reducing costs is through deductibles and copayments. All carriers apply these to some extent. Our copayments are limited and we cannot charge deductibles. Instead of using these restrictive approaches, we manage the care to keep costs down. I am unaware of employer practices that are more restrictive than the ones that I just mentioned.

You asked about the availability of individual health insurance for employees who don't have access to group coverage. Again, I think the practices of carriers differ one from another. Many carriers do not offer individual coverage. We do, but as is the case with other carriers, our coverage is not open to everyone, it's open to people who can pass a medical screen or review. Our charge is the same for that coverage as for group coverage with the same benefits.

That concludes my written testimony. Do you have any questions?

SENATOR LEROY GREENE: Any questions? Thank you, sir. Appreciate your assistance. Miss Leah Morris, State Council of Service Employees.

MS. LEAH MORRIS: Good morning. I'm Leah Morris and I'm representing the 240,000 members of the California State Council of Service Employees International Union (SEIU). I want to thank you for the opportunity to comment today on the issue of labor force health care coverage. In a word, that coverage is lacking.

Historically, health coverage was established through public insurance for the elderly, the poor, and employer-provided private insurance for workers. Today, this system is destroyed by health care costs which are rising at double the rate of inflation and by cost containment efforts of insurers and employers. Many of SEIU's low and moderate wage members are among the uninsured -- janitors, clericals and nurses aides. Our members are typical of all uninsured workers, though many have better access to care through union representation.

But even workers with coverage provided on the job must struggle financially and fight to maintain their benefit levels. The U.S. Department of Labor has documented that employee-paid premiums have increased 19% between 1980 to 1986, and employee deductibles have risen as well.

Increasingly, we see employers reducing health benefits or shifting costs to workers. In Santa Barbara County, workers were recently near striking because the county proposed higher costs for

insurance for children. In San Francisco, health care workers struck for three weeks over reduced health care coverage. It is cruel irony to create a pool of uninsured workers who are themselves the providers of the care they would be denied. These similar stories abound in New York, Oregon, Pennsylvania, and other states across the nation.

Workers faced with rising premiums are choosing to drop health coverage altogether, swelling the ranks of our publicly subsidized health system. In many instances, the workers' very jobs posed serious health hazards, and they can expect little help from our hamstrung Cal OSHA program or the federal OSHA program meant to safeguard their health.

California taxpayers end up subsidizing costs for businesses that do not provide health benefits. The size of the subsidy is enormous. To document this problem, SEIU conducted a study of public subsidies required by home health care workers in Los Angeles County. Of the 5.1 million uninsured Californians, approximately 140,000 of them are health care workers. These are the people who make and serve food, wash linens, the nurses in physician and dental offices, and home health care workers. These people cannot afford to lie on the hospital sheets they change daily, to paraphrase Jesse Jackson.

Our growing service economy produces millions of low-wage, no-benefit, part-time jobs. The Los Angeles homecare workers are a good example. Largely female, with children, earning $3.72 an hour, this part-time labor force provides health care to over 50,000 elderly and disabled Californians. They have no employer health insurance. These people rely on subsidized public health. Seven percent get health insurance through Medi-Cal or Medicare; two-thirds get their care through the back door of emergency rooms, county hospitals, and community clinics. Another 16% are eligible for low-income, cash assistance programs.

The taxpayers' support for these homecare workers totals over $21 million in 1988. Additionally, over 38 million public dollars fund the cash assistance programs for these low-income people.

Taxpayer subsidies have been largely hidden in the debate around the uninsured. Health care through the back door is the most expensive care available. If you get your care at the county emergency room, you are getting the most expensive care at the most expensive place -- the hospital.

To assure access to health care for all, SEIU supports a universal, comprehensive health program, as Dr. Brown has described, one which would be equitably financed with incentives for preventive care. Furthermore, we must remove the current incentives to cut health care costs by layoffs or reductions of work hours for health care workers, or the substitution of low-wage, task-oriented staff for higher paid professional staff. Adequate financing must account for adequate labor to provide the very care that we want access to. Overwhelmingly, health care means the people who provide that care.

SEIU supports partial solutions such as the recent Baby Cal legislation, but we oppose solutions that unfairly burden working people, such as the A.B. 600 catastrophic risk pool proposal. Short of a comprehensive plan, SEIU supports required employer-provided minimum health insurance. Taxpayers are subsidizing those employers whose profit is derived from failing to pay their share of health care

costs. It's time to end that subsidy.

Providing backdoor health care through county emergency rooms is no way to give care. Cutting back on health labor for cost containment is also no way to improve access to health care. Establishing a minimum standard for basic health care at the workplace is vital. Doing so benefits workers and their families, as well as saving taxpayer subsidies and excess costs to businesses that do insure their workers.

Thank you for the opportunity to comment.

SENATOR LEROY GREENE: Is there going to be -- what you're indicating really is that there is a need for more money. Doesn't it boil down to that?

MS. MORRIS: It boils down to redistributing the money that is out there. Dr. Brown described $60 million that would be potentially -- I might be quoting his figures -- that would be lost in tax subsidy under the Keene bill because we would give a tax credit; and yet, for 40,000 people in L.A. County alone, we're spending over $21 million just in state money to give them backdoor, most expensive care. If we redistribute, if we look at requiring some employers to provide services and take some of these people out of the county health care services, then we wouldn't be spending money in the most expensive way possible. Some of it's new money and some of it's redistributing money that we're spending now in the most expensive way for people who are coming in in the most expensive condition. They're more sick because they've waited a long time to be seen and generally they haven't seen a doctor in a long time.

SENATOR LEROY GREENE: Mm hmm. Any questions? Thank you very much. Appreciate it. Miss Lois Salisbury, Health Access.

MS. LOIS SALISBURY: I thought at this moment I'd be testifying to the other Senator Greene, but either way is fine with me, thank you.

SENATOR LEROY GREENE: You can tell us apart; he's much taller than I am.

MS. SALISBURY: Oh, okay. My name is Lois Salisbury. I'm an attorney with Public Advocates. I'm here today as the chair of a statewide coalition called Health Access. Health Access has been on the map for a year and a half. We are the veterans of the effort to stop patient dumping from emergency rooms in California. It was that fight, to which many of you were witnesses here in the halls of Sacramento, that resulted in legislation, authored by both Senator Maddy and Assemblyman Margolin that was passed and signed into law a year ago, that brought many people profoundly concerned with the problems you've been hearing about today together into a coalition. We combine unions such as SEIU, AFSME, and the California Nurses Association with seniors, religious organizations, and civil rights groups such as the NAACP and the ACLU. We also are connected at the local grass roots level with coalitions in most of the major urban areas of the state.

This past year we worked on the key legislative issues affecting health access, including the many different bills that were called Baby Cal as a package which were determined to expand access to prenatal care in California. We worked hard on the budget to make sure that we finally ended the stagnation of the health budget and started addressing some of the crying need that existed in trauma care, emergency care, and other aspects of the private and public sector which have really been

shouldering the load of the patients that we're talking about today. We worked on AIDS discrimination and other issues that we were afraid were only going to worsen our present condition, and we certainly were supportive of the proposals before the Legislature on comprehensive legislation, including Mr. Margolin's 2465, which was a pay or play scheme as the Massachusetts type scheme has come to be known, as well as the comprehensive bills that were carried by Mr. Houser.

One of our first tasks which we did in early spring was the release of this report, "The California Dream/The California Nightmare: 5.2 Million People With No Health Insurance." And while we have provided all the legislators with copies, I'll certainly be happy to provide this committee with additional copies if that would be helpful.

It will also please some legislators and displease others to know that next week we will be releasing a legislative score card on how we feel the legislative session did this past year on increasing access to health care.

"The California Dream/California Nightmare" publication that I just referred to documents in a very personal way some of the statistics that we've been hearing about today, as well as tries to bring some analysis to the problem. What we are really hearing is that the fundamental relationship of work has vastly shifted and changed. It used to be that most of us associated work, and indeed, associated low unemployment statistics that we would read in the headlines, as a source of comfort, a source of well-being, because we felt that meant many people were able to take care of themselves. And what we are now seeing is a rapid disengagement between health care and the workplace that is profoundly rearranging our whole notion of what it means to work, because usually, and Senator Greene mentioned this earlier in the hearing, we all value the work ethic so profoundly because we think it means independence, we think it means a capacity to take care of your loved ones as well as yourself. And to the degree we now have this disturbing problem where whether it's your barber, your dry cleaner down the street, the folks who run the bakery, the taxi driver who last gave you a ride, those people are working hard and they're not even treading water when it comes to the question of health care. They are at risk, their children are at risk.

What this really means is that when you are a working person and you don't have health insurance and your two and a half year old little girl has 104 fever in the middle of the night, you are going to be on the public transportation system, possibly two or three bus rides away, to an overcrowded public emergency room where you may wait four to six hours to see that child attended. None of us would want that kind of health care for our children, and yet that is what we have left available to the worker who has no health insurance. It means that if you're pregnant, contrary to the complete wisdom of getting prenatal care first trimester that we know is tremendously cost efficient, you're going to call up and when you finally break through those busy signals at the public clinics, you're going to find a 10-week wait. You're going to be well into your second, maybe your third trimester before you can get that prenatal care. It means that if you are a person who needs simple prescription drugs to control your high blood pressure, when that drug runs out, your life is endangered and you may simply not have the money to be able to refill that prescription and you walk around daily at risk of a disabling or killing stroke.

SENATOR LEROY GREENE: Well, what was the situation, say, 50 years ago? Was it any different?

MS. SALISBURY: If we go back as far as 50 years ago, we're talking about, of course, the Depression and we're talking about...

SENATOR LEROY GREENE: Well, 1940.

MS. SALISBURY: Well, basically by the close -- if you'll permit me to go post-World War II, if I can push you up to that period -- by the time we start looking at the post-World War II period, this link between working and health insurance was fully forged, and we really had a pattern, if anything, of strengthening that link, of better benefits all the way through the '50s and the '60s and the '70s. What we've seen in this past decade is this disengagement where working people don't have health insurance on the job.

We at Health Access...

SENATOR LEROY GREENE: You mentioned such people, for example, as taxi drivers and so on, you know...

MS. SALISBURY: Yes.

SENATOR LEROY GREENE: They were covered by health insurance back in the '30s and '40s and '50s, '60s?

MS. SALISBURY: You've always had a problem and an increasing problem with...

SENATOR LEROY GREENE: In other words, the very categories that you mentioned -- you know, you gave a group -- did anybody in those groups have coverage at any time in the past?

MS. SALISBURY: My understanding -- and most of those categories that I gave were small businesses -- my understanding is that the problems for small businesses have been aggravated over the past 10 and 20 years, particularly because you've had insurance companies moving away from the trend of treating all-comers similarly and starting to make more and more distinctions between their applicants, and so that small employers were much more capable of playing on an even field 20 and 30 years ago in terms of the purchase of insurance than they are now. This tremendous gap that you've heard so much about from the small business people was not there 20 years ago.

SENATOR LEROY GREENE: Well, I -- again, in listening to your remarks and the categories, you know, that you mentioned, it struck me that I didn't think that any of those categories have or ever had health coverage. Am I wrong?

MS. SALISBURY: Maybe some of the small business people are better equipped to answer this than I am, but we certainly have, and Mr. Brown's data showed, an increasing trend where working people don't have health insurance in new and larger numbers and in new and different categories. Some of the small businesses, their trends 30, 40 years ago, I can't really answer your question precisely, but my sense is that it was much easier for a small bakery, for example, to go ahead and purchase benefits for their business and it was easier for a single person to purchase, like a self-employed guy like a barber, to go out and buy insurance for himself. Now it's just absolutely sky-high and unobtainable for him. So I think we have seen some changes.

SENATOR LEROY GREENE: All right. What you're saying in effect is that individuals on an

individual basis in the past could buy and could perhaps afford to buy that which is not available today on the basis of price alone.

MS. SALISBURY: That's correct. And many of those were self-employed individuals or individuals, for example, who might have coverage for themselves but not their children or their dependents.

SENATOR LEROY GREENE: Well, say musicians are, you know, as a group -- I wouldn't know whether people like that have been insured or not or whether they -- they belong to unions, you know. I suppose there is some coverage through that way. Yeah, I guess so. But dancing troupes and so on. Well, I guess those tend to be covered by unions though.

MS. SALISBURY: Some artists are unionized, some are not. It depends -- I mean, frankly, Senator Greene, we're really not talking, when we talk about the 5.2 million people that have no health insurance, about some of the more bohemian or artistic endeavors. We're talking about lots and lots of working people who are out on jobs where I think -- let me give you an example. San Francisco school teachers, I would have guessed, perhaps naively, that if I were a San Francisco school teacher I got health insurance for me and my family. Wrong. San Francisco school teachers only have health insurance for themselves. There is no dependent coverage if you're a San Francisco school teacher. You have to pick up that bill yourself, and that is not atypical of what people are experiencing. So I think that what I'm trying to get across to you is not to argue with you about the conception that...(cross talking)

SENATOR LEROY GREENE: Well, what I'm going down to as a bottom line is an uneasy feeling that the presence of insurance, which I want and you want and we all want, despite the fact of our wanting it, I have an uneasy feeling that the presence of that insurance is what's made the price of health care coverage so high.

MS. SALISBURY: If you'll permit me, I have some substantial remarks I'd like to address about why our costs are so high, and I'd like to get into that if I may.

SENATOR LEROY GREENE: All right.

MS. SALISBURY: Thanks.

CHAIRMAN BILL GREENE: On this point, though -- thank you, Senator, I know you have to leave --on this point, and I heard your comment, I think you need to understand we're not contesting anyone. We're asking the hard questions because if we're going to be a part of shaping this, we've got to know what some of the hard questions are going to be, we've got to have some answers prepared. So we have to be educated so the only way we do that is ask the kind of hard questions that we know some others are going to ask.

MS. SALISBURY: And I welcome those questions.

CHAIRMAN BILL GREENE: All right. But I don't want you to -- your comment to Senator Greene was because you were debating this. This is not a debate. We have to ask the hard questions. I want to pick up where you left off. You were wrong and uninformed about teachers. Teachers have never had health coverage. We know that. So the fact that they don't have it now is not a surprise. What is new is the proposal that they do have it, and we've got to be able to respond to things like

that. So I understand that you discovered this and you did not know, but we know that.

MS. SALISBURY: Sir, I was a public school teacher and I had health coverage.

CHAIRMAN BILL GREENE: Well, okay, but you were -- I'm not contesting, but you were unusual. You were unusual. There are many that don't have it now. I've never known of it existing except as labor within education became more prevalent and more prevalent, okay?

MS. SALISBURY: Of course.

CHAIRMAN GREENE: All right, but Senator Greene asked you a question that went back several years which is one of the -- you know, we need to be able to show factually how this developed, why, what factors set in, what problems were created, why the need. You see, we cannot proceed on anything on what we believe. We have to do it on the basis of the facts and what we can show, regardless of what we believe, and you need to understand that. So the only way we're able to do that is we've got to dig, dig, dig ourselves so that we are prepared to respond factually, so that we're prepared to analyze bills on the basis of facts, not only on what people believe, so please understand that.

How do we deal with the question, and what factors have taken place out there in the society, and it's got to be bigger than just insurance, that necessitates this great surge in some of the job categories. And I will stay with teachers as you have. You see, we need to be able to respond to that question, and because somebody is going to ask it of us.

MS. SALISBURY: Actually, sir, some of the best information I've seen on this very question has come from your own committee, and we...

CHAIRMAN BILL GREENE: Well, we probe, but see, if you took anything we published as giving an answer that we know it, you took it incorrectly. We were only reporting what we found.

MS. SALISBURY: No, I understand that, but I think that one of the points on the question of the trend, first of all, regardless of what people's perceptions are, my own or somebody else's, there is no question about the trend as documented in Dr. Brown's report.

CHAIRMAN BILL GREENE: Oh, Dr. Brown's report really provides the seed for us to proceed in this direction.

MS. SALISBURY: Exactly.

CHAIRMAN BILL GREENE: I mean, his work is excellent.

MS. SALISBURY: Exactly.

CHAIRMAN GREENE: But it's excellent for other people as well and you need to understand that. That's part of why it's excellent. Any point of view on this could take that and use that as a basis for explanation.

MS. SALISBURY: I understand.

CHAIRMAN BILL GREENE: Because he does honest, good work. Go ahead, I'm sorry. And incidentally, your folks, you do good work, too, but that's another reason why you're the appropriate person I think for me to ask this kind of question. Not that you have the answer, but, you know, maybe you can help us find the answer.

MS. SALISBURY: Certainly.

CHAIRMAN BILL GREENE: But proceed.

MS. SALISBURY: I simply want to make the point that the trend that I began the testimony on, which is that we have had an increasing trend of people who are working but don't have health insurance, I don't think any of us are here to debate today. We agree on the trend. We're trying to understand what is underneath it. And one of the reports that your own committee came out with approximately a year ago -- I could dig it up for your staff if you'd like -- I think really pointed to one of the answers, which is that we are seeing more and more a trend of the workplace finding various ways basically to not lock themselves into any kind of permanent relationship with a worker, and so you're seeing increasing amounts of contract work, increasing amounts of part-time work, increasing amounts of seasonal work. You had an excellent report that documented that trend in showing that for whatever competitive reasons and however real or unreal they...

CHAIRMAN BILL GREENE: That's true but that's only for a portion of the work force and it will always be only for a portion of the work force. I don't care how much it grows, it will always be only a portion of the total work force.

MS. SALISBURY: That's part of it but...

CHAIRMAN BILL GREENE: So we need to take that into consideration but we don't base policy on that alone. We base policy on what affects the majority and overwhelming amount of people and then build in and consider factors such as that.

MS. SALISBURY: Well, I think there's really a basic answer we have to confront and that is that the costs have been so astronomically increasing, that naturally the employment sector has been looking for all sorts of ways to reduce that cost that ultimately, otherwise, is cranked into their whole pricing structure on the goods and services that they're producing.

There was a fascinating program that I would like to bring to your attention -- indeed, I will be getting a transcript of it and will be glad to provide it to you -- just last night the MacNeil-Lehrer Newshour addressing the very question that we're addressing today.

CHAIRMAN BILL GREENE: I saw it.

MS. SALISBURY: Good. I was fascinated particularly by conclusions that were shared from very disparate viewpoints. A most conservative economic analyst from the Heritage Foundation and a man who's known for his very progressive views, Mr. Rashi Fine from Harvard, agreed that we couldn't solve our problem if we didn't work simultaneously to deal with the twin goals of cost containment and accessibility. We saw some tension about which way do we go, do we deal with accessibility first and then cost containment. And it's obvious to me, and indeed to Health Access, that we must work on those goals simultaneously, otherwise we will never get past the disturbing contradiction that this country spends more and gets less for health care than most of our industrialized counterparts.

The fundamental question that we have to ask is why do we pay so much more and why are we getting so much less for our health care dollars than other industrialized countries. And the answer points to gross inefficiencies and fundamentally the fact that in our society our health care system is driven by financing much more than it is by medical need. Joseph Califano, the former Health,

Education, and Welfare Secretary, believes, in fact, that at least one-quarter of the medical care that we provide is wasteful. It's inappropriate care. It comes about because someone's willing to pay for it, not because we need it. And I'd like to highlight some of the sources of the waste and inefficiency that I think give us this very topsy-turvy equation that is so profoundly disturbing and challenging when we're trying to figure out solutions.

First of all, there's some remarkable data emerging that show tremendous differential rates in all sorts of medical procedures. One that has been particularly disturbing has been the question of the rate of Caesarean section births, a phenomenon that is growing. The average rates were much lower 10 and 20 years ago than they are now. But even with the general increase in C-section rates, we find tremendous disparity depending on what kind of doctor you go to. The women who go to the county facilities in this state and the women who go to Kaiser to give birth typically face the odds of about 10 to 15 percent that they're going to have a C-section. On the other hand, women who go to private facilities in this state often encounter 20, 35, 40 percent C-section rates. And it is our belief that when you think about why would there be a difference between Kaiser and counties on the one hand and the privates on the other, one thing that is clear is that if there's anyplace where the high-risk mothers are, it's in those county facilities. So the fact that Kaiser and the county facilities have a parallel rate and the privates don't doesn't go to who they're serving.

The real difference is that the doctors who are making the decision about whether or not there's a C-section get no reward one way or the other when they work at Kaiser or at the county for the decision that they make; whereas, the doctors who are working in the private facilities have a very clear reward, both financial and sometimes one of personal convenience, for the decisions that they make about the C-section rates.

CHAIRMAN BILL GREENE: Plus there's another difference. In the county hospital and at Kaiser, they've got to take care of larger numbers and get them out faster. I mean, that's just a fact of life than in the private hospitals. So, I mean, if we aren't realistic and honest and don't realize that as a factor, if we put it only on the one question of incentive, which is valid, but it's not only that. And see, if we don't honestly face the facts of what we're really dealing with, you know, we start with a weakness in whatever we develop to correct that.

MS. SALISBURY: Senator Greene, I'm sure you're not accusing me of dishonesty.

CHAIRMAN BILL GREENE: No, no. I'm not saying you. I mean all of us collectively. You're only giving information to us and I was just adding that to your information. I don't challenge anything that you say. In fact, we already know that's it correct.

MS. SALISBURY: All right.

CHAIRMAN BILL GREENE: So, I mean, nothing is meant to in fact challenge but it's meant to raise questions that have got to be raised.

MS. SALISBURY: Okay. Well, let me take the very fact that you raise though. One of the other differences that we're looking at that deals with the inefficiencies of our system is the excess beds that exist in the private hospitals versus the Kaiser hospitals and the county facilities. One of the other financial factors that makes it very attractive to have a C-section is you've got an empty

bed that you've got to fill, whereas if you've got an efficient system -- it's so efficient I can even say that when I went to deliver at Kaiser, they had to send me over to Mt. Zion because they do have full beds -- I agree with you but they're also operating efficiently, quite in contrast to the situation we have with excess beds all over California when it comes to our urban, private hospitals.

We also see tremendous inefficiencies that occur because of the very fragmented system we have. We have people in and out of coverage all the time. You lose your job, you lose your coverage. And even with some federal changes that would allow you to purchase that coverage, many people cannot afford the luxury of paying that premium once they've lost their job. You're in and out of Medi-Cal depending on whether you're above or below a different poverty rate at different times. You change jobs and you may end up with a job that no longer covers your family, whereas previously they did cover your family.

The consequences of this fragmented system where there's no continuity of care is that people inevitably end up deferring care and then using the much more expensive forms of care rather than the preventive care and the ongoing outpatient care that would prevent them from being in a crisis in the first place.

We've also seen tremendous analysis going on about the ways in which we pay our doctors. Indeed, the Physician Payment Review Commission that is now overseeing the question of how do we pay our doctors for our federal Medicare system is looking very seriously at a whole different approach to doctor payment. And the reason is that for a variety of marketplace and other factors, including historical ones, some services that doctors provide have come to be valued much more than others, unrelated to the skill or the time or the marketplace competition that is reflected.

Let me just give you an example. Recently, and this was recounted by William Shiao, who's a renowned researcher at Harvard who's been looking into this question, he gave an example of two California patients, both taken care of by the same doctor. The first patient had been referred by his family doctor after several liver function tests produced abnormal results. Adding urgency to the situation was the fact that the patient had lost weight and reported a persistent fever. The doctor spent about 30 minutes reviewing the patient's file carefully. The patient returned two or three days later and then the doctor spent another 30 minutes with him and prescribed the drugs, and the drugs were indeed for a serious disease, sarcoidosis, a life-threatening liver disease that can be fatal if not diagnosed quickly. So the doctor's time was an hour with the patient plus some intervening consultation. His bill for that was $175.

The same day, the same doctor walked over to St. John's Hospital -- he was a Santa Monica doctor -- where another patient was waiting for him in the procedure room. Using a fiber optic device, that doctor spent a total of ten minutes removing a small polyp from the patient's intestine. His bill for that procedure was $650.

It is this kind of discrepancy between how much we reward surgical procedures, how much we reward high tech procedures and the doctors who conduct them, versus how much we pay for the hard investigative work of thorough primary care that is being addressed, and there are a legion number of examples that are being looked at by the federal government. And I think it's fair to predict, at least

those who are close to the process tell me, that they expect a system that is going to start wrestling with these resource allocation questions to come out with a Medicare fee schedule in the near future. And this is something that we have to look at as major guidance for what kind of dollars we're paying for physician compensation, not just public dollars but private dollars in California.

We also have to look at capital expenditures. We have unfortunately not seen the kind of benefits we would hope from competition in winnowing down capital expenditures. If anything, what we know is that in highly competitive urban areas, admission rates into hospitals are 26% higher than they are in areas where they're seeing a better match between the number of beds and the facilities available in the population. In the urban areas is where we have our excess beds, which gets us back to our C-section example.

We have also seen a tremendous spread of specialty services, too thin to benefit anybody. For example, heart surgery, where you have a number of hospitals each setting up very expensive heart surgery units with all the support staff it takes so that they can capture the very high reimbursement that's available for that kind of complicated surgery. What that means is a lot of capital duplication for a special service. It also means that many of those surgeons are basically spreading themselves too thin and are not amassing the kind of intense expertise they need to have to do that procedure properly.

When it comes to technical equipment like the CAT scanner, we literally have more CAT scanners in the State of California alone than all of England has because, again, we allow this tremendous duplication.

Another major source of our enormous price tag is the multiplicity of payers that we have in California. There are several hundred plans. A doctor in private practice literally finds it maddening sometimes to deal with the bureaucracies of those many providers, but we also have to recognize that with several hundred different payers, we're talking about a system that builds into it tremendous duplication in terms of administrative machinery, which we're all paying for. The private companies basically have a ratio of premium to actual care that they're paying for between 60 and 90 percent. That means between 10 and 40 percent of the premium dollar that goes in does not pay for care. It pays for their business.

The public sector does a much better job of a premium: benefit ratio in terms of administration. The public sector typically has about 95% of the premium money that is allocated which goes right back out to services. So we really have to ask why we are permitting such a plethora of bureaucracy and basically both profit and nonprofit interests to eat up so much of the premium dollar that we are paying in for their own self-perpetuating purposes, rather than for purchasing the care that we're all trying so desperately to get to.

Health Access will be, in the coming months, looking and, indeed, will be revealing some proposals to the Legislature that deal with some of these major economic inefficiencies. If we can't get past those inefficiencies, we're not going to get to the access question that we're also profoundly concerned about. We have to simultaneously address cost containment and access. In the coming months we will be coming out with proposals. Our proposal will be certainly shaped by some

principles that we've articulated, and we encourage you in evaluating not only our proposal but others that will be forthcoming in the legislative session accordingly to consider six key principles that together spell cost containment and accessibility.

They are, number one, universal coverage. By providing everyone access to the health care system you eliminate a tremendous amount of this inefficiency of people being in and out and in and out depending on the fortunes of their lives.

Secondly, comprehensive coverage, and this is not just a statement of compassion. It's not only because we want everybody because our hearts feel it to have comprehensive coverage, meaning a full range of benefits, but it's because comprehensive coverage allows us to achieve the efficiencies that save us all money and allow us, again, to achieve access. It means you can pay for prenatal care, well child care. Again, private insurance very typically, unless you're talking about a health maintenance organization, does not even cover well child care. It's all very much backwards from the way it should be, the way we finance our health care. And without paying well child care, then you end up with a very sick kid that could have been prevented.

Our third principle is we must be looking towards progressive financing. It is the case that the vast majority of the people who are uninsured in California today simply could not afford to go out in the private market, even at the best of rates, and purchase health care coverage. If you're a family of four, your typical health care bill would be between $2,500 and $4,000. If you're earning $10,000, that's 25 to 40 percent of your income. Even if you're earning three times poverty at $33,000, it's still 8 to 12 percent of your income, and careful analysis shows, by others as well as ourselves, that you really can't even begin to start paying for health care benefits until you get three times above poverty. And the bulk of the people who are uninsured in California are under that level.

A fourth principle is economic efficiency. I think you've gotten a taste of what I'm talking about on some of the issues that I've raised about why we do spend so much.

Related to that is our fifth principle which is that we must have some public guidance of the allocation of resources so that we're not all paying for the multiplicity of CAT scanners, excess beds, heart surgery units, as well as the other new capital expenditures that are coming down the line mostly to cater to some very well insured if not wealthy patients, but costs that we're all going to bear.

Finally, there must be accountability to the consumers, and we believe this includes consumer choice. We have this terrible contradiction where the United States pays 11.5% of its gross national product on health care compared to the much lower percentages of our neighbor's to the north, Canada, at 8.5% and many of the other industrialized countries. We can do much, much better and we must do much, much better. Health Access is here to work with anyone towards that goal, and, Senator Greene, I hope that contrary to your prediction, that we will be one of the organizations bringing that constituency forward to you. We have a sense that there's a movement afoot. We have the sense that, indeed, this is a very profound concern on the minds of most Californians and that they're willing to face some of the choices, perhaps some bold choices, that we must make to move ourselves to a far more humane as well as efficient health care system.

CHAIRMAN BILL GREENE: Thank you very much. Miss Salisbury, it strikes me that the majority of your testimony really goes to the health policy area rather than the area that is -- not that we don't need to know that -- but most of your suggestions would not be within the purview of our committee. That would be health policy. When you get to the money side, then I have that on the Senate side. That's why I make the prediction that I make.

Access must be a part of it or else you won't have anything go through, because no legislator is going to vote for anything where his own constituency or her own constituency is not included. So we know Access will be a part of it or else you won't have anything.

That's not meant to be a negative but merely just a statement of how to move and how it should be balanced and put together in order to move through the process, because you're dealing with those of us who represent -- I, myself, could not vote for anything and would not vote for anything that did not include that and include my constituency. I don't care if it did 300% good to the other segment of society. Not that you're opposed to it or not that your constituency is, but, you know, you don't bring costs on something that doesn't include you.

Now, let me ask you, your organization deals mostly from the health side, not necessarily from the worker health side. Am I correct or incorrect?

MS. SALISBURY: No, I would say that's not correct.

CHAIRMAN BILL GREENE: I was taking that from your testimony. Your points are all good. We know those, but those deal with health policy. When you were talking about the doctors, the hospitals, see, that's health policy. That's not worker policy, industrialization policy. We deal with how this comes over into the industrial field, where is the cost, how is it organized, what does it mean in terms of other benefit programs, the workers, and what have you. We have to be advised on the health aspect of it, but it seems to me that your comments basically went to the health policy side, not to the exclusion of our purview.

But one thing I do want to ask you, you made a lot of points, but you didn't give any backup information. Does your organization have the backup data and research to pinpoint and support these specific points that you make?

MS. SALISBURY: Yes. In fact, a lot of the particular points on the inefficiencies of the system I was citing are going to be...

CHAIRMAN BILL GREENE: Well, can you provide that to us in writing since you didn't include any of that in your testimony?

MS. SALISBURY: Certainly.

CHAIRMAN BILL GREENE: You merely made the points. You see, this is an interim hearing. Interim hearings function differently than hearings on bills. We can go into more detail on interim hearings. That's what they're for.

MS. SALISBURY: I'd be happy to provide the citations for that.

CHAIRMAN BILL GREENE: And making the points without some comments as to findings and where that was found and what it showed really doesn't do the job for our purposes in an interim hearing. Every point you've made we are knowledgeable that that is a factor, but you didn't present

anything in this testimony to say, for example, we've found in such and such a place, such and such a corporation, or that this and this is what's happening, such a percentage of this. You know, some detail that can be checked that corroborates or is contrary to other research which is available. The points that you make, it doesn't take away from them but we need to know where do we get the data and the research and information that supports that specifically.

MS. SALISBURY: Certainly. I'd be glad to provide all the citations for the points that I was making. They are all backed up by studies and research that have been done.

CHAIRMAN BILL GREENE: If you could provide that to our committee it would be very helpful...

MS. SALISBURY: I'd be delighted to.

CHAIRMAN BILL GREENE: ...to us. Is labor very much a part of your organization?

MS. SALISBURY: I'm sorry?

CHAIRMAN BILL GREENE: Is labor very much a part of your organization?

MS. SALISBURY: SEIU, AFSME, and California Nurses Association are all on our steering committee.

CHAIRMAN BILL GREENE: Okay, but, you see, they have employees within the health field so I could see why they would put great emphasis on that. We need information to -- you know, where do we play to the public and the people out there who are not a part of the health industry who are just workers, and the only time they even think about health insurance is when they get it. Otherwise, see, most of us don't think about health care unless we need it. Now, I do as a legislator, obviously, but, I mean, the average citizen. And we're talking about how do we -- the uninsured. So we're talking about how do we get them covered, and, you know, that's our primary concern, not -- as I said, not that we are oblivious or not concerned with those other points, but, see, our mission is only a piece of the total health plan and that's how do we extend health coverage to uninsured workers.

MS. SALISBURY: Right. Senator Greene, I think that the reason that I somewhat differ with your characterization of my testimony as being on health policy goes back to the fundamental point that I'm trying to make, which is that you want to see those workers covered, we want to see those workers covered. You and I are both aware that the price tag is going to be one of the critical questions that either makes or breaks that possibility, and that unless we address why the price tag is outpacing regular inflation two and three and four times the rate, unless we start bringing that under control, we're just not going to have the money there to make a difference.

CHAIRMAN BILL GREENE: I don't think you understand my point. This committee is not the one that's going to do that. Senator Watson's committee will be the one to do that. That's my point I'm making. That's not our purview. We will not formulate the policy in those areas. The Health Committee will formulate the policy in those areas.

MS. SALISBURY: On one of the questions -- I understand your point now but there will be a critical question that may well be brought before your committee that relates to this, which is similar to the question of how Massachusetts approached this problem, how Assemblyman Margolin approached it in 2465, and how the Kennedy-Waxman bill does, which is whether or not this

committee feels that employer mandates are really in the interest of workers and in the interest of the economy.

CHAIRMAN BILL GREENE: Now, that's a question that we will and the other committee will not deal with that. We will deal with that.

MS. SALISBURY: And let me suggest to you that the points that I was making on that very question of policy, whether or not we go to a mandate, have to do with our capacity to believe that a mandate is something that all of our businesses can really live with. And I think that, for example, and Dr. Brown already alluded to this, that another approach might be to think about an employer payroll tax that really permitted business to get out of the health care benefits programs that they're now so deeply involved in, and allowed some efficiencies to occur and at the same time. It would give business some real stability by knowing what their price tag is going to be over the next five or ten years. Now they have suffered an instability which has been very unnerving and very disquieting to them and, indeed, very dislocating then to the workers who cannot in any way count on a benefits package going with them no matter where they work. And I think that when we face the question of which way do we go, that you will certainly be hearing from Health Access and from some other quarters some real reservations about whether or not we need to really pile it all on necessarily through a mandate scheme, as opposed to looking at much more efficient ways to have business and workers pay their fair share, but not to have industry totally carry the weight of our health care system.

We have a very peculiar history in this country where health care benefits have been attached to work. If we could all wipe the slate clean historically, we probably never would have quite designed it that way, but for whatever reason, that's where we are now. It may well be that as an interim solution or as a way of dealing with some of the immediate problems that we face that we would want to think about a mandate, think about incentives, think about ways of making more employers capable of actually providing health care benefits. But I think in the long run, I'm not sure that they really belong there and I'm not sure that it wouldn't be better to get them out of the business altogether and just have them pay their fair share in a way that they could count on so that they could do what they do best, which is make goods and services available to the consumer and at the same time provide jobs and stability for their workers.

CHAIRMAN BILL GREENE: You've stated the exact reason for this committee being held in the first place. We're not settled on anything from your point or anybody else's points right now. We are probing. And we have no intention of settling in on anybody's points now. We don't know enough about it. And we're going to talk with many, many more people, most of them privately -- nationally renowned, internationally renowned. My economist is abroad right now in Burma, for example, talking with people on questions like this. So I assure you, this is only the first step. We're involved in a project now involving the private sector of labor and we've been holding seminars and meetings and conferences up and down the state entitled, "Health and Human Productivity" because we're looking at it as how it contributes, how a healthy society and a healthy work force contributes to increased productivity. So let me assure you that you and nobody else has sold us on any one point at

this stage, and I would remind you, as I said earlier, I chair the fiscal subcommittee. I'm not at all ignorant on the subject or the factors involved as well as the games that are played. So there are no tenderfoots or freshman involved with this in any fashion, shape, or form, and as I say, we don't make decisions on people's opinions but only on the facts that they bring forth. That's the only way we can because we must shape something which relates to the entire society.

The points that you raise, those points still will be the domain of the policy committee of the Health Committee. There's only one piece, once again, as I say, that will be in our purview, and we need to examine not only how does it relate to health care as a benefit but all other benefits which are already there for workers. And because they've had no experience and it was not structured in that manner in Massachusetts says nothing about California, nothing whatsoever, nothing whatsoever, because I think I know this landscape pretty well and it will be a factor here, not unless the thinking of the total business community in this state turns around and that I don't foresee.

Regardless of how much they might come in on thinking in this regard, the other factors will still remain in their minds and, you know, I mean, that's just a fact of life, and we have to consider it on that basis. You do not have to but we do because we're the ones that make the decisions that bring about the balance in that regard. So none of it's meant, and I don't want you to misinterpret it as having any problem, but trying to decifer and disintegrate in my own mind and indicating it publicly which pieces will -- where decisions will be made on which pieces. The health side, we will have input as it relates to that aspect of it that does relate to us, but I even agree that we shouldn't because we are not the ones who are the most informed in this area of public policy, and we really are having to bone up a little bit more now because we are moving more in considering this over into the health field. You know, that's not the area of immediate expertise of the members of my staff and even of the chair, although I do get off into it more than they do but I have a different style which sits at my side in that regard.

