

A Health Insurance Primer

State of Wisconsin
Legislative Reference Bureau
Research Bulletin 94-1, January 1994

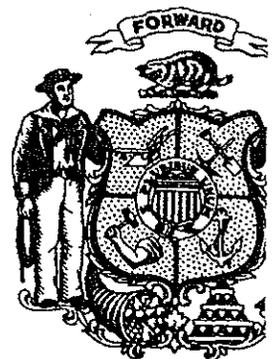


Table of Contents

	<i>Page</i>
I. INTRODUCTION	1
II. THE CURRENT SETTING	1
III. HOW WISCONSIN COMPARES	10
IV. EVOLUTION OF HEALTH INSURANCE IN THE UNITED STATES	12
V. GOVERNMENT AND HEALTH INSURANCE	15
VI. WISCONSIN'S ATTEMPTS TO PROVIDE FOR UNINSURED	16
VII. INNOVATIVE PROGRAMS IN OTHER JURISDICTIONS	25
A. CANADA HEALTH ACT	25
B. HAWAII PREPAID HEALTH CARE ACT	27
C. MINNESOTA	30
VIII. CURRENT REFORM PROPOSALS	33
A. NATIONAL PROPOSALS	33
B. WISCONSIN PROPOSALS	37
GLOSSARY	42
BIBLIOGRAPHY	52

A HEALTH INSURANCE PRIMER

I. INTRODUCTION

Faced with rapidly rising costs and highly sophisticated technology, Americans are finding that access to health care has become much more than a medical issue. It now raises complex questions of social, economic and moral values. Current debate addresses governmental responsibility and intervention, professional medical judgments, rationing of care, free enterprise among insurers and care providers, and even the ability of American business to compete in international markets.

On one hand, the United States receives high marks for the quality of its health care and the resources it devotes to medical research. On the other, it is widely criticized because access to care is limited by rising costs and dwindling insurance coverage. Critics point out that U.S. health rankings indicate weakness in the delivery system, especially where the ability to pay for preventive services is critical, as in the case of prenatal care. In 1990, the U.S. infant mortality rate of 9.1 deaths per 1,000 live births ranked it 21st of the 24 industrialized countries in the Organization for Economic Cooperation and Development. Only Greece (9.7), Portugal (19.0) and Turkey (59.3) had poorer outcomes. Japan had the best ranking at about half the U.S. mortality level (4.6).

This research bulletin will: 1) outline current problems that threaten to leave many Americans without access to health services, 2) describe some of the elements central to the evolution, and eventual reform, of health care financing, 3) review past efforts in the State of Wisconsin to remove barriers to health care, 4) highlight key programs operating elsewhere, and 5) review proposals currently before the U.S. Congress and the Wisconsin Legislature. A glossary of terms is included.

II. THE CURRENT SETTING

Although proposals for a national system of financing health care have been advanced in almost every decade of this century, the issue has only reached critical proportions in recent years. Political observers usually point to the November 1991 special election of U.S. Senator Harris Wofford (D-PA) in a campaign that emphasized universal health coverage as the event which made health reform a key issue of the 1992

National Health Expenditures, By Source of Funds, 1980—2030
(in billions)

Type of Expenditure	1980		1990		2000 ¹		2010 ¹		2020 ¹		2030 ¹	
	Amount	% of Total	Amount	% of Total	Amount	% of Total	Amount	% of Total	Amount	% of Total	Amount	% of Total
Total	\$250.1	100.0%	\$666.2	100.0%	\$1,739.8	100.0%	\$3,787.8	100.0%	\$7,839.4	100.0%	\$15,969.6	100.0%
Private	145.0	58.0	383.6	57.6	859.9	49.4	1,819.2	48.0	3,776.1	48.2	7,753.0	48.5
Out-of-Pocket	59.5	23.8	136.1	20.4	302.7	17.4	621.7	16.4	1,287.6	16.4	2,725.3	17.1
Private Insurance	73.4	29.3	216.8	32.5	491.8	28.3	1,061.9	28.0	2,211.4	28.2	4,460.9	27.9
Other ²	12.1	4.8	30.6	4.6	65.4	3.8	135.6	3.6	277.2	3.5	566.8	3.5
Government	105.2	42.0	282.6	42.4	879.9	50.6	1,968.6	52.0	4,063.2	51.8	8,216.7	51.5
Federal	72.0	28.8	195.4	29.3	617.5	35.5	1,448.4	38.2	3,074.5	39.2	6,321.0	39.6
State and Local	33.2	13.3	87.3	13.1	262.4	15.1	520.2	13.7	988.7	12.6	1,895.6	11.9

Note: Detail may not add to total due to rounding.

¹Projections.

²Includes charitable care.

Source: Summarized by the Wisconsin Legislative Reference Bureau from *Health Care Finance Review*, Volume 14, Number 1 (Fall 1992), Table 9, pages 16-25.

Presidential campaign. It continues as a major concern for both national and state candidates.

Regardless of the political implications, all the players — providers, auxiliary enterprises such as insurers and pharmaceutical companies, government, and the general public — now realize the system is fast running off-track. In fact, many question whether "system" is even an appropriate term for the haphazard mixture of public expenditures, commercial insurance, private payments, and charitable care that makes up U.S. health financing.

Cost Projections, 1990-2030. The economics of U.S. health care grow weaker each year. By 1992, the nation's total health care costs of \$820 billion equaled 14% of the U.S. Gross Domestic Product (GDP), compared to 7.4% of GDP in 1970.

As shown in the table on page 2, the U.S. Health Care Financing Administration (HCFA) projects these figures will rise to over \$1.7 trillion by 2000 (18.1% of GDP) and \$16.0 trillion (or 32% of GDP) by 2030 when the "baby boomers" reach their 70s and 80s.

The 1992 totals break down to \$3,098 per person, according to HCFA. It projects that this per capita cost could climb to \$6,148 in 2000 and \$47,891 by 2030. HCFA emphasizes that these figures are projections and not predictions. They are based on current financing structures and could change substantially if some form of national health insurance were adopted before the end of the century.

The table also presents the HCFA projections by source. The most notable change from 1990 to 2030 is that 9% of total expenditures will have shifted from private sources to the federal government. Even more startling is the projection that combined government expenditures in 2030 will be \$8.2 trillion, almost 30 times the comparable 1990 figure (\$282.6 billion).

Uninsured/Underinsured. In years past, when health care costs consumed a smaller portion of personal income, lack of insurance did not bar access to care. Primary care and routine maintenance activities, even occasional costly incidents such as obstetric care, could be handled in the course of ordinary household budgeting. Today, it is difficult, if not impossible, for many individuals and families to cover average medical expenses, and sizeable bills for premature births or complicated surgeries and therapies may mean lasting financial hardship for the uninsured and underinsured.

The U.S. Bureau of the Census estimates that 14% of the nation's population, roughly 37 million persons under the age of 65, were without health insurance at some point in 1991. An estimated 100,000 lose their coverage each month. Various sources

calculate that 40 million persons have inadequate coverage under their existing policies, so that major medical problems would place them in financial jeopardy or at risk of bankruptcy. It is clear that many Americans feel very vulnerable regarding the long-range reliability of their insurance and their access to health care.

While the uninsured can be defined, the underinsured are more difficult to identify because this status depends on the resources of the person carrying the limited policy. Although the underinsured are usually those with low incomes, they may also be middle- and upper-income persons who have to self-insure at high costs and, therefore, opt for bare-bones coverage. In addition, persons with chronic conditions may find they are unable to get adequate insurance at any price.

Characteristics of Uninsured. The lack of comprehensive data on the nation's uninsured or underinsured seriously hinders the development of a workable system of health care financing. On the basis of survey samples, however, various sources do draw similar conclusions about the profiles of the uninsured.

Despite common misconceptions, the majority of the uninsured are either employed or dependents of employed persons. Often, workers who are given insurance by their employers cannot afford, or are not offered, additional coverage for their dependents. Children are especially hard hit by this omission. In fact, it is currently estimated that children (almost 10 million nationally) represent one-quarter of the uninsured.

The majority of uninsured are young adults, working in lower paying jobs. However, even in this group there is some self-selection. Because they generally are healthier, they may decide to take their chances and not pay premium costs when insurance is offered. It is this younger group that would be forced to pay higher costs under a universal, community rating plan, such as the Clinton proposal.

Since most health insurance is job-related, a person's employment is the major determinant of coverage. The percentage of workers and their dependents without adequate health insurance is rising for a variety of reasons. Recent economic downturns and the escalation of health insurance premium costs — in some cases by 20% or more each year — have made it harder for employers to provide coverage for their workers. The shift of jobs from manufacturing to the service and retail sectors, where employers are less likely to offer insurance plans, means less insurance is available to today's workers. If insurance is not available through an employer, the uninsured person is often hard pressed to find the thousands of after-tax dollars needed to pay premiums for private policies, especially the costlier family coverage plans.

American business and industry originally considered it good practice to offer health insurance in their standard benefit packages because of employe satisfaction and the tax savings available to the company. Recently, business has had to rethink that position as insurance costs have become a major expense. As a result, the line between insured and uninsured has been inching upward into the middle-income families.

Following a year-long study, the Pepper Commission, a committee of the U.S. Congress, reported in March 1990 that the number of dollars employers spent on employe health benefits in 1987 was almost the same as the amount of their profits that year. The cost was equivalent to more than 97% of their 1987 after-tax profits, compared to 74% in 1984 and only 14% in 1965. Promises to fund the health costs of retired workers (whether full premiums for early retirees or the costs not covered by Medicare for those age 65 and over) have become particularly burdensome. In the case of workers still on the job, the choice in collective bargaining may be to forego wages to save health benefits.

General Motors, considered the nation's largest provider of health insurance, reported the bill for its active and retired employes was \$3.7 billion in 1992. According to a September 24, 1993, *Chicago Tribune* report, "the automaker shared in the health-care costs last year of 1.7 million people, many of whom, [Dick] O'Brien [vice president for corporate personnel] said, are dependents of GM workers who opt for GM coverage because it is more generous." GM claims that the price tag of every car it sells includes a health insurance cost of over \$800.

Coverage of the Elderly. The term "uninsured", as used in current discussions, usually does not include persons 65 and older. It is assumed this age group has coverage under Medicare, the federal health insurance program for the elderly and disabled. Actually, many of these persons do have problems financing their health care because Medicare has many gaps. For example, in 1994 an elderly person will have to pay \$493 for the year to cover the "Medicare Part B" premium for insurance to meet nonhospital medical costs, e.g., physician's office visits. Medicare generally does not cover eye glasses and hearing aids, prescription drugs, long-term care in a nursing home, or certain deductibles and copayments. (Nursing home costs currently average almost \$35,000 annually for private pay patients in Wisconsin.) Although some elderly buy high quality "medigap" insurance policies to cover these holes, others cannot afford the premiums or may have health conditions that make them uninsurable.

As medical costs rise, it becomes impossible to exclude the elderly from discussions of health care reform. Some of them claim they already are forced to choose

between life-preserving drugs and food. Families USA, a nonprofit organization researching problems of this age group, reports that even with adjustments for inflation the elderly now pay more than double what they paid for health care before Medicare was established in 1965. When scaled to 1991 dollars, the elderly family's 1991 out-of-pocket costs were \$3,305 (averaging 17.7% of household income), as compared to the pre-Medicare costs of \$1,589 in 1961 (10.6% of household income). (The actual dollar figure for 1961 was only \$347.)

As this age cohort increases drastically with the "graying of America" in the coming decades, their costs will have a heavy impact on health economics. The elderly may face curtailed care as fewer services are covered and fewer doctors are willing to see Medicare patients at controlled costs. Those who enter nursing homes without insurance are likely to become impoverished and put a heavier strain on Medicaid, the federally aided state programs for low-income persons unable to pay for their own medical care. In 1991-1992, the aged made up 11% of Wisconsin's Medical Assistance (Medicaid) eligibles, but they accounted for 36% of the expenditures. (In contrast, and contrary to popular belief, the younger low-income families made up 71% of the MA eligibles that year but were responsible for only 26% of the expenditures. The other major group were the disabled with 18% of eligibles and 38% of expenditures.)

Uninsured Needy. Another erroneous public assumption is that persons who really need health care but cannot pay for it will be assisted through Medicaid or the "general relief" programs run by state and local governments. As described in the following discussion of Wisconsin's health programs, many low-income persons have no access to these programs, because their incomes are not low enough or they do not fall into an eligible category. Access is also a problem as it becomes harder to find doctors who will take patients whose care is government funded, either because these providers consider reimbursements too low or they choose to avoid dealing with government claims.

Lack of insurance may lead people to postpone medical help until the condition becomes so severe that it requires expensive emergency room care. At this point, the treatment is often more medically drastic for the patients and the costs more burdensome, either to the parties themselves, or if they cannot pay, to taxpayers and the health system as a whole. One situation of great concern is that of the pregnant woman who cannot afford prenatal care and only seeks help at the emergency room at the time of delivery. Besides danger to the mother, the babies born under these conditions have

a much higher risk of death or serious and costly health problems which can result in life-long disability.

The burden of providing emergency care to the uninsured has had an especially strong impact on hospitals located in low-income areas, such as inner cities and poorer rural sections.