You're working with the private sector. Are there private sector members of your Health Access group? Members of the private sector. Are there members of the private sector that are members of your Health Access group? I'm just fishing to find out the whole group's makeup.

MS. SALISBURY: Sure. I guess I don't know what you mean by private sector. Our group, let me just give you a quick description which...

CHAIRMAN BILL GREENE: Well, they're in business out there. People who are in business.

MS. SALISBURY: Only as individuals. There are no major businesses. We are...

CHAIRMAN BILL GREENE: They're not there as corporations.

MS. SALISBURY: We are a consumer-oriented group. We include civil rights groups such as...

CHAIRMAN BILL GREENE: Okay, but would that preclude members of the private sector being a part of it?

MS. SALISBURY: Oh, no. If they share our goals, they are more than welcome; and indeed, we are working very closely with many people in the private sector who are very interested, but as actual formal members, that kind of membership has not come forward. We're so far very much composed of consumer-oriented groups.

CHAIRMAN BILL GREENE: All right. One final question from the conclusion of your testimony. You indicated that we were going to have several issues which would be before us in the coming session. Isn't that in kind of a segmental way of going about this? How do we know if we make one change how that's going to relate to other aspects of this, and I'm not suggesting how you should pursue what you're going to pursue, that's your business, but I'm asking it from a point of view of a person that's going to be faced with that. We make one change in one area, how do we know what the effect is in some other area when we're not winning that as well?

MS. SALISBURY: I quite agree with you. I think that that's in fact the dynamic that has gotten us into some of the difficulties we have now, which is that we fix one part of the system for the poor, we fix another part of the system for the seniors, then we try to fix another part of the system for the budget and things get very awry and out of kilter because we have never had a unified approach to these questions. I think the essential guide that we have to have as we face each decision is a vision of where we should be going, and that is why I went over the principles that Health Access has articulated. We think those provide a litmus test to allow you to know whether or not something that's being presented to you moves us forward or might indeed, while having the appearance of a short-term gain, cause us more trouble in the end.

Indeed, Health Access will be putting forward in time for this legislative session our comprehensive program, not just principles, but a program for a comprehensive universal system of health care in California. Obviously, we would be delighted if that was a vision that everybody shared, and that if incremental steps are taken, that they be made in a way that's consistent to move us towards that direction. But whether it's our vision or somebody else's vision, it's critically important that there be some real consciousness of what is our ultimate goal, where do we see ourselves moving, if not this year, in the next five, ten, or fifteen years, so that as we make decisions we don't compound the problem.

CHAIRMAN BILL GREENE: You're more conservative than I am. You say five, ten, or fifteen. I said three. And that's what I had reference to and I -- you know, just in first guessing this and looking at at least the concept that I think I see where we need to go and what we need to do, that's why I very candidly say we aren't going to do this easily or quickly. And an awful lot of constituencies have to come together there in some fashion, shape, or form or I think we're misguiding people as to what we're going to be able to accomplish when. And I think the question is really when. It's not one of will we do it, but it's when will we do it and in what form and fashion. That, I think, is the question. But that's what can take the time, because without our having a constituency out there that includes all factors of this, it doesn't mean that we don't face the subject to begin to wrestle with it, but I would caution that we keep in mind that we would have a lot of work ahead of us. If we could make it a step at a time, that would be far superior.

All right. Any questions, members? From the staff?

MS. SALISBURY: Senator, if I just might add that we at Health Access are very cognizant of the need for this to be a movement that is supported by a variety of constituencies, not just the consumers that we represent, and we have been and are engaged in a process of reaching out to all

the major players to see if we can help move things...

CHAIRMAN BILL GREENE: Because if we're asking people to pick up the tab, they've got to know what they're picking up the tab on.

MS. SALISBURY: That's right.

CHAIRMAN BILL GREENE: Mr. Young.

MR. CASEY YOUNG: Just curious. Are you one of the organizations which CMA is working with to put together a coalition in this area?

MS. SALISBURY: They've certainly talked to us and we've talked to them and we hope to be at the table with them, but unfortunately, we're going to have to get a scholarship for the price tag they're requiring to be at the table.

MR. YOUNG: Thank you.

CHAIRMAN BILL GREENE: Oh, you have to pay to be a member of their organization -- I mean, a member of their team that is...

MS. SALISBURY: I don't want to answer for the CMA, but that's the impression I've had.

CHAIRMAN BILL GREENE: The impression you have of what you know.

MS. SALISBURY: I know from talking to other constituents who have been approached by the CMA that there's an expectation that they...

CHAIRMAN BILL GREENE: But they haven't approached you. You don't know directly of your own -- direct knowledge.

MS. SALISBURY: That they will be asking us for money? They said they're going to expect resources from everybody and we smiled and said well, we don't have $50,000 and that's the point of the discussion...

CHAIRMAN BILL GREENE: Okay, but now, but what I'm asking is that to be a member of the group that is going to come forward with some thinking, is there a price tag to be a member of that group, that's my question.

MS. SALISBURY: Well, the CMA should answer that. I mean, that's...

CHAIRMAN BILL GREENE: Well, you raised it.

MS. SALISBURY: I understand that's what they're putting out there, yes, sir.

CHAIRMAN BILL GREENE: Okay, you've seen that or that's been told to you by them directly.

MS. SALISBURY: Yes, sir.

CHAIRMAN BILL GREENE: Okay. That's all I'm trying to do. I'm not trying to be funny. I'm just trying to get absolute information. If it's secondary and not absolute, then we really are not interested in it because it cannot be established.

Okay. Mr. Davenport, any questions? All right. Thank you very much. We look forward to working with you and we need you to work with us. I would really appreciate it if you would get the details of your points in to us and whatever. That's what we need...

MS. SALISBURY: No problem.

CHAIRMAN BILL GREENE: ...is detailed research and data. Okay. All right. Brent Barnhart, the Association of California Life Insurance Companies. Good afternoon, I can say now.

MR. BRENT BARNHART: Good afternoon, Senator. My remarks will be fairly short. You have already heard I think excellent presentations, both factual and descriptive, of the situation as it stands.

There are many situations — there are many specific proposals with which obviously our companies will disagree on exactly how you should go about changing things, but I think there's no disagreement that the existing situation is bad and getting worse. The figure you heard from Miss Salisbury was 11.5% GNP and we're very soon expecting that we will be spending 12% of our gross national product on health care. If you compare that with Canada, which has nowhere near the number of its people uncovered by any kind of medical care, they're spending 8%. Interestingly enough, if you look at how we got here from where we used to be, in 1966 when we adopted Medicare, we also were spending 8% of our gross national product. The graphs, if you put Canada and the U.S. together, they were right together in '66 and there's an enormous divergence from that point on.

Senator Greene — I'm sorry, Senator Leroy Greene, when he was presiding, was saying isn't it true that the existence of private health insurance or the existence of health insurance has contributed to the inflation problem? The answer is yes. Both private insurance and government insurance, there's no question but that by making more and more dollars available for health care, you increased the amount of money we're going to be spending and essentially the appetite for those dollars. So that undoubtedly was an effect of making insurance dollars available.

However, there also is now a general expectation among our population that they're entitled to health care, that that's something that's a matter of right. Whether it's in the Constitution or whether it's in the Bill of Rights or wherever, people believe they're entitled to it.

As a representative of health insurance companies in this city, I must tell you I am constantly getting calls from legislators' offices saying fix this problem, fix that problem, because their constituents believe they're entitled to coverage. And I don't know that at this point we have the kind of sweeping consensus for/behind any particular political movement to do anything, but I think the operative or descriptive term there has to be, "yet". The building sense among the population, as we feel it as private companies, is that people expect they're entitled to health care and they're going to demand it somehow.

The existing situation is terribly fragmented and I think it's that fragmentation, and in this I think we're totally in agreement with Health Access, that has led to a very bad situation. We deal pretty well all in all with the elderly. We deal pretty well with the poor to some extent and we spend a lot of money at it. We have good coverage all-in-all. Most people who work for large employers and who are parts of unionized work forces. But even in those situations we are seeing such enormous inflation that the disincentive to employers to continue to cover people is becoming almost overbearing.

The trend factor for 1988, in terms of the percentage increase, is not what you see as the CPI index. You keep hearing the medical index being at about 8%. That doesn't tell you the story at all because there's several other factors you have to throw into. We figure it's about 25% for '88 and at least 25 to 30 percent for '89, and that's because of other factors, not only the medical index

so-called but things like an aging population, the cost of technology. Technology alone seems to be about 7% picking up the price of things, and then a lot of other little things that keep boosting it -- people's expectations, too, tend to effect an increase.

So I know that in terms of trying to apply this to the Legislature and to the agenda of any one committee, that we're talking far more elliptically than you can possibly, practically apply. But there's no way to deal with the problem, particularly in this setting, without dealing with it comprehensively.

I do want to speak directly to the whole question of mandated benefits -- mandated coverage for employers. We have opposed previous provisions; although if you took it just from a standpoint of self-interest, hell, it'd be a good thing for our companies to mandate coverage. I mean, that's just more business for us. But I think it's also fair to say that it is not a good way to go.

Looking from the standpoint of the employer, what they have looked at from the last few years is an increased shoving-on to them of responsibility in health care by the federal government. You have, just a few years ago, the federal government, in attempting to balance its budget, unsuccessfully, of course, but attempting to do it and deal with it in one of the monster reconciliation acts, decided a good way to save money was to take all those people over 65 who were employed and who were then -- became eligible -- were on the Medicare rolls to say that well, but if they're employed, then those people -- the primary health coverage will be that of the employer and Medicare will always be secondary. And it saved them several millions dollars, no question about it, a great way. But from the standpoint of employer, now they have -- they now have people over 65 in the work force they didn't used to have to pay for, now they have to.

Then soon thereafter a couple of years later we had continuation coverage added. Continuation coverage also, and this again is one of those piecemeal approaches to the problem, clearly a good policy from the standpoint of seeing to it that people that tend to get lost between the cracks -- between jobs or because there's divorce or because there is a child -- I'm sorry, you have children who are orphaned and spouses who become widows or widowers -- that there be coverage be made available to them by allowing them to stay on, at their option, their employer's coverage. They pay for it, but you can buy the coverage at the employer's rate which is a whole lot less than having to go out and buy individual coverage.

But from the standpoint of the administration, from the employers' standpoint, it's terribly burdensome, not because it costs so much -- but it does cost a lot, as a matter of fact, because of adverse selection -- but because administratively it's another burden. Again, the federal government said, "Employers, you take care of it."

Finally, we have more recently something which I don't think any more than maybe 20 people in the country even begin to understand, the so-called nondiscrimination rules in health care having to do with making sure that the kind of coverage that an employer provides or affords to its employees is not discriminatory between employees; basically, that everybody gets a level playing field in health coverage and so that senior management doesn't get better coverage than somebody down at the assembly level of a plant. Again, a good policy, but from the standpoint of the administration, it is

just absolutely horrendous because you're trying to figure out well, let's see, if this Kaiser policy were less good than the Prudential coverage, which is 80% with 20% co-pay, I mean, you're trying to balance in a whole lot of apples and oranges and what you have is enormous regulations being generated to say when it's okay, and when it ain't okay.

In that environment, the thing that is terribly appealing to an employer is, hey, if I drop my health coverage altogether, I get out from this entire burden; I don't have to worry about it. So you're actually creating a disincentive to cover or at least a disincentive to cover any more than the employee and not to cover dependents.

We could, I suppose, get around all that on the national level or arguably maybe on the state level by simply saying well, all employers are going to have to cover everybody, thus kind of spreading the burden out. That's the appeal of it. But all in all, it may not be a good way to go if you have the kind of things that you have in the Massachusetts plan of basically letting all employers under five employees out, because then all -- that's a great system for lawyers and accountants finding out ways to structure work situations so you never have more than five employees, with all kinds of contracting relationships and all kinds of underground-economy-type things when people were paid in cash.

If you have that kind of a loophole, I am suggesting if you simply shove the burden onto employers, there will be loopholes and they will take advantage of the loopholes. If you're going to go about a comprehensive solution, then you should go about a comprehensive solution, one that really looks to, we would say, to the entire population and not of the country or of the state and not simply try to say well, we'll just shove more onto the employers, let them take care of it. I would suggest to you that it will continue to be an incomplete approach and one which will not be successful.

CHAIRMAN BILL GREENE: Well, it's one which would have problems getting through here also. It depends...

MR. BARNHART: Politically, fairly, some serious problems.

CHAIRMAN BILL GREENE: It depends on who that under-five employees are. Let me ask you a question, which is kind of a conceptual question which I've structured in my mind, and let me see from your point of view how -- you know, off the top of your head what your response would be. And that is as I view this, we're really moving into an arena that fine, regards of the fact that all other nations have it, we have never, in this nation, approached health care in this manner.

MR. BARNHART: No, it's always been piecemeal.

CHAIRMAN BILL GREENE: And we have never thought this comprehensively about health care in this nation on any widespread basis. There were always people who did and what have you, but that is not a concept that caught on to even 20% of the thinking of the population, or what have you. We now have, because of factors that go on out there in everyday life, the citizens that come in the category that you speak of, generally mostly from younger workers, to some degree older workers, but mostly from younger workers who come in and say, you know, we think it's a right. I might also say that you find that more prevalent than your middle-class segment of population than you do in the poorer segments of the population. Not to say that they don't want it and they discard the idea, but

they don't walk in with that idea that it's a right. And I know that to be a fact because I represent a segment of it. It's never said to me by my constituency in that manner, and they say anything they want to me in any manner in which they wish. So I can reasonably, in fact I can for sure conclude, that they aren't saying it to me that way, that's not the way they view it, although they want the coverage, but they do not see it as a right. So I would say that's a segmental opinion.

In view of the fact that we're taking on the job and are embracing a concept which has never ever been a part of public policy before in this nation, does that make it reasonable, from your point of view and from your side of the table, to forget everthing that's out there in terms of shaping anything to the degree that we can take a fresh view of, say, let's build a temple? Is that a fresher, potentially better way of approaching it in terms of coming with something that can maybe serve all of these and interests that it needs to serve and still be something that we could get through and something that has a chance of being workable? Is that a better approach to the degree that that can be accomplished, or should we take what we already have out there and attempt to build on that? And I know I'm asking for a response off the top of your head...

MR. BARNHART: No, I don't mind making it.

CHAIRMAN BILL GREENE: ...and I won't interpret it and we won't interpret it on the record as even being represented by the industry, but you are from the industry and -- well, we will stipulate on the record that that's a question that under no circumstances -- any response that you would care to give will purely be from you as an individual who's expert out there in it and not to represent any thinking of the insurance association.

MR. BARNHART: Yeah. With that caveat, because our people have not formed anything along those lines.

CHAIRMAN BILL GREENE: Yeah, I understand but, you know, as I said, I'm fishing, so I'm going to throw everything out there I can to, you know, to get back whatever I can get back.

MR. BARNHART: Yeah. My personal view, strictly personal, is that yes, that's the only way you can go. You have to look at it from a comprehensive standpoint and how do you go about solving a problem, which at this point seems to be getting worse and worse and less and less satisfactory to people generally. But you have to look at it from some kind of a comprehensive solution. That does not mean that I'm advocating socialized medicine. What I'm saying is the whole situation has to be analyzed and I think that you have to take a fresh approach to it.

CHAIRMAN BILL GREENE: I would also like to have it understood that I know that there's certain ideas out there that have tags. In my mind they have no tags. I don't care whether it's a conservative idea or a liberal idea or idea that has no classification. If it looks like it will work I'm willing to try it. So I don't subscribe to those labels out there. I try to be a thinker, and anybody who is truly a thinker does not limit the range within which they think. So I don't care what the philosophy is behind it, it's how does it fit, is it potentially workable? Now, I know that I differ from many people in that regard but I choose to be different in that regard to make my own analysis.

Any questions from staff? Mr. Davenport.

MR. DAVENPORT: Are you working with the Medical Association, your association, or have

you been asked?

MR. BARNHART: We have been invited to the table and the price to us is $40,000.

CHAIRMAN BILL GREENE: Okay. Okay.

MR. BARNHART: Mm hmm.

CHAIRMAN BILL GREENE: All right. I think we...

MR. BARNHART: We haven't...

CHAIRMAN BILL GREENE: ...have an answer to that question. All right, thank you very much. All right, our next witness will be Mr. Gary DuQuette, California Association of Life Underwriters. Good afternoon, sir. Welcome to our exploratory hearings.

MR. GARY DuQUETTE: Thank you, Mr. Chairman, thank you. I appreciate the opportunity to be here.

CHAIRMAN BILL GREENE: Will you please identify yourself for the record? Then you may proceed as you wish.

MR. DuQUETTE: Okay, thank you. My name is Gary DuQuette. I'm testifying on behalf of the California Association of Life Underwriters, probably more commonly known as CALU.

I own a small insurance agency in Stockton and we specialize in providing group life and health insurance to small businesses, small and medium sized employers, and to individuals as well.

CALU has long been concerned about the availability and affordability of health insurance, and we've been supportive in measures to provide such. We've been supportive since A.B. 600 was first introduced by Assemblyman McAlister.

The people that make up the membership of CALU work on a day-to-day basis with the people that have the problems that we're addressing today, I believe. They are the people that face to face have to talk to people about obtaining health insurance at a reasonable cost.

I think there is a problem when we're told that one in five of our citizens is not covered by health insurance, and why are so many people uninsured? Is it because our system doesn't deliver or is it because some people are not taking advantage of what is presently available?

I know first hand, I've gone out and made presentations to small employee groups and the employees have told me that they would rather have the cash from their employer instead of having the benefits. And most employers, as you've heard, small employers especially, are very -- they're not, you know, rolling in the profits. We all hear about the high failure rate of small businesses and it's not because the people are taking the profits and heading off to the Bahamas, it's there's just less money coming in than going out. And so, when they hear their employees tell them that they would rather have the cash instead of benefits, the employers are going to listen. They're going to say well, why should I spend money, two, three hundred, four hundred dollars, for a family benefit that's not going to be appreciated?

One of the other things that we've heard from employees is when they've said, gee whiz, my spouse or my children are covered by Medi-Cal, so I don't need to -- why should I pay for health insurance when I can go and get it for free from the state? And I don't think they understand the economics of how Medi-Cal works obviously, but that's their impression and that's what their answer

is.

As I mentioned, small employers have a difficult time surviving let alone succeeding today..

There's also a problem, I feel, when we have to tell a person that there's not a health plan available to them because of their present health condition because they're uninsurable. As I mentioned, we support such efforts such as A.B. 600, S.B. 6, and we would hope that with hearings like this that maybe we can collectively work together instead of splintering off. Maybe we can really solve something and come up with a real solution, because I have to tell you that there's nobody that would like to solve the problem of people without insurance more than the person who has to tell a person face to face that no, I can't help solve your problem, I'm sorry; even though you're willing to pay for it, we don't have a product to offer to you.

One of the things that's concerned me a little bit today is I keep hearing about nationalization, nationalization, and of course, I'm from the private sector and I think that's there a confusion amongst a lot of people when they talk about nationalization. Are they talking about nationalizing the health providers or are they talking about nationalizing the health insurance industry? It's always been my impression that we, as an insurance industry, kind of collect the money and take a fee for administration and then disperse it to the ultimate providers -- the hospitals, the physicians, etc. And I don't think we can talk about nationalizing a health insurance industry without talking about some kind of cost features, because we're going to be collecting the same amount of dollars and dispersing them whether -- whoever it is that collects them, because we've got a huge economy out there, the hospitals, the physicians, that need so much money to drive them. Like a gas tank, you've got to put 20 gallons of gas in it if you're going to make that round trip. So it depends on whether you get it from Exxon or Shell, you've still got to put that same amount of gallons in there, and I think that's the way our health economy is. Those doctors, those hospitals, need so much money to fuel them. Whether it's the government that collects it and pays it to them or the private sector, it's a matter of I don't really -- it doesn't make much sense nationalizing the people that are collecting the money.

And we do have a national health insurance program. It's called Medicare, and Medicare, we are presently paying for. Everybody that's employed that's paying Social Security is paying in advance for their Medicare. Those people that are presently receiving Medicare are paying a premium for their Medicare, and then those folks have to go out and buy a supplemental policy from the private sector because Medicare keeps paying less and less of their benefits and doesn't give them the protection that they really feel that the need and the security that they need after age 65. So we do have a national health program and I think we should certainly explore that and how it's worked before we talk about any other national health insurance.

That's about it. Thank you.

CHAIRMAN BILL GREENE: Well, as one who deals with the California plan and deals with the budget side of it, it doesn't work very well.

MR. DuQUETTE: I'm sorry?

CHAIRMAN BILL GREENE: I said as one who deals with the California plan, Medi-Cal, and

who deals with the financial side of it, it doesn't work very well. I would not be willing to vote to put the totality of the population into a plan such as Medi-Cal and how it works. I've got more respect for the people.

MR. DuQUETTE: We can appreciate that.

CHAIRMAN BILL GREENE: It would have to improve greatly before I would even consider it. Let me...

MR. DuQUETTE: Excuse me. May I make two other points, Senator?

CHAIRMAN BILL GREENE: Go right ahead.

MR. DuQUETTE: One point is, when people talk about mandation in California, there are a lot of people that I think aren't aware that when the Legislature passes laws mandating coverages that insurance companies are supposedly obeying, that if a company is domiciled or the trust that ensures the program is domiciled outside of California, they don't obey these laws and they don't have to. There's nothing in California that says you have to obey California laws if your program is domiciled outside of the state.

CHAIRMAN BILL GREENE: Well, it's not quite that absolute but it is different for them. It's not quite as absolute as you state, however. Let me assure you as a legislator, it's not quite that absolute. We do it with people who are not domiciled in other areas. We do not have the same — it does not carry the same impact but they're not totally removed from it.

MR. DuQUETTE: Okay.

CHAIRMAN BILL GREENE: The fact that they -- you know, if they do business here — I mean, you know, there's a legal way that we can bring them under the program. I mean, no government —no state would be structured that way, so, I mean, I assure you. Although we cannot do the same things with them as we can do with one who is domiciled.

MR. DuQUETTE: There was a company, that's a California company, that's now no longer a California company because it was bought by an out-of-state company, that went out of state to set up their trust so that they would not have to provide the full takeover provisions that is mandated in California. But...

CHAIRMAN BILL GREENE: Well, you see, but we would have to deal with what the sections of law which relate to that particular act with what those sections of law say.

MR. DuQUETTE: I see.

CHAIRMAN BILL GREENE: I mean, because, you know, you can't apply that section of law dealing with that particular transaction and say everything that company would be involved in is the same, because various sections of code have various provisions and, you know, they might not even match. So that's the point I would raise with you.

But I wanted to pursue your question — you say that — I can understand that you would have some employees that would say to their employers that they would prefer the cash, but you also said that some indicate that their families are on Medi-Cal now. They cannot be on Medi-Cal. Well, even the working poor is not on Medi-Cal, so how could they be on Medi-Cal? How could there -- well, you raised it, that's why I'm asking you.

MR. DuQUETTE: I understand that. I understand that, Senator. I'm just telling you what I've heard from employees that have told me that their wife -- maybe they're living in sin, I don't know -- but they've told me...

CHAIRMAN BILL GREENE: Well, I don't care what they're living in, they couldn't be on Medi-Cal. I mean, they could be living together but they're not on Medi-Cal. I mean...

MR. DuQUETTE: I don't know the requirements to be on Medi-Cal.

CHAIRMAN BILL GREENE: Okay. But since you had raised the point, I was -- I thought that you felt it was something that should be said to the committee.

MR. DuQUETTE: Well, I thought so because that's what employees...

CHAIRMAN BILL GREENE: Yeah, well, they're incorrect. They're incorrect. They are.

MR. DuQUETTE: They very well could be.

CHAIRMAN BILL GREENE: They either don't care about the family or -- well, I mean, not they very well could be, they are incorrect. There's no way for them to be on. You know, you could have one or two that are cheating, but you aren't going to run into any large succession of -- so, I mean, it's impossible because, you see, you -- see, Medi-Cal is tough enough to get on in the first place and, you know, you have less people fraudulently on Medi-Cal than you do on a lot of other social programs. So I would have to say in that regard they are reasonably, satisfactorily tight. So they either are -- really don't care...

MR. DuQUETTE: I never verified it, I just heard it, and I just passed it on to you...

CHAIRMAN BILL GREENE: Okay. Well, that's the kind of information that we don't need.

MR. DuQUETTE: Okay.

CHAIRMAN BILL GREENE: Not to be personal about it.

MR. DuQUETTE: Sure.

CHAIRMAN BILL GREENE: Okay, any questions from staff? Mr. Davenport.

MR. DAVENPORT: Mr. DuQuette, can you give us some ideas on how the Legislature could help you get a product that you could sell to cover more workers out there?

MR. DuQUETTE: Well, one of the things I think, Mr. Davenport, is that when I first entered the insurance business about 21 years ago, everybody wanted to write business. All the insurance companies wanted to write business so they didn't ask any health questions. You could be a group of three people and you'd have a guaranteed issue policy with no provisions that excluded you from anything. And then all of a sudden -- it's kind of like the mall where the stores were all closed on Sunday and if everybody was closed on Sunday the same amount of business is going to be done from Monday through Saturday. But then one store says well, if I open on Sunday, I'm going to get all that business on Sunday. So they did for a while until everybody else opened.

Well, what happened in the insurance business was that one company says, hey, they're taking these people and they're not even asking questions -- if I start asking questions and find out the healthy ones and I have a healthier group, I can lower my rates. So they lowered their rates and then pretty soon somebody said well, wait a minute, we're getting the unhealthy because we're not, you know, we're blindfolded and those guys are asking all these medical questions and they're getting the

healthier ones so their rates are lower so we're only attracting the unhealthy ones and this is what happens. It's called adverse selection in the insurance industry.

I personally believe that if the insurance companies would go back to where they were and everybody quit asking all the questions, because we write groups of 50 now and they want to know if anybody in there has got a heart attack, how many are pregnant -- they're asking questions of large groups now. For me, a large group is 50. A lot of people, large groups start at about 1,500 or 1,000. But if we would go back to where we quit asking any questions of any group, there would be no adverse selection because all the companies would get their fair share of the healthy and the unhealthy, and I think that would be very simple.

And all this money we're talking about putting into a pool, if we would say then maybe reinsure the groups for the unhealthy that are -- take this money that we're going to put into this pool and start insuring from dollar one, reinsure those losses over $50,000, then the companies could afford to go out there and stand up there like they should and accept these risks. We've got a fine system. I don't think we have to dismantle the whole thing. I think we've got a real fine system to work with.

CHAIRMAN BILL GREENE: On that point. Do you know anything about the Massachusetts plan?

MR. DuQUETTE: Not that much. You've heard some testimony from people that are much more expert than I, Senator.

CHAIRMAN BILL GREENE: The reason I pose that question is to ask you if you knew whether or not that was considered when they were developing the Massachusetts plan.

MR. DuQUETTE: I don't know. I couldn't answer that.

CHAIRMAN BILL GREENE: Okay. All right, thank you very much. We appreciate your testimony.

MR. DuQUETTE: Thank you very much. Appreciate it.

CHAIRMAN BILL GREENE: Is there is somebody here we -- I see Allan Burdick is not in the audience. Is there somebody here from the California Supervisors Association? Seeing no one rise, Michael Dimmit, California Association of Hospitals and Health Systems? Okay. Is there anybody in the audience who wishes to make a presentation before this committee at this time or make any comments or suggestions or criticisms?

Seeing none, that concludes our work for today. Sergeant, let me thank you, and staff, let me thank you. Let me thank all of our witnesses and all of those in our audience.

The meeting is adjourned.

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Testimony Presented by

Bert Seidman, Director

AFL-CIO Department of Occupational Safety, Health and Social Security

before the

California Senate Committee on Industrial Relations

October 20, 1988

The AFL-CIO is pleased to have this opportunity to comment on ways the state of California might expand health insurance coverage. To begin, Mr. Chairman, I'd like to commend you for moving expeditiously to address this issue. With the number of people who are without protection reaching staggering levels nationally and statewide, no state can afford the high social and economic price of inaction.

At the national level, organized labor and many other groups concerned with widespread denial of access to care have endorsed legislation introduced by Senator Edward Kennedy and Congressman Henry Waxman (S. 1265 and H. R. 2508), which would require all employers to provide health insurance to employees and their families as a condition of doing business. We believe that such an employer mandate is long overdue and urgently needed in light of the growing number of employees who are falling through the cracks of the so-called private sector safety net and are not offered health insurance protection through their employer.

We intend to work very hard for passage of this bill. In the meantime, the crisis is too severe for states to wait for Congress to act. We encourage you to develop legislation requiring employers in your state to provide health care to their workers. As you know, every industrialized country except the United State and South Africa has a national policy guaranteeing all citizens access to health care services through an organized system of public and private coverage.

In our country, employers have been allowed to voluntarily decide whether they would offer protection. But recent structural changes in the economy have dramatized the inequities of the current system. Employment has declined in manufacturing and other basic industries, where health care coverage was an integral part of employee benefit plans. At the same time, new jobs have been created in the service sector, where health care coverage historically has been less comprehensive, or not offered at all. In addition, the number of part-time workers has increased and contractual employment has expanded. Some employers have cut off coverage of children and other dependents previously covered. The net effect of these economic shifts has been to leave millions of workers and their families without health insurance.

Since 1980, across the country the number of workers without protection has grown by 40 percent, leaving at least 37 million people without coverage (or 16 percent of the population). In California, the situation appears to be even worse. In 1985, the last year for which state data are available, California had an astounding 21.4 percent of its population uninsured. Alaska, the state with the next most severe problem in the Pacific region, was far behind with 17.4 percent of its population uninsured.

Although we do not know how the uninsured population breaks down in California, it probably corresponds to national trends. For the country as a whole, approximately 52 percent of the uninsured are full-time workers and their families, 8 percent are steadily employed part-time workers and their families and 17.2 percent are workers and who were unemployed briefly during the year and their dependents. Taken together, three-quarters of the uninsured live in families with a strong link to the workplace.

The refusal of some employers to offer health care protection forces many workers and their families to postpone seeking needed medical care. Last year the Robert Wood Johnson Foundation published the results of a comprehensive

survey showing that the proportion of Americans without health care coverage who had not visited a doctor's office in a 12 month period jumped from 19 percent in 1982 to 33 percent in 1986. A disturbing 30 percent of pregnant women with low incomes received no health care during their first trimester of pregnancy, and 20 percent of those with hypertension had not had their blood pressure checked within a 12 month period.

The last and, in many cases, the only resort of the uninsured is to be treated in a hospital emergency room — the most expensive health care setting -- placing the burden of financing care for the working uninsured disproportionately on companies which provide protection and facilities that provide coverage. This is what is known as cost-shifting. In 1986, uncompensated care accounted for 6 percent of total charges in California hospitals. Approximately, 15 percent of all uncompensated care provided in California is borne by public hospitals, the very hospitals on which the burden of coping with the AIDS epidemic has clearly fallen most heavily.

Organized labor urges this committee to develop legislation based on the only equitable solution — requiring employers to provide protection and covering the remaining uninsured through public programs.

Under the leadership of Governor Michael Dukakis, Massachusetts has led the way for the nation. In that state, a comprehensive program has been designed to meet the diverse needs of the state's entire uninsured population. This goal will be accomplished through a series of initiatives phased in beginning in 1989. By 1992, all Massachusetts residents are expected to have coverage. There are five major compenents to this legislation:

- Next year a statewide insurance pool will be established for small firms with six or fewer employees. Individuals in such firms could purchase protection through this pool or their employers could purchase protection on their behalf.

- o Beginning September 1989, all students studying at least three-quarter time will have health insurance coverage offered through their schools.
- o In 1990, a two-year tax credit (20 percent in year one and 10 percent in year two) will be offered to businesses with 50 or fewer employees and which have not offered health insurance in the previous three years.
- o In 1990, persons receiving unemployment compensation will be eligible for employer-subsidized health insurance. Employers will be required to contribute 0.12 percent of the first $14,000 in yearly wages per employee to finance health insurance for the unemployed.
- o In 1992, employers will be required to contribute 12 percent of the first $14,000 in yearly wages per employee. The great majority of employers who presently provide health care coverage will receive an offsetting credit so they will not have to pay this amount.

The Massachusetts program will make affordable insurance available to employers by establishing an insurance pool for small business. This will minimize any adverse selection one firm might face because of the demographic makeup or health status of its workforce. By requiring all employers to have health insurance for their employees the legislation will eliminate the competitive disadvantage that employers providing insurance now face.

The Massachusetts employer mandate applies to all employers except those with five or fewer employees, the self-employed, and new businesses in their first year of operation. All other employers must make contributions for all full-time employees and all part-time employees working at least 20 hours per week

after 180 days or after 90 days, if they are heads of households. Employers with 50 or fewer employees who are severly impacted by the 12 percent contribution will be eligible for financial assistance.

The Massachusetts program will also improve access for those who would not be covered by the employer mandate. Its goal is to expand Medicaid to cover poor families who have no permanent ties to the workplace and to allow early retirees and other individuals with relatively higher incomes to purchase insurance protection from the state pool.

Let me now turn to your situation here in California about which I am, of course, admittedly not an expert. Therefore, I wish to make some general observations based on experience across the nation that you might wish to consider. I am starting with the premise, which I hope you accept, that your aim should be to assure health care coverage to every resident of California just as Massachusetts has done. That does not mean, of course, that your legislation would have to be exactly the same.

National studies have shown that three-fourths of all workers without health insurance protection have incomes under $10,000 per year and 93 percent earn less than $20,000. It is crucial, therefore, in developing your solution that you consider the burden on employees that premium-sharing and heavy out-of-pocket costs would impose. Our view is that any premium sharing should not exceed 20 percent and that deductibles and coinsurance should be as modest as possible. In addition, it is crucial that the state explicitly require that insurance sold to employees through state pools include cost containment features, particularly managed care, to minimize total premium costs and out-of-pocket requirements imposed at the point of treatment.

Currently, we are seeing a great many initiatives of states and local communities attempting to grapple with the access problem. Many have been aided by demonstration grants from the Robert Wood Johnson Foundation. Unfortunately, since these initiatives are new, little data are available about what works. Generally the 15 Johnson-supported initiatives break down as follows:

- o 12 are developing modest, low cost insurance products.
- o 5 are developing mechanisms to pool risk by fostering the formation of multiple employer groups.
- o 5 are subsidizing the purchase of insurance for individuals.
- o 11 are attempting to reduce insurance costs through managed care.

As you may know, Hawaii was the pioneer enacting mandated employer health insurance in 1974. According to all accounts, that program has been quite successful. A number of state initiatives are worth noting.

This year the state of Oregon began offering a five-year tax credit to employers with 25 or fewer employees who offer health care protection. In addition, to encourage broad participation in the program, coverage is being offered through a state pool.

In July of this year, the state of Washington began making available a basic health care plan to families with incomes under 200 percent of the federal poverty level. The state has negotiated preferred provider relationships and will subsidize the purchase of coverage on a sliding scale related to family income.

In 1986, the Wisconsin state legislature developed an ambitious plan that would have gone into effect in 1988. Unfortunately last year, the initiative was vetoed by the new Governor. The proposed plan had five components: it would have offered subsidized coverage to individuals who were unemployed for the

previous six months or not offered coverage through their employers; it would have subsidized the cost of protection for employees who were offered a plan by their employers but could not afford to purchase it; it would have provided high risk individuals access to a pool for medically uninsurables; it would have made short-term loans to the temporarily uninsured; and it would have provided for the development of insurance products for the disabled.

Essentially, these three states illustrate the range of choices available to the California legislature should it decide to move forward. Our view, however, is that none of these options would be as effective in solving the access problem as an employer mandate. The AFL-CIO believes that the Massachusetts model offers an efficient and effective approach for California to consider, and we hope that the legislature will move ahead in this direction.

In cooperation with the California Labor Federation, AFL-CIO we stand ready to provide whatever support we can in the process of developing legislation and implementing a program.

CALIFORNIA'S EMPLOYEES WITHOUT HEALTH INSURANCE

Invited Testimony of

E. Richard Brown, Ph.D.

School of Public Health
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Los Angeles, CA 90024-1772

Committee on Industrial Relations
California Senate
Sacramento, California
October 20, 1988

Thank you, Mr. Chairman, for the invitation to present my research findings about the problem of the uninsured and the implications of this research for solving this problem.

Much of my work on health insurance coverage has been conducted in collaboration with my colleagues Drs. Robert Valdez and Hal Morgenstern at the UCLA School of Public Health. I would like to share with the Committee some of our research findings. We analyzed the health insurance coverage of the California population for the period 1979-1986, using data from the Current Population Surveys conducted by the U.S. Census Bureau. I would like to highlight some of our findings, starting with a general picture of the uninsured population and then describing employment-related characteristics of the uninsured.[1]

The number of uninsured Californians increased dramatically between 1979 and 1986

Compared to a decade ago, more of the United States population is uninsured -- no private insurance, no Medicare and no Medicaid coverage throughout the year.