Uncompensated Care. The Office of Health Care Information in Wisconsin's Department of Health and Social Services recently reported that 141 Wisconsin hospitals provided a total of \$137 million worth of uncompensated care (about 2.4% of their total gross patient revenues) in their fiscal years ending in 1992. This represented \$59.8 million in charity care and \$77.2 million in bad debt. Milwaukee County hospitals alone accounted for 40% of the state's charity care and 30% of the bad debt charges. A total of 455,948 patients received uncompensated care in FY 1992, up from 405,144 in FY 1991, and the hospitals are projecting an increase to 597,147 patients in FY 1993 at an estimated cost of \$154.4 million.

Uncompensated care results either from charity care (for which the provider did not expect payment) or bad debts that cannot be collected. Some doctors and hospitals assume they will perform a certain amount of service without reimbursement, but traditionally the shortfall from a portion of the unpaid bills was shifted to paying consumers. Lately, however, insurers and employers, who must cover the unpaid bills through higher benefit payments and premium increases, are balking at this cost shifting.

Phillip Green, writing in the *Saint Louis Law Journal* in 1989, describes the growth and decline of uncompensated care over the past century. In the early 1900s, when the countries of Western Europe were adopting governmental policies to provide health services, Americans chose instead to continue their traditional reliance on religious and private charities by promoting voluntary, nonprofit hospitals with charters that mandated care for the poor. Later, however, the Depression took its toll on hospitals. There were fewer hospital admissions in the 1930s, and philanthropic contributions declined. This evaporation of funding contributed to the closure of 800 hospitals between 1928 and 1938, and the resulting shortage of hospital beds became acute immediately after World War II.

There is no fundamental (i.e. constitutional) right to health care in the United States. Any assurances the indigent have had regarding access to health care have been based on legislation. One of the best known examples was the federal Hospital Survey and Construction Act, commonly known as the Hill-Burton Act, passed in 1946 to remedy the post-war bed shortage. Hill-Burton included certain requirements that

hospitals constructed with federal funding under the act must provide indigent and nondiscriminatory care. These restrictions, which were the result of political compromise, tended to be ineffective due to vagueness and lack of enforcement. Only 27 Wisconsin hospitals are still operating under the provisions of Hill-Burton.

Several factors dating back to the early 1970s have led to reduced provision of indigent care in both public and private not-for-profit hospitals. According to Green, these include the erosion of government and private subsidies, an emphasis on cost containment, and the growth of profit-oriented corporate hospital chains.

Since 1985, Congress has required that all hospitals wishing to serve patients insured by the federal Medicare program must provide medical assessment (but not necessarily care) for all persons, Medicare-insured or not, who come to their emergency rooms, regardless of the patient's ability to pay. Beyond the assessment the hospital's duty to provide medical treatment applies only to those patients with an "emergency medical condition" or in "active labor".

There is no federal requirement that a hospital must continue to offer care once an indigent patient is stabilized. This has led to the practice of "patient dumping" in which patients who arrive at a private hospital's emergency room without resources to cover the bill are sent to a public facility that must treat them. The only criterion limiting transfer may be whether the patient is in danger of dying in transit. A patient who suffers "personal harm as a direct result of a participating hospital's violation of a requirement" has an explicit private right of action against the hospital, but some have complained the right is hard to enforce because the law is vague.

Increasingly, public hospitals have become the "providers of last resort", but as their uncompensated care costs rise they are experiencing hardships and are decreasing in number due to budgetary difficulties and political problems with their governing boards. Eventually, some close their emergency rooms; others quit operating entirely. In some areas, indigent patients may find themselves without access to even minimal emergency care.

Proposals for Change. Both the U.S. Congress and the state legislatures are confronted with a broad range of proposals for financing health coverage. The plans vary widely from mandated participation to voluntary action. Some involve highly centralized efforts, such as a universal, single payer system like Canada's in which citizens are guaranteed coverage and the government collects taxes to pay care providers. Others are much looser arrangements, such as requiring that employers

merely offer insurance (without having to pay the premiums) or promoting private savings accounts so individuals can provide for their own medical bills.

Drafting federal or state legislation to provide insurance for the uninsured and underinsured is complicated by the many professional groups that have a vital vested interest in the economic outcome of reform. Health care providers, hospitals, prescription drug companies and other suppliers worry that cost controls will make it impossible to provide proper treatment and still stay in business. Traditional health insurers are concerned about regulations, cost containment, and even extinction if a single payer plan is enacted. Business and organized labor are concerned about the economic impacts if job-related insurance remains the major source of coverage. In the past, these varied powerful interests have combined to block reform. However, they are beginning to realize that trying to preserve the *status quo* will also be self defeating. Their new aim may be to develop workable solutions with state and federal lawmakers, while keeping as much of the system intact as possible.

ERISA. Individual states trying to enact universal health insurance plans will find themselves confronted with what may be an insurmountable federal barrier. The Employee Retirement Income Security Act of 1974 (ERISA) currently preempts the authority of any state to regulate health plans that are self-insured by the employer. This means that states cannot mandate health insurance benefits, impose premium taxes, or require financial reserves for company-run health plan. By contrast, insurance plans which the company purchases for its employees on the commercial market may have to meet such requirements as a condition of the insurance company's doing business in a particular state.

When ERISA was enacted 20 years ago, its principal focus was ensuring the solvency of company-financed pension plans. Few firms self-insured for health benefits at that time. Today, about 60% of all employees nationally are enrolled in self-insured ERISA plans. (Wisconsin's percentage is also about 60%.) The ERISA Industry Committee, an association of large employers, estimated in 1992 that nationally about 150 million workers and their dependents were covered by self-insured plans.

The advantage of the ERISA preemption is that it permits large multistate corporations to develop plans without the interference of conflicting laws. Businesses and labor unions that have negotiated specific health care benefits consider this advantageous. They also claim they should not be burdened with supporting state pools for high risk insureds or indigent care pools.

Thus far, the federal government has not imposed many restrictions on the self-insured plans. Although it has developed certain fiduciary, reporting, and continuation requirements, it generally gives an employer broad latitude for tailoring its own health care coverage. Several federal courts have also held that ERISA health plans do not need to meet the more stringent vested rights and fiduciary obligations of ERISA pension plans.

On November 9, 1992, the U.S. Supreme Court refused to hear a case involving a small Houston employer that designed a self-insured plan which capped lifetime benefits for AIDS victims at \$5,000 but maintained a cap of \$1 million for all other coverages. The company changed from commercial insurance to self-insurance with the AIDS limitation after one of its employees was diagnosed with AIDS. The U.S. Supreme Court let stand the decision by the appeals court in *McGann v. H & H Music*, 946 F. 2d 401 (1991), which held that the change was appropriate because it was directed at any AIDS case, not McGann's illness per se. The opinion stated that Congress had recognized the need for flexible coverage in the face of inflation, changes in medical practice and technology, and increases in the costs of treatment.

Employers may modify their self-insured plans to exclude certain conditions as long as doing so does not discriminate against a particular employee. This does not afford much protection for the individual with a chronic illness, genetic defect, handicapping condition or birth defect, because the employer can claim that the change is not related to the individual's circumstances but is based on actuarial soundness.

It remains to be seen whether Congress will make exceptions to ERISA to permit state universal health insurance plans. When it passed a limited exemption for the Hawaiian universal health care plan in 1974, it specified that this was not a precedent for permitting exemptions in other states. The *McGann* case and recent state legislative proposals designed to cover the uninsured have raised questions as to whether it is time for Congress to reconsider ERISA.

III. HOW WISCONSIN COMPARES

Wisconsin appears to have better insurance coverage for its residents than most states. Like the national figures, the number cannot be definitely determined but must be estimated from government and private surveys. Unfortunately, these surveys vary in their methodologies, and they often are not comparable within a single year or across a period of years.

Wisconsin Family Health Survey. The 1992 Wisconsin Family Health Survey (FHS), conducted by the Center for Health Statistics in the Wisconsin Department of Health and Social Services, is the source for Wisconsin insurance information presented in this bulletin. The 1992 FHS data were derived from a series of monthly telephone interviews conducted throughout the year, in which a total of 2,480 households comprised of 6,654 persons were surveyed. The term "uninsured" related to the status of the persons at the time they were contacted. The length of time an individual was without public or private insurance is not known.

Application of the FHS results to the statewide population indicates that 11% of Wisconsin residents (or approximately 528,000 persons) were without insurance in 1992. That figure falls within the 9-12% range determined by other surveys. The FHS does not contact persons in institutions, such as nursing homes, college dormitories or prisons, and it also attempts to exclude all persons who might be eligible for Medicaid and Medicare. However, the 1992 survey estimated almost 5,000 Wisconsin residents over age 64 do not have Medicare coverage.

The uninsured in Wisconsin seem to be typical of the nation as a whole. A majority (75.8%) of the uninsured adults, ages 18-64, were employed. About 1 in 4 of the uninsured (an estimated 138,000) were children under the age of 18 years, although 89.9% of them lived in a family with one or more employed adults. The income status of the uninsured was varied: 22% below poverty level; 32% at 1-2 times poverty level; and 45% at more than 2 times poverty level.

Over the years, various surveys have shown that an increasing number of both the insured and uninsured in Wisconsin have had to forego care they could not afford. According to the 1992 FHS survey, 34% of those who were uninsured reported they had passed up medical care in the past year because of inability to pay, compared to 7% of those with insurance. (It is assumed that the insured who claimed they could not afford care probably had limited coverage.)

Public Opinion — The Wisconsin Survey. The Wisconsin Survey, a statewide survey conducted by St. Norbert College Survey Center and Wisconsin Public Radio, checks public opinion regarding health care and health insurance. The survey center took a recent sampling of 564 telephone interviews, which it considers to be accurate within 4.1 percentage points for Wisconsin's population as a whole. The interviews were conducted during the week of October 23-28, 1993, after President Bill Clinton had submitted his U.S. Health Security Plan to Congress.

The survey shows Wisconsinites are aware of the problems currently facing the country. The top issues they cited were the high cost of health care (selected by 55% of respondents) and the fact some people have no health insurance coverage (27%). When questioned about requiring all employers, regardless of size, to provide insurance for their employees, 57% favored such insurance, 41% were opposed and 2% were undecided.

Views about controlling costs through regulating behaviors were contradictory. When asked whether government should regulate or limit health provider charges, 71% favored controls, 26% opposed and 4% were undecided. (Figures add to more than 100% due to rounding.) The results reversed, however, when the question asked was whether people should be required "to use specific doctors and hospitals to save costs" — 71% opposed, 25% favored and 3% were undecided. The respondents apparently were not willing to surrender their own right to choose care providers regardless of the savings.

When asked about the Clinton plan, reaction was very mixed — 41% favored, 37% opposed and 22% were not sure how they felt. Of the sample, 89% had insurance, and within this group, 59% thought their coverage under the Clinton proposal would be about the same or better, but 31% thought it would be worse. (10% said they did not know what would happen.) Opinion was strongly divided as to who should take the primary role in providing health insurance: 40% said government, 46% favored private insurers and 13% did not know.

IV. EVOLUTION OF HEALTH INSURANCE IN THE UNITED STATES

The fact is often cited that the United States and the Republic of South Africa are the only industrialized nations without a nationwide system for health care or health insurance. American medicine long remained independent of government control or support due to some rather unique circumstances that continue to impact the current delivery of medical services.

Health insurance in the United States is a phenomenon of the 20th century. The impetus for insuring against medical expenses arose when the general public began to use hospitals for surgeries.

In the late 1800s, there were few hospitals, most of them attached to medical schools as laboratories for medical students. In fact, the 19th century American hospitals resembled alms houses, rather than scientific medical facilities. Their purpose was to feed and house patients until they recovered or died, and the latter was not an

uncommon event. Low-income persons were treated there, usually on a charity basis, because their homes were not adequate for doctors' services and patient care. More well-to-do patients expected to handle their illnesses at home with the aid of family or even servants.

Scientific progress altered the picture. Wider use of anesthesia, combined with antiseptic techniques and better treatment outcomes, made surgery more feasible. Doctors preferred concentrating patients at hospitals in order to utilize stationary equipment and save themselves time. As more people saw hospital care as an acceptable alternative to home care, the demand arose for insurance to relieve the potential cost burden. The breakthrough in health insurance occurred in 1929 when Baylor University Hospital agreed to guarantee a group of 1,500 Dallas teachers up to 21 days of hospitalization per year at an annual cost of \$6 per person.

Hospitals throughout the country came to depend on patient revenues by the late 1920s, and they found themselves in financial straits during the Depression. The Baylor program looked like a means to survival. Thus began the Blue Cross plans which now cover the hospital costs of millions of Americans. Despite early philosophical differences, physicians later adopted the idea of insuring against potential doctors' and surgeons' costs through "Blue Shield" plans. These plans not only helped to protect patients and providers in a bad economy, but they also deflected the movement for national health insurance which arose at the depths of the Depression.

From inception, the "Blues" were fundamentally different from commercial insurers. As they developed in state after state, Blue Cross plans were granted a different status because they were considered charitable, nonprofit associations serving hospitals. In most cases, this exempted them from state insurance regulations. Because of their nonprofit or not-for-profit nature, they also were exempt from taxation. In recent years, many of these concessions have been rescinded.

At first, commercial insurers were hesitant to develop a health care product. They thought insuring health costs in the same manner as life, fire, or casualty losses would be actuarially impractical. They were dubious about profitability and skittish about the unpredictability of usage. The success of Blue Cross made them take a second look at health insurance. Unlike Blue Cross/Blue Shield, which used community ratings in setting premiums, the commercial insurers based their premiums on actual risk by using experience rating. (These rating terms are explained in the Glossary.) Experience rating permitted them to group good risks into plans which they could bid at lower prices than the Blues. In some cases, they completely excluded poor risks, such as persons over age 64, and this practice later resulted in the passage of Medicare for all elderly regardless

of their incomes. Another new product that the commercial companies contributed was the major medical policy, which afforded expanded coverage by combining sizeable copayments and deductibles with high benefit caps.