Our study found that the problem in California is more severe than in the country as a whole and that conditions have been deteriorating more rapidly. In 1979, 17% of California's population under 65 years of age were uninsured (when the U.S. average was 15%), but by 1986, 21% of nonelderly Californians were without any coverage (when the U.S. rate was 18%).

Between 1979 and 1986, the number of Californians without any health insurance coverage increased from 3.5 million to more than 5.1 million, nearly a 50% increase in seven years.

The problem in Los Angeles and some other parts of California is even more severe than for the state as a whole. In 1986, 26% of Los Angeles County's nonelderly population were without private or public health insurance coverage all year, up from 20% in 1979. More than 2 million Los Angeles residents are uninsured all year.

Among the 20 largest metropolitan areas in the United States, Los Angeles, Orange County, and San Diego have the first, second, and third largest proportions of uninsured nonelderly population, respectively.

Half the increase in the number of uninsured was due to rising rate of uninsured

The 1.6 million increase in the number of uninsured Californians was due partly to the growth in the state's population and partly to changes in the proportion of the population who have insurance coverage. In Figure 1, the steeper line reflects the number of people who were actually uninsured during this period, and the line below it represents the growth in the number who would have been uninsured if the rate of insurance coverage had remained constant at the 1979 level of 17%. Thus, the number of uninsured people would have been about 4.3 million in 1986 if the rate had not changed, a growth of about 800,000 attributable to the increase in population.

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[1] Much of this testimony concerning research findings on the uninsured is adapted from E.R. Brown, R.B. Valdez, H. Morgenstern, P. Nourjah, and C. Hafner, *Changes in Health Insurance Coverage of Californians, 1979-1986*, Berkeley: California Policy Seminar, University of California, August 1988. This study, undertaken for the California Legislature, was funded by the California Policy Seminar.

The difference between these two lines represents the increase in the number of uninsured attributable to the growing *rate* at which people were uninsured. About 800,000, or one-half the total increase, were added to the ranks of the uninsured by changes in the rate of health insurance coverage.

Children and young adults are at greatest risk of being uninsured

The proportion of uninsured children and adults increased in all age groups, but the percentage of young adults (18-29 years of age) without health insurance increased most dramatically -- from 22% in 1979 to 30% in 1986.

The proportion of near-poor who are uninsured has increased dramatically

Near-poor children (those living in families with incomes between the federal poverty level and 150% of poverty, or $16,800 for a family of four) experienced a massive increase in the percentage who were uninsured -- from 27% in 1979 to 40% in 1986, a rate that is nearly twice that of all nonelderly Californians.

The percentage of uninsured adults increased among all income groups. The proportion of uninsured poor adults increased from their already very high rate of 41% in 1979 to 46% in 1986. The increase for the near-poor was the most dramatic -- from 29% in 1979 to 39% in 1986.

Poor and near-poor children and adults now constitute 45% of all uninsured Californians, up from 38% in 1979, as illustrated in Figure 2.

Nevertheless, a large proportion of the uninsured are not poor at all: 27% of all uninsured Californians (1.4 million) had family incomes at least three times the poverty level (about $33,600 for a family of four in 1986).

Latino children and adults experienced startling increases

One in three Latino children and adults were uninsured in 1986, up from one in four in 1979, the highest rate among all ethnic groups. Although lower than the rate for Latinos, the proportions of uninsured blacks, Asians and other ethnic groups are also higher than the rate for non-Latino whites.

However, the problem of uninsured Californians is not just a minority group problem. Although non-Latino whites consistently have had the lowest rates of being uninsured among all ethnic groups, their rates in California have averaged about two percent higher than the rates for non-Latino whites in the U.S. as a whole.

The proportion of workers who are uninsured increased

Of greater concern to this Committee, however, is that the uninsured in California, as in the rest of the country, are predominantly workers and their families. Working people themselves constitute more than half the uninsured.

The number of Californians (16-64 years of age) who work for a living but have no health insurance coverage rose from 1.7 million in 1979 to 2.7 million in 1986. Uninsured workers have increased faster than uninsured persons not in the labor force and faster than uninsured children, so that workers now represent a somewhat larger share of the uninsured than they did in 1979. As Figure 3 illustrates, in 1986 uninsured workers represented 53% of the uninsured population.

The number of uninsured workers grew rapidly because of the steadily rising rate at which they were uninsured, as shown in Figure 4, from 15% in 1979 to 20% in 1986. And throughout this period, California's rates were one-third higher than for the U.S. as a whole. For example, in 1986, 15% of U.S. workers were uninsured, compared with 20% for California.

The uninsured rate rose among the self-employed and private-sector employees

Although the proportion of government employees who were uninsured hovered between 6%-8% from 1979 to 1986, the rate for self-employed workers increased sharply from 30% to 37%.

However, private-sector employees had the largest absolute impact on the uninsured problem. The percentage of employees of private-sector firms who were uninsured increased steadily from 15% in 1979 to 20% in 1986, as Figure 5 illustrates. They alone constituted 43% of all uninsured Californians in 1986.

The probability of being uninsured increased sharply among full-time and part-time workers. Among full-time full-year employees (those who worked at least 35 hours a week for at least 50 weeks a year), the uninsured rate rose from 9% in 1979 to 12% in 1986. The uninsured rates for full-time part-year and part-time employees were more than twice the rates for full-time full-year employees. But full-time full-year workers (who represent a very large part of the workforce) are now a larger share of all uninsured employees -- up from 34% in 1979 to 42% in 1986, as shown in Figure 6.

Low-income employees are far more likely to be uninsured than are more-affluent employees. Among all full-time employees in California in 1986, 48% of those with family incomes below 150% of the poverty level ($16,800 for a family of four) were uninsured, four times the rate of 12% for those with family incomes above that level.

The proportion of employees with health insurance as a fringe benefit has fallen

Because most people still get their health insurance through their employment, it is not surprising that increases in the proportion of employees who are uninsured correspond to decreases in health insurance coverage provided as a fringe benefit by employers. Among full-time full-year employees, as Figure 7 illustrates, 78% were covered by their employers' health plan and 9% were uninsured in 1979, compared with 75% covered by their own fringe benefit and 12% uninsured in 1986.

Far fewer full-time part-year employees receive health insurance as a fringe benefit, and their proportion has been falling even more rapidly. In 1979, as shown in Figure 8, 51% of full-time part-year employees were covered by their employers' health plan and 21% were uninsured, compared with 45% who received this fringe benefit and 28% who were uninsured in 1986. The ranks of the uninsured would have been even greater in 1986 if full-time full-year employees had not increased as a proportion of all employees, from 55% in 1979 to 62% in 1986. It should be noted that the proportion of employees with privately purchased health insurance also declined during this period.

As is now well known, the proportion of employees who are covered by their employers' health plan is much lower in some industries than in others. Even considering only full-time full-year employees, the proportion with this fringe benefit was lower in the personal services sector (41%), agriculture, forestry and fisheries (44%), the retail sector (61%), and construction (66%) than in, for example, transportation (81%), professions (81%), and durable goods manufacturing (86%).

Why is the growing lack of health insurance a problem?

First, *compared to people with health insurance coverage, the uninsured have much less access to necessary medical care.* A 1977 study by the U.S. National Center for Health Services Research found that insured persons averaged more physician visits per year than people without insurance.

Similarly, a 1986 study by the Robert Wood Johnson Foundation found that, compared to insured people, the uninsured were less likely to see a physician in a 12-month period, less likely to get their young children adequately immunized, less likely to receive prenatal care in the first trimester of pregnancy, less likely to have their blood pressure checked, and less likely to see a physician if they had serious symptoms. The Foundation study also found substantial deterioration in the access to care of the uninsured between 1982 and 1986.

Second, the little research that has been conducted on the impact on people's health of being uninsured suggests that *reduced access to medical care due to lack of insurance coverage may contribute to a severe decline in individuals' health status*, especially among persons with chronic illnesses. For example, a study at the UCLA Medical Center found that loss of Medi-Cal coverage had a serious adverse impact on the health status of patients with diabetes and high blood pressure.[2]

Finally, *everyone pays for care that the uninsured do receive.* Uncompensated care (bad debts and charity care) cost California's hospitals $827 million in fiscal year 1984-85, up from $531 million in 1981-82. In inflation-adjusted dollars, uncompensated care increased 27% in just three years.[3] Taxpayers shoulder the financial burden of uncompensated care provided by California's county hospitals -- $345 million in 1984-85. This problem is likely to worsen as the number of AIDS patients, including those who are medically indigent, increases during the next few years.

Private hospitals in California provided the other $481 million of uncompensated care in 1984-85. Private hospitals shifted the costs of much of their uncompensated care to privately insured patients and their employers, who pay most of their health insurance premiums. But as cost-shifting has become more difficult over the last few years, more and more private hospitals have found ways to keep out uninsured patients. Many have closed their trauma centers and shut their emergency room doors to "911" rescue ambulances. Eleven hospitals in the downtown Los Angeles area are now threatening to downgrade their emergency rooms in this way, an action that would create a black hole for emergency care that could directly affect hundreds of thousands of people. The fact that 2 million residents are uninsured helps explain why so many hospitals in Los Angeles have experienced severe financial burdens of uncompensated care.

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[2] N. Lurie, N.B. Ward, M.F. Shapiro, and R.H. Brook, "Termination from Medi-Cal: Does It Affect Health?" *New England Journal of Medicine*, 1984, *311*:480-484; and N. Lurie, N.B. Ward, M.F. Shapiro, C. Gallego, R. Vaghaiwalla, and R.H. Brook, "Termination of Medi-Cal Benefits: A Follow-up Study One Year Later," *New England Journal of Medicine*, 1986, *314*:1266-1268.

[3] T.G. Rundall, S. Sofaer, and W. Lambert, "Uncompensated Hospital Care in California: Private and Public Hospital Responses to Competitive Market Forces," presented at American Public Health Association annual meeting, New Orleans, October 21, 1987. The authors analyzed data from the Office of Statewide Health Planning and Development.

Need for public policy action

The number and the proportion of Californians, including full-time workers, who are uninsured have increased dramatically. Similar trends have been identified nationally, but the problem is more severe in California than in much of the rest of the nation. The problem of the uninsured already has reached crisis proportions. It urgently requires public policy action.

But what solution strategies would be appropriate? One solution that has been twice approved by the California Legislature and twice vetoed by the Governor is a risk pool for people who have been denied health insurance because of pre-existing medical conditions. This approach has a lot of appeal because it targets people whose desperate need for coverage is obvious even to the most skeptical observer. However, one study estimated that of the 5.1 million uninsured people in California, 244,000 are medically uninsurable, and that not more than 15,000 would be likely to participate in even a heavily subsidized risk pool. Although such risk pools are helpful to some people, they do not benefit very many of the uninsured and are expensive for the state to subsidize.

Because most of the uninsured are workers and their families, it is logical to look to employers as one solution to this problem. One approach, recently enacted in California (S.B. 2260), will provide tax credits to small employers who offer their employees health insurance coverage. It is difficult to estimate how many uninsured workers and their families will benefit from this or similar tax-credit proposals because this approach relies on voluntary efforts by employers. Their participation rate is likely to be influenced by the costs of health insurance plans that are available to them, the market for their own products or services (that is, would adding insurance premiums to their labor costs make them less competitive?), and the labor market (can they get and keep workers if they don't provide health insurance?). However, if we assume that 200,000 workers and dependents were covered under this program in plans that cost not more than $100 per month per person, foregone tax revenues would cost the state $60 million. If 1 million people were eligible for this subsidy -- one-fifth of all uninsured Californians, the cost to the state would be $300 million. That is a substantial cost in state revenues which would grow by $300 million for every 1 million additional eligible people, and it could be much more if insurance premiums exceed $100 per month.

The high cost of such programs has encouraged many legislators and members of the Congress to propose legislation that would mandate employers to provide health insurance to their employees and dependents. This strategy would place the full cost of such health insurance on employers and their workers, unlike the tax-credit approach in which the state would absorb 25% of the cost. This has obvious advantages for the state, but it has some equally obvious disadvantages for employers.

The effectiveness of this strategy depends upon what cut-points are adopted: how many hours per week would an employee have to work to be covered by this provision? would small employers be exempted, and if so, how small is small? If we make a few assumptions about the provisions of such a bill, we can examine how this approach would affect the uninsured population in California. Our data analysis thus far considers part-time workers as those who work less than 35 hours a week. To illustrate the effect of one type of employer mandate, I will assume that the proposal would cover all employees who work at least 35 hours a week and their dependents, regardless of the size of the firm in which the employee works. If it is 100% effective, then 1.7 million employees would receive health insurance together with about 860,000 children and another 250,000 homemakers, for a total of about 2.8 million people, or 55% of all the uninsured in

California. Of course, extending eligibility downward to employees who work 17.5 hours a week or more, as the Kennedy-Waxman and Stark bills propose, would include a greater proportion of the uninsured. However, employers might respond by reducing working hours for many part-time employees to keep them below the insurance threshold. Excluding employees who work less than, say, two months for one employer and excluding small employers would substantially reduce the effectiveness of the mandate.

An employer mandate certainly would be a welcome relief to the uninsured who are covered by it and to public and private providers who now care for them. But it also would impose substantial burdens on low-wage paying employers. For example, the Kennedy-Waxman bill would raise labor costs of employers who pay very low wages by as much as 20%, according to the Congressional Budget Office.[4] Moreover, an employer mandate would not solve numerous other systemic problems, such as continually rising health care costs and the fragmentation of health programs and plans.

Incremental strategies, such as risk pools, tax-credit programs, and employer mandates, can help small to large numbers of uninsured people, depending on how they are structured. However, for the most part, they would add new patches to what is already a badly frayed crazy quilt. Specifically targeted solutions, even those that are as broad in scope as the recently enacted Massachusetts legislation, would add more fragments to an already fragmented, increasingly confusing, ever more costly system of health care.

Another, broader alternative would be a universal and comprehensive health insurance system, particularly one that would overhaul the way we finance and pay for care. A state or national health insurance system could promote equitable access to quality care, help allocate resources more effectively and efficiently, and control the amount of money that we as a society spend on health care.

There is strong popular support for public policy interventions, including national health insurance, to address these problems. Recent national public opinion polls have found support for national health insurance among about two-thirds of adult respondents, and support is even stronger in California.[5] In a poll in Orange County, California, an area that is not known for its liberal political views, 75 percent of respondents favored national health insurance, including 67% of Republicans.[6] I believe that this strong public support should encourage legislators and policymakers to propose and enact the most effective solutions to this pressing problem.

Thank you, Mr. Chairman and members of the Committee, for considering my views.

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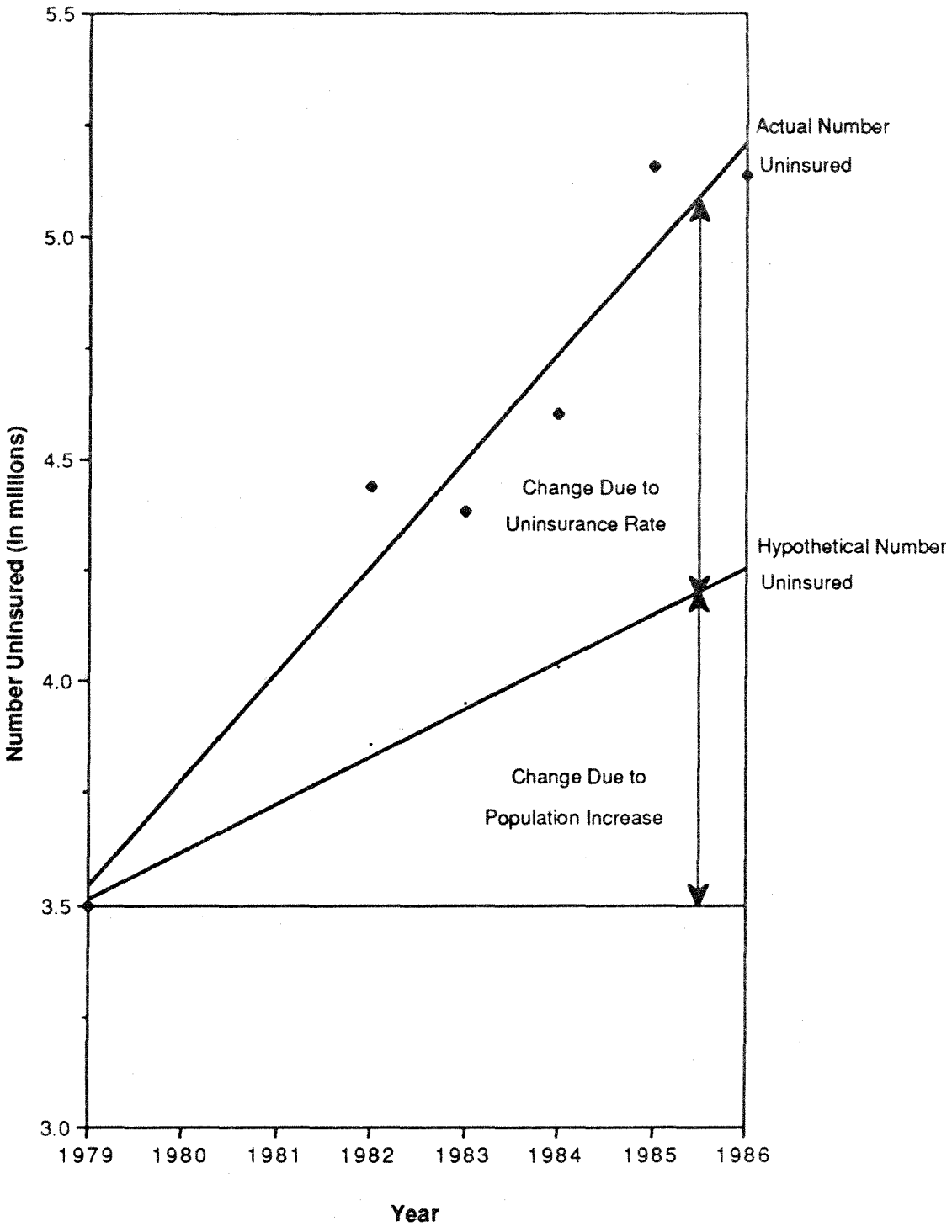
[4] Statement of Edward M. Gramlich, Congressional Budget Office, Nov. 4, 1987.

[5] A. Parachini, "Health Care Debate: Who Will Pay the Way?" *Los Angeles Times*, Aug. 30, 1987, pt. VI, pp. 1, 10-12; A. Parachini, "AIDS Is No. 1 Health Issue in State Poll," *Los Angeles Times*, March 29, 1988, pt. V, pp. 1, 2, 7; and G. Pokorny, "Report Card on Health Care," *Health Management Quarterly*, 1988, *10*:3-7.

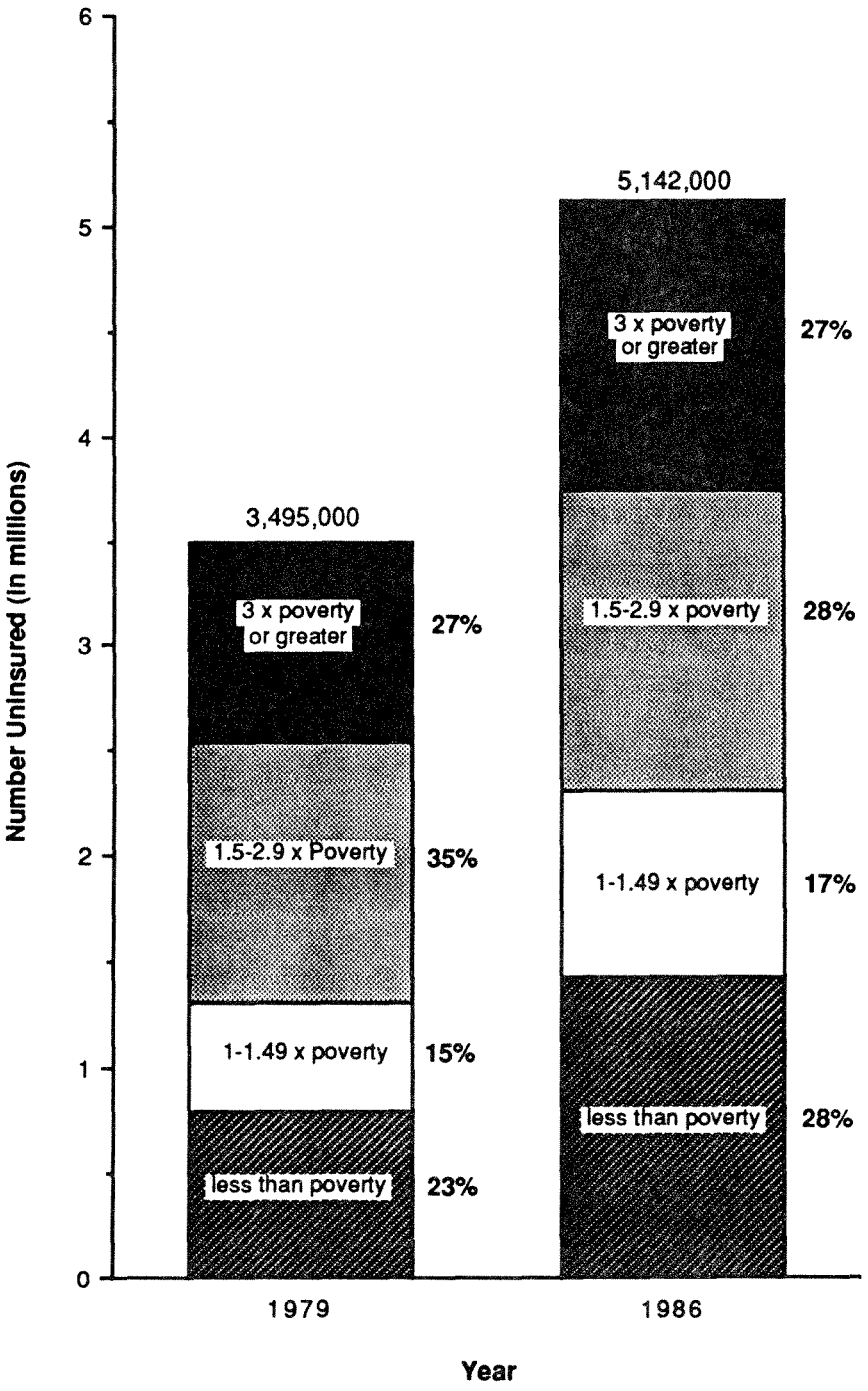
[6] S. Peterson, "Poll: 75% in OC Favor National Health Insurance," *Orange County Register*, Sept. 22, 1987, pp. A1, A10-11.

Figure 1. Components of Change in Number of Uninsured Nonelderly Persons: Actual Number Versus Hypothetical Number of Uninsured if Uninsurance Rate Remained Constant at 17%, California, 1979-1986



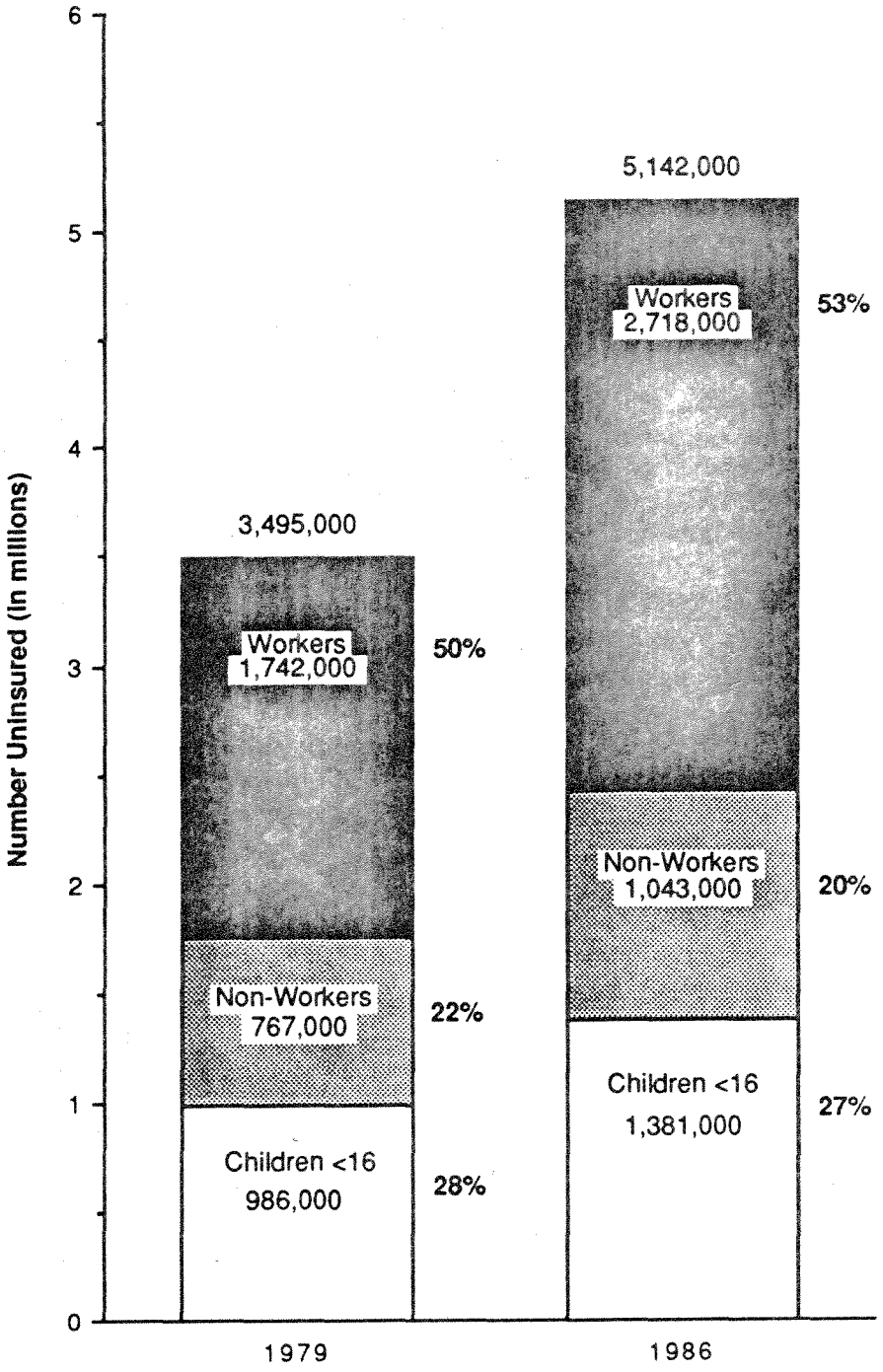
Source: March Current Population Survey data tapes, 1980, 1983-1987

Figure 2. Change in number of Uninsured Nonelderly Persons By Family income Relative to Poverty, 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980 & 1987

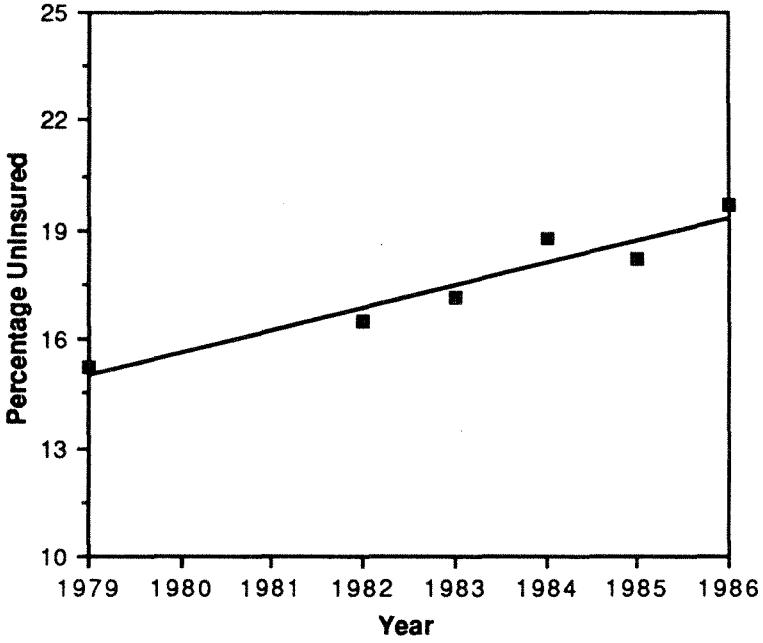
Figure 3. Number and Percent of Nonelderly Uninsured Persons By Labor Force Participation in 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980, 1987

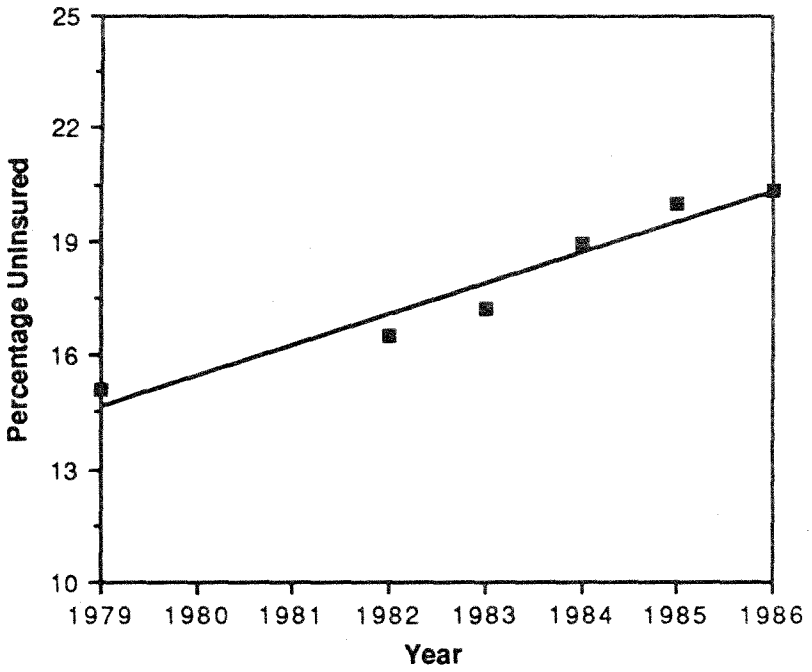
Note: "Workers" includes employees and self-employed persons.

Figure 4. Percentage of Workers (Age 16-64) Who Were Uninsured, California, 1979-1986



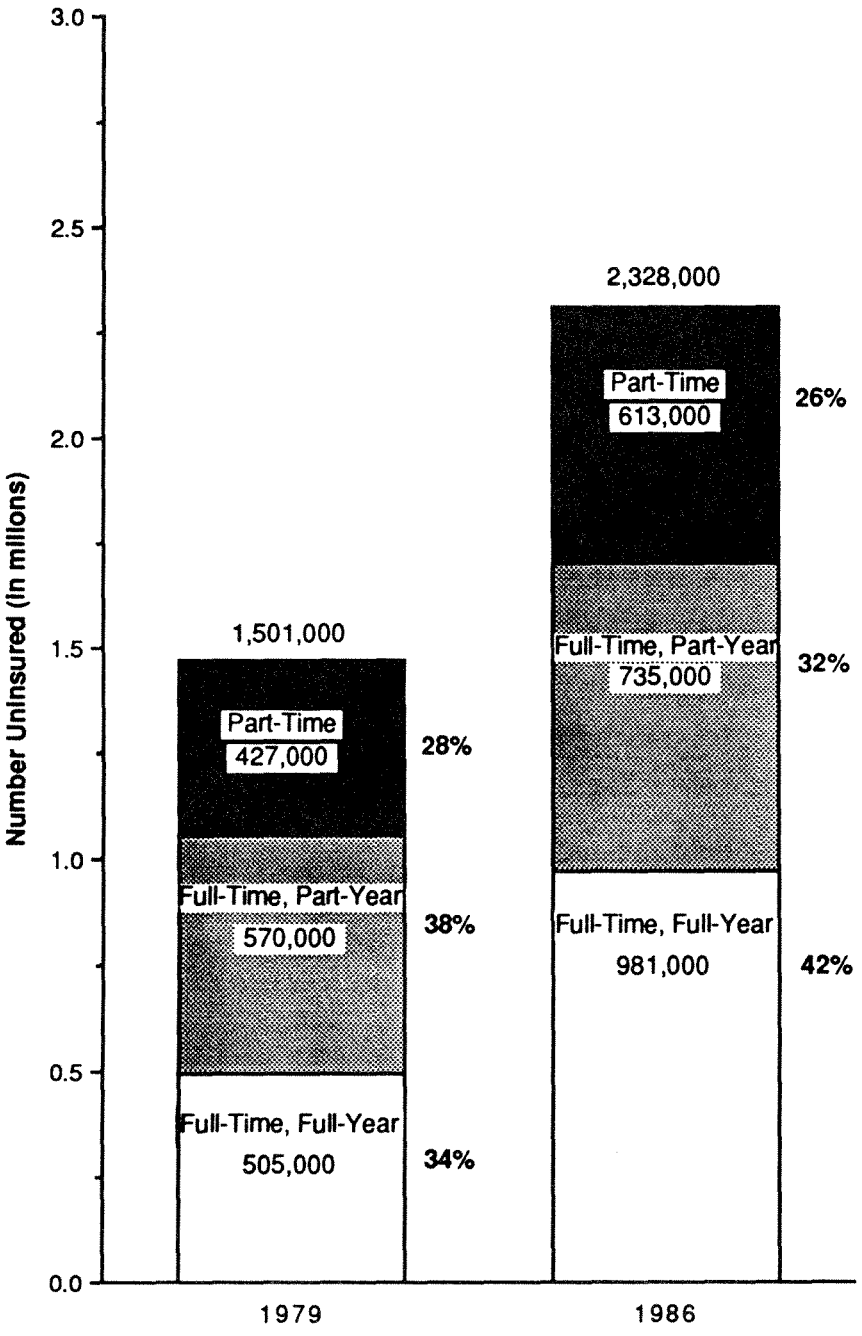
Source: March Current Population Survey data tapes, 1980, 1983-1987

Figure 5. Percentage of Private-Sector Employees Who Were Uninsured, California, 1979-1986



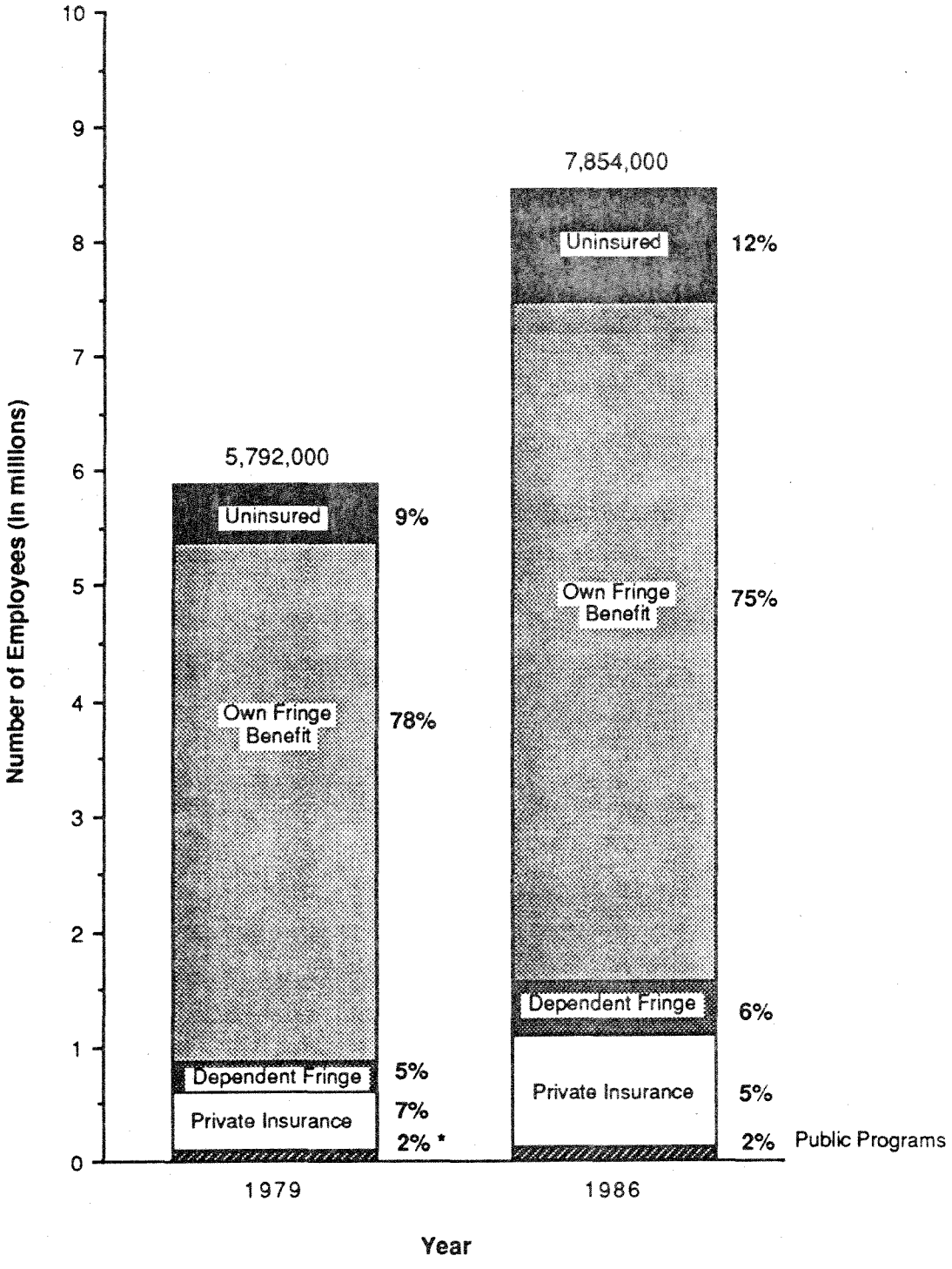
Source: March Current Population Survey data tapes, 1980, 1983-1987

Figure 6. Number and Percent of Uninsured Employees by Full- & Part-Time Employment, California, 1979 & 1986



Source: March Current Population Survey data tapes, 1980, 1987

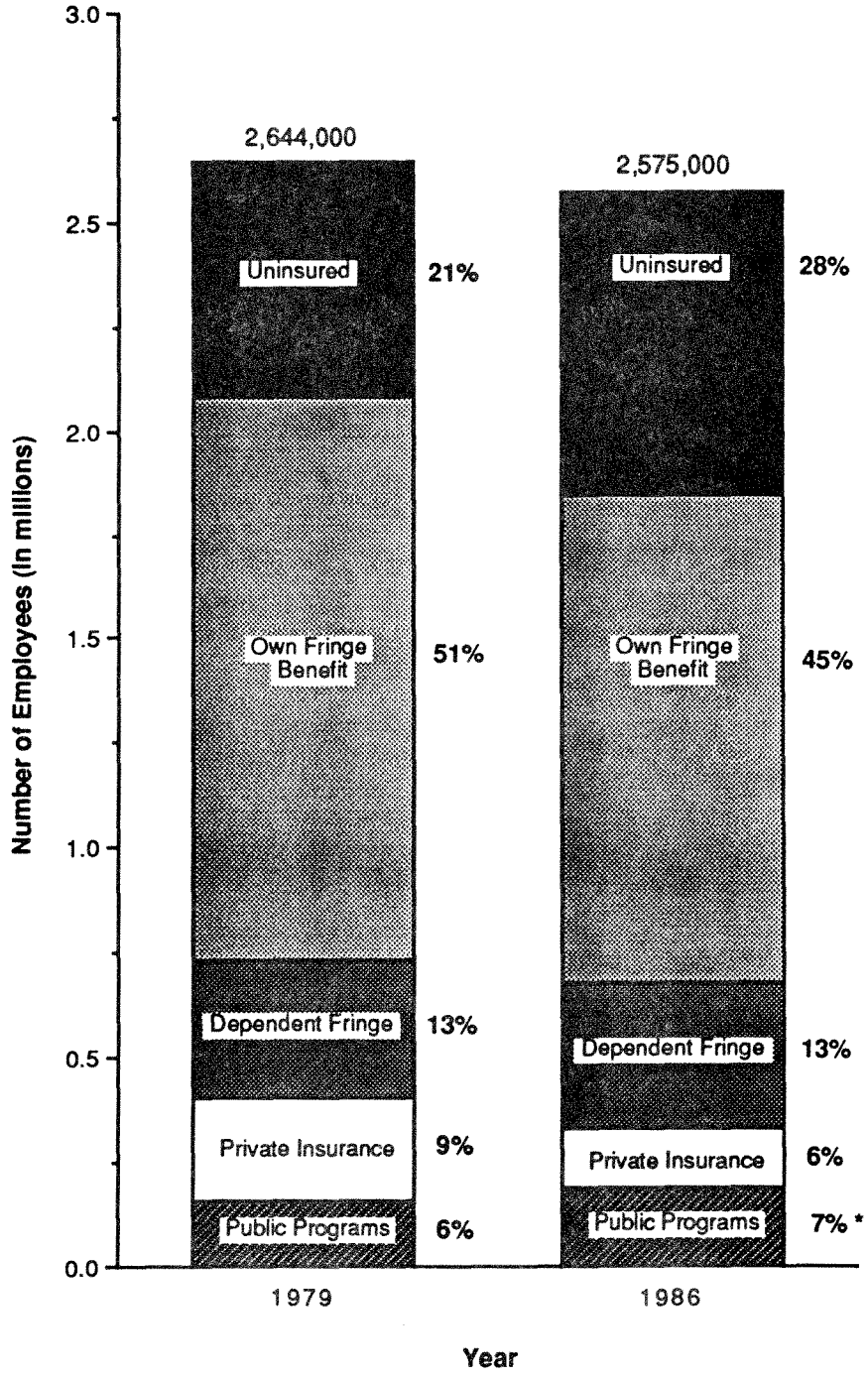
Figure 7. Full-Time, Full-Year Employees By Health Insurance Status And Source of Coverage, 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980 & 1987

*Does not add to 100% due to rounding.

Figure 8. Full-Time, Part-Year Employees By Health Insurance Status And Source of Coverage, 1979 and 1986, California



Source: March Current Population Survey data tapes, 1980 & 1987

*Does not add to 100% due to rounding.

STATEMENT OF

PATRICIA E. POWERS

BAY AREA HEALTH TASK FORCE

BEFORE THE CALIFORNIA SENATE INDUSTRIAL RELATIONS COMMITTEE

ON

"EXPANDING HEALTH CARE AMONG SMALL BUSINESSES"

OCTOBER 20, 1988

INTRODUCTION

Mr. Chairman, and members of the Committee, I am pleased to be a part of this hearing on business and health care. My name is Patricia Powers. I work for the Bay Area Health Task Force, a coalition of policy makers, purchasers, and health care providers convened by United Way of the Bay Area. Last year the Task Force conducted an in-depth study of San Francisco's working uninsured population. Based on these data, we are initiating a Health Benefits Information and Referral Service for uninsured small firms in the Bay Area. The Service will provide health care information and link employers with brokers and health maintenance organizations dedicated to finding them coverage.

Prior to my work for the Task Force, I served as the Advocate for Health Policy for the Chief Counsel of the U.S. Small Business Administration in Washington, D.C. I worked with Congressional and Administration staff to explore ways to provide health care coverage for the uninsured.

There is a growing amount of statistics on the uninsured and I defer to several knowledgeable witnesses who are here today to provide you with in-depth data. Instead, I will first briefly present some key characteristics of uninsured small businesses and their employees. These characteristics reveal that small firms' ability to sponsor health benefits differs from that of large businesses. Understanding these differences and the difficulties small employers face in sponsoring health benefits can provide insight into developing ways to assist them. Finally, I will discuss a range of Federal, state, and local initiatives

that focus on the expansion of health insurance among small firms.

THE IMPORTANCE OF HEALTH CARE TO SMALL BUSINESS

Health care is second only to vacations among all fringe benefits provided by employers. Employer-sponsored plans have burgeoned since World War II, when they began to receive favorable tax treatment; 84 percent of health insurance is now provided through the workplace. In order to attract and retain employees, employers strive to establish health care plans.

There are three trends that make health care an issue of highest concern for small firms. First, health expenditures in the United States have increased from $42 billion in 1965 to nearly $500 billion in 1987. Health care expenditures comprise almost 11 percent of the Gross National Product, and growth in health care costs continue to outpace the rate of inflation. In 1986, health care costs averaged 8 percent of payroll, for an employer outlay of almost $1,500 per employee (The Wyatt Company, 1986). Small employers, who in general pay from 10 to 40 percent more for health care than large employers, are especially interested in keeping costs down, while providing reasonable benefits.

Second, changing demographics will heighten the importance of affordable health plans to small business. An increasingly elderly population means that even greater efforts will be needed to check rising health costs. In addition, as growth of the labor supply slows and there are fewer workers available, health benefits will be an increasingly important tool in

helping small employers compete for the most qualified labor.

Third, there is much debate about the ramifications of the growth in the medically uninsured population in this country. In light of government fiscal constraints, policy makers are turning to employers as a vehicle for resolving a large portion of the problem. Small businesses are at the center of this focus because most of the working uninsured are found in small firms. Small employers in turn are concerned about mandated benefits and the trend toward increased regulation of welfare plans. Firms without plans fear that the result of mandated health insurance will be fewer jobs and lower wages. Firms with health benefits find it costly and administratively burdensome to keep up with new, complex requirements.

WHY THE UNINSURED IS A SMALL BUSINESS ISSUE*

There are between 32-37 million nonelderly uninsured persons (17%) nationwide, 5.1 million uninsured persons in California (21.6%), and an estimated 189,000 adults (18.3%) and 80,000 children (26.8%) in San

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*National data used throughout the testimony can be found in The State of Small Business: A Report of the President, (Washington, D.C.: U.S. Government Printing Office, 1987), Chapter 4, pgs. 133-183. California figures are from "Changes in Health Insurance Coverage of Californians, 1979-1986", California Policy Seminar, University of California, 1988. San Francisco data are from the "Bay Area Health Task Force Final Report on The Project on the Working Uninsured, Phase I 1987-1988," May 1988.

Francisco who are uninsured.

Nearly eighty percent of the uninsured across the country and across the state are employed or dependents of workers. National data indicate that about one-quarter, or 8.2 million, of the uninsured are private sector wage-and-salary workers. Of these working uninsured, 6 million are in firms with under 500 workers, with the majority (3.9 million) employed in firms of 1-24 employees. In addition, there are another 1.6 million uninsured business owners, primarily sole proprietors, and 1.6 million government, farming and household workers without any source of insurance.

In California, there are an estimated 2.7 million uninsured nonelderly workers. Approximately 48,000 persons who live and work in San Francisco are uninsured. Among the working uninsured, self-employed persons, followed by private-sector workers, are at highest risk.

Not surprisingly, as is true for all fringe benefits, the prevalence of health care increases with firm size. Both national and San Francisco employer surveys indicate that only slightly more than half of employers in firms with 25 or fewer employees offer coverage, compared to almost 100 percent in larger companies. For businesses with ten or fewer employees the figures are 46 percent nationally, and 41 percent in the San Francisco.

There are several key firm characteristics associated with lower health coverage, including industry, age, and legal form of business. Nationally

and in California small business-dominated industries, notably certain services, retail trade, construction, and agriculture, forestry, and fishing, are more likely to lack health benefits. In San Francisco, the arts and health care industries also have significantly lower rates of coverage.

The older the firm, the more likely it is to provide health benefits. National data show that there is about a 15-percent difference between small businesses with fewer than 25 employees operating 10 years or less and those in operation more than 10 years. Similarly, a San Francisco employer survey revealed that 36 percent of firms in business less than five years offered health benefits, compared to 57 percent of firms established for over five years.

There is also a significant gap between unincorporated businesses' (generally sole proprietors) and incorporated firms' coverage. Even for firms in the smallest size category of 1-9 employees, unincorporated firms are about half as likely as corporations to provide coverage to owners and workers.

Workers nationwide and in California who are more likely to be without employer-provided health care--and more often found in small businesses--are younger and older workers, women, Hispanics, less educated, part-time, low-wage and single workers. Working uninsured

persons in San Francisco are also disproportionately young and single; however, in contrast to the nation as a whole, they tend to be white, better educated, and more affluent. Nearly 30 percent of the working uninsured in San Francisco reported incomes greater than $25,000.

REASONS WHY SMALL BUSINESSES LACK HEALTH COVERAGE

Health insurance is more expensive for small employers.

Data indicate that group insurance premiums in small companies run from 10 to as much as 40 percent higher than large firms. One national study, for example, showed that in 1985, small firms (under 100 employees) average monthly premiums were $85 for single coverage and $205 for family coverage, compared with $77 and $181, respectively, for firms employing more than one hundred workers. If benefit and in-house administrative differences are taken into account, and if the costs of large business' self-insured plans are used as a point of comparison, the gap widens further.

There are several reasons why small firms pay more. First, it is simply more costly to administer a health plan for a small company. It is much cheaper to market and sell insurance to one firm with one thousand

employees than one hundred firms, each with ten employees.

Second, small firms experience higher turnover and employ relatively more part-time workers, which further drives up administrative costs. Health care for part-time workers is also costly for the employer since the cost is the same as that of a full-time employee.

Third, small businesses generally cannot enjoy cost-savings associated with self-insurance. Only five percent of firms with under 100 workers are self-insured, while at least 40 percent of firms with over 500 employees use this method. Cost-savings associated with self-insurance include avoidance of state mandated benefits and state premium taxes, as well as greater control over cash flow and the incorporation of cost containment features. Because of their size, small companies often must acccept a standard insurance package and do not have leverage to negotiate provider discounts. Their ability to exercise control over benefits, or provide a variety of plans with varying deductibles and copayments as costs saving measures is also more limited.

Fourth, small business owners do not have time to understand the complexities of health care or shop around for a plan that suits their firm. They are too busy running their business; one study revealed that small business owners spent an average of four hours a year on health care. The recent enactment of Federal legislation, such as mandatory continuation coverage for employees and dependents, and welfare

nondiscrimination rules, merely exacerbates this problem by increasing employer responsibilities when they do establish a health plan. These firms usually cannot afford trained benefits personnel to select plans, assist enrollees, or follow health regulations.

Fifth, firms less likely to offer health benefits tend to be "marginal," with low and variable profits. They are often reluctant to commit to an expensive benefit with uncontrollable costs.

Finally, as previously mentioned, data indicates that even in the smallest size category of 1-9 employees, unincorporated businesses are about half as likely as incorporated companies to offer health benefits. The reason for this may be at least partially attributable to a Federal tax inequity related to business ownership. While corporate business owners may deduct the full health premium for themselves, unincorporated business owners can only deduct 25 percent of their own premium. This provides less of an incentive for these individuals to purchase a plan for themselves and their workers.

Small businesses are usually subject to medical underwriting standards.

Firms with under ten, or in some instances, under twenty employees, usually must have each employee complete a medical questionnaire in order to assess their health status. Because they are better able to spread risk, large companies are not subject to this requirement by commercial

insurers (or they are self-insured). Small firm employees' health status is not significantly different from large firm workers. Rather, insurers view small firms as higher risk because of adverse selection (i.e., higher risk individuals are more likely to join the plan), high employee turnover, and frequent carrier changes. This medical screening process for small businesses adds to the cost of their insurance. More important, it serves to either screen out high-risk employees or their pre-existing condition, or result in no coverage for the entire firm.

Additionally, failure to meet any number of underwriting requirements may mean that the firm is refused coverage. These include minimum participation standards for eligible employees (e.g., 75-100 percent), a minimum employer contribution (e.g., 50-100 percent), or the purchase of other benefits (e.g., life insurance). Frequently, certain industries that are perceived as high-risk or costly because of high employee turnover, such as bars, restaurants, and beauty salons, are deemed completely ineligible or are subject to special restrictions.

The prevalence of AIDS has led to even tighter medical underwriting restrictions in certain areas, notably San Francisco. Examples of insurers refusing to cover certain zip codes or industries perceived as likely to have a high incidence of AIDS has led to litigation. One broker recently told me that some insurance companies now request all medical records for every applicant living in San Francisco who is single. While the cost of an AIDS case can more readily be absorbed by a large company,

insurers often hike small firm premiums in anticipation of these claims.

The bottom line is that medical underwriting and insurer requirements for small companies means that (a) insurance is more difficult to obtain, and (b) it is more expensive.

Health insurance may not be affordable or desirable for small firm workers.

Many small business employees are "secondary wage earners" and covered by a spouse's health plan. The firm, therefore, may not be able to meet an insurer's minimum participation requirement to qualify as a group. Also, small business workers are disproportionately low-wage earners and may prefer higher wages to health benefits when there is a trade-off, or simply are unable to afford the employee or dependent coverage contribution. These individuals are also disproportionately young persons who tend to be healthy workers and frequently view health care as an unnecessary expense.

THE POLITICAL CLIMATE FOR HEALTH CARE: WHO SHOULD PAY?

Providing minimal health coverage to every medically uninsured person in California would cost upwards from $8 billion. The difficult question facing us is: if we want to cover all of these people, who is to pay?

The choices lie among employers, beneficiaries, or government.

There is a trend toward shifting benefit costs away from Federal government and onto states, localities, and employers, along with stricter regulations and enforcement of benefit plans.

There has been a trend to shift the responsibility to provide health care away from government and onto employers. In Fiscal Year 1987 alone, additional health costs to employer plans are estimated at $1.8 billion in benefit payments, plus an additional amount in administrative costs. For example, employers with health plans are now the primary payer, rather than Medicare, of elderly workers' and elderly spouses', and disabled workers' health care. Under the 1985 Consolidated Omnibus Budget Reconciliation Act (COBRA), employers are also required to continue to offer health insurance to employees who leave, widows, divorced spouses, and certain dependents. If they elect such coverage, beneficiaries pay 102 percent of the premium costs. People with poor health tend to take advantage of this coverage, thereby increasing the cost of the group as a whole. Also, beginning January 1, 1989, employers must comply with complicated new nondiscrimination rules for health plans.

The trend toward requiring more responsibility of the employer in exchange for tax favorable treatment of benefits is evident by the plethora of recent proposals introduced in Congress. These include mandating a minimum health benefits package for all employers, mandating specific

benefits, such as prenatal/child care, or catastrophic care, mandating long term care, and mandating family leave benefits. These proposals are generated by societal concern over the growth in the uninsured and underinsured and an unwillingness to use public sector dollars.

State legislatures have enacted numerous health insurance mandates and are experimenting with ways to cover the uninsured

Regulation of group health benefits is not new for state legislatures. By 1987, there were over 600 specific types of mandated benefit laws enacted across the country, requiring coverage of certain providers or treatments or continuation coverage. In California alone there are at least 23. Currently only two states, Hawaii and Massachusetts, require (or will require) employers to establish employer-sponsored health plans.

Outside of employer-mandated insurance, state governments are also enacting legislation or fostering local projects that target the working uninsured. I applaud the recently signed California tax credit for small businesses providing health insurance for the first time. This type of incentive will make health care more affordable for these firms and their workers.

There are two unique projects in California that are part of The Robert Wood Johnson Foundation's Program on the Uninsured. In San Diego, the Council of Community Clinics is devising a way to provide low-cost primary care to the uninsured working poor in firms of ten or fewer employees and unemployed persons in the County.

The project I am working with, The Bay Area Health Task Force, is attempting to provide objective health benefit information to small employers with 25 or fewer employees, and link them with area brokers and HMO representatives. There are over 2,000 insurance products available to small firms in San Francisco. The Health Benefits Information and Referral Service will assist employers that are in a position to offer health care find a plan appropriate to their employees' needs and the firm's resources. The project's aim is to reduce the search costs for small employers, as well as insurers' and HMOs' marketing costs. The project will initially target San Francisco small employers, but will eventually expand to other Bay Area counties.

There are thirteen other Foundation-funded projects underway around the country, many of which work closely with state and local governments, in addition to employers, insurers, and providers. The demonstration approaches include developing or modifying insurance products, creating pooling arrangements, subsidizing low-income uninsured persons, and obtaining provider discounts.

To assist their medically uninsurable population (i.e., high-risk individuals who have been turned down by at least two insurance companies) at least fifteen states have established state risk pools. In general, these pools cap the individual's premium. Costs incurred in excess of the premiums are generally covered by taxes on group insurers, or through general revenues. The number of state risk pool enrollees and the success of the financing schemes vary.

POLICY RECOMMENDATIONS

The uninsured population is diverse, requiring not one simple solution, but a complex combination of approaches. I have three broad recommendations for reducing the working uninsured population in California: First, spread the costs of the uninsured as widely as possible. Proposals such as employer-mandated health insurance impose a tax on entrepreneurs and small employers, who are least able to absorb such a cost, and fail to address why these firms currently lack coverage. Second, lower the cost of health insurance for small employers. The key to expanding employer-sponsored health plans is to lower either the administrative or actual plan cost for these firms. Third, build cost containment features into any selected approach. If fiscal responsibility is not a part of the solution, it will only serve to fuel the already exorbitant cost of health care.

Below are some specific ways to assist small businesses in obtaining health insurance.

1. Eliminate/curtail the growth of state mandated benefits.

State mandated benefits have been estimated to increase group health insurance costs by 10 to 15 percent and have encouraged larger companies to self-insure. Several states have recently enacted legislation that requires a proponent of a new mandated benefit to perform a cost-benefit

analysis before the benefit is taken up by the legislature. This law ensures that careful consideration is given to the financial impact of the proposed mandate.

Alternatively, the state may allow insurers to offer a bare bones health benefit package that is not subject to mandated benefit requirements.

2. Assist public-private group pooling arrangements for small firms.

Many states and localities have created pooling arrangements for small companies to spread their risk. Such an arrangement enhances the employers' attractiveness to the insurer/provider. Moreover, it provides leverage to the group purchaser acting on behalf of many employers to negotiate for discounts.

There are a variety of ways to encourage such pooling arrangements. Last year Oregon enacted legislation to establish a state-administered health insurance pool for small firms in conjunction with a tax credit for participants. Massachusetts' recently enacted comprehensive health legislation includes a pool for small businesses, to be administered by the new Department of Medical Security (DMS). The DMS is also responsible for making sure small firms have access to health plans at the same rates as larger companies. In Arizona, the provider network which serves Medicaid patients is being used to attract the small firm market.

Setting aside funds for counties, chambers of commerce, or others can provide the needed incentive to establish a small business pool. The return on such an investment will be a reduction in state and local costs for indigent care.

3. Analyze the feasibility of a state risk pool for medically uninsurables.

At least fifteen states have created subsidized health care pools for the medically uninsurable - i.e., persons who have been turned down by at least two insurance companies. Many self-employed persons and others with pre-existing conditions can afford to pay a reasonable health care premium, yet are unable to qualify for a plan. Creation of a state risk pool can provide an avenue for these persons to receive insurance. This mechanism would also allow small firms that otherwise would be deemed high risk because of such individuals to establish a health plan.

4. Scrutinize insurance industry practices in medical underwriting, especially with respect to industry exclusions, employer requirements, and assessments related to AIDS.

The trend toward tighter medical underwriting standards for small firm plans should be closely examined. The California Department of Insurance and the Department of Corporations should verify that such restrictions are based on sound actuarial data and not discriminatory practices.

5. Educate the public on the crisis of the uninsured and the importance of health insurance.

A key component to the Bay Area Health Task Force Project on the Uninsured is a community-wide education campaign. Individuals must understand the consequences of not having health insurance if a catastrophe strikes. Demand on the part of employers will serve as an incentive for employers to offer health benefits. County business and health coalitions, consumer groups, community clinics, and public health departments can be useful sources for information dissemination.

CONCLUSION

In sum, providing health care to California's 5.1 million uninsured citizens is a significant challenge. Employers can help in meeting that challenge...at least so far as the uninsured are in the work force. The issue of the working uninsured is largely a small business issue. One easy answer would be to merely require these employers to offer and pay for health benefits for their workers. Upon examining the nature of these firms and the reasons why they lack coverage, however, the solution is not so simple and would adversely affect business formation and employment growth.

I recommend voluntary incentives to lower the costs of small group health insurance. Specifically, I recommend eliminating or curtailing state

mandated benefits, creating pooling arrangements, both for small employers and the medically uninsurable, and relaxing medical underwriting standards for small group plans. These approaches, combined with a concerted education campaign and the newly enacted tax credit for small employers to purchase insurance, will go far toward expanding health care for the working uninsured.

I appreciate the opportunity to appear here today and will be pleased to respond to the Committee's questions. Thank you.

THE BAY AREA HEALTH TASK FORCE

The Project on the Working Uninsured:
Phase I
1987 - 1988

Executive Summary

"Insurance brokers are not user friendly."

Small Business Owner
Focus Group - August 1987

"I don't have the time or resources to devote to marketing my services to these small businesses."

Insurance Broker
Focus Group - August 1987

"There are too many choices - I don't have the expertise in my office to decide which coverage is best for my staff."

Owner of Liquor Store
Focus Group - August 1987

"I just haven't got around to buying it. Besides, I'm young and healthy so I really don't need insurance."

Artist - Self-Employed
Telephone Interviewee - October 1987

Introduction

This reflects just some of the data and information obtained during a one year planning effort by the Bay Area Health Task Force to learn about the needs of the working uninsured in San Francisco.

The Bay Area Health Task Force was selected as one of the 15 recipients to participate in a national demonstration program sponsored by the Robert Wood Johnson Foundation. The purpose of the planning grant was to determine the health insurance needs of the working uninsured, and whether there was sufficient interest and potential demand for a proposed information service to assist small businesses in obtaining health coverage.

Background

In the Fall of 1985, the Bay Area Health Task Force began meeting to discuss the growing problem of the uninsured and the underinsured in San Francisco. The Task Force was convened by the United Way of the Bay Area, and is comprised of representatives from the public and private sectors as well as providers and purchasers of health care. It is the only forum of its kind in San Francisco where these different groups can meet to discuss issues of mutual concern. The Task Force has focused its efforts on the challenge of improving access to appropriate care.

As its first activity, the Task Force commisssioned a report that was released in July 1986 which defined the magnitude of the problem for San Francisco, and proposed several strategies to address the issues identified. According to the findings of that report, an estimated 143,000 to 221,000 people in San Francisco are considered to be uninsured or underinsured, representing over a third of the population under 65. The report also identified that about 57% of the uninsured and underinsured were working - approximately 80,000 to 125,000 individuals.

The Task Force felt that the needs of the working uninsured were different than those individuals who were uninsured and not working. Therefore, as their second major activity they applied for a grant from the Robert Wood Johnson Foundation in conjunction with the Foundation's Health Care for the Uninsured Program. The Bay Area Health Task Force was selected as one of the recipients to participate in this national demonstration, and was awarded a one year planning grant in March 1987.

Underlying Strategy

Small businesses and their employees were chosen as the target populations because of the 1986 report commissioned by the Bay Area Health Task Force, which estimated that over one-half of the uninsured population in San Francisco are employed. In considering why the working

uninsured do not have health coverage, the Task Force hypothesized that it was not due to lack of insurance product availability. According to a 1986 San Francisco Medical Society survey, nearly 150 different insurance coverage options and products were available. While some policies had expensive premiums, others were more affordable in the $60-$80 per month range (for workers under 30).

This finding led the Task Force to hypothesize that a large component of the uninsured problem may simply be lack of information. It was hypothesized that small employers often do not have the time and resources necessary to search for appropriate insurance policies nor the expertise to evaluate their differences. In contrast, large employers often have staffs solely devoted to evaluating different health benefit options.

It was further hypothesized that if lack of adequate information about insurance options and accessibility to that information was one of the major factors preventing small businessess and the self-employed from obtaining coverage, then a central information resource could be of great assistance.

Methods

Several different data gathering techniques were incorporated to obtain information on the needs and characteristics of the working uninsured, and on the feasibility of creating a new information service.

1. A questionnaire mailed to 2,726 business owners.

2. A telephone survey of 258 working uninsured employees

3. Focus groups comprised of small business owners, employees, and self-employed (the working uninsured) and insurors.

4. A telephone survey of 261 small business owners.

What Was Learned About the Working Uninsured in San Francisco?

Characteristics of the Working Uninsured:

- The working uninsured is predominantly young - 59% are under age 34, and are younger than the general San Francisco population.
- While 35% of the working uninsured report income less than $15,000; over 28% report incomes greater than $25,000. It appears that not all of the working uninsured are indigent.
- Of those who do report low incomes (<$15,000), less than half work full time.
- 30% of uninsured had some college education; 44% had a college or graduate degree.
- Survey respondents were predominantly single (61%).
- 80% report to be in good or excellent health.
- Estimated size of working uninsured population in San Francisco is about 45,000 to 48,000 individuals.

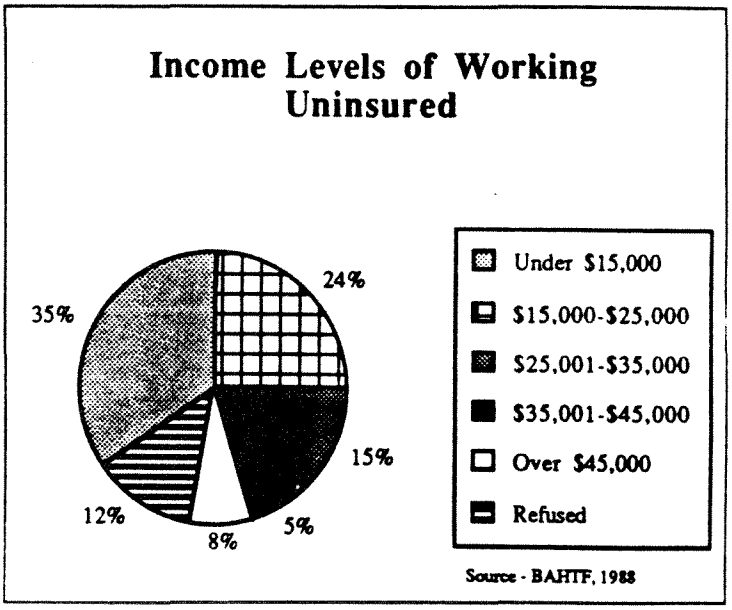

FIGURE 1.

Insurance Expectations of the Uninsured:

- People have unrealistic expectations of what insurance would cost: 41% would pay only up to $25; 32% would pay between $26-$50 per month. A more realistic cost is between $50 - $100 per month.
- The majority of uninsured work for firms with less than 25 employees, and 32% work for employers with less than 6 employees.
- The majority report no regular source of care (60%).
- 29% said they did not seek needed care because of lack of insurance.
- The majority sought emergency room coverage and it was also reported to be the primary source of care for the uninsured.

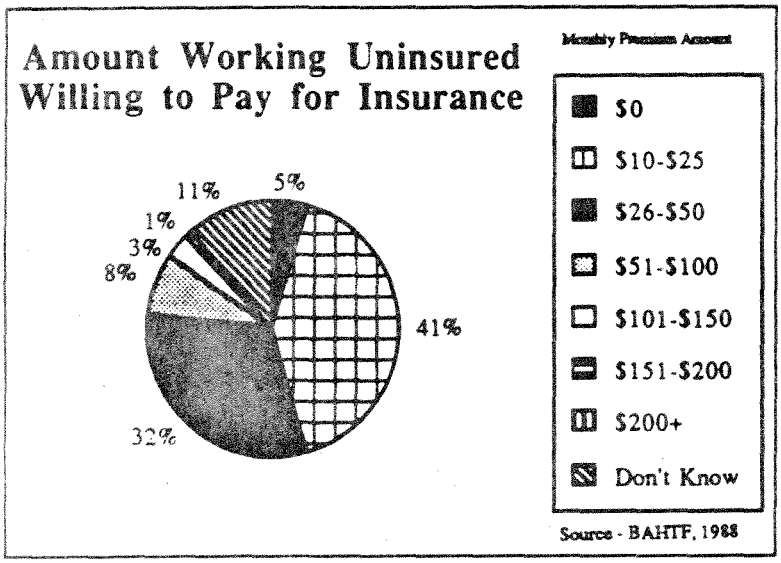

FIGURE 2.

Characteristics of Small Businesses:

- Of the estimated 31,000 small businesses with less than 25 employees, it appears that only 52% offer insurance. It appears that at least 15,000 small businesses are in need of insurance.
- Firms with greater than 25 employees were most likely to offer insurance.
- The smallest firms and the youngest firms were least likely to offer insurance.
- In San Francisco, there are about 21,153 firms with 1 - 3 employees, and it is estimated that of these only 8,250 offer insurance.
- The primary reason small businesses report not offering insurance is that it is too expensiuve. Firms also expressed difficulty in obtaining adequate information about relative costs and benefits.

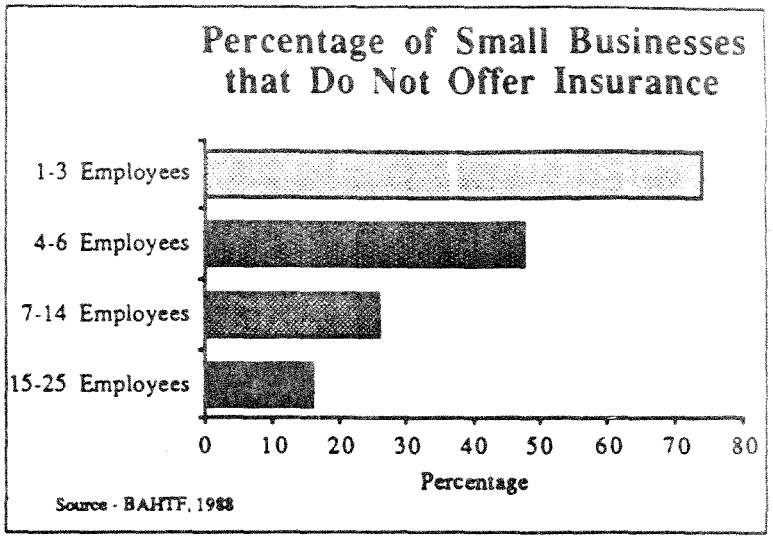

FIGURE 3

What is Different About San Francisco?

These data and other information obtained suggest that there are several features about the working uninsured in San Francisco, which may be different than in other communities:

(1) A large proportion of the uninsured report being healthy and, therefore, are not a high risk population for insurors as they often feared.

(2) There is a sizeable portion of the uninsured who appear to be able to afford the costs of health insurance.

(3) There are many uninsured and small business owners who have very unrealistic expectations about the actual costs of health insurance.

(4) There are many different insurance options and products in this region, which can make a decision more difficult due to inadequate information.

(5) The growth in the San Francisco business economy is predominantly provided by new small businesses.

(6) The large proportion of individuals who earn incomes greater than $25,000 and do not purchase insurance may reflect the region's entrepreneurial spirit, and willingness to take risks - even foregoing health insurance.

(7) Health care costs are higher here than in other parts of the country.

Recommendations: A Proposed Health Benefits Information Service

The findings obtained from the data gathering strategies strongly supported the need for the implementation of an information and referral service. The underlying principle of the proposed Health Benefits Information Service is that it is essentially a win-win strategy. During this planning year, it was learned that many small businesses do not have adequate information nor time to evaluate the many different insurance options offered in the Bay Area. In turn, it was also learned that it is not efficient for brokers to spend their time marketing to very small businesses. The proposed service would provide a mechanism for both those needs to be met.

The proposed service would provide the dual function of educating small businesses and the community on the need for health insurance, how to go about purchasing it, and what are reasonable cost expectations. Callers to the service would then be referred to a list of health insurance professionals (brokers and agents) who have insurance products specifically designed to meet the needs of small businesses and the self employed. To date, a number of brokers and agents have already committed to serving the small business community. Funding to operate the service is now being sought, and it will be located at the United Way of the Bay Area.

This proposed strategy is intended to address only one aspect of the complex issue of the uninsured. It targets those individuals who have the capacity to purchase insurance while they are still young and healthy, i.e., before they could have difficulties in becoming eligible. A different strategy will be needed to assist those who either cannot afford even the lowest premium, or who have preexisting conditions. State risk pools or pending legislation could be the mechanism to address those other important needs. The Bay Area Health Task Force will continue to develop innovative strategies to improve access to health care in our community.

Support for this Project Was Provided by:

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United Way of the Bay Area

Written by:
Susan Wilner, Sc.D.
Project Director
May 1988

United Way of the Bay Area

STATEMENT
BEFORE THE SENATE COMMITTEE ON INDUSTRIAL RELATIONS
HEARING ON LABOR FORCE HEALTH COVERAGE

Submitted by Kaiser Foundation Health Plan, Inc.

October 20, 1988

Mr. Chairman and Members, I am Steve Zatkin, Counsel to Kaiser Foundation Health Plan, Inc. We recognize the importance of the issue which the Committee is considering--the lack of health benefits coverage for a large number of Californians many of whom are employed persons or their dependents. Our comments address the five questions raised by the Committee on page 2 of its Notice of Hearing on Labor Force Health Coverage.

1. What options are available to California to significantly increase the availability of health insurance coverage for the uninsured workers?

   The Notice of Hearing refers to programs recently enacted in several states. These may be divided into the following types of programs:

   a) Mandates on employers to provide specified health benefits coverage. Hawaii is the only state with such a mandate. Implementation of the mandate required a specific exemption from the federal ERISA preemption which would be difficult for other states to obtain.

b) Tax on employers reduced by employer expenditures for health benefits. Massachusetts recently enacted this type of program. Effective January 1, 1992 employers with more than five employees must pay a tax equal to 12 percent of the first $14,000 of wages for employees who have worked a specified number of hours. Employers may deduct from this tax their average expenses per employee for health benefits. Revenue from the tax will be to finance, in part, a health care program for the uninsured.

c) Tax credits for a portion of the cost of health benefits coverage for employers who have not provided coverage within a specified period. Oregon has established such a program. California recently enacted such a program (SB 2260) which will take effect in 1990 if specified conditions regarding the state's fiscal condition are met.

d) Health benefits coverage with income-related subsidies. The Massachusetts program creates a new state agency with the responsibility to arrange for the purchase of health benefits coverage for the uninsured through private plans. Enrollees will have the cost of coverage partially subsidized by

public funds. Financing is derived from the 12 percent tax on employers, a supplemental employer tax of .12 percent to cover the unemployed, and state general funds.