Wage controls during World War II had a peculiar impact on the health insurance industry. While wage increases were limited, changes which improved working conditions or fringe benefits were not. Workers used the opportunity to push their employers into assuming insurance costs in whole or part for employes and their dependents. The employers, for the most part, favored the insurance agreements. They were a positive contribution to good labor relations, and the costs were both low and tax deductible as a business expense.

Two identifiable outcomes of this wartime development continue to impact today's health insurance coverage. First, health insurance became firmly linked to employment. Secondly, those parts of the country where union bargaining was strong were more likely to have insured employes. Fifty years later, access to insurance is still job linked for the most part, and workers in the Northeast and Midwest (including Wisconsin) continue to have better coverage.

Today, when the cost of health care often cannot be covered "out-of-pocket", serious questions are being raised about these historic arrangements. Why should one's employer determine whether a family — particularly dependent children — can get health insurance? Is it equitable, or even feasible, to place this responsibility on the business sector, especially when premium costs grow annually by 20% or more? If the employer's insurance costs result in downsizing or even business closures, will the worker be the ultimate loser?

What was a benefit a half century ago is fast becoming a burden for both labor and management. Those unions that once fought for the employer-based insurance system — automobiles, steel, coal, and heavy industry — no longer possess the bargaining strength they once had. Organized labor is now confronted with cuts in the employer's share of premium payments for active and retired workers, reduced policy benefits, or layoffs that end their coverage entirely. In all sectors, unions report that workers are giving up wage increases to maintain health insurance coverage, and health insurance has become a major issue in collective bargaining. Meanwhile, employers warn that they face serious competitive disadvantages because their foreign counterparts benefit from nationally paid insurance.

V. GOVERNMENT AND HEALTH INSURANCE

The question of whether the government should assist in providing health insurance has been around almost as long as health insurance itself. Germany established "sickness insurance" in 1883, and many other European nations followed suit before World War I. In the United States, where social services were the province of local governments, the federal government did little to regulate the economy or promote social welfare until the Depression.

In the early part of this century, government-sponsored health insurance became an issue for the social progressives who were members of the American Association for Labor Legislation (AALL), an academic organization which included University of Wisconsin economists John R. Commons and Richard Ely. They viewed health insurance as assistance for the poor who lost wages when they were ill. At first, the AALL garnered informal support from the American Medical Association (AMA), but by 1917 stiff opposition had developed from the AMA, which feared economic controls. Other strong opponents were the National Association of Manufacturers, which was suspicious of the costs; the insurers that stood to lose business; and even the American Federation of Labor, which worried that insurance would tie workers to their jobs and weaken unions.

As medical costs rose in the 1920s and the Depression took its toll, health care became an issue of concern to the middle class, and the proposal for government provision of health insurance was resurrected when the Social Security Act of 1935 was considered. Based in part on the advice of Edwin Witte, a former chief of the Wisconsin Legislative Reference Library, who was serving as staff director of the Social Security drafting committee, President Franklin D. Roosevelt deliberately chose not to pursue national health insurance because he feared its opponents, particularly the AMA, would end up scuttling the larger social program. Public opinion at the time supported the idea of government-sponsored health insurance but recoiled at paying extra taxes to cover the program. Roosevelt later indicated that he would consider an insurance program after World War II.

In the readjustment period following the war, President Harry S. Truman sought passage of a national health insurance act. The AMA quickly launched a sophisticated, well-financed campaign opposing the idea as "socialized medicine", although the plan's regulatory effects were definitely limited as compared to the far-reaching British system of nationalized medicine. ("Nationalized medicine" should not be confused with current proposals for "national health insurance". The latter term relates only to public financing

and does not advocate turning medical providers into government employes or privately owned hospitals into government institutions.)

The next crest of interest in health insurance came in the mid-1960s and culminated in the passage of Medicare to insure the elderly and disabled and Medicaid to assist certain low-income persons. Those fighting the current battles over government-based health insurance — pro and con — point out that circumstances were much more favorable for enactment of these 2 programs than is the case today for a more generalized plan. The groups being considered in 1965 were expensive to serve and placed a strain on the medical delivery system. They were limited in numbers and were not a market for the private insurance industry. Though many physicians initially opposed the government programs on general principals, they were not particularly concerned at this point with government control of fees because the elderly and the needy often were unable to pay their full fees anyway. As a concession to the doctors' arguments, Congress permitted balance billing for Medicare and specified that the government should not interfere with physician-patient relationships when administering these programs.

There were other significant differences between passage of the 1965 programs and legislation proposed for the 1990s: the groups interested in passage then were well organized; they knew what they wanted; and, most importantly, federal financial resources were available. In direct contrast, today's attempts to fabricate a national insurance plans have run into 3 major roadblocks, any one of which could result in serious delay: there is no consensus among the principal players within the insurance and provider sectors; the public does not support a particular plan; and the federal deficit limits the national government's funding options.

VI. WISCONSIN'S ATTEMPTS TO PROVIDE FOR UNINSURED

Failure to spend the dollars needed for preventive care and early diagnosis, such as prenatal care, immunizations, mammograms, and blood pressure screening, can result in much higher intensive care costs to treat the unattended problem. If the illness results in catastrophic costs, the burden may fall on taxpayers. Wisconsin, like other state and local jurisdictions, has recognized the need to assist its residents in coping with these problems.

Health costs and insurance coverage have been a matter of concern for the Wisconsin Legislature since the 1970s. In his comprehensive report, Health Access for

the Uninsured (updated December 1989), Tim Wong of the Department of Health and Social Services' Division of Policy and Budget points out that Wisconsin has chosen not to mandate any sort of health insurance program but has preferred to promote action by private employers using commercial insurance options. The 1991 Legislature continued this approach by enacting a state-promoted voluntary insurance program for small businesses.

The following section describes in approximate chronological order the various programs Wisconsin has used to aid state residents who lack health insurance because of medical or economic difficulties.

Medical Assistance — Categorically Needy. Wisconsin's "Medical Assistance" (MA) program began July 1, 1966, following creation of Medicaid in 1965 which authorized partial federal support for state-administered medical care programs serving low-income families. The federal government guarantees it will pay participating states half of their Medicaid costs, but it may pay a higher proportion, based on state income levels. For the federal fiscal year 1994, Wisconsin's MA split is 60.46% federal — 39.54% state.

Some Wisconsin families or individuals are eligible for Medical Assistance because they fall into a particular category that the federal government says must be covered. For example, those eligible for Aid to Families with Dependent Children (AFDC) or federal Supplemental Security Income (including certain aged, blind and disabled individuals living independently), as well as low-income pregnant women who will become eligible for AFDC after the birth, are termed "categorically needy". Some children under 18 who do not qualify for AFDC because of family structure or place of residence are, nevertheless, considered categorically needy and MA-eligible based on their family's income and resources.

Ironically Medical Assistance can impede welfare reform because AFDC recipients fear the loss of MA eligibility if they take jobs that increase their income but have no health insurance benefits. As a partial remedy to this situation Wisconsin applied for and was granted a federal waiver, effective February 1, 1989, which permits it to extend MA coverage for 12 months after a recipient loses AFDC coverage due to excess earned income.

In fiscal year 1992, a total of 455,692 persons were classified as categorically needy. They constituted 97.2% of those eligible for Medical Assistance in Wisconsin. The remainder fell into the "medically needy" group.

Medical Assistance — Medically Needy. Some persons are eligible for Medical Assistance because the state has determined they need help to pay medical bills, based on their limited incomes and lack of assets. In most cases, their financial resources have been reduced to state welfare standards specifically because of their medical expenses. The "medically needy" group includes many of the types already described, e.g., aged, permanently disabled, or women in their first pregnancy. Assistance is extended to them because their incomes are limited, though not as low as those of the categorically needy.

Currently, 37 states extend Medicaid coverage to the medically needy, but some limit their coverage. In Wisconsin, the categorically needy and medically needy receive the same benefits.

In fiscal year 1992, a total of 13,075 persons were classified as "medically needy", and they constituted 2.8% of those eligible for Medical Assistance that year.

General Relief. Single, able-bodied adults, ages 18-64, who have no dependents and are not pregnant cannot qualify for Medical Assistance. In some cases, however, General Relief (GR) programs will cover basic living expenses, including certain medical costs, for these needy individuals or for families ineligible for AFDC. GR also provides interim assistance until needy persons can qualify for other programs, such as AFDC and unemployment compensation.

GR recipients generally are single adults without children, usually male and under 55. Most are unemployed, and over 20% of them may be unemployable due to illness, alcoholism or borderline retardation. The Legislative Fiscal Bureau calculates that county governments, which establish GR eligibility criteria, spent \$50.2 million in medical expenses for GR recipients in calendar year 1992. The state reimburses portions of these expenditures at various rates based on the size of the medical bills and whether the county utilizes a prepaid health maintenance organization (HMO) to provide services.

Insurance Continuation. Loss of a job for whatever reason may leave a person without access to an adequate and affordable health policy. Wisconsin dealt with the problem of health insurance continuation in Chapter 285, Laws of 1979, by requiring coverage continuation for terminated employes and their dependents. 1983 Wisconsin Act 27 increased the length of continuation from 12 months to 18 months, and long-term care policies were added by 1989 Wisconsin Act 31.

Federal action has modified Wisconsin's law to some extent. The major federal legislation on continuation was enacted in the Consolidated Omnibus Budget

Reconciliation Act of 1985 (COBRA), but it applies only to businesses employing 20 or more. Thus, though the Wisconsin law was preempted to some extent for larger firms, it is still fully applicable to smaller employers not included in the federal provisions. (Another exception are those Wisconsin small businesses that self-insure under ERISA and are so covered by COBRA provisions only.)

Under continuation the former employer usually pays the employer's full cost of the insurance. The advantage is that the employer probably has contracted for broader coverage at a better price than the worker could secure as an individual buyer. Continuation also offers temporary protection for persons who encounter a waiting period with their next employer or who run into insurability problems due to preexisting conditions.

Continuation is an imperfect solution. Many employees cannot afford to pay insurance premiums if they have been laid off. In addition, the terminated insured (and dependents) cannot claim continuation if the employer no longer has a health plan. This limitation is critical for a worker whose firm goes out of business.

Community and Migrant Health Centers. The services of the community and migrant health centers comprise the largest component of care for the low-income uninsured in Wisconsin. In 1992, they served a total of 56,495 medical patients and 7,012 dental patients and accounted for almost 355,000 provider visits.

The centers operate as private nonprofit agencies that provide primary health care services to the medically underserved. They offer dental and ambulatory medical care through a sliding fee scale, based on ability to pay after application of public and private insurance benefits. The remainder of the cost, typically 75-85%, is paid through governmental assistance. The centers may provide Medicaid, Medicare, and the Women, Infants and Children (WIC) supplemental food services.

Federal funding for this type of center began in 1974. It is distributed through annual competitive grants awarded on the basis of the community's need for a center and the center's effectiveness. Most of the centers in Wisconsin receive federal funds, but some, such as the Madison Community Health Center, are locally supported. Although inpatient services are not covered by the federal funding program, local hospitals cooperate with the centers by providing uncompensated care.

There currently are 9 programs in Wisconsin that are partially funded by the U.S. Public Health Service. They include 6 year-round community health centers: 3 in Milwaukee and 3, based in Lakewood, Marshfield, and Minong with satellite clinics. (A seventh community health center is scheduled to open in Cashton in the spring of 1994.)

The other 3 programs offer medical and dental care for the homeless in Milwaukee and Green Bay and seasonal services for migratory and part-time workers in the 9-county area surrounding Wild Rose.

National studies suggest health centers can reduce hospital use among their clients by 22% or better when compared to similar populations not so served, and a 1992 California study showed that the centers reduced Medicaid per patient expenditures by 33% of projected costs. This success at containing costs has been attributed to the emphasis placed on preventive care.

Health Insurance Risk Sharing Pool. Wisconsin's Health Insurance Risk Sharing Pool (HIRSP) is one of the oldest and largest state-run risk pools in the United States. It was created on July 1, 1981, to offer individual coverage to those unable to buy health insurance in the private market because of particular health conditions. Wisconsin was the third state to enact such a program, after Minnesota and Connecticut. Twenty-six states now have similar plans.

To be eligible for the program, which is administered by the Office of the Commissioner of Insurance (OCI), a person must be under age 65, be ineligible for either Medical Assistance or insurance from an employer, and have been turned down for insurance at reasonable rates by a private insurer.

As of December 31, 1992, HIRSP provided coverage to 12,707 Wisconsin residents through one of 2 plans: a standard major medical plan or a Medicare supplement for those eligible for Medicare. The average age of HIRSP enrollees was 50.19 years in 1992.

Persons in the HIRSP program are expected to pay premiums, plus a \$1,000 deductible and copayments of 20% toward service charges. Although HIRSP is designed to be self-sufficient, companies selling commercial health insurance in Wisconsin are required to make up the difference between premiums collected and benefits paid. (The HIRSP assessment does not apply to businesses that self-insure under ERISA plans.)

Because insurance companies share the pool's costs, the end result is that all health insurance buyers across the state help pay for HIRSP. The commercial insurers have paid assessments throughout the program's existence, despite upward adjustments of the HIRSP premiums that the insureds must pay and the premium subsidy support provided by the state since 1985. In 1991, a total of 251 insurance companies were assessed over \$15 million for HIRSP, based on their volume of business in Wisconsin.

Since 1992, state law has required that HIRSP premiums cover 60% of program costs, but premium subsidies are available for persons with household incomes of \$20,000 or less. Another cost control instituted in 1992 required the HIRSP administrator

to reduce all payments to providers and pharmacies to 90% of billing, and billing the remainder to the patients is prohibited.

Part of the problem with the HIRSP pool is that it is a grouping of high risk persons. Some have suggested that it would be better to diversify by grouping the HIRSP population with other state programs, such as Medical Assistance, GR recipients, or public employe groups.

Wisconcare. Wisconcare, a program to assist the temporarily unemployed, began October 1, 1985. Its prototype was "Share Care", a temporary program created in the fall of 1983 to provide free primary outpatient care and inpatient maternity coverage to persons who lost their insurance due to recession-related unemployment or underemployment. Share Care was operated by a coalition of private organizations in 17 counties and was supported by state and federal funding and provider-donated services. It enrolled 19,000 participants and was terminated in most cases by June 30, 1985.

Wisconcare served approximately 3,000 persons in fiscal year 1992-93. Recipients were located in 17 counties but tended to be concentrated in the northern half of the state and the populous southeastern counties. The program continues to cover outpatient and diagnostic services, inpatient maternity and newborn services, and prescription medicines. The 1992-93 Wisconcare budget of \$1.5 million was raised through assessments to Wisconsin hospitals based on their gross receipts from private pay patients. These dollars are used principally to cover expenses, such as laboratory costs, medicines and supplies. Most providers donate their services to the program.

State Health Insurance Program. The first concerted effort to solve the problem of the uninsured in Wisconsin began almost a decade ago with legislation enacted on April 23, 1984 (1983 Wisconsin Act 348), which required the Department of Health and Social Services (DHSS) and the Office of the Commissioner of Insurance (OCI) to develop model health insurance plans. The law required 2 versions: one which could be offered by private business and the other a joint venture of the state and private insurers.

The legislature's stipulations for the plans included many of the elements being considered in current legislative deliberations. Both versions were expected to target low-income persons (including single persons with dependent children), unemployed persons and those who could not obtain health insurance through their employers. Premiums and cost-sharing features were to be based on ability to pay and, to the extent possible, the plans were to utilize prepaid capitation payments and the direct negotiation

of payment rates with providers. The plans were expected to obtain maximum federal funding, avoid adverse selection, and deter employers from dropping insurance already offered. The inclusion of MA clients was also considered.

The resulting plans, which were transmitted to the legislature on February 5, 1985, became the basis for the State Health Insurance Program (SHIP), as created in the 1985 budget. After several years of research and evolution, DHSS was directed by 1987 Wisconsin Act 413 to conduct 3 SHIP pilot projects over a 3-year period from June 17, 1988, through June 30, 1991.

Unfortunately, as the University of Wisconsin Center for Health Policy and Program Evaluation (CHPPE) pointed out in its final evaluation of SHIP, the eventual design of the 3 pilots was a political compromise following the governor's veto of the legislature's original plan for 6 pilots:

...Eventually, a set of SHIP pilots were authorized as part of the Welfare Reform Act of 1987 (Wisconsin Act 413) The authorizing legislation represented a political compromise rather than the outcome of a deliberate policy development process. And with but one exception, the Advisory Council had little involvement in the deliberations out of which the SHIP concept was formulated and developed. For these reasons, some observers in the legislature never considered SHIP to be a serious and substantive response to the underlying public policy challenge. Even before SHIP was fully operational, other legislative proposals were being developed and debated. (p. 12-14)

According to the CHPPE evaluation, the SHIP pilots were inconclusive and failed to illustrate the potential of a statewide program. Because they were limited in geography, time and concept, they could not offer a comprehensive, long-range picture. Part of the distortion in the pilots was that, due to the brief period of operation, employers may have been hesitant to buy subsidized insurance they might not be able to afford to continue after the pilots expired.

The 3 SHIP pilots included 2 employment-based models and a third targeted to persons having difficulty buying insurance because of preexisting medical conditions:

1) The Non-Insuring Firm Pilot, conducted in Outagamie and Portage Counties, was partially funded by a matching grant from the Robert Wood Johnson Foundation. It subsidized insurance offerings by small businesses (with fewer than 20 full-time employes) that had not provided comprehensive health insurance within the 12 months

prior to application for a SHIP subsidy. Employees seeking a premium subsidy had to be Wisconsin residents with a gross family income less than 175% of the federal poverty level. They were required to make some contribution toward the premium, but their out-of-pocket costs were capped. SHIP estimated that 6.1% of all eligible workers in the counties were enrolled (77 employees with 175 dependents in 73 firms), but this included 28 persons who were found to be medically uninsurable under the employers' plans and eventually were placed in the HCCP pilot described below.

2) The Insuring Firm Pilot targeted employees with incomes below 175% of federal poverty level who had access to health insurance through their jobs but were unable to pay their share of the premium either for themselves or other family members. The pilot was designed to test whether a subsidy could motivate uninsured employees to purchase coverage. This pilot targeted small firms (employing fewer than 100 full-time workers) that had offered a comprehensive group health plan for at least 6 months. The subsidy was available to those who had not participated in their employer's plan for at least 6 months prior to application to SHIP. Participants with uninsured dependents had to include them in the SHIP coverage. This pilot operated 21 months in Portage County and 20 months in Rock County. SHIP estimated that about 13.7% of all eligible workers in these counties were enrolled (47 employees in 24 firms, plus 82 dependents).

3) The Health Care Coverage Pilot (HCCP), originally called the "Alternative Plan", was designed for Milwaukee County adults with legally defined disabilities or other health conditions that made them ineligible for standard health insurance. (It was also used to cover persons who, but for their health conditions, would have been eligible for enrollment in the Non-Insuring Firm pilot.) A departmental goal in establishing this pilot was to permit persons with disabilities to hold jobs from which they might have been previously barred because employers could not fit them into existing health insurance plans. A total of 374 Milwaukee County residents participated in HCCP. Of these, 333 were subsidized in the full plan, 11 were in the full plan without a subsidy, and 23 purchased wrap-around plans which added to coverage they already had. Seven were unclassified.

The CHPPE evaluation concluded that the provisions under which the 3 SHIP pilots were expected to operate were too restrictive and too difficult for insurance agents, employers and employees alike. For example, it pointed out that among all the state health insurance initiatives for the uninsured, SHIP was the only one that required individuals to meet both a firm-size and income limit. It concluded: "[These constraints] exclude a large percentage of the working uninsured from pilot eligibility — almost 40 percent of the uninsured in non-insuring firms and two-thirds of the uninsured in

insuring firms. We estimate that only 35 percent of all uninsured families were eligible for a SHIP subsidy...."

The Department of Health and Social Services did not propose extension of the SHIP pilots in its 1991-93 budget request to the governor. Enrollment in the projects was closed in January 1991 and state subsidies were discontinued in June 1991.

Small Employer Health Insurance. 1991 Wisconsin Act 250, the major piece of health care reform legislation enacted by the 1991 Legislature, laid the groundwork for the Basic Health Benefit Plan that private insurers could offer to small employers in Wisconsin. The development of the plan was handled by the newly created 11-member Small Employer Insurance Board, composed of 5 participating employers and 5 participating employees, appointed by the governor with the advice and consent of the senate, plus the Commissioner of Insurance or the commissioner's designee, acting as nonvoting chair of the board.

Small employers eligible for the plan include private firms employing 2 to 25 full-time employees in Wisconsin (including the owner) or a village or town government with 2 to 10 employees, as long as the employer has not provided health insurance coverage in the 12 months prior to application for coverage. It is expected there will be savings on premiums for the basic plans because participating insurers, although required to meet all state benefit mandates, can offer policies geared to minimum levels of coverage.

In order to be eligible to participate in this market, the small business insurers must guarantee to issue their basic plans regardless of the medical condition of individuals in the group. However, exclusion of or limited coverage for a preexisting condition can be imposed for up to 12 months from the initial date of an individual's coverage.

To be considered full time and eligible for a basic plan, employees must work a minimum of 30 hours per week for at least 50% of the weeks the business is in operation for the year. Participating employers are expected to pay 50% of individual employee premiums and 40% of family premiums. Under the basic plan, the maximum benefit per calendar year is \$30,000 per insured. The individual is responsible for 80% (\$4,000) of the first \$5,000 of charges and 5% of the remainder of charges up to the plan limit.

Basic plan coverage is portable. Employees who have completed the waiting period for a preexisting condition under a small employer's plan will not be required to satisfy another waiting period with a future small employer.

VII. INNOVATIVE PROGRAMS IN OTHER JURISDICTIONS

A. Canada Health Act

Canadian national health insurance is often cited as a possible model for the United States. Under Canada's "single payer" system, the government collects the taxes and pays the providers.

The Canadian universal system has evolved over a long period of time, and its history may prove helpful. It began with a single province, much as some Americans have proposed a state-by-state approach. National hospital insurance had its beginnings in the 1947 Saskatchewan Hospital Services Plan. The idea spread through the provinces until it was nationalized in the Hospital Services and Diagnostic Services Act of 1957. In 1962, Saskatchewan again led the way for a physicians' insurance plan which was enacted nationally as the Medical Care Insurance Act of 1966. The Canada Health Act of 1984, which consolidated the separate hospital and medical plans, required that all residents be covered by national health insurance, and the provincial governments achieved compliance by 1987.

Even today, the term Canadian "national health insurance" is somewhat misleading. In reality, there are 12 programs (10 provinces and 2 territories) which are administered at the provincial level with subsidies and some directives from the federal government. This structural decision was made in the 1940s because it was thought that federal administration might require a constitutional amendment (as had previously been necessary when a national program for unemployment insurance was created). Supporters also faced the political reality that the provinces did not want to transfer control of health services to the federal government.

Health providers are paid by the provincial government according to predetermined rates. Most physicians are reimbursed on a fee-for-service basis, according to rates negotiated annually between the provincial government and the provincial medical association. Hospitals are paid in 12 or 24 installments per year which cover the operating costs they have projected in their annual global budgets that the province has approved. Installment payments eliminate much of the administrative cost involved in per-case billing.

The single payer feature of the Canadian plan permits hospitals and physicians to operate without the billing staffs which have proven so costly in the United States. Each Canadian is given an identification card to access the medical system. Doctors are prohibited from billing any extra amounts over the agreed rate schedule, so the patient

uses the card and never sees a medical bill, unless a noncovered service, such as a private room or cosmetic surgery, is involved.

Health services are funded through a variety of sales, income and payroll taxes; federal grants; and some scaled premiums. The combination is determined by the provincial government.

The 5 primary conditions for federal assistance to the provinces, as established by the 1984 Canada Health Act, are: basic comprehensive benefits, universality of coverage, accessibility, portability, and public administration. These elements are often favorably cited by advocates of a U.S. single payer system.

Basic comprehensive benefits are those "medically necessary" services a standard hospital is equipped and staffed to provide at the standard ward level, plus the "medically necessary" services of both general practitioners and specialists, and such outpatient treatment as the province decides to offer. The national government determines the basic benefits which every province must support, and individual provinces can add benefits to the basic package.

The provinces were required by the 1984 act to achieve *universality of coverage*, i.e. coverage of all residents, and they did so by 1987. Prior to that the maximum coverage level had been 95%.

The Canada Health Act increased *accessibility* by specifying that \$1 in federal aid would be deducted for every \$1 a patient was billed by a hospital or physician in excess of agreed rates. This curtailed balance billings by physicians and user charges by hospitals. (These practices had emerged in the 1970s when funding was strained by increased utilization.) All provinces were in compliance with the accessibility mandate by 1987. Because there is no extra billing now, all patients, even those with low incomes, have access to care.

Portability assures that insurance is provided in those situations where a citizen moves from one province to another or where persons are temporarily outside their province while traveling or attending school. Differences have to be worked out if the home province reimburses service at a rate lower than that of the province providing care.

The Canadian national health insurance program operates through *public administration* rather than the private administration systems used by U.S. commercial and self-insured health plans. This requirement has led to lower costs. It is estimated that the providers' administrative costs amount to only about 2-1/2 cents of every dollar spent on health care. According to recent reports from the Congressional Budget Office

U.S. Medicare administrative costs are similar (2 cents of every dollar spent) but administration of private health plans averages about 7 cents per dollar.

No one claims perfection exists north of the border. Opponents cite a variety of problems, including shortages of high technology equipment, waiting lists for surgery, and increasing difficulties with cost shifting from the federal government to the provinces. Proponents claim that on balance these factors are not as bad as portrayed, and they point to the more favorable health outcomes (such as an infant mortality rate that is approximately half the U.S. rate), better cost controls, and universal coverage. Perhaps the best gauge of the Canadian plan's success to date are the public opinion polls of the Canadians themselves that consistently indicate a large majority are satisfied with their health insurance. Still, observers in both countries wonder whether a system that has operated for over 30 years can be adapted in the 1990s by a nation with a very different temperament and 10 times the population.

B. Hawaii Prepaid Health Care Act

The Hawaii Prepaid Health Care Act, which became effective January 1, 1975, was the first compulsory, universal health program in the nation to require employers to provide minimum levels of health insurance coverage.