Washington State, Oregon and Wisconsin have established pilot programs to provide health benefits coverage to the uninsured, financed principally through general revenues.

e) Technical assistance to employers in the purchasing of health benefits coverage. Massachusetts has established a program to assist small employers in purchasing health benefits coverage. West Virginia enacted a risk pool for small employers. The Robert Wood Johnson Foundation is funding several projects to assist small employers to combine their efforts in purchasing coverage.

f) Risk pools for the medically uninsurable. At least fifteen states operate programs that provide health benefits coverage to persons who have been turned down for individual health coverage by private

carriers because of their health status. Most of these programs are subsidized by assessments on health benefits carriers; however, self funded plans cannot be assessed because of the ERISA preemption. More recently, states have sought other sources of subsidy such as general funding (Illinois) and the disability insurance tax (AB 600 - California). Risk pools for the uninsurable would cover only a small portion of the working uninsured.

The major new approaches available to increase coverage for the working uninsured are employer mandates, employer taxes that have the effect of mandates, and publicly subsidized health benefits coverage. We would strongly recommend that any publicly sponsored health benefits program for the working uninsured provide eligible beneficiaries with a reasonable choice of cost effective health plans. Public financing for such a program should be broadly based and equitable in impact so that the financial burden does not fall disproportionately on any one sector.

2. How do proposals for increasing health insurance coverage affect health care costs and how are these costs distributed in society?

Health care costs for the working uninsured currently are paid through a variety of sources. These include:

a) employees from their own funds;

b) state and federal funds, in the case of employees who are eligible for Medicaid or other state or federal programs;

c) local and state funds, in the case of employees who receive health care through county health facilities or private facilities eligible for payment by counties;

d) health care payers, including other patients, health benefits carriers and other employers, in the case of employees whose care provided by physicians, hospitals and other providers is uncompensated and the cost of that care is passed on to other payers,

e) health care providers, in the case of employees whose care is uncompensated and the cost of that care cannot be passed on to other health care payers.

The costs of care for uninsured workers are spread indirectly and unevenly to providers, payers and taxpayers. Proposals to increase the availability of care would redistribute this cost and, because of increased third party coverage, would probably increase it as well. The nature of the redistribution would depend upon the financing method which is adopted. Employer mandates or taxes would place the burden on employers not presently providing health benefits coverage. Subsidized health insurance and tax credits would place the burden on the revenue sources taxed to finance the subsidy or tax credit.

3. <u>What makes employer provided health insurance more affordable and available to some employers and industries and less affordable and available to others</u>?

Three factors may determine differences in the cost and availability of group health insurance: (1) the group's size;

(2) the group's utilization of covered services and (3) the efficiency with which covered services are provided.

It is more costly to administer a small group than a large one and all health benefits carriers have minimum group sizes below which they will not provide group coverage. Thus, very small employers may have difficulty obtaining coverage. Some state programs and Robert Wood Johnson projects are designed to pool the resources of smaller employers to permit them to purchase the equivalent of large group insurance.

Experience rated carriers calculate a group's rates based upon the group's utilization of services; groups with higher rates of service use pay higher rates. Kaiser Foundation Health Plan employs community rating for most of our groups. This maintains affordable rates for all such groups and their members.

The efficiency with which covered benefits are provided is a matter of increasing concern to employers. As a result, growing numbers of employers are using managed care programs, including HMOs and PPOs to provide health benefits coverage.

Employer access to health care coverage can be improved by programs which provide them with technical and financial assistance in purchasing health benefits. Small employers in particular could benefit from such programs.

4. What types of limits and exclusions are being proposed or implemented to restrict admittance to group health insurance plans, and what options do excluded workers have to obtain health care coverage?

Many health benefits carriers and self-insured employers impose preexisting condition restrictions and waiting periods on employees enrolled in their plans. Federally qualified HMOs are prohibited from using those restrictions. Increased deductibles and copayments are being imposed by many employers and carriers to reduce health benefits costs. HMOs are similarly restricted in the extent to which they may impose copayments and deductibles by federal and state law. Instead of imposing these restrictions, Kaiser Foundation Health Plan has sought to contain costs by the efficient provision of covered services.

5. Are individual health insurance policies available and affordable to employees and self-employed persons? To what extent are premiums higher for individual policies and what accounts for this?

Kaiser Foundation Health Plan offers individual coverage to persons who apply and pass medical review screening and to any group enrollee who loses group coverage. Our individual coverage is community rated and is, therefore, comparable in cost to group coverage for the same benefits. A modest charge is added to the price of our individual coverage to cover the additional administrative cost.

Many health benefits carriers do not offer individual coverage. Those that do, except for community rated plans, charge much higher rates to enrollees in an attempt to protect against adverse selection and to compensate for administrative costs.

We appreciate the opportunity to comment on this very important issue.

SERVICE EMPLOYEES
INTERNATIONAL UNION, AFL-CIO, CLC
CALIFORNIA STATE COUNCIL
1510 J Street, Suite 140 • Sacramento, CA 95814 • (916) 442-3838

TESTIMONY BEFORE THE CALIFORNIA STATE SENATE

COMMITTEE ON INDUSTRIAL RELATIONS

SENATE HEARING OCTOBER 20,1988

"LABOR FORCE HEALTH CARE COVERAGE"

I am Leah Morris, representing the 240,000 members of the California State Council of Service Employees International Union, SEIU. Thank you for the opportunity to comment today on the issue of labor force health care coverage. In a word, that coverage is -- lacking.

As recent research has well documented, there is an ever increasing number of Californians who lack health insurance. The biggest threat to universal health care is the breakdown of

health coverage at the workplace. Historically, health coverage has been widely established through public insurance for the elderly, disabled and poor, and employer-provided private insurance for workers and their families. Today this system is being swiftly destroyed by health care costs rising at double the rate of inflation, by changes in the service sector economy and by cost containment efforts of insurers and employers. The result is that today 80% of uninsureds are working people and their families. When added to the 10% of uninsured dependents of insured workers, approximately 90% of the uninsured are in some way attached to the workforce. Many of SEIU's low wage workers fall among the ranks of the uninsured -- janitors, clericals, and nurses aides.

Even workers <u>with</u> employer-provided coverage must struggle financially and fight with employers to maintain their benefit levels. The US Department of Labor, Bureau of Labor Statistics, documents that employee paid premiums increased 19% between 1980 to 1986, with employees now paying 37% of premium costs for family plans. Employee deductibles have risen as well: in 1982 -- 63% of plans had deductibles of $100 or more, by '86 -- 85% of plans had deductibles of $100 or more. Deductibles of $150 went from 4% to 15% in that same period.

On an ever increasing basis we see employers trying to take-back health benefits or shift costs to workers. In Santa Barbara the

county workers were recently near striking because the county proposed to increase dependent coverage premiums. In San Francisco, over 1600 health care workers struck for three weeks over the employer's proposal to reduce health care coverage. It is cruel irony to create a pool of uninsured workers who are themselves the providers of the care they would be denied. California is not alone in this circumstance, similar stories abound in New York, Oregon, Pennsylvania and other states across the nation.

Many workers, faced with rising premiums, are choosing to drop health coverage altogether. These workers swell the ranks of a publicly subsidized health system which is constantly cutting services and staff due to financial crises. In many instances the worker's very jobs pose serious health hazards -- and they can expect little help from our ham-strung Cal OSHA program or the federal OSHA program meant to safeguard their health.

The failure of employers to provide health insurance, and the loss of coverage due to rising premiums, puts a terrible burden on the health care system, as well as endangering workers and their families. California taxpayers end-up subsidizing the costs for businesses that do not provide health benefits. Federal, state and local governments, and employers who insure workers, all subsidize health care for the growing ranks who lack health coverage. Most people with no employment-based

health coverage rely on publicly subsidized services -- through public hospitals, county clinics and health departments. The size of the subsidy is enormous. To begin to document this problem, SEIU conducted a study of public subsidies required by home health workers in Los Angeles County.

Of the 5.1 million uninsured Californians, approximately 140,000 are health care workers. Dietary staff, linen personnel, registry nurses, and home health workers are a few of the health care workers who may lack coverage. To paraphrase Jesse Jackson, these people cannot afford to lie on the hospital bed sheets they change daily.

The growing service economy has produced millions of low wage, no benefit, part-time jobs. The Los Angeles homecare workers we surveyed are a good example of this service sector. Largely female, with children, earning $3.72 an hour, this part-time labor force provides health care to over 50,000 elderly and disabled Californians. Their employer offers them no health insurance. These people rely on subsidized public health services for their care:

* 7% get health insurance through direct public insurance, either MediCal or Medicare.

* 54% get their care through the "back door" by relying on emergency rooms and County hospitals as their primary source of care.
* 10% use community clinics for their primary care, and
* 16% are eligible for direct low-income cash assistance programs.

How does this translate into dollars?

Taxpayer support for this one group of 40,000 workers, for uncovered health care which can't be paid out of their paychecks, totals over $21 million dollars in 1988. Additionally, over $38 million public dollars fund the cash assistance programs. Federal dollars, State dollars, and Local dollars subsidize the health care of these workers. All are taxpayer dollars.

The taxpayer subsidy for employers who do not provide health benefits has been largely hidden in the debate around the uninsured and underinsured. Though hidden, the costs are not inconsequential. Paying for health care through the "back door" is more expensive due to exacerbated illnesses from lack of care, premature births from poor perinatal access, and the inefficiency of indirect financing for indigent care through hospitals, the most expensive health care providers. Hospitals pass those costs along to insurers, be they public or private. This is an expensive and poor use of taxpayer dollars to

subsidize employers who do not provide health coverage. Employers who do provide coverage also bear the burden through higher costs shifted to them by insurance companies. Premiums go up, employers may try to shift the costs to employees, workers drop coverage because they can't afford premiums, end up in county hospitals... and the vicious cycle continues.

As the means of assuring access to health care for all Californians, SEIU supports enactment of a universal, comprehensive health program. Equitably financed, the program must provide incentives for preventive care. Furthermore, it must remove the current reimbursement system incentives to reduce costs through layoffs or reduction of work hours for health care workers, or the substitution of low wage task-oriented staff for higher paid professional staff. Much of the current attempts at cost-containment mistakenly aim at reducing the staff, since labor constitutes a large share of the health care dollar. Adequate financing must account for adequate labor to provide the very care we want access to. Overwhelmingly, "health care" means the people who provide that care.

SEIU supports partial solutions for improving access, such as the recent Baby Cal legislation. However, we oppose solutions that place an unfair burden on working people, such as certain catastrophic risk pools. Finally, short of a comprehensive plan,

SEIU supports required employer-provided minimum health insurance. The taxpayer subsidy of profitable employers who do not provide health coverage must end. The expense and inefficiency of such subsidies is a price California cannot afford to bear much longer. Additionally, those resources are vitally needed to stabilize essential public and county health services such as prenatal care, emergency services, and funding for long-term-care.

Our health care system is in a crisis in terms of costs, quality and access. We must establish a minimum standard for basic health care at the workplace as a cost of doing business. Doing so benefits workers and their families with better health care and protection from financial devastation, as well as savings in taxpayer subsidies and excess costs to businesses that do insure their workers.

Thank you for the opportunity to testify today.

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CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

TESTIMONY
Michael Dimmitt, Ph.D.
Director of Management Information Services
California Association Hospitals and Health systems
to
Senate Industrial Relations Committee
October 20, 1988

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In May of 1988, the California Association of Hospitals and Health Systems (CAHHS) established a task force of hospital and physician leaders to evaluate the CAHHS position on marketplace health care and prepare recommendations for consideration by the CAHHS Board of Trustees.

The Task Force was established because there is a consensus among CAHHS members that marketplace health care is failing to meet anticipated goals of policy makers, patients and providers. The most striking shortcoming is the growth in the number of people who do not have access to the health care delivery system. In 1988, it is estimated that there are nearly six million Californian's, 21 percent of the state's population, who do not possess health insurance coverage.

The Task Force recognizes that its efforts to date comprise the first step in a continuing process. Specific recommendations will be developed from the policy statements in this Summary. Revisions will be necessary to respond to the dynamics of a constantly changing society and health care system.

The Task Force identified five key principles which should be advanced by health policy--access, quality, effectiveness, efficiency, and adequate, fair and timely payments. The Task Force evaluated the current health care environment with respect to each of the five key elements. Particular note was made of the distinctive challenges in each of these policy areas posed by rural hospitals, hospitals that treat a disproportionate share of unsponsored patients, and specialty institutions. The Task Force also examined the processes used by society and government in making health policy decisions.

The Task Force reviewed the issue of access and the question of whether access to care is a right or a privilege. The Task Force's primary conclusion is that society, acting primarily through government, has an obligation to assure equitable access to necessary health care as a basic human right and an essential condition of productive participation in society.

The Task Force's primary recommendation is that a basic benefits package of necessary health care must be made available to all the residents of the state. The specific details of the package -- such as the structure of a risk pool, the financing sources, and the payment mechanisms -- will be developed by the Task Force for recommendation to the CAHHS Board over

the next several months. An essential aspect of the recommendations will be the recognition and evaluation of the trade-offs between efficiency, access, quality, effectiveness, fair and adequate payment.

The health policies of the public and private sectors should foster an environment in which the health care system can provide quality care that contributes to the health and well-being of individual patients and the population as a whole. The Task Force recommends that public policies be directed at developing a better understanding by patients and purchasers of what quality is and that a process for setting and updating standards should be established.

Health policy should promote the use of effective diagnostic or therapeutic regimens which are both efficacious and appropriately applied to meet the unique needs of individual patients. The Task Force recommends that the public and private sectors devote more time, attention and resources to research on effectiveness in order to develop separate and more universally accepted standards in this evolving field.

Since the early 1980s, a number of statutory and regulatory initiatives have been implemented to reduce costs. Financing constraints and utilization review have imposed a strong discipline. Clearly, strides have been made

by hospitals and health systems to reduce inpatient use, constrain the increase in unit costs, and improve productivity. However, the overall efficiency of the delivery system is affected by factors beyond the control of individual hospitals such as: price increases in the general economy; demographic factors like an aging population and the spread of AIDS; accelerating technological changes; a growing "middle layer" of reviewers, processors and agents; personnel shortages and wage inflation; and maldistribution of resources. The Task Force recommends that any policy which incorporates financial incentives for the efficient production of services must identify and reconcile conflicts among the goals of efficiency, access, quality of care, and allocation of resources.

In this era of constrained resources, hospitals and health systems are being asked to provide increasingly sophisticated care to all persons at payment rates which do not cover all the costs incurred in the delivery of that care. The Task Force contends that to maintain and improve the availability of care, the payment policies of public and private payers must be adjusted to reflect fair compensation for services rendered.

In addition to establishing and examining the health policy criteria to be used in assessing future directions in health care, the Task Force identified the need to improve the processes for making policy decisions. While

government should take the lead in putting a more coherent health policy in place, participants must be drawn from all interested parties. Thus, participation can assure that all views are represented, that appropriate expertise is available, and that those who have a stake in the outcome help foster consensus and accountability when policy decisions are made and implemented.

Currently, health policy is being driven by budgetary considerations, rather than by a concern over meeting health care needs. When measured by net patient revenues, patient days or outpatient visits, Medicare and Medi-Cal have decreased as a percent of the total since 1982. From 1982 to 1987, the rate of increase in payments from Medicare, Medi-Cal and third-party payers has slowed to the point that most payments no longer cover the costs of providing inpatient or outpatient services.

The issue of paramount concern to hospitals is that payment constraints to promote efficiency, when carried too far, can have an adverse impact on access, quality and effectiveness. Overall, the quality of hospital care still is excellent and generally comparable among the differing elements of the population. However, the access for the six million unsponsored residents and the three million Medi-Cal recipients is rapidly deteriorating. The continued inadequacy of payments for these populations threatens health

care quality and access for all population groups within the state as providers are forced to close their doors.

California hospitals place the highest value on preserving life, treating patients with dignity and making quality care accessible to all. New, bold policies are needed to ensure access to high quality care. Payment systems that support the adequate, equitable, effective and efficient delivery of health care are essential. Teamwork and cooperation must be the prevailing attitudes if this nation's most important asset is to be preserved.

OCT 6 1988

NATIONAL MULTIPLE SCLEROSIS SOCIETY

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idorsed by the Los Angeles
ocial Services Department

Oct. 4, 1988

Senate Industrial Relations Committee
State Capitol, Room 4039
Sacramento, CA 95814

Members, Senate Industrial Relations Committee:

Although we are unable to send a representative of our chapter to testify at your Oct. 20, 1988, hearing on labor force health care coverage, we think it's vitally important for you to understand the way in which the problem you are addressing affects people with multiple sclerosis.

An MS diagnosis generally brands a person as medically uninsurable--even if the disease follows a mild course. If symptoms force a patient to stop working (or even cut back from full-time to part-time), the patient is likely to lose employment-based health coverage while simultaneously becoming unable to get individual coverage at any price.

Furthermore, as the enclosed Los Angeles Times article points out, the pre-existing condition exclusions that are part of many group plans can force the MS patient and family to choose between health insurance and the job mobility enjoyed by other Californians. Despite the article's 1979 publication date, the issue remains unresolved.

Just last week, Gov. Deukmejian vetoed SB 6 (Robbins), which would have made policies available to the uninsurable. As valuable a step as enactment of SB 6 would have been, the policies would have remained quite expensive and thus beyond the reach of many of those who most need them.

Living with MS is hard, but the existing situation makes it even harder: Unreimbursed health costs can bankrupt the MS family, and if you, as head of the household, are medically uninsurable, you'll probably have trouble getting coverage for your children. We urge you to plug this serious gap in our state's health care system soon.

Sincerely,

Jacob S. Blass
Executive Director

Laura Remson Mitchell
Government Issues Coordinator
(818) 882-6462

JSB/LRM:mtc

PLAN TOMORROW'S GIFT TODAY – REMEMBER THE MS SOCIETY IN YOUR WILL
CALL OR WRITE FOR INFORMATION

Los Angeles Times Sun., Mar. 11, 1979—Part VI 5

Health Insurance for the Uninsurable—It Could Be You

BY LAURA REMSON MITCHELL

I have multiple sclerosis, but this isn't a sob story. In fact, I see myself as one of the world's lucky people. MS is a highly unpredictable disease that is generally characterized by periods of disability (exacerbations) followed by periods of partial or complete improvement (remissions). For some people, though far from all, MS means coping with life from a wheelchair. As I write this, however, my condition is in full remission. Even my "exacerbations" have been comparatively mild.

I'm also very lucky that I was covered by health insurance when my case was diagnosed last April. If I hadn't been insured through my husband's group health plan at work, I would have had problems obtaining health insurance that would cover MS-related conditions at an affordable premium—if at all.

Laura Remson Mitchell lives in Los Angeles and is a free-lance writer specializing in economic issues.

MS is far from the only disease that simultaneously makes the need for health insurance vital while decreasing its availability. Diabetes and heart disease are just two of the more common examples of "pre-existing conditions" that insurance companies are loath to insure against for policy applicants who have been diagnosed as having such chronic illnesses.

It's true that some group health insurance plans do not exclude pre-existing conditions. But many other plans will cover such conditions only after a specified period. It can be as long as a year or two if the patient has received any "treatment," which can include even a simple checkup for the excluded condition. That's a year or two when a person with a potentially devastating disease has no financial protection whatsoever—a time in which a major flareup of the disease could wipe out everything the patient and his family have built up over a lifetime.

Furthermore, some jobs offer no health benefits, and unemployment can mean an end to group medical coverage. Private, individual policies are virtually impossible for uninsurables to obtain.

Existing public programs offer some help to those whose income and assets are very low. But that's little comfort to middle-class people who would have to be rendered poverty-stricken before getting financial help for a serious illness.

There are many arguments for doing nothing about this problem:

—Private health insurance is a business, not a public service, and insurance people have the right to make a profit. To fully insure known high-risk patients at the same rate as low-risk patients would be unsound business practice and/or would result in higher premiums for low-risk individuals.

—Taxpayers are tired of being expected to remedy every social problem that comes along. Besides, government "solutions" tend to be inefficient and seldom work the way they're supposed to.

—The world is a hard place, full of tough breaks. Society at large cannot possibly remove all of life's risks.

Individually, each argument may seem persuasive, but taken together, they add up to an excuse for ignoring the needs of flesh-and-blood human beings in favor of philosophical abstractions. These arguments also overlook the fact that anyone, at any time, might find himself the victim of some disease or condition that renders him at least temporarily uninsurable. Such a circumstance can be a trap even for those who already have group health plans through work, since insurance problems may make it financially impossible for them to change jobs if better opportunities come along.

Insurability was not something I'd thought much about until I learned I have MS. But my husband had changed jobs—and thereby health insurance plans—only a short time before my diagnosis. If my MS had been discovered two months earlier, I would have remained uninsured for MS-related problems for up to a full year. The thought of that possibility led me to wonder about those people with severe MS who require extensive—and expensive—medical care. Suddenly, I felt as if I were standing near-naked in a snowstorm.

Perhaps the private sector could deal with the problems faced by uninsurables, but private action seems unlikely in the absence of a financial incentive or political pressure to change the present system.

National health insurance could help, but the politics of the issue seem to be working against a solution. At present, it seems doubtful whether even a limited plan to plug the gaps in the private health insurance system has much chance for enactment in the current session of Congress. And while the politicians argue over which approach to take—or else ignore the question entirely—the problems faced by uninsurables continue to mount.

A year ago today, I would not have thought that this was an urgent matter either. But it is. The time has come for pressure to be applied by those affected by this problem—the uninsurables, and everyone who might by a stroke of fate join that category. It could be you.

HEALTH ACCESS

A Coalition Dedicated to Affordable Health Care for All Californians

1535 Mission Street
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December 9, 1988

Senator Bill Greene
Chairman
Senate Committee on Industrial Relations
State Capitol
Sacramento, CA 95814

Dear Senator Greene:

Thank you once again for providing Health Access an opportunity to testify at your illuminating hearing on October 20, 1988 addressing questions affecting labor force health care coverage. You asked for, and I am pleased to provide you, some supplementary information as well as citations for some of the data that I described in my testimony.

Health Access released in March, 1988, a comprehensive 95-page report entitled The California Dream, the California Nightmare: 5.2 Million People with No Health Insurance. You and your staff have been provided with copies and we would happily provide you with more if that would be helpful. In thinking back over the hearing, there was little testimony on what it is like to be an uninsured, working person in California today. Health Access' analysis might be helpful to you and your fellow committee members as you grapple with solutions for California's workers and employers.

SOUTHERN CALIFORNIA OFFICE: 1010 South Flower Street, 5th Floor, Los Angeles, CA 90015 213 744-0724

A. WHAT IT IS LIKE TO BE AN UNINSURED, WORKING CALIFORNIAN

The full answer is presented in Chapter 2. Through this letter, I highlight some of our findings. Health Access found that most data was national, not California-based. Nonetheless, we do have some important statistical indicators of how difficult it is to gain access to health care when you are among California's working, uninsured low-income population. Follow-up on the fate of California's several hundred thousand Medically Indigent Adult Medi-Cal beneficiaries who in 1982 were dropped from Medi-Cal and became a county responsibility is one major indicator. Another benchmark is the declining prenatal health status of California's pregnant women and their babies, who despite being members of working families and often working themselves, are increasingly uninsured. Finally, to round out what statistics were available, Health Access conducted a 7-county investigation, tapping into the available data as well as the view points of health care providers on the front lines in community clinics, emergency rooms, and county hospitals inundated with uninsured workers throughout this state.

1. The Used-to-be-Insured: The Declining Health of California's Medically Indigent Adults

The story of what happened to the Medically Indigent Adults ("MIA's") who were dropped from the Medi-Cal rolls as part of the legislature's 1982 package of cost cutting and health care reforms not only tells their fate but illustrates the constricted

health care system encountered by all uninsured people. When poor people such as the MIA's or the working poor need health care, they rely on the county where they live. Follow up studies in a wide variety of counties reveal serious deficiencies in the care that the MIA's received once they were dropped from Medi-Cal. These people were, by and large, people aged 45-64, especially women, uninsured workers, temporarily disabled workers, the under-employed, and the unemployed. The U.C.L.A. Medical School found that six months after the termination of Medi-Cal coverage a group of 186 patients in Los Angeles showed a marked deterioration in health; furthermore, three deaths probably could be attributed to failure to receive timely and appropriate health care.[1] Another report recently issued by researchers at the U.C.L.A. School of Public Health concluded that, as a group, the former Medi-Cal recipients in both Los Angeles and Orange Counties have received fewer health services than would have been expected had they remained eligible for Medi-Cal.[2] A study by the Dept. of Public Health in San Francisco found that the transfer of MIA's in the county similarly decreased access to health care and adversely affected

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[1] K. Davis and D. Rowland, "Uninsured and Underinsured: Inequities in Health Care in the United States," Milbank Memorial Fund Quarterly, (1983), p. 61.

[2] E.R. Brown and M.R. Cousineau, "Assessing Indigent Health Care Needs and Use of County Health Services," California Policy Seminar, University of California, 1987.

health status.[3] Finally, a recent examination of the effect of being uninsured in Orange County found that many were "slipping through the cracks". Doctors at U.C. Irvine traced the health care available for 200 uninsured patients who first came to the U.C. facility but were referred elsewhere. Over 60% of the patients had medical problems with a moderate to high likelihood of long-term adverse health consequences. Yet, virtually all (90%) of the patients suffered a severe reduction in the quality of the medical care they could obtain when compared to community standards.[4]

2. Prenatal Care: A key barometer of how poorly California is doing for its uninsured people.

Lack of access to prenatal care has grave health consequences. Pregnant women who receive inadequate care have an increased risk of bearing an infant who is stillborn, who has a low birth weight, or who dies during the first year of life.[5]

Back to Basics, a report issued by the Southern California Child Health Network and the Children's Research Institute of

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[3] M.A. Pittman-Linderman, "The Impact of California Medi-Cal Cutbacks on Utilization and Satisfaction of Health Care for Medically Indigent Adults: San Francisco Case Study," Paper presented at the 1984 Annual Meeting of the American Public Health Association.

[4] L. Rucker, H. Waitzkin, et al., "The Medically Indigent of Orange County: A Study of Patients Who Cannot Obtain Medical Care," October 10, 1986.

[5] C.A. Miller, A. Fine, S. Adams-Taylor, L.B. Schoor, Monitoring Children's Health; Key Indicators, (Washington, D.C.: American Public Health Association, 1986,) p. 16.

California, presents a grim portrait of the state of prenatal care for indigent persons in California. Between 1970 and 1986, California's rank among all states in terms of infant mortality dipped from 7th to 14th place; its rank in terms of the proportion of babies born with low birth weight dipped from 12th to 17th; and its rank in terms of pregnant women receiving prenatal care during the crucial first trimester of pregnancy fell from 10th to 36th.[6] Statistics about babies who are members of ethnic and racial minorities are especially disturbing. Black babies are twice as likely as all others to weigh less than three pounds at birth and to die during the first year of life.[7] Hispanic women are more likely than others to receive either delayed or no prenatal care.[8]

A growing proportion of women of childbearing age have no medical coverage for maternity services, with estimates ranging from 70,000 per year to 100,000, as California's annual births approach 500,000.[9] Yet, public programs for the uninsured throughout the state are uneven.[10] Fourteen counties have no

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6 Back to Basics, op cit., p.vii.

7 Ibid., 46.

8 Ibid., 46.

9 C.C. Korenbrot and Tarara E. Lewis, The Gap in Health Insurance for Maternity Care in California, January 31, 1988 and Lucien Wulsin, A Review of California's Indigent Care System, draft, 9/1988, p.42.

10 C.C. Korenbrot and Tamara E. Lewis, The Gap in Health Insurance for Maternity Care in California, January 31, 1988.

state or federally funded clinics which provide any prenatal care.[11] The publicly-sponsored maternity services which exist in many other counties are so overloaded that they cannot meet the demand. Pregnant women requesting appointments in clinics operated by the Los Angeles County Department of Health Services wait many weeks before receiving care. Some clinics refuse to schedule appointments over the phone, requiring women to appear in person.[12] A clinic which does allow women to make appointments by phone told one caller:

> "We take appointments on one day each month. Call back on the 24th at 8:00 in the morning. There are lots of pregnant women out there, and the appointments go really fast. Just keep calling and calling and calling. That's all you're going to do that day, just like you did today. Make sure you call early, because all our appointments are gone by one or two o'clock."[13]

Financial constraints compelled prenatal clinics in Orange county to turn away 2,000 indigent women in 1985.[14] During one three month period in 1985, clinics in San Diego were unable to accommodate 1,245 pregnant women requesting prenatal care.[15]

Not surprisingly, public hospitals throughout the state report increases in the number of women who deliver babies without having received any, yet alone adequate, prenatal care.

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11 Back to Basics, op cit., p.viii.

12 Los Angeles Herald, July 29, 1987.

13 Ibid.

14 Back to Basics, op cit., p.viii.

15 Back to Basics, op cit., p.viii.

One out of every seven babies delivered at Highland Hospital in Alameda County in October 1986 was born to a mother who had received no prenatal care; this represented a 31 percent increase over the previous year.[16] At Martin Luther King/Drew Medical Center in Los Angeles, as many as one fifth of all babies are born to women without any prenatal care;[17] the rate has doubled during the past two years.[18]

Doctors at Martin Luther King estimate that 50 percent of the hospital's infant deaths can be attributed to the lack of prenatal care.[19] A pediatrician in the newborn intensive care unit at Harbor/UCLA Medical Center has stated, "A week does not go by here . . . that I don't see a baby whose outcome would not have been significantly improved if the mother had received prenatal care." The denial of prenatal services to indigent women has financial as well as human costs. According to the Institute of Medicine of the National Academy of Sciences, every $1 spent on prenatal care saves $3.38.[20] California could save $25 million by providing adequate prenatal care to women who now receive either late care or none at all.[21]

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16 Ibid., 79.

17 Los Angeles Times, June 25, 1987.

18 Back to Basics, op cit., p.139.

19 Los Angeles Times, June 25, 1987.

20 Back to Basics, op cit., p.13.

21 Ibid.

We hope, of course, that the legislature's recent action to expend Medi-Cal funding for pregnant women up to 185% of poverty and the improved Medi-Cal provider rates will help. But approximately half of California's uninsured pregnant women will still not be reached.[22]

3. The County Health System: "People are Already Dying Unnecessarily"

Whatever limited care the uninsured, working poor do obtain comes primarily from the county where they live. County programs in California serving the uninsured are grossly underfunded, especially in light of the increasing numbers of uninsured who crowd their doors.

Throughout the Fall of 1987, Health Access investigated seven diverse California counties for a contemporaneous snapshot of the health care which is and is not available for the uninsured. Common problems plagued the counties and imperiled the patients. Overtaxed physical plants, outmoded technologies, unconscionable delays in getting regular and specialist appointments, four and five hours in waiting rooms, backed up emergency rooms are all part of the litany of county problems. Without assessing blame, the investigation shows that adequate health care is simply not available, that as one county health

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[22] S.B. 2579, 1988 Legislative Session; 1988-89 Budget; Lucien Wulsin, consultant, Medi-Cal Oversight Committee

director admitted "people are already dying unnecessarily."[23]

For the complete results of this investigation, please see pages 38 through 48 of the report. The following excerpts typify what Health Access found:

> "We have poorly controlled epilepsy patients who would be seen every two weeks in private practice; we see them every few months . . .. Instead of seeing people with appropriate frequency, we try to treat them over the phone." Chairman, Neurology Department, Harbor/UCLA Medical Center
>
> ". . . At minimum, I've seen 50 . . . patients at this hospital who have had to get a foot amputated as a side effect of diabetes. At least half of these patients could have delayed the amputation a significant period of time, or avoid an amputation entirely, if they had better access to foot care." Dr. Carter Clements, Emergency Room, Highland Hospital, Oakland
>
> ". . . the net effect, I think, of these [eligibility] barriers is not to weed out those who are ineligible, but those who are physically or emotionally unequipped to wage the kind of persistent, protracted struggle that it takes to get past their gatekeeper." A 61-year-old Orange County resident with hypertension who waited five months for treatment
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> " . . . we often have burst appendices because patients with appendicitis are forced to wait so long before they are taken to surgery." Emergency room physician at Martin Luther King/Drew Medical Center, Los Angeles County
>
> "We can only accept 50 patients for immunizations every day. By 7:00-7:30 a.m., the patients are lined up. Every day, we have to refuse people." A nurse at a Los Angeles County clinic

Summary

No Californian by choice would rely on the system of public and charitable health care which now is the only resource available to the uninsured working poor. While the doctors,

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[23] David Kears, Director of Health Services Alameda County, Tribune, January 1987.

nurses, technicians and administrators who staff these clinics and hospitals are committed, unquestionably competent providers, the odds are nonetheless overwhelming that the health care received will be too little, too late. These health care workers are on the battle lines of a system near collapse. While it is not the stated policy of this state to subject its working citizens to inferior, almost nonexistent health care, that is, in fact, the status quo.

These unconscionable circumstances call for effective solutions which reverse the current trend of ever-diminishing access to health care for working families, as well as eroding access for those who depend on Medi-Cal. Health Access has articulated six guiding principles (see The California Dream, the California Nightmare: 5.2 Million People with No Health Insurance, chapter 3) which we think should provide a litmus test as California policy makers face critical opportunities to forge solutions. The choices before us can either move Californians towards a coherent, stable system of access to health care or further fuel the fragmentation and the medical inflation spiral which is already so debilitating the economy, let alone the individual families which suffer exclusion from health care. Health Access, in short, believes that equity cannot be achieved unless we simultaneously rein in medical cost inflation.

B. EFFECTIVE COST CONTAINMENT IS THE KEY TO ACHIEVING QUALITY HEALTH ACCESS FOR ALL CALIFORNIANS

In my testimony, I emphasized a number of key areas which we

think should be the focus of cost containment measures that must go hand-in-hand with any financing scheme, including one which imposes any new or different obligations upon employers. A private sector freighted down with continued uncontrollable costs of health care could fail to thrive, adversely affecting the very workers we are trying to benefit through expanded access to health care. These points are briefly recapitulated below with citations, each pointing to the answer of why the U.S. pays so much more than its industrialized counterparts for health care.

1. Irrationally Varying Practice Patterns. When demographic differences are eliminated, there remain tremendous geographic variances in practice patterns unrelated to any standard of appropriate or inappropriate utilization rates. For example: caesarian section rates at Kaiser and the county hospitals frequently hover in the 10-15% range as is recommended by the American College of Obstetricians; private hospitals, C-section rates in California range from 20-40% for patients who, if anything, are less at risk for caesarian sections.[24]

Similarly, careful studies of geographic variations show that there are often anomalous patterns of practice which are very expensive, frequently risky if not adverse to the patients, which cannot be justified by appropriate standards of care. For example:

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[24] "Runaway C-Section Rates Reflect Crisis," Los Angeles Times, August 21, 1988, p.1, Sec.1.

-- The AMA recently reported a study on treatment practices which rated 14% of heart bypass surgeries as inappropriate and an additional 30% of uncertain value.[25]

-- A recent Rand study concluded that over one-half of the 120,000 pacemakers implanted annually performed in the United States are unnecessary.[26]

-- Boston residents are twice as likely as New Haven residents to have their knees and hips replaced. New Haven residents are more likely than Boston residents to undergo hysterectomies and back operations.[27]

-- A heart patient in LaJolla, California is three times as likely as a patient in Palo Alto, California to undergo a coronary by-pass.[28]

2. Physician Payments Reward Expensive High-Tech Care Over Cost-Effective Primary Care. Recently concluded studies by William Hsiao, a Harvard University health economist, have documented that tremendous discrepancies exist in our system of payment to physicians.[29] Typically, physician payment has become highly skewed in favor of hi-tech, expensive, often surgical, solutions. Dr. Hsiao, for example, cites the doctor who spends an hour on a complicated liver diagnosis and is compensated $175.00 compared to the $650 that some doctor would receive for

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25 "Many Heart Bypass Operation Are Unnecessary, A Study Says", San Francisco Chronicle, July 22, 1988.

26 New York Times, April 2, 1988.

27 New York Times, April 2, 1988.

28 A.C. Enthoven, Health Plan.

29 Hsiao, William C., et. al., "Estimating Physician's Work for a Resource-Based Relative-Value Scale", New England Journal of Medicine, Vol. 319, No. 13, September 1988, pp.865-867.

10 minutes spent removing a small polyp.[30] While at one time these discrepancies may have reflected market realities such as the training, sophistication and complexity involved in the procedures, the rates have remained quite disproportionately high to any objective value which can be placed upon the physician's time, training and skill. While Dr. Hsiao's proposed "relative based resource allocation" can be revenue neutral, when coupled with effective utilization review, this payment system could begin to tilt the balance far more in favor of cost effective primary care and away from the very expensive, often questionable, specialty care which dominates so much of the U.S. and California health care dollar.

3. Administrative Inefficiencies. Contrary to common perception, the government is the most efficient utilizer of health care premium dollars. When comparing the ratio of premium dollars which go to care versus administration, Medicare shines at 97%, Medi-Cal does well at 94.5%, with private payers typically trailing at 85-90%, at best.[31] Private insurers, such as those which provide health benefits through workers comp, typically use 65 cents of every dollar paid as premiums for patient care and/or workers compensation.[32] The rest goes to administration. These inefficiencies are compounded dramatically

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30 Los Angeles Times, July 24, 1988

31 Lucien Wulsin, consultant, Medi-Cal Oversight Committee.

32 Op cit.

by the fact that hospitals and doctors must deal with a multiplicity of payers, each with their own system of administration, prior approval, and fee schedules, as well as with their own separately identified beneficiaries, be they government eligible or private enrollees.

4. Excess Capital Expenditures. The United States and California, in particular, have tremendous excess capacity in our capital investments for hospitals and other high ticket medical investments, such as CAT scanners. California has, for example, only 50% hospital bed occupancy statewide[33] and many more heart surgery units than can or should be functioning if efficiency and expertise are to be maximized.[34] Not surprisingly, many analysts correlate this excess capitalization with excess use: the systems which have overextended themselves are now driven to recapture those expenditures through higher admission rates.[35] Thus, in urban settings where most of the overcapitalization has occurred, admission rates are 26% higher than those in areas, be they rural or suburban, where vacant beds are not a problem.[36]

As the committee which you chair examines different choices for spreading the financial burden of health care among the

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[33] Op cit.

[34] A.C. Enthoven, Health Plan, (Reading, MA: Addison-Wesley Publishing Co., 1980), pp.37-41; also Los Angeles Times, July 24, 1988.

[35] H. Luft and J. Robinson, "Competition and the Cost of Health Care 1972 to 1982" Journal of American Medicine, p. 3241.

[36] Ibid.

employers and workers of California, Health Access believes it is critical that the fiscal burden is no greater than needs be. Indeed, Health Access sees much validity in removing employers altogether from the business of providing health benefits. The United States' approach of using employment as the cornerstone for access to health care is anomalous in the industrialized world. Were we the architects of a new system starting from scratch, most if not all experts would not recommend reliance on work-place benefits. But, employers are now caught between a rock and a hard place: failed cost containment and consequent cost shifting, which is borne by workers, shareholders, consumers, and taxpayers.

Finally, in an era when all of us in California are profoundly concerned about the vitality of our employment sector vis-a-vis international competition, Health Access asks whether it wouldn't be better for a vital economy and ultimately for California workers if health care costs were not imposed so directly upon the costs of goods and services produced in California. If health costs could be progressively funded, stabilized and capped, workers and employers alike would face a much more predictable future that would permit planning and, where appropriate, bargaining that is now precluded by the escalating health care costs which the work place must absorb.

I hope that this letter, as supplementary testimony, assists you and your committee in evaluating the many profound questions we will be facing as California meets the challenge of making

sure that its working people are rewarded with the modicum of security that most us believe should be a given--health care access for ourselves and our family.

Sincerely,

Lois Salisbury, Chair

cc: Allen Davenport
mc

California Legislature

Senate Committee on Industrial Relations

STATE CAPITOL
SACRAMENTO CA 95814
TELEPHONE (916) 445-1237

NOTICE OF HEARING

LABOR FORCE HEALTH CARE COVERAGE

October 20, 1988 - 9:30 a.m.
State Capitol, Room 4203
Sacramento

The Senate Committee on Industrial Relations has scheduled a hearing on the availability and financing of health insurance for California workers. The hearing will be held on October 20, 1988, in Room 4203 of the State Capitol, commencing at 9:30 a.m.

Earlier this year, the committee considered and rejected Assembly Bill 600 (Isenberg), a measure which proposed to make available and subsidize health insurance for "medically uninsurable" Californians, financed in part by an increase in the State Disability Insurance tax paid primarily by private sector employees. The committee was uncomfortable with this particular proposal, but voted to conduct an interim hearing to explore options for expanding the availability of health insurance coverage to California's labor force.

Working people reportedly comprise more than half the estimated 5.2 million medically uninsured Californians, and the proportion of uninsured workers in the labor force has been increasing. Additionally, more than a quarter of the uninsured population are children, many of whom are dependents of working parents. The proportion of full-time workers with health insurance as a fringe benefit has declined in recent years from 78 percent in 1979 to 75 percent in 1986. Clearly, providing adequate health care to the workers is critical to the resolution of many of the difficult issues in health care, such as the demands on the Medi-Cal system, inadequate access to prenatal care, and all the problems related to uncompensated medical care.

The committee is soliciting testimony from labor, management, researchers, providers, insurers, and other interested parties to provide information on the extent to which workers and their dependents are uninsured, the consequences of a growing population of uninsured workers, and options for increasing the availability of health insurance coverage to the uninsured sector of the labor force.

Specifically the committee is seeking comments on the following:

- What options are available to California to significantly increase the availability of health insurance coverage to currently uninsured workers in the labor force, particularly in view of the limits on government revenue and expenditures? Do the comprehensive health care approaches in other states, such as Massachusetts, Minnesota, Oregon, Washington, and Wisconsin, provide viable models for California?

- How do proposals for increasing the availability of health insurance coverage affect health care costs and how these costs are distributed in society? Who is now paying for insured and uninsured workers' care, and how would this be changed under the various options?

- What makes employer-provided health insurance more affordable and available to some employers and industries and less affordable and available to others? What can be done to improve employer access to health care coverage for their employees?

- What types of limits and exclusions are being proposed or implemented to restrict admittance in group health insurance plans, and what options do excluded workers have to obtain health care coverage?

- Are individual health insurance policies available and affordable to employees and self-employed persons? To what extent are premiums higher for individual policies, and what accounts for the price differential?

Individuals and organizations who desire to present oral testimony at this hearing should contact Mr. Allen Davenport (916-324-6883) or Mr. Casey Young (916-445-1237) by October 10, 1988. Written testimony will also be appreciated.

Promoting Health Insurance in the Workplace:

State and Local Initiatives to Increase Private Coverage

An Action Planning Guide Implementing Selected Recommendations of the Report of the Special Committee on Care for the Indigent

American Hospital Association

AHA

In recent years, the number of uninsured has been expanding relentlessly, in good times and bad, in periods of high unemployment and in periods of economic recovery. From 1980 to 1987 alone, the number of uninsured grew by 25 percent to reach 37 million (Gramlich 1987), and many millions more are underinsured. There are many reasons for this growth, but one part of the problem has been a weakening of the strong historical link between work and health insurance.

The workplace has long been the predominant source of health insurance in the United States. Encouraged by a federal tax structure that subsidizes group health insurance and other fringe benefits by permitting employers to purchase them with pre-tax dollars, most businesses offer health insurance coverage to at least some of their workers, and most businesses with health plans make some arrangement for dependent coverage. The provision of employee health coverage is a high priority for most businesses, and employers spend a large and increasing amount of money to purchase this protection. The result has been extensive private coverage of workers and their families:

- Over 130 million of 200 million nonelderly Americans receive health care coverage, directly or indirectly, through the workplace (Chollet 1987).

- In 1985, 66 percent of the total nonelderly population, and 76 percent of the working population, had employer-sponsored health coverage (table 1).

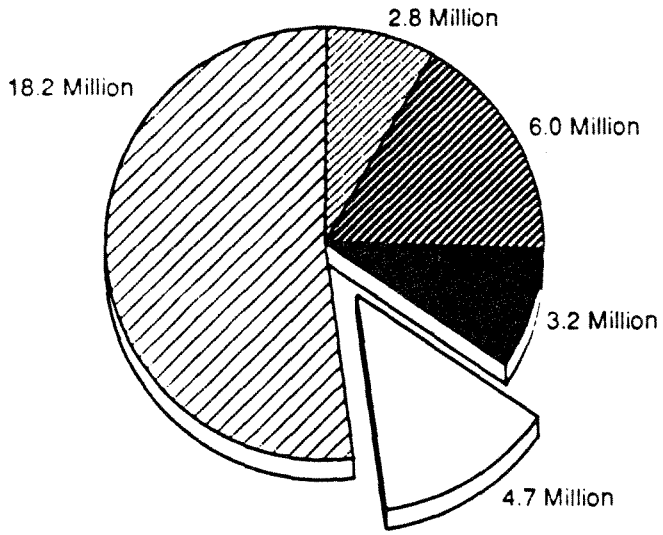
- Over 90 percent of all employees are in firms that offer health insurance to at least some of their workers (ICF Incorporated 1987).

Despite this strong link between insurance and work, there also is a strong, growing, paradoxical, link between non-coverage and work. That is, while the vast majority of the insured are receiving their coverage at the workplace, the vast majority of the uninsured also are workers, or dependents of workers, for whom the current system somehow is not working. Figure 1 shows, for example, that:

- Three quarters of the uninsured live in families with a strong, fairly consistent link to the workplace and over half live in families of full year, full-time workers.

- Only 13.4 percent of the uninsured have no connection to the workplace.

Figure 1 Nonelderly Population without Health Insurance by Employment Status of Family Head, 1985



Full-year, full-time workers and their families. Includes only steadily-employed. **52.3%**

Full-year, part-time workers and their families. Steadily-employed, part-time. **8.0%**

Sometimes unemployed workers and their families. Includes only workers that worked or sought work 35 weeks or more during the year. Almost all are full-time workers. **17.2%**

Part-year workers and their families. Workers who worked or sought work fewer than 35 weeks. **9.1%**

Non-workers and their families. **13.4%**

Source. Adapted from EBRI 1987a

While getting a job may be the most common way to obtain insurance coverage, therefore, it is not a certain route. Recent data suggest, moreover, that the link between employment and insurance has been eroding, particularly for dependents. Specifically, figure 2 shows that three things are happening (see also tables 1, 2 and 3):

- Employer policies are covering a declining percentage of workers.
- Employer policies are covering fewer dependents, even in terms of absolute numbers.
- Other private coverage is declining, particularly in the case of children.

These declines in private coverage certainly are not the sole cause of the growing uninsured problem. As noted in the 1976 report of AHA's Special Committee on Care for the Indigent, the burgeoning number of uninsured and underinsured owe their plight to many public and private forces and, in particular, to deteriorations in Medicaid coverage of the poor. Clearly, then, expansions of employer-sponsored coverage cannot be expected to provide the sole solution, and any comprehensive solution to the medical indigence problem must include Medicaid reform. To support and encourage such reform, last year AHA published Medicaid Options: State Opportunities and Strategies for Expanding Eligibility, a resource guide for state hospital associations and other groups interested in pursuing necessary state-level, public-sector solutions to the problem.

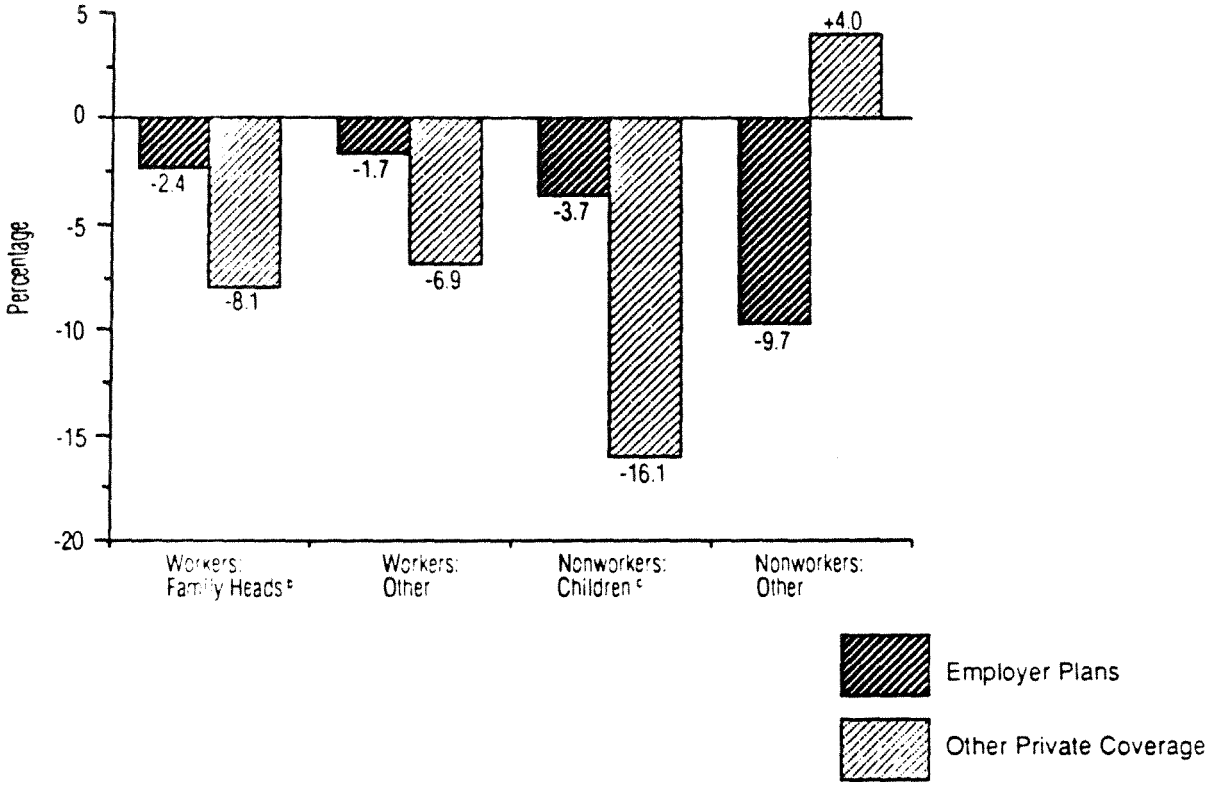
On the other hand, because employer-sponsored coverage is the fundamental component of America's pluralistic health insurance system, any deterioration in such coverage must be viewed with alarm, and reinforcing employers' ability and incentives to sponsor health insurance coverage for employees and their families must be a high policy priority.

At the national level, this policy imperative has led to discussions of several proposals - most notably, the Kennedy-Waxman mandated employer coverage bill - to alter incentives and legal requirements for employers. AHA has been actively involved in these discussions. At the moment, however, private health insurance issues largely are a state, rather than a federal domain, and some of the most innovative, promising efforts to promote employer-sponsored coverage are occurring at the state and local levels. Hospitals have had an important part in initiating, advocating, shaping and implementing some of these programs. This book, the second in the series of four resource guides implementing the recommendations of AHA's Special Committee on Care for the Indigent, is designed to support such efforts.

The guide is divided in four parts:

- Part one examines the conditions for employer-sponsored coverage, and analyzes which groups of workers and workers' families are most likely and least likely to be covered.

Figure 2 Percentage Change in Portion of Workers and Non-Workers Covered Through Employer Plans and Other Private Coverage, 1982-1985[a]



[a] Data exclude people under age 18 employed in the military or in agriculture and members of their families.

[b] The family head is the family or subfamily worker with the greatest earnings; all other family members earnings are designated as secondary workers.

[c] People under age 18 that reported no earnings and were not the family head.

Source: Calculated from table 1.

- Part two examines the environmental trends and practices which have affected the patterns described in part one.

- Part three analyzes types of state and local initiatives being taken to encourage and facilitate employer-sponsored coverage.

- Part four summarizes case studies illustrating some of the approaches discussed in part three.

Conditions for Employer-Sponsored Coverage

The first step in designing policies to promote insurance at the workplace is to discern which employee groups are currently lacking coverage and why. Workers are uninsured for many reasons and policies designed in response to one reason will not address other noncoverage problems.

The data analysis in part one shows that there are three explanations for why the employed lack coverage: some firms have no health plan, some employees are ineligible under their firm's policy, and some employees reject coverage. These situations are most likely to occur when employees have low salaries, the business is small and therefore at a disadvantage in purchasing insurance, the firm is unincorporated and therefore disadvantaged by current tax laws, and the firm is in an industry such as retail where noncoverage is common.

More specifically, the evidence from part one indicates that any program addressing the problem of coverage at the workplace will have to take account of some fundamental, but not always recognized, realities about currently-unprotected workers:

- About two thirds of all workers who lack coverage on the job work for employers who already offer insurance to at least some people in the firm. Of every 35 people not insured through their workplace, 13 are unable or unwilling to purchase coverage, 12 do not qualify under their employer's plan, and only 10 work for an employer who has no health plan.

- While small firms are less likely to offer insurance than large ones, half of the uninsured work in firms with over 25 employees, and a quarter of them work in firms with over 500 employees.

- Of all workers without health insurance, 74.5 percent have personal earnings under $10,000 a year and 93.3 percent earn less than $20,000 a year.

- Insurance coverage patterns in small incorporated firms approach levels found in much larger firms. Only 29 percent of sole proprietorships with 1-9 employees have coverage, whereas 70 percent of similarly-sized incorporated business have health insurance.

The other grim reality which must be faced is the crisis in coverage for the children of workers, who are more and more likely to remain uninsured even if their parents are insured through employer-sponsored plans (see Gold, Kenney and Singh 1987). As discussed later, the non-coverage of many of these children may be laid at the feet of the Medicaid program, and recent expansions in state eligibility levels (American Hospital Association 1987b) may improve things, at least for very young children. In a large portion of cases, however, children's non-coverage appears to stem from growing gaps in private insurance.

- By 1985, 11 million children - almost 20 percent of all children - were uninsured, lacking protection either from Medicaid or from the private sector.

- One fifth of all uninsured children live with a parent who has employer-sponsored coverage.

- Employers who offer family coverage have been cutting back on premium share, with the result that a greater part of the premium now must be paid by the worker.

These findings have several policy implications:

- Because of their very low salaries, most of the employed uninsured are unable to afford more costly individual policies, and therefore have to rely on employer-sponsored group policies if they are to have private coverage at all. If a large share of the premium must be paid by the employee, even a group plan will be unaffordable for many.

- Non-insuring firms tend to have a low salary scale and often low profit levels as well. In order for health insurance to be a feasible and attractive benefit for most of the employers not sponsoring insurance plans now, therefore, the costs of group coverage will have to be quite low, and probably will need to be subsidized for some groups.

- Large growth in the number of employed uninsured, coupled with the low salaries of these noncovered workers, suggests that much of the problem results from a deterioration in Medicaid eligibility policy. If Medicaid continued to cover 65 percent of the poverty population, as it did in 1976, rather than the 38 percent it covers now, a sizable number of the employed uninsured would have coverage. For families in the lowest economic groups, reforms in Medicaid or other public sector programs may be the only feasible way to provide coverage.

- The current incentives for offering group health insurance appear to be stronger for large firms than small firms, regardless of the salary structure of the firm, so a major component of any policy to increase employee coverage must involve a strengthening of the small business incentive and capacity to sponsor a plan.

- Initiatives to promote coverage must pay particular attention to the situation of unincorporated businesses, regardless of business size. Strengthening tax incentives will help, but such firms also may benefit from educational programs to increase their awareness and savvy concerning health insurance.

- Proposals which focus on creation of new coverage plans in currently-uninsured businesses address only one aspect of the problem, since most of the employed uninsured work in firms which already have insurance plans.

- Proposals focusing exclusively on worker coverage rather than family coverage also can miss an important dimension of the problem. Many of the most vulnerable uninsured are living in families where the primary breadwinner already has coverage but has not been able or willing to pay the generally higher premium share required to insure the rest of the family.

Incentives and Impediments

In order to design policies to promote insurance coverage, it is necessary to look behind the variables identified in part one to see what trends or practices are driving them and how these trends or practices might be changed. At this broader level, four factors appear to be influencing insurance availability: the nature of insurance and the insurance industry, employer incentives under federal and state tax and insurance laws, demographic and work force factors, and changes in federal programs.

The insurance system, as it has evolved so far, works better for some employers than for others. For a variety of reasons, small businesses are particularly disadvantaged by the present system, paying higher costs for fewer benefits. Of each $100 paid in premiums, small firms derive only $75 in benefits, whereas large firms receive $95. There seem to be several reasons for this:

- Large firms benefit from economies of scale and from the ability to perform administrative services in-house.

- Large firms provide a large base over which risks can be spread, whereas the enrollment of small groups creates insurer fear of "adverse selection."

- Small firms are, or are perceived to be, less stable as businesses, more likely to have high employee turnover, and more likely to change insurance carriers.

- Understanding how insurance works, how to cost out and compare benefits, and how to decide what package will best serve a particular firm is not a quick or easy task, but small firms typically spend little time researching their insurance options.

- Despite the fact that small firms in general have less money available to spend on insurance coverage, there is very little variation in product design and benefits between small and large firms, and small firms in some ways tend to be more generous than larger ones.

The policy challenge is to discern which of the factors which currently serve to increase insurance costs and decrease benefits for small business are immutable and which could be changed or overcome through creative public or private sector approaches. To a large extent, this is the purpose of the programs described in parts three and four.

The analysis in part two also sheds some light on the problem of noncoverage in large groups. In particular, the data show that large firms tend to be less generous than small ones in contributing to family coverage:

- Over half of very large (over 500 employees) firms require employees to pay 40 percent or more of the premium for family coverage, but only 27 percent of very small (1-9 employee) firms require such a large employee contribution.

- 70 percent of very small firms, but only 34-35 percent of very large firms pay the entire premium for family coverage and therefore require no employee contribution at all.

- The average employee premium share is 13 percent in very small firms and ranges from 31 to 35 percent in firms with 25 or more employees.

- Even though total per capita insurance costs are greater in small firms, per capita costs to the employee are greater in large firms.

The tendency of large firms to contain costs by setting a high employee premium share for family coverage (and, in some cases, for individual coverage as well) makes it increasingly difficult for low-wage employees to participate in employer-sponsored health plans, and particularly difficult for them to afford family coverage. The relationship between cost containment and access to insurance is complex, and efforts to increase the prevalence of insurance by transferring costs from the employer to the employee can backfire.

While the nature of the insurance industry itself has a major impact on the relative ability of different types of employer groups to obtain coverage, many of the factors affecting employer coverage stem from an array of broader forces in the environment: legal requirements and tax incentives for employers, demographic changes, and changes in public insurance programs. The bad news is that many of these factors are mutually reinforcing, and therefore create a strong momentum towards noncoverage.

The problem of coverage for children provides a case in point. The growing number of uninsured children results from the confluence of several very strong forces, including trends in the insurance industry, family structure,

industrial composition, and Medicaid coverage. Traditionally, the unit of coverage for health insurance policies was the family. When most people spent most of their lives in two-adult families, each employer's decision to offer a plan potentially enabled two adults, and any children, to obtain coverage - regardless of the work status of the second adult. With changing family structures, the traditional family coverage model is applying to fewer people, and people who formerly could have been covered under a spouse's policy now must seek coverage on their own.

This development lends greater significance to other demographic changes. With divorce, previously non-employed spouses are entering the labor force, but the greatest growth in jobs is in businesses where coverage is less common. Even if both of the divorcing spouses have been employed, secondary wage-earners formerly receiving indirect coverage under a spouse's policy may find themselves uninsured.

At the same time, the family coverage model is undergoing an erosion from the employer side. In recent years, employers have begun to cut back on offerings of - or, at least, support for - family coverage, even as the increasing divorce rate and the growing number of single-parent families has disqualified many people from existing family policies. Finally, declining Medicaid coverage of poor mothers and children has limited the ability of this public program to pick up the slack left by these other changes.

Approaches for Increasing Employer-Sponsored Coverage

Because the growing problem of uninsured workers and their families has many different, mutually reinforcing causes, it has no single solution. Uninsured families are not a monolithic group, left unprotected because of any single flaw in the economy or the insurance system. For the most part, they are victims of an accumulation of disadvantages resulting not only from the insurance system itself but from legal factors, demographic and industrial trends, and changes in federal programs as well. The good news is that each of these environmental factors provides a different avenue for approaching and therefore influencing the problem of uninsured workers and their families.

As shown in parts three and four, states, regions and local groups are experimenting with numerous ways to sort through this "accumulation of disadvantages," to test out ways to lower costs and increase access to group insurance, and they are showing great creativity and variety in addressing the problem from each of these perspectives, generally by using several approaches at once. The most common efforts include initiatives to:

- Form new large groups, for example through multiple-employer plans, employee leasing, state insurance pools, and required employer coverage.
- Include more people in existing groups, for example by "piggybacking" on existing groups, expanding Medicaid eligibility, and improving enrollment rates in existing groups.

- Subsidize coverage, through provider and insurer subsidies, other private donations or public subsidies.

- Change the product or its delivery, for example through the use of special products, health maintenance organizations, and cost containment measures; and through a variety of employer strategies such as self-insurance, collecting utilization data and "shopping around."

- Increase product awareness by marketing new programs and improving the employer's search process.

Implications

Because most of these initiatives still are in very early stages of development, it is too early to say what will work and what won't. Those interested in fashioning solutions for their own communities can draw some early lessons, however, as discussed in the conclusion to this guide.

- The need for careful targeting. Policy-makers need to discern what shape the employed uninsured problem takes in a given community, and then mold and target the response accordingly, because the causes of noncoverage will vary considerably from community to community and a policy response designed for one problem will not work for another.

- The need for a multifaceted response. Given what we know about the economic resources of most uncovered workers, their families and their employers, it is unrealistic to expect any single approach to solve the problem. Most of the initiatives described in part four, therefore, are using several mechanisms to reduce costs, and are coupling cost-reduction efforts with extensive marketing.

- The need for a broad coalition. For cost reduction and community outreach to work, insurers, employers, providers and community groups will need to be involved and working together.

Both individually and as members of these coalitions, hospitals have been and should be very actively involved in efforts to facilitate insurance coverage. As discussed in the conclusion, there are several things hospitals can do:

- Take the initiative in forming coalitions to design community-wide strategies along the lines of those summarized in part four.

- Use hospital marketing expertise to help publicize newly-developed options for public or private coverage.

- Help educate businesses in the community concerning the social and economic costs of employee and dependent noncoverage.

- Show leadership and initiative as employers in establishing their own health care benefit policies.

- Lobby for expansions in Medicaid coverage of the working poor and their families.

Employer surveys consistently have shown that employers want to provide health insurance for their workers, and presumably many more would do so if they had greater access to what they considered an adequate, affordable product. The policy challenge is to create the set of conditions which will maximize this possibility.

Oregon

Employer Health Care Tax Credit Law of 1987

Oregon's 1987 Employer Health Care Tax Credit Law authorizes creation of a new insurance pool and a tax credit for small businesses which offer health insurance to their employees through the pool.

The tax credit will be available beginning in 1988 once the pool is established, and will be phased out over a five-year period. For the first two years of participation, an employer can claim a credit of up to $25 per month per eligible covered employee, or 50 percent of the total amount paid by the employer during the taxable year, whichever is less. The maximum tax credit is reduced each of the ensuing years. By the sixth year, the employer would receive no tax credit.

In order for the employer to be eligible for the credit, the employee(s) must work an average of at least 17.5 hours per week. Independent contractors, those working on an intermittent or irregular basis, and those who have been working for the employer for less than 90 days do not qualify the employer to receive the tax credit. Employers with more than 25 employees cannot receive the tax credit. In addition, the employer cannot have contributed to his employee's health insurance premiums within the past two years. An employer can opt to cover only a portion of his employees; however, he must offer the coverage to all employees in the class. For example, if some management employees were offered coverage, all management employees must be offered coverage.

The Act authorizes two types of health coverage, Part I and Part II. Part I coverage is not subject to state mandated benefit requirements and focuses on the provision of episodic acute care and recovery care for catastrophic illness or accident, and includes a deductible and a high stop loss. Part I coverage only provides insurance for the employee and not family members. The Act specifies that the employer shall contribute no more than $40 per month for coverage for each eligible employee. The employer may require a minimum contribution from the employee for coverage; however, the employee contribution cannot exceed 25 percent of the premium for Part I coverage. All individuals who are covered under this Act must be covered under Part I.

Part II coverage consists of several additional benefit packages which can be purchased by employees.

- Access to primary and preventive care services, and reduction of the deductible specified in Part I coverage.
- Coverage for dental and optical care.
- Coverage of the employee's family members.

Employer contributions from Part II coverage are also eligible for tax credits subject to the maximums previously described as deductible tax credits. The Insurance Pool Governing Board can determine that certain benefit packages are not available to employees who are not covered by certain other packages.

The premium rates for employers and employees will be set by the Insurance Pool Governing Board. The employer and employee will pay the entire cost of the premium. An employer is not required to enroll an employee who is enrolled in another health plan. The employee can authorize in writing that his premium contribution be deducted from his paycheck.

The legislation limits the number of employees who can participate in the pool to 10,000 during 1987-1989.

Contact Person: Jim Swenson
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21 Labor Industries Building
Salem, OR 97310
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Washington

Basic Health Plan

The Washington Health Care Project Commission was created by the Washington State legislature to study and address the needs of the state's uninsured. The legislature required the Commission to produce a report which included recommendations for a Basic Health Plan which could be provided for enrollees at about $50 per month. The Commission completed its report in December, 1986. The report included the following proposals:

The first proposal consisted of a plan which would provide ambulatory and acute inpatient care for approximately $55 per person per month. Cost containment mechanisms would include a $5 copayment for prescription drugs, a $10 copayment for office visits, and a $25 copayment for emergency room visits. Providers would serve enrollees for a 20 percent discount.

The second plan would eliminate the copayment for office visits and reduce the copayment for prescription drugs and emergency room visits. Coverage for dental benefits would be included in the plan and providers would perform these services at a 20 percent discount. This option was determined to cost about $73 per enrollee per month. Both plans include the provision of a state subsidy which would be determined by using a sliding fee scale based on the enrollee's income.

The Commission recommended that responsibility for administering the new program be given to a public authority created to performs these duties.

The state subsequently enacted the Basic Health Plan, a modified version of the commission's proposal for ensuring that working individuals and others who lack coverage be provided with necessary basic health services in an appropriate setting. The office of the Washington Basic Health Plan was created to administer and oversee the program, to select a benefits package, to design a sliding fee scale, to determine the cost saving mechanisms, and to negotiate with providers who wish to participate in the program. Enrollment is to begin by July 1, 1988.

To be eligible for the plan, an individual must be under 65, and have a gross family income that is at or below 200 percent of the federal poverty level. Coinsurance premiums will be required based upon gross family income but they will be decreased for lower income individuals. Those families below the poverty level will pay about 10-15 percent of the cost of providing the benefits and those enrollees at or above 200 percent of poverty will be required to pay the full cost.

The state subsidized portion of the premium will be funded from state general fund taxes rather than the payroll tax or dedicated increase in professional services taxes originally suggested by the commission. There is a 30,000 cap on the number of individuals that can receive subsidies, and a sunset review in 1992. The entire program is exempted from state insurance laws. The plan will be tested in several demonstration sites, and eligibility for the plan will be limited to individuals living within the demonstration areas. One such initiative is Seattle's Health Systems Resources project funded by the Robert Wood Johnson Foundation and described in a later section.

House Bill 99, recently signed by the governor, may have an effect on the success of the Basic Health Plan. The legislation creates a high risk sharing insurance pool for those individuals with pre-existing medical conditions. Enrollment of high risk individuals in this new pool can help avoid adverse risk selection in the Basic Health Plan projects.

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Wisconsin

Small Employer Health Insurance Maximization Project

The Division of Health within the Wisconsin Department of Health and Social Services, in collaboration with the Office of the Commissioner of Insurance and the University of Wisconsin, was awarded a 3-year grant from the Robert Wood Johnson Foundation to implement The Small Employer Health Insurance Maximization project aimed at addressing the health care needs of uninsured workers in small businesses.

The project is part of the State Health Insurance Program mandated by the State legislature and outlined in a report (described in a later section) entitled The Plan for a State Health Insurance Program (SHIP-Plan). Subsidy pilot proposals to demonstrate state health insurance program approaches were vetoed in July of 1987 by the governor. Discussions on SHIP pilots have continued, but as of this writing, the legislation has not been introduced. Consequently, the RWJ pilot component to test a state subsidized voucher plan has not been implemented.

The RWJ program had three components, some of which have been implemented.

- The promotion of multiple employer trusts. The grantee has surveyed a sample of insurance companies, including those which established Multiple Employer Trusts, in order to obtain information on their marketing strategies, underwriting practices, and pricing policies. The survey also will be used to determine the effectiveness of METs in insuring small employers, including firms which employ individuals who are considered high risk. In-depth interviews of insurers have been used in comparing MET plans with individual group plans offered to small firms. If the survey results show that METs are an effective way of insuring workers in small businesses, and depending on how widespread they are, then the Wisconsin Office of the Commissioner of Insurance will promote the development and expansion of METs across the state.

- Testing the state-subsidized voucher plan. This component of the project involved creating a state-subsidized insurance program featuring the use of vouchers for low income workers employed by small businesses which don't offer health benefits. The vouchers were to be tested as a pilot in the project. The family's income rather than a single family member's wages was to be used to determine the amount the worker must contribute to receive a voucher of specified value. The voucher could have been used by the worker to obtain health care services or could have been combined with those of other workers so that the employer could purchase care for the entire group. The voucher was to be redeemable only in insurance plans which had met the state's criteria for acceptability. If legislation is reintroduced, the voucher or subsidy pilot will become part of the revised project work scope.

- Expansion or modification of HIRSP. Wisconsin has had in place, since 1981, the Health Insurance Risk-Sharing Pool (HIRSP) which was created to provide coverage opportunities for those unable to obtain health insurance because of high risk medical conditions. Those eligible for the program pay premiums as well as deductibles and co-insurance amounts. The costs of the premiums are limited by statute but they are still much higher than typical group rates. At present, HIRSP has only 2,000 enrollees. The RWJ plan is to encourage small employers to enroll employees with adverse health risks in HIRSP. A firm is expected to be able to contribute to HIRSP for the high risk employee the same amount it would contribute for regular group coverage for other workers. This strategy will be pursued under a revised project strategy. The intention is to make the small employers market more attractive to insurers by minimizing the threat of adverse selection.

Currently, the project is exploring non-subsidy intervention aimed at making the market work more effectively. The specific strategies have not yet been defined.

The project continues to be managed by a team approach. The Office of the Commissioner of Insurance performed the survey of insurers and insurance agents, and developed the modified HIRSP plan. The Health Division of the Department of Health and Social Services inititated a series of employment-based surveys and was to develop the voucher plan. The University of Wisconsin Center for Health Policy and Program Evaluation designed the survey instruments and provided consultation to the Commissioner and to the Health Division. The Wisconsin Survey Research Laboratory conducted (to be completed in March '88) employer and employee surveys.

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Wisconsin

State Health Insurance Plan

In January 1986, the Wisconsin Council on the Uninsured issued a report entitled the Plan for a State Health Insurance Program (SHIP-Plan). The report, which was mandated by state legislation, expanded upon an earlier report which addressed the same issues. The first report, Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions, identified the demographic characteristics of the state's uninsured population and presented several alternatives for dealing with the problem. Based on the initial report, the legislature created the Council on Health Care Coverage for the Uninsured to help the Wisconsin Department of Health and Social Services design a state health insurance program for the medically indigent. The SHIP-Plan included and recommended five of the alternative approaches for use in a demonstration project.

The original legislation required that the state health plan developed cover medical assistance recipients as well as the uninsured, avoid adverse selection, offer a choice of either catastrophic or comprehensive coverage, use competitive bidding, be prepaid on a capitated basis, use vouchers or direct payments to providers, and require income-based contributions from employees.

Although the SHIP-Plan examined many approaches for dealing with the problem, it did not recommend a singular approach. The report did recommend that as family income increases, the amount of the subsidy it receives should decrease.

The report included five recommended strategies for addressing the problem. All of the strategies or plans were to be tested as demonstration projects for a minimum of 18 months. After an evaluation of the demonstration projects, the results were to be reviewed and the recommendations were to be presented to the state legislature for the possible implementation of a statewide health insurance program. Each of the five pilot projects included in the SHIP-Plan are described below.

One plan, the Individual Voucher, would permit enrollees to use a voucher to buy any existing policy which would fulfill the family's needs while meeting the specified minimum state standards. Enrollees would have had to contribute to part of the cost of the premium and some copayment and deductibles would have been required. In order to participate in the plan, enrollees must have been uninsured for at least the last six months, and must have been not offered a plan where they worked. These provisions were to discourage workers from dropping existing coverage or turning down available coverage so that they could participate in the state subsidized program.

A second demonstration project, the Group Plan Subsidy, was to have addressed the needs of employees who work for firms which provide coverage, but where the employee is not able to contribute the necessary amount for themseleves and/or their dependents. The employee's contribution to the premium would have been subsidized.

A third project, the Robert Wood Johnson pilot, known as the Small Employer Health Insurance Maximization Project (described above), involved subsidizing low income employees or small firms and allowing high risk employees to enroll

in the state's Health Insurance Risk Sharing Plan (HIRSP) for persons with high medical risks. There are two reasons why employment-based coverage was to be subsidized. First, by subsidizing the premiums of the high risk workers and moving them into HIRSP, the group rate for the remainder of the plan's enrollees would have been more affordable. This was possible because the high risk worker would have been eliminated from the group experience rating. Second, small firms are at a disadvantage for offering health insurance to their employees due to high costs. A state subsidy would assist the group in obtaining coverage. The Wisconsin Department of Health and Social Services had received a Robert Wood Johnson Foundation grant to develop and test this pilot project.

A fourth project, the Health Insurance Loan, involved making short-term loans to the temporarily uninsured. The loans would have been made to only those considered credit worthy. The loans were to serve as a temporary bridge to permanent insurance coverage. Those intended for inclusion in this kind of plan included, among others, temporarily unemployed individuals, displaced or dislocated workers, and students.

The legislation mandated that a fifth, Alternative Plan, be developed for those uninsured individuals who were not appropriate for the other projects. This plan was to focus on the disabled who, because of a higher medical risk, are excluded from traditional policies, or are allowed to purchase them but at a price that it is unaffordable. The Department and Council hoped that if comprehensive coverage were available at an affordable price, that some of the disabled population would opt to seek employment rather than disability payments. Because this population consists of individuals who are high utilizers of health care services, the Council suggested that the care be provided through a managed care delivery system and that claims be administered through the state's Medicaid program.