Mandated Coverage. The law generally requires that the employer pay at least half of the employee's health insurance cost for an approved health care plan. The employee must contribute the balance with the limitation that an employee's contribution is capped at 1.5% of wages. If the employee's cost exceeds that percentage, the employer must also pick up the difference. (As health premiums have risen more rapidly than wages, employers are finding it necessary to pay an increasingly larger percentage of the costs because of the cap.) An employer also may choose to pay a higher percentage of the costs than the legal mandate or add coverage for dependents.

The employee's free choice of a physician is protected, and, though not required to do so, many employers provide a choice of insurance plans. In addition, the law preserves workers' collective bargaining rights to negotiate agreements which provide more favorable coverage than the minimum requirements.

More than 20,000 employers participate in Hawaii's prepaid health care plan. The law recognizes that costs may be burdensome for some smaller employers, so it provides that firms with less than 8 employees eligible for coverage may request "premium supplementation". The supplement, provided by the state government, covers that portion of required health insurance costs which both exceeds 1.5% of the firm's total wages and is also greater than 5% of the employer's income before taxes.

Currently, persons eligible for Medicare and Medicaid and certain federal, state and local government workers who have their own health plans are not covered by the state plan. Exception is also made for persons working on commission, seasonal employes, part-time employes working less than 20 hours, and dependents covered by someone else's prepaid plan. Persons who are unemployed, in a labor dispute, or in the 4-week waiting period as a new employe may be temporarily excluded.

Coverage Standards. By law, standard coverage for Hawaii's prepaid health plans must be based on the standards set by those plans which "have the largest number of subscribers in the State." To keep coverages flexible, 2 large plans (the Kaiser Foundation Plan 1 and the Hawaii Medical Service Association Plan 4) have been recognized as standard setters for the act. The Kaiser plan is an HMO structure and HMSA, which is the Hawaiian "Blues" organization, represents fee-for-service providers. Other plans must be approved by the Prepaid Health Care Advisory Council as meeting these standards.

Coverage of Residents. When the Hawaiian plan was first proposed in 1969 it was estimated that 11.7% of the residents were without hospital insurance and 17.2% lacked medical insurance. Based on enactment of the Prepaid Health Care Act and expansion of Hawaii's Medicaid program, state officials estimated that by 1989 coverage of state residents had increased to approximately 95%.

Those not covered by the employer mandate or Medicaid came to be known as the "gap group". This group, consisting primarily of persons who could not afford to purchase health care insurance privately, numbered about 30,000 to 35,000 in 1989. The State Health Insurance Program (SHIP), enacted June 26, 1989, was designed to ensure the availability of "basic health insurance coverage" for uninsured residents. They can privately purchase a SHIP policy, assisted by a sliding scale subsidy based on the purchaser's income. According to a February 1991 report by the Hawaii Department of Health, SHIP cut the gap group by about one-half to approximately 17,000 persons. Estimates are that 98% of Hawaiian residents now have insurance coverage.

As its next step, Hawaii proposes to pool an estimated 100,000 indigent and low-income residents from its 3 subsidized programs (SHIP, Medicaid, and General Assistance) into a new program called HealthQUEST by April 1, 1994. HealthQUEST will emphasize capitated rates and managed care to control costs.

Hawaii's Special Circumstances. Some proponents of national health insurance have suggested the Hawaiian Prepaid Health Care Plan as a model for the rest of the states. However, based on conversations with staff of the Hawaii Legislative Reference Bureau and various written sources, it is apparent that this plan was enacted under

especially favorable circumstances that would be hard, if not impossible, to replicate. Listed below are some of the factors these observers report were unique to Hawaii in the mid-1970s when the plan was adopted:

- When proposed, the prepaid health care plan had little opposition. There were no major interest groups united against it, in part because so many employers already provided health coverage and partly because Hawaii from statehood had a reputation for liberal social legislation.

- Because a large portion of workers already had insurance benefits, the cost impact on business was not as heavy as might be expected in other states. Those firms that had to shoulder new costs because of the law were smaller ones, so the overall impact on the state's economy was not as great. In addition, supplements were available for small employers.

- The Hawaiian business setting was very favorable for establishment of universal health insurance in the mid-70s because the early part of the decade was a time of economic growth and prosperity for the state.

- Hawaii's major industries — tourism, military activities and agriculture (particularly pineapple and sugar cultivation) — account for about 40% of the gross state product and are specific to the state. Thus, the employers that had to absorb the major portion of the plan's costs could not be undercut by competitors in other states. As one Hawaiian official stated, these employers were captive to the situation; they did not have the option of moving across the state line to save health costs.

- Hawaii moved at an advantageous time when health insurance costs were quite low. When the law was enacted the range of monthly premium charges was \$22.60 to \$25.71 for a single worker, and the employer was usually obligated to only half of that. Today, a state might be looking at rates 5 to 10 times that amount.

- The Hawaiian health care system developed in unique ways that helped to contain costs. In 1974 there were 2 major insurers, HMSA and Kaiser, that handled about three-fourths of the coverage. Other carriers accounted for about 14-16%, with self-insurers making up the difference. The competition between the 2 dominant insurers was described as "real and active" with budget constraints, efforts to limit utilization, and attempts to control providers' fees. Many other states lack such competitive forms of coverage.

- Hawaii had some unique health factors which helped to keep employers' health costs under control when the plan was first initiated: a comparatively young population; greater life expectancy; lower infant mortality; the lowest incidence of alcoholism; a low

ratio of hospital beds; a higher proportion of physicians engaged in multi-specialty practice; and a public accustomed to the use of copayments.

- Hawaii's utilization pattern, which was very different from other states, helped control costs. Because coverage for home and office physician's care was an early feature of Hawaiian insurance policies, Hawaiians were used to seeing a physician for preventive care or early treatment. They often dealt with a general practitioner before contacting specialists or electing surgery, and the hospitalization rate in Hawaii was 45% of the age-adjusted national standard for the United States.

- The timing of the passage of the Prepaid Health Care Act relative to federal enactment of ERISA was most fortunate. Standard Oil Company of California challenged Hawaii's preemption of ERISA in the U.S. Supreme Court and won, but Hawaii was granted an exception by Congress because its Prepaid Health Care Act and ERISA had passed almost simultaneously in 1974. Whether the federal government will allow exceptions for other states almost 2 decades later is a critical point of current debate. It should be noted Hawaii has not been able to place new requirements, such as mental health coverage, on ERISA plans. In effect, it is still locked in by the congressional action that permitted enforcement of the law's original 1974 provisions.

The major argument against enactment of the Hawaiian plan in 1974 appears ironic in retrospect:

By far the strongest objection, mentioned many times in opposing testimony, was the idea that it would be inappropriate, foolish, or at least unnecessary for Hawaii to enact such a law because Federal action on the same subject was imminent. The HISS testimony in 1971 noted that "with everyone proposing a system of national health insurance and with no one in opposition, some one or some combination of these bills will pass. How soon? Sometime during this year is a possibility — next year in all probability." (van Steenwyk, p. 29)

C. Minnesota

MinnesotaCare, enacted in April 1992, is a subsidized health insurance coverage plan designed for permanent residents of the state (based on at least 180 days residency). Those eligible for the plan must have limited incomes and may pay their premiums on a sliding scale. Plan charges range from 1.5 to 8.8% of gross family income under the subsidized premium plan. Copayments are required for selected adult services, but not for services to children.

MinnesotaCare was part of the HealthRight Act (Laws of Minnesota 1992, Chapter 549), a broad health care reform initiative that had 4 major components: cost containment, insurance reform, rural health incentives, and insurance for the uninsured. (The term "MinnesotaCare" is used for the insurance portion because "HealthRight Plan" had to be downplayed after it was discovered that a California HMO already had legal rights to the name.) The plan is being phased in over the period from October 1, 1992, to July 1, 1994.

The foundation of the plan was the previously enacted Children's Health Plan under which the state provided coverage for children ages one through 17 whose family incomes did not exceed 185% of the federal poverty guidelines and who were not eligible for Medicaid or otherwise insured. The charge for this insurance was an annual enrollment fee of \$25 per child (maximum of \$150 per family).

Beginning October 1, 1992, the program was extended to parents and dependent siblings of these children. Adults were charged premiums based on a sliding scale, but children continued under the \$25 enrollment fee until July 1, 1993, and then went onto sliding scale. Eligibility was limited to permanent Minnesota residents who were ineligible for Medicaid and had lacked access to employer subsidized-coverage for 18 months. (Subsidization is defined as 50% or more of the premium covered by the employer. If the employer subsidizes only the worker and not the dependents, the latter would still be eligible for MinnesotaCare.) In addition to these limitations, persons had to have been uninsured for at least 4 months, unless terminated from Medicaid, General Assistance, Medicare or a plan for the uninsured.

As of January 1, 1993, the income limit was raised to 275% of federal poverty guidelines and coverage was extended to all children under 18 (including those less than one year old), plus their parents and any dependent siblings.

On July 1, 1994, MinnesotaCare is scheduled to expand to include single adults and families with or without children whose incomes are approximately 275% or less of federal poverty guidelines. Eligibility criteria for this group will be the same as for those previously covered.

Although persons whose incomes exceed the plan limits are blocked from entering the plan, those whose incomes exceed the limits after they have once been included may continue their enrollment but must pay the full, unsubsidized cost of the premium.

Providers who participate in the Minnesota Medical Assistance (MA) program are eligible to offer care under MinnesotaCare. They are reimbursed at MA rates less any copayments due from adult enrollees.

MinnesotaCare is administered by the Minnesota Department of Human Services, which has estimated that enrollment will increase from an average of 40,700 in FY 1993 to an average of 158,200 in FY 1997. The department has also estimated that state costs for premium subsidies would rise from \$6 million for FY 1993 (excluding Children's Health Plan costs) to \$252 million in FY 1997. (Expenditures had been projected at twice that figure by 1997, but legislators pared costs, beginning July 1, 1993, by capping adult inpatient hospital benefits at \$10,000 with a 10% copay.)

The funding sources for the premium subsidies and other initiatives of the HealthRight Act are:

- A 5-cent increase in the cigarette tax, beginning July 1, 1992, which will be devoted to start-up costs for 2 years. (Later, collections will become part of the General Fund.)
- A 2% tax on the gross revenues of hospitals and surgical centers, beginning January 1, 1993.* For the first year the hospitals can pass the tax through to third party payers.
- A 2% tax on the gross revenues of other health care providers and wholesale drug distributors, beginning January 1, 1994.*
- A 1% premium tax on HMOs and nonprofit health service corporations, beginning January 1, 1996.

*Payments to providers or nursing homes for Medicare, Medicaid, General Assistance Medical Care, and MinnesotaCare are not included in gross revenue calculations.

The revenue sources listed are expected to raise an estimated \$31.4 million in FY 1993, increasing to \$314.4 million by FY 1997. In addition, enrollee premium payments are expected to total \$994,000 in FY 1993, increasing to \$49 million by 1997.

Even when MinnesotaCare is fully operational, well over half of the state's residents will remain uninsured. A 1990 statewide telephone sample survey indicated 370,000 (or 8.6%) of Minnesota residents were uninsured for all or part of the year. Almost an equal number (366,000 or 8.5%) were underinsured. Another 900,000 Minnesotans covered by small businesses were also vulnerable. They face high premiums, high deductibles and stringent underwriting that could result in denials and cancellations or exclusion of preexisting conditions. Despite these figures, it was estimated that Minnesota has the second lowest state rate of uninsured next to Hawaii. It has been fortunate in that it has had a number of good health plans for poor and high

risk persons, and it has a strong managed care tradition. In fact, it pioneered the development of HMOs and large-group practices.

VIII. CURRENT REFORM PROPOSALS

A. National Proposals

U.S. Health Security Plan (Clinton Plan)

Currently, national proposals for health insurance reform focus on the U.S. Health Security Plan, which President Clinton initially discussed before a joint session of Congress on September 22, 1993. (The plan was formally introduced several weeks later in the Senate and the House as S 1657 and HR 3600, respectively. Its bill form varied in some details from the September joint message but the main structural features generally remained the same.)

The Health Security Plan is structured as a universal plan which would provide comprehensive health insurance for all American citizens and legal residents, regardless of job status or preexisting medical conditions.

Coverage and Premiums. The plan requires that all employers provide coverage for their workers with premium costs split between employer and worker at 80% and 20%, respectively. An employer would not be required to pay more than 7.9% of its payroll toward health insurance, but smaller businesses would have lower requirements. For example, a low-wage business with fewer than 50 employes (which was raised to 75 by the bills) could have its insurance costs capped at 3.5% of payroll. Employers who currently cover a greater portion of the premiums than required in the plan might decide to continue such a fringe benefit. They would be permitted to do so, but after a 10-year period the extra benefit would count as income taxable to the employee.

Individuals who work less than a full year (or families who jointly have not earned a full year of employer's contributions) would be responsible for any unpaid employer share to the extent that they have nonwage income. Persons who are unemployed, self-employed or working part-time would be required to pay a larger portion of their own premiums, but subsidies would be available for those with low incomes. In addition, premium costs for the self-employed would be fully tax deductible. (Currently, only 25% of the cost is deductible.)

Another type of premium subsidy was proposed for persons who retire before age 65 and are not eligible for Medicare. If the employer chooses to provide insurance in

the interim, it would pay 20% of the premium and the government would pay 80%. If the employer provided no premium assistance, the individual could pay the 20% and the government would still pay the 80%. This subsidy could benefit companies wishing to downsize through attrition. On the other hand, it could be a very costly and unpredictable feature of the plan because it is impossible to predict the number who may want to take early retirement but are delaying because of possible loss of health insurance.

The Health Security Plan would be accessed by a personalized identification card, which would carry encoded billing information. It is assumed this simplified billing procedure would dramatically reduce administrative costs. With the card, insurance would be portable from one employer to another, and this could end the "job lock" that reportedly hinders those who want to change jobs but cannot risk losing the coverage provided by their current employer. Workers would not encounter any waiting period when they started work with a new employer. An employee could not be terminated from the plan for any reason (including nonpayment of premiums) and could not be canceled by a previous employer until enrolled in another plan.

Premiums would be based on 4 categories of plans: individual, couples without children, single-parent families, and 2-parent families. Those within the same category would have the same basic premium for a particular plan. This means that firms belonging to a particular regional alliance would be obligated to pay only 80% of the average premium for each worker according to that person's category. A worker could choose a plan with a higher premium, but the employer would still only be required to pay an amount equal to 80% of the average premium.

Health Alliances. The Health Security Plan is built on "regional health alliances", operating on a state-by-state basis. The only exception would be "corporate alliances" which large companies with more than 5,000 employees could organize to bargain directly with insurers.

Each alliance would function as a purchasing group or broker, networking health care providers and consumers. Within each state, the regional alliances would be organized by the state government, as state agencies, quasi-governmental units, or nonprofit corporations. They would have a variety of regulatory, administrative, and marketing functions, including certification of provider plans for the region, collection and dispersal of the region's premiums, and publication of performance data to aid enrollees in selecting providers.

The alliances must approve the health plans that operate in their regions. A certified plan could be one of 3 types: an HMO or similar type of managed care plan, a fee-for-service plan, or a combination of the 2.

In the managed care plan, sometimes referred to as the "low cost plan", subscribers would have to use the plan's providers (including doctors and hospitals). It is expected that, because this type of plan would have the lowest costs, it would determine the basic premium scale for all plans approved by the alliance. There would be no deductibles or costs for preventive outpatient care, except that each doctor's visit would cost \$10. Patients who choose a physician outside the basic plan would be responsible for 40% of the bill.

The combination plan, similar to the "point of service plan" in Wisconsin, would feature low out-of-pocket costs for services of approved doctors, but the patient would pay 20% of the cost for going out of the network.

The fee-for-service plan, sometimes referred to as the "high cost plan", would allow individuals to choose any doctor, but the insured individual would have to pay an annual deductible of \$200 (maximum \$400 deductible per family). The patient would be responsible for a 20% copayment for all doctor, hospital and laboratory bills beyond the deductible.

In general, preventive services would be covered in all plans, and all consumers, regardless of the plan they chose, would be protected against catastrophic medical costs. Out-of-pocket medical expenses would be capped at \$1,500 for an individual and \$3,000 for a family.

Benefits. The basic, uniform benefit package would include: hospitalization; emergency care; preventive care; physician and other professional services; prescription drugs; post-hospital care in a skilled nursing facility or at home; limited mental health/substance abuse services; pregnancy related services; hospice; eye and ear examinations; preventive dental services for children; and durable medical equipment (e.g., braces). Services not considered "medically necessary", such as private hospital rooms, private duty nurses, cosmetic surgery, hearing aids, in vitro fertilization and custodial care, would not be covered.

While an individual state can offer more extensive benefits than proposed in the federal standard package, there is some question whether it would have the inclination or the finances to do so. In the end, despite multistate administration, the outcome is expected to be a more uniform pattern of coverage than the current combination of private insurance and Medicaid.

The only conditions under which a particular plan within an alliance could restrict its enrollments would be if it had limited service capacity or the financial stability of the plan was threatened.

National Health Board. A 7-member national health board, appointed by the president, would be responsible for setting a national health budget by targeting annual spending ceilings for alliances. (This potential for controlling prices has been a focus of attack by board opponents.) The board would recommend changes in the benefit package and could set state standards and enforce them. It also would have authority to investigate drug prices.

Role of the States. The states would play a major role in coordinating the proposed plan. They would administer subsidies for low-income families and employers, establish and govern the alliances, certify and regulate the finances of participating health plans, and collect data for management purposes. The proposal offers states the option to adopt a single payer plan in lieu of private plans. If a state does not opt for a single payer plan, it must ensure the solvency of the private plans, including the establishment of a guarantee fund to pay providers if a plan should default. If no plan applies to serve a particular region, the state would have to assure at least one plan was available to eligible residents. Although alliances cannot cross state lines, the states themselves might facilitate interstate coordination between plans.

Originally states were expected to enroll in the system between January 1, 1995, and December 31, 1996. (When the bill was submitted to Congress, the deadline was changed to December 31, 1997.) Those that fail to establish alliances by the deadline could find their federal health appropriations, such as Medicaid funding, withheld. If necessary, the federal government could bypass the state and levy payroll taxes directly on employers to provide coverage.

Congressional Proposals

Six major proposals, which have originated in the U.S. Congress, illustrate the spectrum of health insurance options. Representative Jim McDermott (D-WA) is sponsoring the American Health Security Act, a single-payer plan modeled on the Canadian system previously described. This represents the liberal end of the spectrum in terms of government intervention in health care financing. Another single-payer plan has been offered in the House by Representative Pete Stark (D-CA) who proposes to expand Medicare to include all Americans, not just the elderly and certain disabled persons.

Two bills, the Health Equity and Access Reform Today (HEART) Act, proposed by Senator John Chaffee (R-RI), and the Managed Competition Act, jointly sponsored by Senator Jim Cooper (D-TN) and Fred Grandy (R-IA), occupy the middle ground. Like the Clinton plan, both of these bills are based on managed competition and utilize large buying pools of consumers to lower premium costs.

The Chaffee bill is a universal plan that would require all Americans to obtain health insurance by January 1, 2000, but there is no mandate that employers must provide the coverage. Persons without coverage at work could buy insurance through the purchasing cooperatives. Government subsidies would be available for low-income buyers, and medical savings accounts (also called medical IRAs) would be offered.

The Cooper-Grandy bill focuses on "universal access" in which everyone is given a chance, but not required, to buy insurance. It does not mandate that employers provide health insurance, but small businesses (with fewer than 100 employees) that do offer coverage must buy it through a pool. Subsidies would be provided for low-income consumers.

Two of the major proposals take a conservative approach to modifying elements of the current health financing system. The Affordable Health Care Now Act, sponsored by Representative Bob Michel (R-IL), and the Comprehensive Family Health Access and Savings Act, authored by Senator Phil Gramm (R-TX) are quite similar. Both plans stipulate that all Americans should have the right to buy insurance, i.e., universal access, but there is no mandate that employers must pay any part of the premiums. Government subsidies (and tax credits in the Gramm plan) would be available for low-income persons. Both plans provide for medical savings accounts which would permit individuals and families to deposit pretax dollars to pay for routine care and catastrophic insurance.

B. Wisconsin Proposals

In Wisconsin, 3 major health insurance proposals are currently being discussed by the state legislature. Two of them, the Wisconsin Health Care Partnership Plan and the Universal Health Plan, were introduced early in 1993. The Wisconsin Health Security Act is scheduled for introduction during the Spring 1994 Floorperiod, according to information released by its author, Representative Judith Robson (D-Beloit). The principal difference among the 3 approaches is that Governor Tommy Thompson's Health Care Partnership Plan is voluntary and is predicted to cover about 93,000 of

Wisconsin's 528,000 uninsured, whereas the other 2 are mandatory and universal. The plans are discussed below in the order in which they were proposed.

Universal Health Plan

1993 Assembly Bill 247 and its companion, 1993 Senate Bill 100, both of which were introduced in March of 1993, would create a statewide Universal Health Plan (UHP) for Wisconsin. These bills, sponsored by Representative Peter Bock (D-Milwaukee) and Senator Charles Chvala (D-Madison), are based on a single payer plan similar to the provincial operations in Canada.

The universal plan would offer each Wisconsin resident "reasonable medical service necessary to maintain health, enable diagnosis, or provide treatment or rehabilitation for an injury, disability or disease." Specifically exempted from plan coverage are orthodontia for persons age 18 or over (unless medically necessary) and cosmetic surgery.

While the 2 bills do not detail the plan's provisions, they do prescribe the governmental structure for UHP administration and policy planning, and they mandate the legislative drafting steps needed to put the UHP in place by the required starting date of July 1, 1996.

Regional Health Care Councils. The bills create 6 regional health care councils to study and recommend policy alternatives in their respective areas for consideration by the state Health Policy Board. Council size ranges from 12 to 17 members who represent constituent counties and are appointed by their respective county boards. (In the case of the Milwaukee County regional health care council, 6 appointments are made by the county executive from outside the Milwaukee city limits and 6 city residents are appointed by the mayor of Milwaukee.)

The councils are required to continuously monitor the delivery, quality, and accessibility of health care services in their regions. They must report annually to the Health Policy Board regarding problems and concerns of the region and recommended improvements.

Department of Health Planning and Finance. The bills would create a Department of Health Planning and Finance under the direction and supervision of the Health Policy Board. The duties and functions of the department are not prescribed, but the board is required to propose later legislation covering these matters.

Health Policy Board. A Health Policy Board would be created to direct and supervise the Department of Health Planning and Finance. It would include 6 members

selected from the membership of the regional health care councils, and 5 members appointed by the governor to insure a broad based representation of gender, race, age, business management, labor and disabled persons. The 11 board members would serve 6-year terms and could not be health care providers or administrators of health care facilities.

The board is expected to develop the details of the universal health plan and have the necessary legislative drafts prepared by January 24, 1995. It must formulate policies regarding: the scope of health services under the UHP; employers' taxes and a graduated individual income tax to finance UHP coverage; indexing revenues to cover cost increases over time; establishment of a trust fund for the UHP revenues; criteria for rate negotiations and payments to providers and capital expenditures for health care facilities; periodic review of the effectiveness of the UHP; and preparation of the annual budget for the state universal plan, including cost containment provisions.

Wisconsin Health Care Partnership Plan

Governor Thompson unveiled his proposed Wisconsin Health Care Partnership Plan on March 15, 1993, and it was introduced as 1993 Senate Bill 327 on June 3, 1993. It is designed to provide voluntary regional purchasing pools which would permit public and private employers and self-employed persons to band together to lower their health insurance premiums. The proposal assumes employed persons who currently are uninsured could gain access to coverage if their employers were able to purchase insurance more economically. The plan depends on market forces and there are no subsidies for low-income persons.

A key leverage point of the Partnership Plan would be that state government employees within a particular region would be required to participate and could form the nucleus for bargaining with providers.

Regional Health Councils. The governor's plan emphasizes a local approach to health care cost containment in which consumers and providers would join in "regional health councils" to address cost and quality issues. The councils would be responsible for establishing pools in which participants could purchase coverage through insurance carriers, managed care plans or directly from hospitals and care providers. The pool could make only one purchase from each type of carrier and each purchaser in the pool would pay the same price for the same coverage. Any insurer authorized to offer health care coverage in the state would be eligible to contract with a regional council.

The regional councils would be organized as private corporate bodies with general corporate powers. The 9 council members would represent purchasers and providers

of the region. Eight of them would be appointed by the governor for staggered 3-year terms upon nomination by their respective groups; the ninth would have to be a member chosen from the state Comprehensive Health Board. Except for some seed money budgeted by the state for start-up costs, providers and purchasers would be expected to cover council expenses.

All state employes would receive their health insurance through the regional councils. Voluntary participants could be employers of any size (public or private); associations of individuals or employers; and certain individuals not eligible for their employer's plan. Eligible associations would have to offer coverage to all members. Employers would have to cover all employes who worked at least 20 hours per week. Self-insurers would be allowed to participate on the same basis as other employers, if they offered coverage to all employes who worked 20 hours or more per week.

Those who enrolled during an open enrollment period could do so without a waiting period or exclusion of preexisting conditions. Persons covered by HIRSP would have to move to council-negotiated plans within 20 months after the Partnership Plan became available in their region.

OCI Responsibilities. The Office of the Commissioner of Insurance (OCI) would be responsible for implementing and monitoring compliance with the Partnership Plan. It would advise the regional councils and provide them with technical, actuarial, legal and other professional assistance. Each council would submit an annual plan of operations to the commissioner describing its benefit designs and rates and its measures for determining quality control and access to care. If the commissioner approved the plan of operations, all contracts between the council and providers, hospitals, or insurers would have to conform to it.

The commissioner would promulgate the administrative rules to define the core benefit plan and the riders for supplemental coverage. The councils would then decide which riders to offer in their regions. At a minimum, the coverage would have to be as comprehensive as that now provided to state employes. Both individual and family coverages would be available and coverage options would include at least one fee-for-service plan and one HMO plan. The regional council could provide different copayment and deductible options under each plan.

Comprehensive Health Care Board. The Partnership Plan would create a new state agency, the Comprehensive Health Care Board, composed of state administrators and employes, to approve the health insurance contracts that the regional councils negotiated for state employes. The state board would have rule making authority for the regional councils and a member from the state board would sit on each council.

Wisconsin Health Security Act

Although formal introduction of her plan is not expected until the Spring 1994 Floorperiod, Representative Robson has publicly announced that it will be specifically configured to mesh with the U.S. Health Security Act in order to ease transition if the federal plan passes as proposed. Like the Clinton plan, the Wisconsin Health Security Act eventually would involve a mandatory, universal system, operating through health insurance purchasing groups or alliances.

According to her recently released statement, Representative Robson proposes a standard package of benefits "roughly equivalent to those provided by the state or large corporation[s]." Employees would be expected to pay a portion of their premium costs, but low-income workers and the self-employed might be eligible for subsidies. Likewise employers who could not afford their portion of the premiums might be assisted by tax credits or direct financial incentives.