Although not included in the SHIP-Plan report, there was a sixth proposed pilot program authorized by state legislation during the budget period. This project would have tied WisconCare (a state health care program) to a health insurance plan for low income workers.

The Legislature, during the 1987 budget process, voted to fund subsidies and administration for pilots. The legislation authorized the creation of a council responsible for oversight and implementation of the projects. Enrollment in the projects was scheduled to begin in July of 1988. In July of 1987, however, the governor vetoed implementation of the projects. It is possible that some aspects of the projects will be reintroduced in new legislation, but as of this writing it has not happened.

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Uncompensated Care—The Threat and the Challenge

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The growing crisis in uncompensated health care poses one of the most serious threats facing the medical profession today. If left unresolved, it will not only erode the health of our society and lead to an erosion of the clinical autonomy of physicians, but it will also undermine the very principles on which our health care system has been built. In addition, it will lead to increased regulation of the practice of medicine, and, quite probably, to a government-controlled health care delivery system.

To understand this threat, the challenge it poses, and our critical role in its resolution, we must first consider the evolution of our American health care system.

The health care system we enjoy in this country was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer. We physicians were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered, and the cost was merely shifted to someone who could pay, through an incremental increase in their bill or in their insurance premium.

It is important to realize that this policy was no accident but was the result of conscious decisions in both the public and private sectors. In the public sector, the enactment of Medicare and Medicaid in 1964 extended coverage to the poor and the elderly. At the same time, there was a rapid expansion of private health insurance policies funded primarily through employment. This rapid growth of public and private third-party insurance coverage led to the belief that, in America, health care for the poor was free, when in fact it was being subsidized primarily by the government and by the business community.

Thus, we created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they needed or wanted regardless of their income. Physicians could practice pure medicine, viewing their patients primarily from the standpoint of their health needs without concerning themselves about their ability to pay. But this system also encouraged utilization and led to the deeply held social belief in this country that health care is a right. Not surprisingly, this resulted in a dramatic increase in expenditures. The amount we spend each year on health care has grown from $75 billion in 1980 to nearly $500 billion today. More telling, however, is the growth of health care expenditures as a percentage of the gross national product: 7.4 cents on the dollar in 1970 versus about 11 to 12 cents today. If this rate of increase were to continue, by the turn of the century we would be spending 20% of the gross national product on health care and by about 2020, we would be spending 40 cents out of every dollar on health care.

Obviously, this rate of increase is not going to continue. While our health care system makes a great deal of sense in terms of a social policy, it makes very little sense in terms of an economic policy. Even a beginning student of economics recognizes that no single set of expenditures can continually grow at a rate faster than the rate of growth of the gross national product. Every dollar we spend on health care is a dollar that cannot be spent on something else. There are many other interests and priorities in which this country must invest.[1]

And while the prosperity we enjoyed over the past 20 years has allowed us to absorb these rapid increases in health care expenditures, it also masked the underlying fallacy of the way health care is financed in this country. By 1980 that mask had been stripped away when a number of factors combined to bring our ideal health care system into a collision with economic realities.

First, new medical technologies were being developed and being used—at a tremendous cost—because the system contained no financial restraints. Second, there has been a significant increase in the elderly as a percentage of the population. The elderly use more health care services than the nonelderly and have a higher incidence of chronic diseases. Both advances in medical technology and an aging population have increased the financial strain on the system.

Two additional factors forced those who had traditionally been subsidizing the cost of health care for the poor—the business community and the government—to reevaluate their ability to continue doing so. The first was the economic stagnation experienced in the United States at the beginning of this decade. While we could absorb the rapid increases in the cost of health care when the economy was growing, it was far more difficult to do so when productivity dropped. Our nation's annual productivity growth was a healthy 3% in the 1960s and 1970s but fell to 0.5% by 1979 and was actually negative in the early 1980s.

The federal budget deficit increased from about $73 billion to $211 billion in five years, and we liquidated all our foreign assets to become the largest debtor nation in the world. By the early 1980s, the government recognized that it

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could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit, or making deep cuts in other domestic programs. The government became interested in cost containment to balance the budget.

At the same time, this country entered the world market. American businesses began recognizing that they were no longer competing just among themselves, as the auto industry once did, they were competing with mainland China, West Germany, Japan, Italy, and Canada. They realized they had to cut costs, particularly labor-related costs, in order to remain competitive with cheap labor industries abroad. They could not, for example, just pass the cost of health care on to their consumers and still remain competitive in a world market, particularly when American businesses had to carry the cost of health care on the books as a necessary expense and were competing with many countries that did not have to carry these costs because of nationally sponsored health care programs. The business community became interested in the need to contain costs to remain competitive.

This brought about very similar responses by both the government and the business community. The objective was simply to reduce the exposure to the cost shift and reduce the funding and subsidy of the cost of providing health care for the poor. It should be noted that the subsidy was not taken out of the system, it was merely shifted onto individuals and providers. Here is how it was done.

In 1983 the federal government enacted DRGs [diagnosis-related groups], which is a prospective reimbursement system that shifted economic risk onto providers. The federal government also began requiring first-day hospital deductibles for those on Medicare and increasing the Part B monthly Medicare premium that pays for physician services. This shifted costs onto the individuals. With Medicaid, the program for the poor, the federal government cut its match rate and shifted that to the states.

The first thing the states did was cut provider-reimbursement rates. Physicians currently average 45 to 50 cents on the dollar for taking care of someone on welfare. That pushed costs and responsibilities onto the providers. When that did not balance the budget, the states increased the requirements for Medicaid eligibility, which pushed people off the program altogether. That shifted responsibility to the individuals. In the past ten years, 800,000 women and children have been squeezed off Medicaid, and the program, which used to cover 65% of the poor, today covers less than 38%.

The private sector reacted in exactly the same way, with increased involvement in health maintenance organizations, preferred provider organizations, and other prospective managed care plans that put providers at risk. Businesses increased copayments and deductibles for their employees that shifted costs onto individuals.

The important point here is that these cost-containment actions reflected absolutely no social policy beyond that of cutting costs for the government and for the business community. There was a recognition that the amount of money that could be spent on health care for the poor was limited, but there was no consideration of the implications of those decisions on access to health care. The funding in the system was reduced but not what the public expected from the system.

Today, our health care system is in transition. We are still ostensibly committed to the principle of universal access, but now the system is driven by economic factors, not by the social factors that drove it in the 1960s and the 1970s. Providers are at economic risk. We are losing the ability to cost shift.

As I mentioned earlier, our ability to deliver on the principle of universal access has depended on cost shifting and the willingness of the business community and the government to subsidize the cost of care for the poor. While there is still supposedly a commitment to universal access, we are seeing a progressive shifting of the responsibility to pick up that cost. Between 1965 and 1980 that subsidy was borne by the government and by employers, who spread it out over taxpayers in general and over most of the workforce. Society was paying for what was essentially a social policy objective: universal access to health care.

Because of the cost-containment measures that have occurred, however, that subsidy has been shifted onto providers, who have far less ability to absorb it. What used to be subsidized care for the poor is now showing up as uncompensated care. As physicians reach a point where they cannot absorb additional uncompensated care and still pay the bills, they push the costs onto individuals. And, today, if a person does not have insurance coverage and does not have money, that person is increasingly likely to lose access to the health care system, either because providers will not accept any additional indigent patients or the patient delays treatment because of an inability to pay for it.

This has dramatically changed how health care is financed in this country. Our health care system has traditionally had a bifurcated financing mechanism. On the one side is the public system, which is Medicare and Medicaid. On the other side is the private system, which is mostly employment-based policies and some individual policies. There has always been a little gap in between where some people slipped through the cracks. But as long as the government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and has really contained only society's truly downtrodden.

Today, however, those two third-party payers, government and business, are trying to escape from the subsidy. As we see a reduction in government expenditures, the growth of copayments and deductibles in Medicare, and increases in Medicaid eligibility, people spill off the public side into the gap. As competition in the world market increases, as we shift from a manufacturing to a service-based economy with large numbers of low-paid, nonunionized workers without health insurance coverage, and as premium rates go up, people spill off the private side and into the gap. Today, the gap is not narrow: it contains 37 to 40 million Americans. And they are no longer just society's truly downtrodden. Of those uninsured people, 70% are working full time or part time or are dependents of someone who is working. Those in the gap are generating 75% of the uncompensated care.

Why should we be concerned about this shifting responsibility to pay for the care of the poor? We should be concerned because there are some serious social consequences affecting all of us, and some serious professional consequences affecting physicians in particular.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. A

since market systems were not designed to foster social responsibility, it should not be surprising that no one is competing to care for the poor. Public health clinics are closing. We are seeing patient dumping from hospital to hospital, physician to hospital, and between physicians. There are treatment delays. And there are a growing number of people in the gap.

That leads to the second social consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two thirds of those mothers do not receive adequate prenatal care. Of the poor in America, 40% are children. Only a third of them are covered by Medicaid; the other two thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in cases of pertussis and increases in pediatric nutritional problems. There is case after case of people actually dying because of a lack of access to the system—people dying of strokes because they could not get their blood pressure medication prescription refilled, people dying of heart failure and having myocardial infarctions because of a lack of routine checkups or medication; and people dying of perforated ulcers because of treatment delays.

The third and perhaps most serious social consequence is that we are mortgaging our own future. I think this is very important and would ask you to bear with me for a moment. As I mentioned, 40% of the poor in this country are children, and two thirds of them are in the gap with no insurance coverage. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we are expecting to fuel the economy and pay for a growing retired population. How are they going to do that in the face of $170 billion owed to foreign governments and nearly a $3 trillion national debt? How are they going to do that in the face of a $10 trillion unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security, and federal pensions, most of which are automatically indexed to inflation and do not have income eligibility requirements? We are asking them to do something that we have all refused to do: to recognize that increases in personal consumption have to be balanced with increases in productivity.

In the past ten years, American workers have averaged a $3,100 increase per capita in personal consumption and only $950 of that has been paid for by increases in what each one produces. The remaining $2,150 has been paid for by cuts in domestic spending and investment and by foreign debt (P. G. Peterson, *The Atlantic Monthly*, Oct 1987, p 47). We are asking this group of people to be more productive than anyone in the history of this country and to probably take a reduction in their standard of living. Having asked them that, we are crippling them going in, by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is healthy and well-educated. That is a very, very serious implication.

There are also some disturbing professional implications. The first is that the growing problem of uncompensated care is catching physicians between what society expects from our health care system and economic realities. When the government and the business community moved to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals and without publicly or explicitly abandoning the idea of universal access because they shifted that subsidy onto the providers. But when physicians move to limit their exposure to this subsidy, and for exactly the same reason, they have to deny access to individuals. When physicians reach the point where they cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring.

That puts us in direct conflict not only with our professional ethics but with social expectations for the health care system. It casts us in a very unfavorable light. Many people still view physicians as we were seen in the halcyon days of the 1960s and 1970s when the economy was booming and incomes were rising. Most legislators are not physicians—I am the only physician in the Oregon legislature. Many legislators do not understand the relationship between cost shifting and subsidizing care for the poor, and do not understand the implications of taking cost shifting away from providers.

The thought that a wealthy profession would be denying access to the poor is unacceptable to most legislators, a fact that puts physicians in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react. They are going to say, "If you physicians are not going to take care of the poor voluntarily, we are going to force you to do so." There are many ways that coercion can be accomplished.

As a condition of licensure, physicians can be forced to take care of a certain number of indigent patients. That bill was actually introduced in Oregon last year. A gross income tax can be applied to physicians' earnings to help pay for indigent care. That bill was introduced in Washington in 1985 and has been considered in Pennsylvania. These types of intrusive regulatory measures are being introduced in state legislatures across the country. Unfortunately, all they do is force physicians to assume the fiscal responsibility for taking care of the poor. They ignore the fact that society, while paying lip service to universal access, has made a decision to limit the amount of money that will be spent on health care. The problem remains unresolved. When someone convinces corporate America that a government-sponsored health care program will put them in a better position in terms of competition in the world market, then we will be looking at a nationalized health care program. In the short run, we are looking at increased regulation and an erosion in our own clinical autonomy.

What do we do about this problem? To solve this crisis in uncompensated care, we have to start by accepting three hard realities.

The first reality is that resources are limited. That is a difficult one for physicians to accept because they have never had to accept it. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars.

We have a national debt approaching $3 trillion that we must reduce. We have a huge defense budget that has been traditionally hard to pare down. We spend $450 billion a year on Medicare, Social Security, and other federal pensions. At the same time, we are cutting aid to education and invest-

ments in roads, bridges, sewers, and water systems. We are cutting civilian research and development. We are cutting all of the things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut. At the same time, however, we want to reduce government spending; we want good roads and schools, safe streets with criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, and clean water. And we want to do all that, of course, with lower taxes and higher wages.

Now, obviously that does not work. There is a finite amount of money that this country can invest in health care versus the other things that we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality, which is simply that the rich are always going to have access to more health care than the poor. I think that is probably all right if what the poor get is adequate and if they are all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis of income, not necessarily on need or merit. We readily accept that in most instances. We do not expect public housing to look like the Ritz. We do not expect food stamps to be redeemed in expensive restaurants. But because of our concept of universal access, we have taken for granted that the poor should have access to all the health care services that are available to the rich. I would remind you that this is the only part of our system that operates on this open-ended economic principle. We have in effect rejected a multitiered system based on income, but in reality we already have that kind of a system. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available at home. The rich have had consultations and elective operations to which the poor have not had access. So what we have really is a poorly defined definition of what we think everyone has a right to and what perhaps they do not have a right to.

I think we would all agree that everyone should have a right to prenatal care, but we may argue whether or not the public should pay for an elective face-lift for everybody on welfare. The question becomes much more difficult, however, when we are trying to balance a transplant versus prenatal care.

We need a better definition of adequate health care to address that question. If we know resources are limited, if we know people with high incomes can buy more health care than people of lower incomes, and if we know that society cannot buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get. That means defining adequate health care and brings us to the third reality.

The third reality is the inevitability of rationing. This is also a very difficult concept for physicians to come to terms with, but when you define adequate health care, you also define what is more than adequate. And that provides the basis for the explicit rationing of health care. Before we overreact to this reality, I would suggest that rationing already exists in our system. We clearly already ration by income and by transportation barriers. More important, however, we ration inadvertently through legislative decisions because we lack any policy to guide how our health care dollars are spent. Rationing is the result of limits. If there is a limited amount of money in the health care budget and it is spent on one set of services, it is not available to be spent on another set of services. That is rationing.

Consider how this is being done today. Almost $2,000 per capita is spent each year on health care in America, far more than any other country in the world. Yet our wellness, as measured by morbidity and mortality statistics, is not significantly better than that in England, which spends $500 per capita, or even Singapore, which spends only $200 per capita (R. Lamm, "The Ten Commandments of Health Care," speech given at the Midwest Health Conference, Kansas City, Mo, March 28, 1988).

Why? Because we have no policy to guide how we spend our health care dollars. We are spending huge sums on some and we are spending virtually nothing on others. We spend more per capita on health care than any other country in the world, yet 37 million Americans have no coverage and many of them are losing access to the system. We spend $3 billion a year on neonatal intensive care while denying prenatal care to hundreds of thousands. We spend $50 billion a year on people in the last six months of their lives while closing pediatric clinics.[2]

That is like having someone in charge of a corporate truck fleet who adopts a policy that the oil in the trucks will not be changed until the engine blocks melt. The trucks won't be maintained but will be serviced only when there is a major breakdown. I doubt if you would endorse this policy for your car, nor would you employ anyone who did, but that is exactly how we spend health care dollars in this country. Rather than spending money on prenatal care, we spend it on neonatal intensive care. Rather than treating hypertension, we treat people who have had strokes. We are rationing by default, unguided by any social policy. It is inequitable, inefficient, and we are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly as opposed to explicitly is because we do not want to come to grips with our own limits.

To solve the problem of uncompensated care, with all of its ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system based on the three realities that I mentioned: limited resources, acceptance of the fact that the rich will always be able to buy more health care than the poor, and the need for rationing.

We have to recommit ourselves to universal access—not universal access for everyone to everything—rather, universal access for everyone to an adequate level of health care. That will put our system back on a sound economic foundation. It also means that we are going to end up in this country with a three-tiered system of delivery. In reality we already have a nondefined, implicit multitiered system: the medically indigent, Medicaid, workers with insurance, the wealthy. What I am suggesting is that we stop pretending it doesn't exist, accept its inevitability, and take steps to make it work equitably and efficiently. This would mean a government-sponsored tier for the poor, a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services.[3]

I want to reiterate one point. The government has a responsibility, in my mind, to pay for the poor but not for the elderly unless they are also poor. The government should pay

for the poor regardless of their age. There is no reason Lee Iacocca needs Medicare, or Johnny Carson, or even my parents. Government-subsidized health care programs should have income eligibility requirements.

This is important because it is at the first, or public, tier that we have to come to grips with rationing. It is at this tier that we must set the socially acceptable minimum level of health care for this country. How do we get there?

Let me describe what is being done in Oregon, where we are attempting to resolve this problem. There are three elements involved: first, a clear social policy; second, a definition of adequate health care; and third, a universal insurance system to guarantee that people get access to that care.

Because of my time constraint, I will only cover the first two elements. Concerning universal health insurance coverage, however, let me say that while it is an essential component of the final solution, it is putting the cart before the horse. We need to recognize that the objective of our social policy of the 1960s and 1970s was, in fact, universal access. One of the reasons we are in trouble today is that we were, in the short run, able to cover everybody for almost everything. But unless we first define the level of care for which people are universally covered, we still have an open-ended system that we cannot afford.

Therefore, we first need a clear social policy to ensure that we spend our limited health care dollars in a way that is efficient and equitable. In Oregon we have made an attempt to recognize our limits and to adopt such a policy. In the past legislative session, we discontinued funding for heart, pancreas, bone marrow, and liver transplants for people on welfare and used that money to extend preventive and prenatal services to a far larger group of people who had been in the gap. This constituted an explicit rationing decision. Let me go over the issue we were dealing with because, I assure you, it has not been an easy one to defend, politically or as a physician, although I firmly believe that it was the correct decision given the reality of limited resources.

The question was not whether transplants have merit; clearly they do. The issue was not whether in the short run we could find some additional money to buy a few more transplants for people on public assistance; clearly we could have. The issue was simply that if we were going to put additional money into health care, where was the best place to spend the next available dollar? Did it make more sense and was it a better use of limited public funds to buy high-tech services for a group of people (those on Medicaid) who already had access to virtually everything available in the private sector, or to extend services to a larger number of people who were in the gap, many of whom did not have access to any health care whatsoever?

We felt it made more sense to serve the larger number of Oregonians. Thus, the policy adopted in Oregon is one of universal access to adequate health care, and we have made that the first priority for spending the additional dollars that we can get into our health care budget. That still leaves the second element: defining adequate health care. Oregon's definition at this point does not include major organ transplants because we have made a decision that they are of a lower priority than preventive care. But we do need a more complete decision.

Before I describe to you the process we are using in Oregon to arrive at that decision, let me say that once you get a definition of adequate health care and array your health care services on a priority basis, you are changing, in a fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus, and it goes like this. We have one heart and three potential recipients. Do we give that heart to a 17-year-old unwed mother of three on welfare, do we give it to a 35-year-old man serving time for rape and armed robbery, or do we give it to a 40-year-old corporate executive?

This scenario raises the kinds of imponderable ethical and moral questions that society, almost by definition, cannot resolve on an individual basis. But once we develop a definition of adequate and array our health care services in a priority order, we shift that debate from an individual focus to a societal focus. We are no longer debating which service should be given or denied to which person, we are debating which priority of funding should be given to each service, given the reality of limited resources. Because society has made the decision to limit the amount of money it spends on health care, society needs to make the decision on how to spend that money. In addition to providing basic health care to a far larger number of people, this approach also takes physicians out of the squeeze and allows them to continue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. In Oregon we are working with a group called Oregon Health Decisions, founded in 1982 by Ralph Crawshaw, MD, a Portland psychiatrist. It is a private, nonprofit group dedicated to educating Oregonians on the health policy choices and confronting them with the consequences of those choices. It was the first such group in the country. Now 14 states have similar organizations, including an active one in California.

We have appointed a steering committee of which I am the chair. We are breaking down everything on which Oregon currently spends its health care dollars. We are making a decision package for each service with a summary document that describes the number of people getting the service and the cost, the number of people not getting the service and the economic and health implications of not giving them that service, and then the cost to extend the service to everybody in the unmet-need population.

The plan over the next few months is to arrange this list in a tentative priority order and take it out to town hall meetings around the state of Oregon where citizens can actually get involved in working through the trade-offs and choices necessary to set up a priority list of health care choices, given the fact of limited resources. We will bring that information together this fall to generate a final list that will be submitted to the legislature.

Once the health care resources are arrayed in that kind of priority list, we come to the second step, which is to integrate this information with the legislative budget process. This requires that funding go to the first item on the priority list for everybody in the population for whom the state has responsibility. Going down the list, the second item is fully funded before moving to the next, then the third, the fourth, and so on, until the available money is exhausted.

This process puts accountability into the system. If, for example, a state legislature decides to cut $20 million out of the health care budget, it will no longer be an abstract ac-

counting exercise but will mean deleting specific services for specific individuals off the bottom of the priority list. The debate becomes far more focused. If someone wants to re-fund the transplant program, clearly they either have to knock something else off the priority list—and they must make a choice, a clinical choice and a political choice, between those two health care services—or they have to rob another program or raise more money (increase taxes).

The final point with this type of system is that if it is done on the basis of sound clinical information, money can actually be saved. A California obstetrics-access study suggested that the cost of treating an indigent woman for prenatal care and delivery was $1,000 and the cost of treating a low-birth-weight infant was $28,000, up to six figures. The study suggested that if prenatal care were provided to all the indigent women who needed it, $22 million a year could be saved in the health care system. That is money that can be used to add services on the priority list, such as major soft organ transplants. It could be used to raise provider reimbursement to a reasonable level and thus remove the current economic disincentive to treat the medically indigent and those on Medicaid, or it could be used for roads. In any event, the debate becomes much clearer and more focused. Accountability is inescapable.

What is the role of physicians in resolving this problem? The first and most significant role we have to play is that we must come to grips with our own limits. We have to recognize that health care resources in America are, in fact, limited. If the leadership of professional medical organizations is going to publicly refuse to recognize that health care resources are limited, how can we expect the public to accept that, and how can we expect state legislatures to recognize that as well? If we are not willing to recognize this ourselves, we are inviting all of the ominous social and professional consequences that uncompensated care is bringing our way. As a first priority, therefore, physicians must recognize and accept limits in health care, express that view publicly, and talk it over with each other and with their patients.

Second, through our professional organizations we need to adopt policies on how to expend limited public health care dollars. Your society or association may already have such a policy but, if not, I would suggest one that states that the first priority should be to extend an adequate level of care to everyone. Then, and only then, should we indulge ourselves in the debate over how to spend what is left in the budget.

This means, of course, that we must also get involved in the definition of adequate. Physicians are really the only group in this country with the qualifications to provide sound clinical information to the state legislature. We need to say: "Yes, we are going to have to ration health care in this country. It is inappropriate and unethical for physicians to do the rationing; society needs to do it. And if you, the legislature, are going to ration health care, here is a list of priorities that make sense clinically. This makes sense in terms of marginal costs and marginal benefits. This makes sense in terms of probable outcome." Physicians have to provide that input. Then we have to support legislative decisions that make responsible resource allocation choices. We have to do that publicly, in our community, and at the legislative level.

This, then, is the threat and the challenge of uncompensated care. The solution, I believe, is a partnership between public policymakers at the state legislative level and leadership in the medical community. If left unresolved, this problem of uncompensated care is going to result in an erosion in our social commitment to universal access to health care and a deterioration of health for a growing number of Americans, with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system, which will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We need not accept this outcome. In fact, we cannot accept this outcome. With the active involvement and leadership from the medical community, we can meet this challenge and restore some rationality and equity and economic stability to our health care system.

I ask you to join me in meeting that challenge.

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THE BATTLE OVER HEALTH INSURANCE

Without getting into the details or the dollar signs, Governor Dukakis promises "health care for all." Vice President Bush wants government to stay on the sidelines. ■ *by Lee Smith*

SURPRISE, Kina, you're a campaign issue. At least the engaging 4-year-old and her mother pictured here are as fitting representatives as any of the 23 million American workers and their families not covered by health insurance. Governor Michael Dukakis wants business to buy all of them protection. Republicans, including Vice President George Bush, regard that as a typically simplistic and expensive Democratic remedy. Mother's boss, they say, might come up with the money for the new premiums by cutting back the work force and tossing her out of a job.

Should uninsured workers be covered? At what price? Who should pay, business or government? And what, if anything, should be done for the 12 million unemployed Americans who have no insurance?

The case for forcing business to pick up the workers' check, or a big part of it, is by no means overwhelming, but history gives it some legitimacy. Willy-nilly, health insurance in the U.S. has grown around employer-paid coverage, beginning in World War II when wage and price controls prevented companies from raising salaries; they gave insurance instead.

The system was more or less ratified in 1965 by the creation of Medicare for those over 65 and Medicaid for the indigent. Says Sharon Canner, an assistant vice president at the National Association of Manufacturers: "We arrived at a social contract that if government would take care of the old and the poor, the private sector would take care of the working." Otherwise, says Uwe E. Reinhardt, professor of economics at Princeton, the U.S. would now have a universal health system controlled by government, like other Western nations.

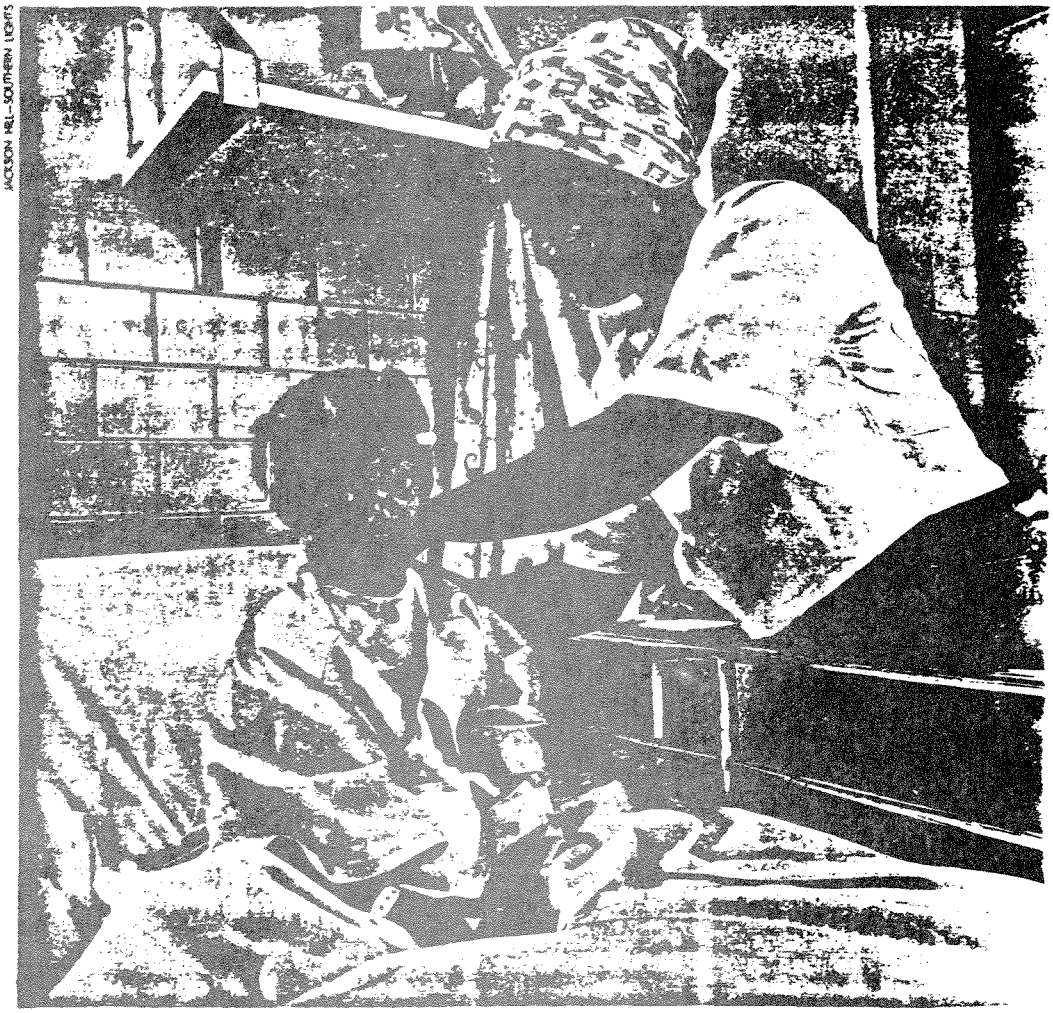
Should Americans regret that peculiar evolution? The U.S. health-care system is the world's most expensive. It consumes 11% of GNP and is on a trajectory pointed toward 13% by 1992. Without doubt it is wasteful, which is why frugality ought to govern its extension to the uninsured.

But by and large, Americans get more medical service than anyone else and get it faster. Canada supplies health care to all its citizens with only 8.5% of its GNP, but Canadians have to wait in line for what is routine in the U.S., a hip or knee replacement, for example. Britain spends 6% of GNP, too little to prevent the National Health Service from deteriorating in recent years. Few patients past their mid-50s are allowed to begin kidney dialysis. "To rationalize such a decision the doctor might say of an

REPORTER ASSOCIATE *Susan Schaeffer*

Uninsured Kina and Wendy Taylor rely on Charity Hospital in New Orleans for emergencies.

JACKSON HILL—SOUTHERN LIGHTS



older patient that he is a bit crumbly," says Dr. William B. Schwartz, a Tufts University professor of medicine. That doesn't happen in the U.S., where Medicare pays for dialysis for all who need it, young or old.

STILL, the American system is plainly unfair. About 85% of the population is sheltered by private insurance or by one of the two major government programs (see chart below). Left out are many of the unemployed: the 60-year-old widow too young for Medicare as well as the 25-year-old looking for a job. But fully two-thirds of the uninsured, 23 million, are employed or are workers' dependents. Many work part time for major corporations, while about half toil for companies with fewer than 25 employees, concentrated in agriculture, construction, and retailing. "They're everybody you see behind the counter on your Saturday rounds to the dry cleaners, the hardware store, the barbershop," says Katherine Swartz, a senior economist at the Urban Institute.

Kina's mother, Wendy Taylor, 19, is typical. For nearly three years she has served chicken at a fast-food franchise in New Orleans for $3.45 an hour, a dime over the minimum wage. The boss provides no health insurance for her or Kina, who suffers from chronic asthma.

Wendy's situation illustrates a couple of inequities. Although Wendy has no insurance, she buys insurance for someone else. Of every $100 she earns, the payroll tax nicks her $1.45, and her boss a matching amount, to provide Medicare for today's elderly. In 46 years Wendy, too, will be eligible, assuming that Medicare is still solvent—if present trends continue, an aging U.S. population would bankrupt the program in a few years.

Even more unjust, Wendy would be better off financially if she quit her job. Her take-home pay for 100 hours of work a month is a little over $300. Without a job she would qualify for Aid to Families With Dependent Children, which would entitle her to $138 a month, food stamps, subsidized housing, and Medicaid. The government would pick up the tab for Kina's medicine, sometimes $70 a month.

Let's not exaggerate Wendy's plight. If they are desperate, people like the Taylors get treatment, often the best and for free. When Kina has an asthma attack, Wendy rushes her to New Orleans's Charity Hospital, the sort of institution that would be familiar to viewers of the TV show *St. Elsewhere*—depressing building, distraught staff, dangerous-looking clientele. But the care can be excellent. During the Republican convention the Secret Service secured a room at Charity for President Reagan, in case he came to harm.

What the uninsured generally fail to get is the early treatment that can head off a panicky race to the hospital. The Robert Wood Johnson Foundation has found in its surveys of the uninsured that only 40% of those without coverage seek help when they have such worrisome symptoms a chest pains, rectal bleeding, or frequent los of consciousness; more than 65% of simila sufferers with insurance go to a doctor.

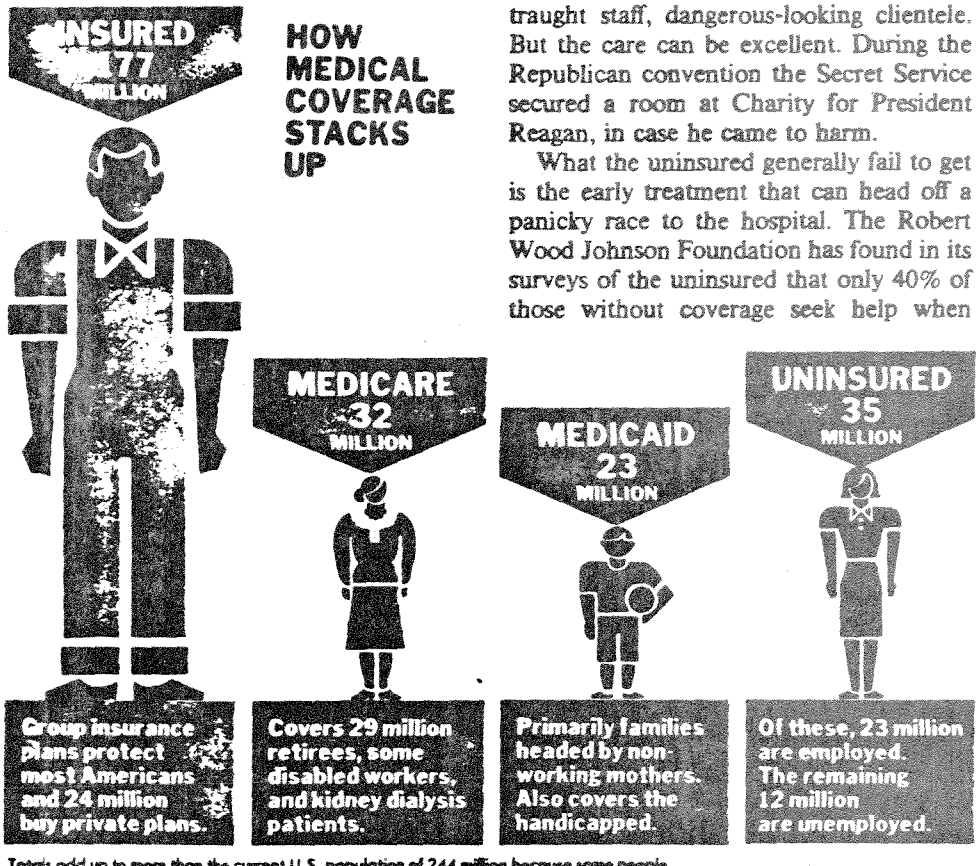
A fifth of women without insurance d not see a doctor in the first three months o pregnancy. Those same women are twice a likely as others to bear fragile, low-weigh babies who require intravenous feeding special monitors, and nurses around the clock that can easily run up a hospital bil of $100,000.

A DECADE AGO hospitals could easily tuck the costs of serving the uninsured into the bills they sent Medicare and private insurers, calling such charges general overhead, or whatever. But as medical costs keep soaring, insurance carriers go over their bills far more carefully. Medicare pays hospitals only for services performed on its clients and according to its own tightfisted price list. Many corporations now demand discounts, and hospitals must oblige or lose precious patients—those who can pay. Some Los Angeles hospitals have closed or reduced service in their emergency rooms, the opening through which bad debts roar in like a raw wind.

No wonder the first operation a hospital wants to perform on an incoming patient is the wallet biopsy, an examination of the insurance policy. Private hospitals often reroute the uninsured to public hospitals like Charity. Even Charity, squeezed by a restrictive state budget, may wish it had been baptized under a different name, maybe Let's Make a Deal.

Both Democrats and Republicans worry about the uninsured and the hospitals that serve them, but Democrats are about three times as concerned, judging by the parties' different estimates for fixing the problem.

Deborah Steelman, director of domestic policy for Vice President Bush, sizes it up at $8 billion a year, roughly the amount of uncompensated care provided by hospitals. Bush believes the private sector should handle the problem primarily on its own, with no mandate from the government to insure workers. His Administration would make it easier for small businesses to form insurance pools, however. In the Senate, Bush's running mate, Dan Quayle, took a more activist position, sponsoring a bill that would start a few experimental projects for about $50 million, much of that in grants to employers to buy partial Medicaid coverage for their workers. *continued*



Totals add up to more than the current U.S. population of 244 million because some people fall into more than one category. All categories include dependents.

ILLUSTRATION BY JAVIER ROMERO

California Medicaid picked up the bill for Carl Bryant's $125,000 heart transplant—after he got broke enough to qualify.

Democrats want a much broader program that would not only reimburse hospitals and other providers for the care they give, but also bring the uninsured to the doctor for preventive care. Dukakis promised "health care for all" in accepting the presidential nomination. He wants business to pay for much of it.

IF BUSH is elected, it is unlikely that any substantial new health insurance program will become law for a while, or so guess lobbyists and legislative aides. Presumably he would veto anything very expensive that comes out of a Democratic Congress. Even if Dukakis wins, there is only an outside chance for passage of health insurance legislation next year.