It is expected the Robson plan will control expenditures by funding existing community health care centers and developing community-based care delivery sites, such as school-based clinics. Another factor in controlling insurance costs would be the requirement that premiums be determined on a statewide community rating basis.

Representative Robson has stated that the act will: "Guarantee health care coverage regardless of health status or employment; Control costs so that health care inflation is no more than inflation for other goods and services; Emphasize primary health services instead of specialized and expensive health care; Eliminate waste in health care administration and insurance practices; [and] Prohibit discriminatory insurance company practices against the sick or those they believe might become ill."

* * * *

As pointed out by Robert J. Samuelson in *Newsweek* (October 4, 1993), the trouble with trying to devise a satisfactory health care system is that the 3 desired goals of a successful plan — universal coverage, free choice of providers and treatments, and cost control — cannot be mutually attained. One or another will have to give way. For example, as medical treatments become more successful (and costly), more people will want their insurance to cover all these procedures at the expense of controlled costs.

Eventually, compromises must be made, and their quality will be the key to effective health care. The questions of access to health care that confront government can be catalogued, but their answers, which will effect all citizens literally from birth to death, will have to evolve through bipartisan efforts and the cooperation of many diverse interests at the local, state and federal levels.

GLOSSARY

ADMINISTRATIVE SERVICES ONLY (ASO) PLAN - Arrangement between an insurance company (or independent organization) and a self-insured group to administer claims and benefits for the self-insurer. The plan administrator is a "third-party administrator".

ADVERSE SELECTION - The problem created when a particular health plan attracts members who are in poorer health than the general public. This results in the pooling of high risks, places higher liabilities on the insurer, and may make the plan economically unsound.

ALL-PAYER SYSTEM - A system in which all bill payers — whether private insurers, government plans or individuals — pay the same amount for the same service. This prevents undercharging some and cost shifting to others.

AMERICAN ASSOCIATION OF RETIRED PERSONS (AARP) - A national interest group that lobbies on behalf of individuals age 50 and older. It is especially concerned about this group's access to health care, particularly legislation affecting Medicare and Medicaid.

AMERICAN HOSPITAL ASSOCIATION (AHA) - An umbrella group for hospitals and health care facilities which represents their interests at the national level.

AMERICAN MEDICAL ASSOCIATION (AMA) - A professional organization that includes about half of the country's doctors and represents them at the national level.

BALANCE BILLING - Practice of billing the patient personally for the difference between the reimbursement rate set by the private insurer or the government and the provider's charges.

BENEFITS - Services which will be reimbursed by the insurance company to an insured or a claimant according to coverage terms of the policy.

BLACK LISTING - Practice of insurers to refuse coverage to high risk individuals, e.g., those who are likely to inherit diseases or persons in dangerous industries or professions.

BLUE CROSS/BLUE SHIELD - The 69 Blue Cross/Blue Shield not-for-profit corporations across the nation which collectively are the nation's oldest and largest private insurer, covering more than 67.5 million Americans. Blue Cross plans cover hospital care on a service basis. Blue Shield plans cover surgical and medical care on a service basis.

CANADIAN PLAN - Often used as synonym for "single-payer plan". (See SINGLE-PAYER PLAN.) The operation of the Canadian system is described in detail in this bulletin.

CAPITATION - Payment system, usually associated with HMOs, in which the provider is paid a fixed amount per patient per year for a specified set of benefits, regardless of the actual cost of the services rendered.

CARVING OUT - (See CREAMING for generic definition.)

CASE MANAGEMENT - Practice under managed care systems, such as HMOs, whereby the primary care provider decides the type and extent of medical services a patient requires, including the patient's access to specialists. (Also referred to as "gate keeping".) A broader definition would include management impacts resulting from the services of nonmedical professionals, such as social workers.

CATASTROPHIC INSURANCE - Type of medical policy in which deductibles and copayments are so high that coverage is actually designed to limit financial loss rather than pay health care bills.

CHAMPUS - Acronym for the Civilian Health and Medical Program of the Uniformed Services. This major federal insurance program covers dependents of U.S. military personnel on active duty, plus retired military personnel and their dependents.

CHARGE BACK - (See BALANCE BILLING.)

CHERRY PICKING - (See CREAMING.)

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1985. A complex federal budget act that contained several health insurance provisions. It required most group health plans for firms with 20 or more workers to offer insurance continuation to

terminated employes and their spouses and dependents. Effective for plan years beginning on or after July 1, 1986, COBRA also extends the health insurance requirements of the Age Discrimination in Employment Act by removing the upper age limit of 70 for employers' health insurance obligations to older workers.

COINSURANCE - Specified percentage of the bill for a particular benefit or service which insurer agrees to cover, while the insured is responsible for the remainder, e.g., the policy may pay 80% of the costs and the patient 20%.

COMMUNITY RATING - Practice of basing insurance premiums on the projected average medical costs for all persons covered by the policy in the geographic area. Community rating is usually based on a large pool of insureds in order to lower costs. (See also **EXPERIENCE RATING**.)

COMPREHENSIVE HEALTH INSURANCE - A policy designed to give the protection of both a basic policy and a major medical health insurance policy. It is characterized by low deductible amounts, smaller copayments, and a high maximum benefit limit.

CONTINUATION - Practice of permitting an employe who has left a job to continue insurance coverage for a period of time under the group contract rates but at personal expense.

CONVERSION PRIVILEGE - Benefit given to the insured to change from group coverage to individual insurance without medical examination. The conditions under which the conversion may occur are defined in the group master policy.

COORDINATION OF BENEFITS - Procedure to eliminate duplicate coverage when a person has more than one insurance plan, so that total benefits paid do not exceed 100% of the amount claimed.

COPAYMENT - Requirement that the insured pay a flat fee toward the service charges, e.g., a \$5 charge for each prescription filled. The term is sometimes used to cover both percentage payments and flat fee requirements. (See also **COINSURANCE**.)

COST SHARING - Requirements in the insurance contract that the insureds must cover some of their own medical expenses by paying deductibles or copayments.

COST SHIFTING - Practice of providers to make up part of their losses from uncompensated care by passing the costs along to other patients, which means the commercial insurer, self-insurer, government or private payer eventually covers the cost.

CREAMING - Practice of selling insurance only to healthy persons not likely to apply for benefits and dropping them if they do. (Also called "cherry picking", "skimming", or "carving out".)

DEDUCTIBLE - Amount of covered costs which must be incurred and assumed by the insured before insurer will pay any benefits.

ERISA - Employee Retirement Income Security Act of 1974. This federal law, in addition to regulating pension plans, provides exemption from state regulation for companies that self-insure their employees' health care costs.

EXCLUSIONS - Specific costs which the insurance policy explicitly states it will not cover.

EXPERIENCE RATING - Practice of basing insurance premiums on the combined past claims' experience of the members within the group seeking insurance. (See also **COMMUNITY RATING**.)

FEE FOR SERVICE - Billing system in which the provider charges for each separate service rendered.

GATE KEEPING - (See **CASE MANAGEMENT**.)

GLOBAL BUDGETING - Limits placed on public and/or private spending for health care by a state or federal authority. (Also called "global caps".)

HEALTH ALLIANCE - Governmental (or quasi-governmental) agencies proposed by President Clinton's Health Security Act, which is described in detail in this bulletin. The alliances would be established by each state to organize consumers into purchasing pools and serve as brokers for their health plans.

HEALTH CARE FINANCING ADMINISTRATION (HCFA) - The agency within the federal Department of Health and Human Services that administers Medicare and the federal portion of Medicaid.

HEALTH INSURANCE ASSOCIATION OF AMERICA (HIAA) - Association of medium and small insurance companies that represents their interests at the national level.

HEALTH MAINTENANCE ORGANIZATION (HMO) - Organization which provides comprehensive health care services on a prepaid basis whereby the providers associated with the HMO are paid a fixed amount per year per patient. Any organization can sponsor an HMO, including governments, medical schools, hospitals, employers, unions, and insurance companies.

HOSPICE - Facility, program, or organization which provides medical care or support services to the terminally ill, often in their own homes. Hospice services may be covered by private insurance or Medicare.

INDEMNITY - Benefits paid on a predetermined basis in the event of a covered loss.

INDEPENDENT PRACTICE ASSOCIATION (IPA) - The IPA contracts with individual doctors, who see patients in their own offices. IPA doctors can contract with several IPAs at one time and can continue seeing fee-for-service patients.

JOB LOCK - Situation in which employees feel compelled to stay on their current jobs for fear of losing insurance coverage if they shift employment.

LONG-TERM CARE - Maintenance and health services provided to chronically ill or physically or developmentally disabled persons. Services may be available on inpatient, outpatient or at-home basis. The term is often used in connection with nursing home services to the elderly and disabled.

MAJOR MEDICAL INSURANCE - Policy designed to pay the expenses associated with very costly episodes of illness or injury, such as accidents, transplants or cancer. It is generally characterized by high maximum benefits, which may be calculated on catastrophic coverage per illness or total benefits to be paid over an insured's lifetime.

High deductibles and extensive coinsurance (copayments) are also typical of this insurance.

MANAGED CARE - Systematic integration of the financing and delivery of health services which encourages providers and patients to adjust their use of the medical system in order to achieve more economical care. (See HEALTH MAINTENANCE ORGANIZATION and CASE MANAGEMENT.)

MANAGED COMPETITION - Free-market approach to health care delivery, which does allow some regulation, such as grouping individuals into large purchasing pools.

MEDICAID - Title XIX of the federal Social Security Act. This federal program, created in 1965, provides matching funds to support state medical assistance programs for eligible persons whose income and resources are below a specified level. State laws vary within federal requirements and programs may be called different names, e.g., MediCal (California) and Medical Assistance (Wisconsin). Nationally the various plans tend to be grouped under the term "Medicaid". In 1992 the nation's Medicaid plans covered 32.6 million people and cost \$50 billion in state funding and \$68 billion in federal funding.

MEDICAL ASSISTANCE - (See MEDICAID.)

MEDICAL IRAs - (See MEDICAL SAVINGS ACCOUNTS.)

MEDICAL SAVINGS ACCOUNTS - A type of "savings" or holding account into which employers and employees can place contributions on a tax-deferred or tax exempt basis to be used later to pay health care expenses as they are incurred.

MEDICARE - Title XVIII of the Social Security Act as amended in 1965. This federal program provides health insurance for eligible persons who are disabled, blind or age 65 and older.

MEDICARE PART A - Universal hospital insurance portion of Medicare (funded by premiums and payroll taxes).

MEDICARE PART B - Voluntary portion of Medicare that helps pay physicians' bills (funded by premiums and general federal revenues).

MEDIGAP PLANS - Private insurance plans that supplement Medicare benefits. These plans may cover all or part of services not covered by Medicare, e.g., Medicare does not provide coverage for prescription drugs but the medigap policy may reimburse some or all of the charge.

MULTIPLE EMPLOYER TRUST (MET) - A legal entity combining small, unrelated employers for the purposes of providing group health coverage, whether through commercial insurance or self-insurance.

NATIONAL HEALTH INSURANCE - A health insurance system that covers all citizens of the nation and also may cover other residents who are not nationals.

OPEN ENROLLMENT - An interval, usually occurring once a year, during which insurers will accept all applicants regardless of insurance risks.

OUTCOMES ANALYSIS (or PATIENT OUTCOME RESEARCH) - Examination and evaluation of alternative medical treatments for a specific clinical condition and their respective outcomes.

OUT-OF-POCKET LIMITATIONS - Limits placed on the amount insured must pay personally in a coverage period (usually a year).

PATIENT OUTCOME RESEARCH - (See OUTCOMES ANALYSIS.)

PER CAPITA FINANCING - (See CAPITATION.)

PHARMACEUTICAL MANUFACTURERS ASSOCIATION (PMA) - A national lobbying group representing pharmaceutical firms that research, develop and manufacture prescription medicines.

PLAY OR PAY - Universal coverage plan under which employers are mandated to provide the minimum insurance benefits set by law. Those who opt not to "play" (i.e. provide coverage through their own policies) are required to pay a payroll tax toward a government plan which will provide the required benefits.

POINT OF SERVICE (POS) - A POS provision in a health insurance plan uses financial incentives to encourage insureds to use a particular group of providers but permits them to use non-POS providers at higher cost. The POS plan is supposed to offer the participant more choice than an HMO.

PORTABILITY - Insurance practice whereby workers can continue their insurance coverage as they move from one job to another. A universal system would permit this.

PREEXISTING CONDITION - A physical or medical condition which has been diagnosed prior to the issuance of a policy. An insurance policy may specify that it will not cover preexisting conditions.

PREFERRED PROVIDER ORGANIZATION (PPO) - An insurance contract in which providers agree to furnish services at lower than usual fees in return for a certain volume of patients. Patients are expected to see only the providers who are part of the plan contract. In some cases insureds are permitted to see non-PPO providers, but they will have to pay a higher portion of the cost.

PREMIUM - Amount paid by insured (or on behalf of insured) to secure insurance coverage.

PREMIUM TAX - State tax on premiums collected by insurance companies.

PRIMARY CARE PROVIDERS - Providers, such as physicians practicing in family medicine, internal medicine or pediatric medicine, who are responsible for basic or routine care and make referrals to specialists. They often manage and coordinate care for HMOs or managed care programs. In some states, nurse practitioners or physician's assistants are also authorized to provide primary care.