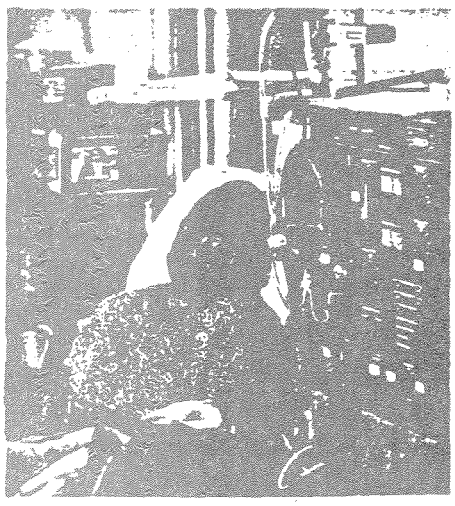
Although Dukakis has tentatively endorsed a health insurance bill shaped by Senator Edward Kennedy, he may want to to put his own imprint on an issue that is clearly important to him. Under his direction, Massachusetts this year became the second state, after Hawaii, to mandate health insurance.

The Kennedy bill, which is moving along in the Senate but has a longer way to go in the House, would require all companies to provide employees with what the Senator calls basic health insurance. Others disagree. "It's not basic, it's a Cadillac plan," complains Fred Krebs, a lobbyist for the U.S. Chamber of Commerce.

Kennedy's labor committee staff figures the cost at $27 billion a year, but some critics argue it might cost several times that. True, not all of that would be additional money. Some costs would simply be shifted from companies that now provide insurance to those that don't.

A handful of major corporations, including Chrysler, applaud the idea of making freeloaders pay up. Like many companies that offer insurance, Chrysler protects not only the worker on the payroll but also his wife, perhaps employed in a local bakery. If she gets sick, her care shows up in the cost of K cars, not croissants. American Airlines approves of the Kennedy bill because by forcing rival Continental to offer an expensive health plan it would narrow the differential in labor costs between the two.

Medicare pays $16,000 a year for Chicago nursing student Lynell Beard's dialysis.



But most businesses, large and small, loathe the bill for both philosophical and practical reasons. Earl Hess, who runs a testing laboratory in Lancaster, Pennsylvania, and insures his 270 employees, empathizes with the struggling entrepreneur. "We want him to be responsible for health care, day care, a whole lot of societal risks for ten other people," observes Hess. "If I have to carry some of the burden to keep the little guy from going under, I'm willing."

Kennedy's medical plan is not the only new cost he would impose on business. Like other congressional Democrats, he would like to increase the mimimum wage from $3.35 to $4.55 an hour. Kennedy estimates his health bill would come to an additional 50 cents an hour per employee. So the cost of keeping Wendy Taylor on the payroll would rise by half her current salary.

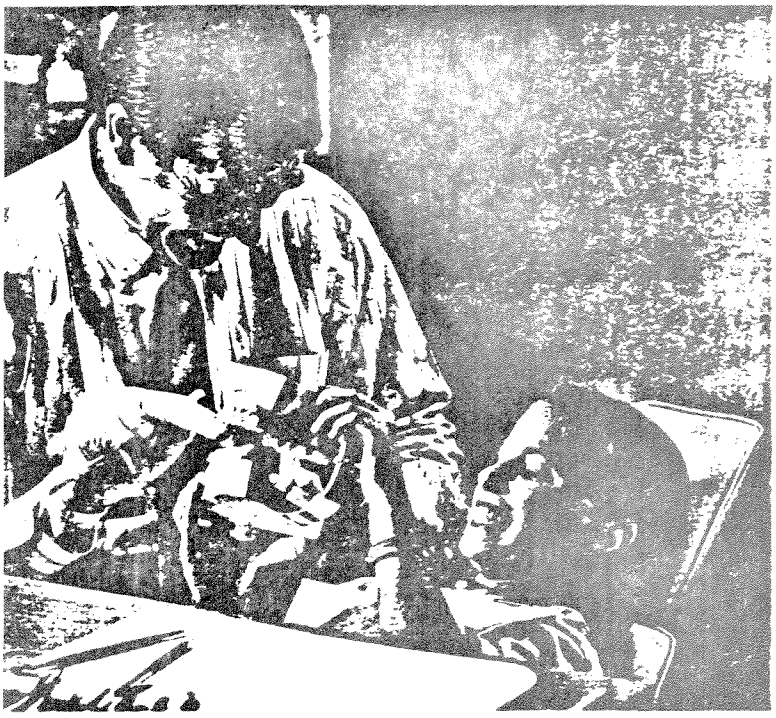
JUST HOW MANY workers would be thrown out of jobs is difficult to forecast. Kennedy's staff guesses 100,000 or so from the health plan alone, not a huge number if it were spread across the general population. But low-wage workers, including black teenagers, would bear the brunt.

Even companies that now offer generous insurance do not measure up to all of Kennedy's standards. The deductibles he sets are appropriate, $250 for an individual and $500 for a family, high enough to discourage frivolous trips to the doctor. But employers would pay 80% of expenses above the deductibles for both workers and dependents, whereas some companies pay only 50% for dependents. Companies would also have to pay the whole cost of prenatal care for female employees and workers' wives, and three or four checkups for their infants, services that even bountiful IBM does not pick up entirely.

Some of the requirements would undermine attempts by corporations to control costs in existing plans, says James A. Klein, deputy director of the Association of Private Pension and Welfare Plans. For example, the stipulation that employers must pay 80% of the costs above the deductible might eliminate a useful device for encouraging employees to get a second opinion before surgery. Now some companies agree to pay 80% only if the employee seeks that additional opinion. If he declines the plan will contribute perhaps 50%.

The mental health lobby has been able

to graft on to the bill a clause that mandates 45 days of care, if needed, at a rest home or similar institution. Therapy of that kind, costing up to $500 or more a day, would be expensive enough in itself. Standard corporate plans cover only 28 days of live-in treatment for drug addicts and alcoholics. More ominous, such a specific proviso is an invitation to every other medical discipline to lobby for inclusion, just as they have done in state legislatures. Florida and Nevada, for example, insist that insurers selling health policies within their borders pay for acupuncture. Dermatologists persuaded the lawmakers of Minnesota to guarantee coverage for hair transplants.



Insured to the teeth by her father's employer, Baxter Healthcare, Emily Jacobson visits her orthodontist in Wilmette, Illinois.

All this runs counter to some encouraging new trends. Auto manufacturers, steelmakers, and others are trying to take back extravagant promises they made earlier to scratch an employee's every itch. Says Carson E. Beadle, managing director of Mercer Meidinger Hansen, an employee benefits consultant: "Podiatrists ran wild through Detroit, convincing everyone they had foot problems."

The Dukakis plan for Massachusetts, which is being phased in over five years, will not require companies to promise specific benefits or even to provide insurance at all. It gives them a choice: Companies with six employees or more will either spend $1,680 per employee a year on health insurance, or pay a 12% tax on the first $14,000 of each employee's income. That money will go into a state-managed insurance pool, from which their employees as well as those in firms with fewer than six workers can buy coverage. In addition, all companies with more than six employees, whether they provide insurance or not, will pay $16.80 per employee a year to provide a $45 million fund for the 27,000 or so temporarily unemployed who have no health insurance.

The appeal of the Dukakis approach is that the cost to an employer seems predictable. But it is hard to estimate what the aggregate costs will be. Businesses that pick the tax option would escape another snare they fear in the Kennedy plan, responsibility for former employees. According to existing federal law a company with a health plan must allow an ex-worker to continue his insurance for 18 months. The company may charge him, but no more than 102% of the average cost of covering a current employee. Because sick alumni are more inclined to sign up than well ones, continuing policies are quite expensive for companies with high labor turnover.

Still, the $1,680 per employee required by the Dukakis scheme is a lot of money. And whereas Kennedy's plan would protect only the workers and their families, Massachusetts employers must cover those out of work as well. That is relatively cheap to do in that state where unemployment is only 3.2%, but would be a burden elsewhere. "For the whole country the Dukakis plan is probably too rich," says Robert Reischauer, a senior fellow at the Brookings Institution. "We shouldn't try to swallow the whole enchilada at once."

What ought to be done? A case can be made for taxing businesses that do not offer insurance, in order to help protect the uninsured in the work force and their families. But the cost per employee should be no more than $1,000, an amount Reischauer and other researchers think could buy barebones coverage.

Distribution of the money ought to be left up to the states or local governments. The Robert Wood Johnson Foundation is sponsoring a pilot project in Memphis. For $75 to $100 a month per worker, depending on family size, the sick and injured are guaranteed unlimited visits to the doctor, if they put up $5 a trip, and hospital stays free after a $200 deductible.

That does not buy medication, however, or pay the keep of those institutionalized for mental illness or for drug or alcohol abuse. Workers have to pay for such care, or buy extra insurance, or go broke and fall back on Medicaid, as many do now.

Even $1,000 per worker would be too expensive for many companies, especially on top of a hefty increase in the minimum wage. Any law requiring businesses to provide health insurance, therefore, should include the trade-off of smaller minimum wage raises—most economists would rather see the minimum wage abolished than increased.

Medicaid already covers about half the poor. Under a new revision that helps the *working* poor, a pregnant woman or an infant up to a year old will soon qualify for medical coverage simply by being a member of a family at or below the poverty level, $9,690 for a family of three. "One of the best-kept secrets of the Reagan years is that Medicaid has been expanding," says Reischauer.

BUT MEDICAID plans vary widely, and some 12 million people not connected to the workplace now fall between the cracks. Filling in the cracks will not come quickly or easily, given the pressures of the budget deficit. Medicaid will cost the federal government $31 billion this year and the states another $24 billion. One equitable way to finance a moderate extension of Medicaid, however, might be to tax those covered by the most generous corporate health plans. Benefits up to $2,000 a year, say—not what an employee is actually reimbursed but his prorated share of the company's health package—might be tax-free, and benefits above that taxed as income.

Critics properly point out that extending medical insurance does nothing to alleviate, and may even aggravate, the urgent problem of controlling the nation's health expenses. True, but it isn't right to cut costs by denying even minimal care to the forgotten.

UNFINISHED BUSINESS

SB 2260

Keene (D) & Maddy (R)

8/26/88

Majority

p. 6847, 6/30/88
(See vote last page)

70-0, p. 10358, 8/30/88

SUBJECT: Income taxes: health coverage: tax credits

SOURCE: California Medical Association
California Association of Hospitals and Health Systems

DIGEST: This bill enacts the Small Employer Health Coverage Incentive Act of 1988.

This bill establishes personal income and bank corporation tax credits for small employers' costs for providing health coverage for employees, as specified.

The credit would be in effect for five years after its operative date.

Assembly Amendments:

1. Replace the term employee with individual throughout the bill and include within the definition of individual an owner-operator or a managing partner who provides at least an average of 35 hours per week in personal services to the business for which health coverage is contracted.

2. Make other clarifying and technical changes.

ANALYSIS: Existing law allows a deduction for the ordinary and necessary expenses of doing business. A deduction may be taken by the employer for the cost of health insurance premiums for employees. The value of the health insurance coverage is not included as taxable compensation for the employee.

SB 2260 allows a personal income and bank and corporation tax credit for a portion of payments made to provide health coverage for eligible individuals and their dependents. This credit would be the greater of $25 per month per covered

individual or 25% per month of the total amount paid for the health coverage during the taxable year, plus $25 per month or 25% of the total amount paid or incurred per month per covered individual's dependent or dependents. An additional $5 per month credit would be claimed for supplemental health coverage for prenatal and well-baby care which meets guidelines established by the American Academy of Pediatrics and mental health benefits consisting of at least:

1. Inpatient hospital care for a mental disorder for not less than 45 days per year.

2. Outpatient psychotherapy and counseling for a mental disorder for not less than 20 visits per year.

In order to claim the credit, the employer would have to:

1. pay at least 75 percent of the cost of health coverage for an eligible individual or the dependent of an eligible individual,

2. employ no more than 25 individuals in California,

3. make participation available to all eligible individuals at least once per year and to newly hired individuals within 60 days of employment, and

4. not have provided health coverage for individuals in the last two years.

Eligible individuals are those who work an average of at least 35 hours per week for the employer or who work less than that amount but for whom the employer provides health coverage, or an owner-operator or a managing partner who provides at least an average of 35 hours per week in personal services to the business for which health coverage is contracted.

The credit would be in lieu of the deduction currently allowed for these costs.
Any unused credit would be carried over to subsequent tax years. The bill defines eligible health coverage.

This credit would become operative on January 1 of the year following a certification by the Legislative Analyst and the Department of Finance that the Governor's budget, as enacted and reflected in the change book, provides for a $3 reserve and that the Department of Finance projects real personal income growth of at least 4%. The credit would be in effect for five years.

Requires the Legislative Analyst to conduct a study at the expiration of the period for which the bill is operative on the impact of the tax credits. It is to include the effect of the tax credits on:

1. the affordability of health insurance policies for small employers and the self-employed,

2. the availability of health insurance policies for small employers and the self-insured,

3. state revenues,

4. competition and costs in the health care industry,

5. subscribers, health care providers, health insurers, and the public,

6. the Medi-Cal program and MIA program.

The Legislative Analyst is to submit a report of the study to the Legislature of the year following the last year that the bill remains in effect.

FISCAL EFFECT: Appropriation: No Fiscal Committee: Yes Local: No

According to the Legislative Analyst:

Cost:
1. Unknown, probably minor, General Fund costs to develop regulations and administer the specified tax credit program.

2. Additional costs of approximately $100,000 to legislative funds to conduct a specified study.

Revenue: Unknown General fund revenue losses for a four-year period, potentially in the range of $13 million annually, contingent upon the certification of specified fiscal conditions.

SUPPORT: (Verified 6/28/88) UNABLE TO REVERIFY SUPPORT AND OPPOSITION DUE TO TIME LIMITATION

California Medical Association (co-sponsor)
California Association of Hospitals and Health Systems (co-sponsor)
Association of California Life Insurance Companies
California Business Roundtable

OPPOSITION: (Verified 6/28/88)

Department of Finance

ARGUMENTS IN SUPPORT: The sponsor states that recent surveys indicate that 3.7 million California workers and their dependents have no health insurance. At least half of these workers are employed in small firms with less than 25 employees. These small businesses cannot afford the cost of health insurance premiums which run 10 to 40 percent higher for small versus large firms. SB 2260 would lessen the financial burden on small employers in providing health insurance to their employees.

They believe that SB 2260 is a viable means to easing the burden on small businesses to enable them to provide health insurance to their employees. Furthermore, as more employers provide health insurance to their employees, the burden on public hospitals and the state created by uncompensated care costs of the working uninsured will be lessened.

They also indicate the bill provides the following benefits:

"Provides an option, not a mandate, to employers while addressing the imminent problem of uncompensated care in our state.

"Enables small business owners to retain valuable workers by offering health benefits.

"Increases the productivity and health of workers by providing preventative health care.

"Allows the growth of private insurance in the free market system while increasing the selection, diversity and availability of coverage."

California hospitals and physicians are tremendously burdened by one billion dollars worth in uncompensated care they were forced to provide last year. Public hospitals provided approximately $600 million in bad debt and charity care to people without insurance.

ARGUMENTS IN OPPOSITION: The Department of Finance is opposed because of the General Fund revenue loss. They also state that this bill would result in inequitable tax treatment. Employers who have conscientiously provided health coverage for employees in the past would get nothing, while those who provided no coverage would have half of their health coverage expenses paid by the state.

Since federal law does not allow a credit such as this, SB 2260 would move the state further away from federal conformity and simplicity.

DW:lm 8/30/88 Senate Floor Analyses

CALIFORNIA LEGISLATURE JUN 1 1988

Senate

STATE CAPITOL
SACRAMENTO, CALIFORNIA
95814

June 23, 1988

Dear Colleague:

Earlier this year Massachusetts became the first state in the nation to enact a universal health care law, ensuring access to health care for all of its citizens.

The problem of access to health care is a vexing one for states such as Massachusetts and California. Because of restrictions in eligibility for government-sponsored health care programs, increased emphasis on competition and health care cost containment in the health care industry, and a continuing shift of jobs to the services industries, more than 5.2 million nonelderly Californians have no health insurance and consequently face uncertain access to health care. At least 1.5 million of California's uninsured are children under the age of 18.

Inadequate access to health care causes a financial burden of uncompensated care on hospitals, doctors, and other health care providers, a burden which is currently estimated to cost hospitals in California close to $2 billion per year. Employers who currently provide health benefits to their employees pay much of this cost through increased premium charges.

Massachusetts' law addresses these problems by addressing the following major trends affecting access to health care:

- The growing shift of the ranks of the medically uninsured from the aged, disabled, unemployed, and very poor to the "working uninsured" -- individuals who work full-time but do not receive health insurance for themselves or their family members as a fringe benefit;

- The growth of uncompensated care and the increasing inability of health care providers to pass those costs on to third parties, which threatens to reduce the amount of charity provided;

- The special health care needs of certain populations, such as pregnant women and children and the growing need to extend cost-effective preventive care to these populations;

- Welfare dependence perpetuated by the loss of health care benefits when welfare recipients take their first job.

Historically, California has been stymied in its efforts to enact significant proposals to extend health care coverage to the uninsured because of fiscal concerns, disagreements over who should bear the responsibility for the problem, and difficulties achieving consensus among the numerous groups affected. Hopefully, Massachusetts' accomplishment will serve as a model for California as it debates ways to extend health care coverage to its uninsured and underinsured residents.

In order to better understand Massachusetts' law, SOR has prepared the enclosed summary entitled, "Universal Access to Health: Recent Lessons From Massachusetts." We urge you to read it. If you have any questions regarding the report, please contact Peter Hansel (916) 445-1727.

Sincerely,

Barry Keene

BARRY KEENE
Majority Leader

Diane E. Watson

DIANE E. WATSON
Chairperson
Senate Health and
Human Services Committee

INTRODUCTION

In April of this year, Massachusetts became the first state in the nation to enact legislation ensuring access to health care for all its citizens.

The Massachusetts law, known as the "Health Security Act of 1988," extends health insurance coverage for the first time to approximately 600,000 Massachusetts residents who do not have health insurance and do not qualify for Medicare or Medicaid (Medi-Cal) benefits. Because of restrictions in eligibility for government-sponsored health care programs, increased competition and emphasis on cost containment in the health care industry, and a continuing shift of jobs from the manufacturing to the services industries, an increasing number of Americans find themselves without adequate health insurance and consequently face uncertain access to health care. In 1977, such persons constituted 13% of the U.S. population under age 65; in 1985 the number had grown to 17.6 percent. Were the Massachusetts law to be enacted in California, it would potentially benefit 5.2 million uninsured persons -- 21.6 percent of the state's non-elderly population -- 1.5 million of them children under age 18.

The Massachusetts law is significant for a number of reasons. First, it is one of the first laws in the nation to address the needs of the "working uninsured" by requiring employers who do not provide health insurance to their employees to make a contribution towards the cost of a state pool which would make coverage available to them. It is the first law to do so without imposing a direct mandate on employers, which would have been preempted by the federal Employee Retirement Income Security Act (ERISA).

(Even so, the Massachusetts law is likely to be challenged on the grounds that it indirectly violates ERISA.) The working uninsured are those persons working full-time (and their dependents) who do not receive health insurance as a fringe benefit and whose income and age disqualify them for Medicaid (Medi-Cal) or Medicare assistance. In contrast to a decade ago, when the majority of the uninsured were aged, disabled, unemployed, or very poor, the working uninsured and their dependents now comprise 50-75% of the total uninsured population in most states (75% in California). By requiring employers to contribute towards the cost of health care for these persons, Massachusetts has effectively addressed this growing shift.

Second, the Massachusetts' legislation recognizes the growing burden of uncompensated care costs on hospitals, health care providers, and employers, who ultimately pay the bulk of uncompensated care costs through increases in health insurance premiums. In California, uncompensated care is estimated to cost hospitals close to $2 billion annually and doctors 9% of their billings. The Massachusetts' law recognizes that under the status quo businesses that do provide health insurance to their employees are effectively paying twice -- once through the premiums for their own coverage and once through premium increases to cover uncompensated care costs. By placing a cap on the private sector burden for uncompensated care, which declines as universal health insurance coverage is phased in, Massachusetts has acted to minimize the impact of this double payment on responsible employers.

Third, the Massachusetts' legislation recognizes the special health care needs of certain groups, such as pregnant women and children, and the benefits of ensuring access to preventive treatment to these groups. In California, 60,000 pregnant women at any given time have no health insurance coverage, and

1 in 13 women get no or inadequate prenatal care in the course of their pregnancy. As a result, a record $104 million in public funds was spent in California last year on hospitalization costs for sick and premature babies. Every dollar spent on prenatal care saves 3 dollars in intensive neonatal care costs for babies born with problems. In extending health insurance protection to pregnant women, employed or otherwise, Massachusetts has effectively capitalized on these savings.

Finally, the Massachusetts' legislation is significant because it recognizes that the loss of health care benefits is one of the primary factors perpetuating welfare dependency. Loss of health care benefits is one of the most frequently cited reasons for AFDC recipients to stay on the welfare rolls. In most cases, the entry level job they would otherwise accept does not provide health insurance benefits for themselves or their children. By creating a "window" during which the welfare recipient may leave welfare and still be eligible for Medicaid, the Massachusetts' law breaks this aspect of dependency.

In enacting Massachusetts' law, several major policy questions were raised, among them:

(1) Is the law preempted by the federal Employee Retirement Income Security Act (ERISA), which regulates employee benefit plans offered by self-employed employers? According to the legislative sponsors, the law is not preempted because it does not impose a mandate on employers to provide insurance, but rather requires a contribution towards state-sponsored care from those who do not provide such coverage.

(2) Will small businesses be adversely affected by the bill? According to Massachusetts' legislative sponsors, the bill is designed to minimize the impact on small businesses by exempting employers with fewer than five employees from the Act, establishing eligibility for a two-year tax credit for

small businesses which have previously not offered health insurance benefits to their employees, by exempting start-up businesses from the full impact of the bill, by establishing a 4-year phase-in period for the law, by establishing a small business health insurance pool, and by providing technical assistance grants to groups brokering health insurance plans to small businesses.

In enacting a health care measure of this magnitude, Massachusetts had several advantages that California does not, among them the fact that 13% of Massachusetts' non-elderly residents have no health insurance, compared to 21.6 percent in California, and the prior existence of an uncompensated care pool, financed by surcharges on insurance premiums by which private sector employers were contributing over $300 million towards the cost of health care for the uninsured in the state. Even with its magnitude, the plan still falls short of the expectations of some by excluding coverage of long-term care benefits.

Despite its strengths and shortcomings, the Massachusetts law will be looked to as a model by other states in the coming years. In order to facilitate further discussion and debate of the law, the Senate Office of Research has prepared the following summary. The summary is presented in the following sections:

- Mandated Employer Health Care Contributions
- Department of Medical Security (New)
- Small Business Programs
- Uncompensated Care
- Special Provisions for Pregnant Women and Children
- Health Care Cost Containment
- Special Provisions for Welfare Recipients and the Working Disabled
- Schedule for Universal Health Care
- Miscellaneous Provisions
- Fiscal Impact

If you have questions about the Massachusetts legislation or would like a copy of the legislation, please contact Peter Hansel (916) 445-1727.

SUMMARY OF THE MASSACHUSETTS HEALTH SECURITY ACT OF 1988

Mandated Employer Health Contributions

- Beginning January 1, 1990, requires Massachusetts employers with more than five employees to pay an unemployment health insurance contribution equal to .12 percent of the first $14,000 of wages paid to all employees. The money would go into an Unemployment Health Insurance Contribution Account and would be used by the Department of Medical Security (created by the bill) to help provide health insurance for persons receiving unemployment compensation.

- Beginning January 1, 1992, requires Massachusetts employers with more than five employees to pay a medical security contribution equal to 12 percent of the first $14,000 of wages paid to employees who have worked for the employer for at least 90 days, who work at least 30 hours per week (or 20 hours if a head of household or an employee of six months or more), who are employed to serve for a period of at least five months, who are not seasonal agricultural workers, and who are not covered by Medicare, Medicaid, or health insurance paid for by someone other than the employer. Revenues collected would be deposited in a Medical Security Contribution Account and used by the Department of Medical Security to help provide health insurance coverage for employees of businesses that do not provide health insurance benefits and their dependents.

- Allows employers to deduct from the medical security contribution the amount of their average expense per employee for health insurance or other health care benefits if they provide such insurance or benefits.

- Starting in 1993, requires unemployment and medical security contributions to be increased at the rate of inflation or at a higher rate if necessary to fund the health insurance programs for employees and for recipients of unemployment compensation created by the bill.

- Exempts new employers from paying the contributions until after the first twelve consecutive months of operation; allows new employers to pay at one third the usual rate in the second full year of operation and two thirds in the third. Self-employed individuals are exempt from the requirement altogether.

- Subjects employers who fail to make the required contributions to a penalty of $35 per day or five dollars per employee per day, whichever is greater.

- Provides that the employer contributions are charged only against the first $14,000 in wages or the actual gross wage level, whichever is less.

- Requires employers who offer health insurance but spend less than $1680 per year per employee ($14,000 x 12 percent) to pay the difference between the actual cost and $1680.

- Provides that the employer contributions are deductible business expenses.

- Makes no explicit provision that revenues received from employer contributions are exempt from state's tax cap; however, since the revenues received are deposited in trust funds and trust funds are outside of the state's tax cap, the new revenues should not be affected by the tax cap.

Department of Medical Security

- Declares that access of residents of the commonwealth to basic health care services is a natural, essential, and inalienable right protected by the state Constitution.

- Establishes a new Department of Medical Security (DMS) to purchase insurance for persons who are not otherwise insured.

- Defines resident so as to prohibit coverage for persons entering the state for the sole purpose of receiving health benefits under the bill; authorizes the DMS to adopt regulations to further define resident, as necessary.

- Requires DMS to establish schedules of covered health care services to enrollees and to set schedules of premium contributions, co-payments, deductibles, and co-insurance amounts to be paid by individual enrollees for policies purchased by the Department. Requires the schedules to establish a sliding scale of payments for enrollees based on family income and size; requires enrollees whose income substantially exceeds the federal poverty standard to pay 100 percent of the premium contributions.

- Will result in individual enrollees on average paying 25-30 percent of the cost of premiums.

- Requires the DMS, subject to its appropriation and the availability of funds, to negotiate the purchase of one or more health insurance plans providing hospital, surgical, medical, and other health insurance benefits and covering: (1) unemployed persons who are receiving unemployment compensation; (2) employees and their dependents who are not eligible for group health insurance paid for employers and who are not enrolled in any other health insurance plans; and (3) and all other residents not enrolled in any form of health insurance plan.

- Requires that every enrollee shall have a choice of at least two plans providing health insurance and requires that no more than 30 percent of the enrollees be enrolled in any single health insurance plan.

- Requires that any health plan provided by the Department to its enrollees shall provide a reasonable range of health care services, shall ensure access to an adequate range of providers, and shall include any mandated benefits otherwise required by law. Further requires that any managed health care plan offered to enrollees shall at a minimum offer inpatient and outpatient hospital and physician's services, diagnostic and screening test services, preventive care, prenatal and well-baby care, and emergency room care.

- Requires DMS to promulgate regulations regarding eligibility criteria, enrollment, and termination policies and to establish a procedure by which individuals can appeal determinations by the Department.

- Requires the DMS to establish two advisory boards, one regarding small business access to affordable health care and one regarding the uninsured.

- Explicitly prohibits DMS from operating as an insurance company; limits the Department's authority to making health insurance plans available through the purchase and brokering of such plans.

- Encourages DMS to buy managed health care plans or other cost reducing plans.

- Requires DMS to establish phased-in initiatives on a regional, statewide, or population basis to test the relative advantages and disadvantages of alternative methods of providing health insurance.

- Requires HMOs to accept Medicaid recipients if they are to compete for insurance contracts with DMS.

Small Business Programs

- Requires DMS to set up programs to help small businesses to purchase health insurance for their employees at rates equivalent to those paid by large businesses.

- Requires the DMS, subject to its appropriation and to the availability of funds, to establish a small business health insurance pool to enable small businesses to purchase group health insurance at rates more commensurate with those of larger businesses. Requires DMS to negotiate the purchase of health insurance plans covering employees of small businesses with fewer than six employees, and their dependents.

- Requires DMS, subject to its appropriation and availability of funds to establish a health insurance hardship program to assist small businesses for which the medical security contribution exceeds 5 percent of gross revenues.

- Grants a partial tax credit for the tax years 1990, 1991, and 1992 to small businesses of up to 50 employees who pay at least 50 percent of the health insurance premiums for their employees and who did not make a similar expenditure in the preceding three years. The credit amounts to 20 percent of the business' premium expenditures in the first year and 10 percent in the second (a business may only take the credit for two of the three years it is available).

- In addition to the above, requires DMS to do the following:

  - Study the insurance market to find reasons for the difficulties experienced by small businesses in providing health insurance.

- Phase in initiatives to broker the purchase of health insurance for small businesses.

- Provide technical assistance grants to private brokers of health insurance for small business.

- Evaluate the effectiveness of the initiatives and tax incentives in making insurance available to small business employees.

- Requires DMS to report to the Legislature by July 1, 1991 regarding the effectiveness of the small business programs and need for repeal or modification of the medical security contribution requirement.

Uncompensated Care

Extends Massachusetts' uncompensated care pool and financing scheme with the following changes:

- Shifts the responsibility for administering the pool from the state's Hospital Rate Setting Commission to the Department of Medical Security.

  - Requires that the pool consist of revenues collected from hospitals through the uniform statewide allowance for uncompensated care included in hospital rates and state appropriations for the pool.

  - Requires DMS to set up a payment system for net liabilities to and from hospitals and a mechanism for enforcing hospitals' obligations to the pool.

  - Places a declining cap on revenues derived from the private sector (from hospital surcharges reflected in insurance premiums) for the uncompensated care pool of $325 million for FY 1988, declining to $312 million in FY 1991,

reflecting an expectation that the volume of uncompensated care will decline as the availability of health insurance increases.

- If the net liability of the pool to all hospitals exceeds the cap on private sector liability, provides for the pool to be supplemented by state appropriations to cover up to 15 percent of the excess and 50 percent of any excess above the 15 percent level.

- Places payments to the pool in an uncompensated care trust fund and allows DMS to expend amounts in the fund to pay hospitals and purchase managed care plans for persons in the pool.

- Establishes a Medicare shortfall fund to compensate acute hospitals for shortfalls in Medicare payments resulting from any failure of Medicare rates to keep pace with health care inflation. Provides $50 million in state funds annually for this purpose.

- Makes no explicit provision that revenues received from hospital surcharges are exempt from state's tax cap; however, since the revenues received are deposited in trust funds and trust funds are outside of the state's tax cap, the new revenues should not be affected by the tax cap.

Special Provisions for Pregnant Women and Children

- Extends the state's "Healthy Start" Program in the Department of Public Health to provide Medicaid assistance to pregnant women whose income does not exceed 200 percent of the poverty level. Provides that assistance shall include medically necessary care during pregnancy and delivery, postpartum obstetrical and gynecological care, and newborn care (state funded).

- Provides medicaid coverage to pregnant women and their infants who are not otherwise eligible for public or private medical assistance if their income is not greater than 185 percent of the poverty line.

- Establishes a mandate that commercial insurance policies and Blue Cross and Blue Shield provide coverage for preventive and primary care services for dependent children of an insured until six years of age.

Health Care Cost Containment

- Continues Massachusetts' hospital rate control policy by establishing hospital rate controls for FY 1988-1991 for all acute care hospitals.

- Establishes a minimum rate increase for FY 1988 of 4.6 percent; allows increases after 1988 at the rate of inflation plus 1 percent.

- Provides rate adjustments for low volume and low cost (efficient) hospitals for FY 1988 and 1989; provides further ongoing rate adjustments to compensate for Medicare shortfalls and for excess or insufficient revenues.

- Requires hospitals to spend 80% of the initial rate adjustments provided by the bill for labor costs.

- Denies low volume rate adjustments to hospitals with rapidly declining inpatient volume except for sole and community provider and specialty hospitals, to facilitate the conversion of underutilized hospital capacity.

- Extends the state's Determination of Need (DON) process for capital facility expansion; increases the threshold for activation of DON process for acute hospitals to $7.5 million and most other facilities to $800,000; allows an annual

adjustment to the DON thresholds. Exempts expansion of nursing home beds in certain underbedded urban access from the DON process.

- Requires the Department of Public Health to annually adjust each acute hospital's number of licensed medical-surgical beds so as to ensure a 75% occupancy rate.

- Establishes an acute hospital conversion board to assist closing or converting hospitals and their employees. Allows board to increase revenues to a hospital that is in difficulty and whose closure would jeopardize the health of a significant number of persons.

Special Provisions for Welfare Recipients and the Working Disabled

- Requires the Department of Public Welfare to establish a comprehensive health care program for persons eligible for General Relief, including coverage for inpatient and outpatient care, physicians services, and prescription medicine.

- Extends Medicaid coverage for 24 months to persons who leave welfare because of employment and find employment with an employer who does not offer health insurance. (This provision sunsets April, 1992, when employer health insurance contribution kicks in.)

- Requires the Department of Public Welfare to establish a Medicaid buy-in program for disabled adults and children who are not otherwise eligible for Social Security disability because of gainful employment and who are not covered for medical costs of their disability by an employer's group health insurance plan and who are not eligible for medical assistance under any work incentive programs.

Schedule for Universal Health Care

Establishes a schedule for achieving the goal of universal access to health care by March 1, 1992. Establishes the following interim deadlines towards that goal:

- Upon passage of bill, DMS begins study of adequacy of existing health insurance and of insurance market for small business and begins purchase of health care plans for individuals in the uncompensated care pool.

- As of July 1, 1988, DMS begins the Medicaid buy-in for disabled adults and children and undertakes at least two phase-in initiatives.

- As of July 1, 1989, DMS begins the small business health insurance pool, small business insurance brokering, and technical assistance grants for small business insurance brokers; tax credit for businesses offering health insurance for the first time becomes effective.

- As of January 1, 1990, DMS begins programs to provide health insurance to those receiving unemployment insurance.

- As of January 1, 1992, DMS begins program to provide health insurance to employed persons and their dependents.

- As of January 1, 1993, DMS completes study of impact of all new programs on availability of health care to the uninsured.

Miscellaneous Provisions

- Establishes Medicaid rates for the next four years, subject to the federal Medicare cap.

- As of September 1, 1989, requires every public and independent institution of higher education in the state to ensure that

all full-time and three-quarters time students are covered by health insurance which satisfies the minimum requirements established by the Department of Medical Security.

- Establishes a comprehensive job placement and reemployment training program for hospital employees who lose their jobs because a hospital closes or converts to another use.

- Requires insurers under contract to the state, Blue Cross, Blue Shield, HMOs, to notify divorced or separated spouses when insurance policies are cancelled.

- Establishes a statutory procedure for physicians to be terminated from the Blue Shield contract to protect patients of such terminated physicians.

- Allows the Division of Insurance to regulate Preferred Provider Arrangements (PPAs).

- Covers HMOs in statute requiring child support obligors to provide health insurance for their children, including children born out of wedlock.

- Covers HMOs in statute requiring alimony obligors to provide health insurance for their spouse.

- Creates a blue-ribbon commission on health insurance reform to assess alternatives for financing health care by increasing competition and improving the availability of affordable non-group and Medicare supplemental health insurance.

- Requires study and development of a Massachusetts Health Service Corps whereby individuals enrolled in medical school whose education is supported by state funds would be required to provide a specified term of service in an underserved area of the state and become a Medicaid provider for a specified period of time.

- Establishes a commission to plan the consolidation of the Medicaid Program, Group Insurance Commission, and Department of Medical Security by July 1, 1989.

- Requires the Department of Medical Security to study the impact of national health insurance.

Fiscal Impact

FISCAL IMPACT OF HEALTH SECURITY ACT OF 1988

($ millions)

	FY 1988		FY 1989		FY 1990		FY 1991		FY 1992		FY 1993		Net Change For 1988-1993 Period
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed	
State Government	$ 86.6	$ 86.7	$ 95.5	$ 129.5	$ 105.5	$ 182.3	$ 116.4	$ 263.3	$ 128.5	$ 244.9	$ 141.8	$ 323.9	$556.3
Businesses Offering Group Health — Uncompensated Care Pool	$ 306.8	$ 310.4	$ 340.6	$ 306.6	$ 378.1	$ 310.7	$ 419.6	$ 318.9	$ 465.8	$ 390.7	$ 517.8	$ 387.4	- $403.5
Businesses Not Offering Group Health	$ 18.9	$ 18.9	$ 20.8	$ 23.7	$ 22.9	$ 53.4	$ 25.2	$ 84.4	$ 27.7	$ 143.2	$ 30.5	$ 208.3	$386.0
Individuals	$ 178.0	$ 178.0	$ 195.8	$ 198.9	$ 215.4	$ 254.5	$ 237.0	$ 279.8	$ 260.7	$ 346.5	$ 286.7	$ 480.3	$364.4
TOTALS	$ 590.3	$ 594.0	$ 652.7	$ 658.7	$ 721.9	$ 800.9	$ 798.2	$ 946.4	$ 882.7	$1,125.3	$ 976.8	$1,399.9	$903.2