PROVIDER - An institution (e.g., hospital or clinic) or person (e.g., physician, dentist or nurse) that provides medical care.

REASONABLE AND CUSTOMARY CHARGE - A charge which is consistent with the overall rates in a particular geographical area for the same or similar health care services. Some policies limit their benefits to this level rather than paying the provider's full bill if it is higher.

REINSURANCE - Practice of insurers whereby the original insurer contracts with a third party to assume a portion of the risk which would otherwise be the responsibility of the original insurer. For example, in the case of a policy with a lifetime benefit limit of \$1 million, the original insurer might cover the first \$200,000 and reinsure with the third party to cover the costs beyond that up to the policy's limit.

RENEWAL - Continuation of coverage after expiration of the original contract which occurs when the insurer accepts a subsequent premium to cover a new policy term.

RIDER - An amendment to an insurance contract that may increase or decrease benefits or waive certain provisions of the original policy.

SELF-INSURANCE - Private insurance coverage in which the employer assumes liability for the workers' health insurance coverage, rather than contracting with an outside insurer. (See also ERISA.)

SINGLE PAYER SYSTEM - A universal plan in which the state or national government collects premiums and administers the health plan benefits for all its citizens. If this system were adopted, it would eliminate the need for commercial insurers.

SKIMMING - (See CREAMING.)

TAX EXPENDITURE - As related to health insurance, tax revenue foregone because insurance premiums paid by employer on employe's behalf are excluded from personal income calculations. This favorable tax treatment is most beneficial for upper income employes and represents an estimated \$400-500 million annually in foregone tax revenues in Wisconsin.

THIRD-PARTY ADMINISTRATOR - An individual or corporation that handles the administration of the insurance plan of a self-insured group, but assumes none of the group's liabilities. (See also ADMINISTRATIVE SERVICES ONLY PLAN.)

THIRD-PARTY PAYER - A party other than the patient (the first party) or care provider (the second party) that pays the bills for care — usually a public or private insurer.

UNCOMPENSATED CARE - Health care for which a provider is not paid, either because it was intended as charity care or because the patient's bill is not paid by an insurer, the government or the patient personally (i.e. bad debt). Often the costs are passed along by charging paying consumers (or their insurance companies) more.

UNDERINSURED - Individuals who depend on health insurance, public or private, that is inadequate to their needs, e.g., they do not have the out-of-pocket resources to meet their copayments, deductibles or the costs of uncovered services.

UNDERWRITING - Process whereby an insurer decides whether to accept an application for insurance and what the proper premium would be for the amount of risk assumed. Underwriting practices may apply high premiums to discourage applicants who are likely to use an above average quantity of health services. (See also CREAMING.)

UNIVERSAL COVERAGE - Provisions within the design of national or state health care insurance that give all residents of the jurisdiction access to the insurance.

UTILIZATION REVIEW - A technique in which health care professionals monitor their peers by reviewing patient records to ensure quality of care and proper use of total health care resources.

WAITING PERIOD - The length of time between initial date of employment or application for insurance and the date coverage actually begins.

BIBLIOGRAPHY

- Aaron, Henry J. *Serious and Unstable Condition: Financing America's Health Care*. Washington, DC: The Brookings Institution, 1991.
- Anderson, Odin W. *Blue Cross Since 1929: Accountability and the Public Trust*. Cambridge, MA: Ballinger Publishing Company, 1975.
- _____. *Health Services in the United States: A Growth Enterprise Since 1875*. Ann Arbor: Health Administration Press, 1985.
- Burner, Sally T., Daniel R. Waldo and David McKusick. "National Health Expenditures Projections through 2030," *Health Care Finance Review*, Volume 14, Number 1 (Fall 1992): 1-29.
- Butler, Patricia A. *Too Poor To Be Sick: Access to Medical Care for the Uninsured*. Washington, DC: American Public Health Association, 1988.
- Center for Public Representation. *What Can We Do About Soaring Employee Health Costs?* Madison, WI: Center for Public Representation, 1982. 614.02/C33.
- Christianson, Jon B. *Competition in the Hawaii Market for Health Care*. Minneapolis: InterStudy, 1978.
- Chollet, Deborah J. *Employer-Provided Health Benefits: Coverage, Provisions and Policy Issues*. Washington, DC: Employee Benefit Research Institute, 1984.
- Chun, Randall. *MinnesotaCare (HealthRight)*. St. Paul: Research Department, Minnesota House of Representatives, October 1992. 368.6/M6c.
- Commission on Medical Care Plans. *Financing Health Care for the Unemployed and the Uninsurable in Wisconsin*. Madison: WPS, the Blue Shield Plan of the State Medical Society of Wisconsin, March 1972.
- Davis, Karen. *National Health Insurance: Benefits, Costs, and Consequences*. Washington, DC: The Brookings Institution, 1975.

Drake, Jonathan, and Robert Peterson. *The Needs of Wisconsin's Rural Uninsured*. Madison: Community Based Maternal and Child Health Project, Center for Public Representation, November 1985.

Evans, Robert G. *Strained Mercy: the Economics of Canadian Health Care*. Toronto: Butterworths, 1984.

Fain, Tyrus G., ed., with Katharine C. Plant and Ross Milloy. *National Health Insurance*. Public Documents Series. New York: R. R. Bowker Co., 1977

Feder, Judith, ed., with John Holahan and Theodore Marmor. *National Health Insurance: Conflicting Goals and Policy Choices*. Washington, DC: The Urban Institute Press, 1980.

Fein, Rashi. *Medical Care, Medical Costs: The Search for a Health Insurance Policy*. Cambridge: Harvard University Press, 1986.

Fisher, Peter. *Prescription for National Health Insurance: A Proposal for the U.S. Based on Canadian Experience*. Croton-on-Hudson, NY: North River Press, Inc., 1972.

Frech, H. E., III, ed., *Health Care in America: The Political Economy of Hospitals and Health Insurance*, San Francisco: Pacific Research Institute for Public Policy, 1988.

Fuchs, Victor R. *The Health Economy*. Cambridge: Harvard University Press, 1986.

Green, Phillip. "Cobra: Another New Patch on an Old Garment," *Saint Louis University Law Journal*, 33 (1989): 743-785.

Hawaii. Department of Health. *Report to the Legislature — State Health Insurance Program*. Honolulu: Department of Health, October 1989.

_____. *Report to the Legislature — State Health Insurance Program*. Honolulu: Department of Health, February 1991.

Health Insurance Association of America, Department of Policy Development and Research. *Source Book of Health Insurance Data, 1991*. Washington, DC: Health Insurance Association of America, 1991.

Huber, Carol, ed. *Uninsured Families: Problems and Solutions*. Madison, WI: Center for Public Representation, 1988.

Kennedy, Edward M. *In Critical Condition*. New York: Simon and Schuster, 1972.

Klaw, Spencer. *The Great American Medicine Show: The Unhealthy State of U.S. Medical Care, and What Can Be Done about It*. New York: The Viking Press, 1975.

Kriznay, John, and Andrew Wilson. *The Patient as Consumer*. A Twentieth Century Fund Report. Lexington, MA: Lexington Books, 1974.

Leavitt, Judith Walzer, and Ronald L. Numbers, eds. *Sickness and Health in America*. 2nd ed. rev. Madison: The University of Wisconsin Press, 1985.

Levit, Katherine R., Mark S. Freedland, and Daniel R. Waldo. "Health Spending and Ability to Pay: Business, Individuals, and Government." *Health Care Financing Review* (Spring 1989): 9.

Merritt, Richard, and Susan Mertes, eds. *State Innovations in Health: A National Conference of State Legislatures Conference*. Washington, DC: The George Washington University Intergovernmental Health Policy Project, March 30, 1980. 614.01/G29b.

Minnesota Health Care Access Commission. *Final Report to the Legislature*. St. Paul: Minnesota Health Care Access Commission, January 1991. 614.01/M6c.

Mitchell, Bridget M., and Charles E. Phelps. *Employer-Paid Group Health Insurance and the Costs of Mandated National Coverage*. Prepared under grants from the Department of Health, Education, and Welfare (R-1509-HEW). Santa Monica, CA: The Rand Corporation, September 1975.

Munts, Raymond. *Bargaining for Health: Labor Unions, Health Insurance, and Medical Care*. Madison: The University of Wisconsin Press, 1967.

-
- New York. Council on Health Care Financing, Subcommittee on Health Insurance. *Health Insurance — Public Policy In New York*. Albany: New York State Legislature, 1984. 368.6/N48a.
- Novacheck, Mary T. *The Health Insurance Needs of Wisconsin's Farmers: A Working Draft*. Madison: Community Based Maternal and Child Health Project, Center for Public Representation, April 1986.
- Numbers, Ronald L., ed. *Compulsory Health Insurance, The Continuing American Debate*. Contributions in Medical History Series, Number 11. Westport, CT: Greenwood Press, 1982.
- Podolsky, Doug. "Affordable Preventive Care." *U.S. News & World Report*, January 6, 1992, 111.
- Reimer, David R. *Wisconsin's Uninsured: The Scope of the Problem and Alternative Solutions*. Milwaukee: December 24, 1984.
- Rockefeller, Sen. John D. IV. "A Call for Action: The Pepper Commission's Blueprint for Health Care Reform". *Journal of the American Medical Association* 265 (May 15, 1991): 2507-2510.
- "RX: Competition: The Spiraling Costs of Health Care." *Business Week*, February 8, 1982, 58-64.
- Ryon, Sue. "Trade-offs: Would US Tolerate Them?" *Milwaukee Journal*, June 8, 1990.
- Sinclair, Frank. *Blue Cross in Wisconsin*. Racine: Western Printing and Lithographing Co., 1965. 368.6/Si6.
- Starr, Paul. *The Social Transformation of American Medicine*. New York: Basic Books, 1982.
- Strosberg, Martin A., Joshua M. Wiener, Robert Baker, with Alan Fein, eds. *Rationing America's Health Care: The Oregon Plan and Beyond*. Washington, DC: The Brookings Institution, 1992.

Taylor, Malcolm. *Insuring National Health Care: The Canadian Experience*. Chapel Hill: The University of North Carolina Press, 1990. 368.62/T21

Thompson, Governor Tommy G. *The Wisconsin Health Care Partnership Plan*. Madison: Office of the Governor, March 15, 1993.

U.S. Bipartisan Commission on Comprehensive Health Care (The Pepper Commission). *A Call for Action — Final Report*. Washington, DC: U.S. Government Printing Office, September 1990. 368.6/X12/Pt. 1.

U.S. General Accounting Office. *CANADIAN HEALTH INSURANCE: Lessons for the United States*. GAO/HRD-91-90. Washington, DC: U.S. General Accounting Office, June 1991.

_____. *EMPLOYER-BASED HEALTH INSURANCE: High Costs, Wide Variation Threaten System*. GAO/HRD-92-125. Washington, DC: U.S. General Accounting Office, September 1992.

_____. *CARE: Rochester's Community Approach Yields Better Access, Lower Costs*. GAO/HRD-93-44. Washington, DC: U.S. General Accounting Office, January 1993.

_____. *HEALTH INSURANCE: A Profile of the Uninsured in Michigan and the United States*. GAO/HRD-90-97. Washington, DC: U.S. General Accounting Office, May 1990. 386.6/X15/Pt. 7.

The University of Wisconsin-Madison. Center for Health Policy and Program Evaluation. *Evaluation of Wisconsin's State Health Insurance Program (SHIP) Pilots: Executive Summary*. Policy Paper 91-1. Madison: University of Wisconsin, September 1991.

_____. Center for Health Policy and Program Evaluation. *Wisconsin's State Health Insurance Program (SHIP): Evaluation of Insuring Firm Pilot and Non-Insuring Firm Pilot*. Policy Paper 91-2. Madison: The University of Wisconsin, September 1991.

-
- Van Ellet, T. *State Comprehensive and Catastrophic Health Insurance Programs: An Overview*. Washington, DC: Intergovernmental Health Policy Project, The George Washington University, October 1, 1981.
- van Steenwyk, John. *Universal Health Insurance in Hawaii; A Report on the Hawaii Prepaid Health Care Act*. Federal Contract No. 299-77-0014. New York: Martin E. Segal Company, August 18, 1978.
- Walker, Harold Lloyd. "The American Medical Association and Compulsory National Health Insurance: The Molding of Public Opinion, 1920-1965." Ph.D. dissertation, The University of Texas at Austin, 1978.
- Weisberg, Roger. *Borderline Medicine*. TV documentary narrated by Walter Cronkite. 57 min. Carle Medical Communications, 1991. Videocassette.
- Westerfield, Donald L. *Mandated Health Care: Issues and Strategies*. New York: Praeger Publishers, 1991. 614.01/W521
- The White House Domestic Policy Council. *The President's Health Security Plan*. New York: Times Books, 1993.
- Wilensky, Gail R. "Viable Strategies for Dealing with the Uninsured". *Health Affairs* (Spring 1987): 33-46.
- Wisconsin. Council on Health Care Coverage for the Uninsured. *Plan for a State Health Insurance Program*. Madison: Council on Health Care Coverage for the Uninsured, January 1, 1987. LRB State Documents Collection: HSS/H/p.
- Wisconsin. Department of Health and Social Services. "Reports on Model Health Insurance Plan for the Uninsured and Long Term Care Insurance", Transmittal Letter from DHSS Secretary Linda Reivitz. Madison: Department of Health and Social Services, February 5, 1985. 368.6/W7e/Pt. 1.
- Wisconsin. Department of Health and Social Services, Division of Health. *Health Care for Wisconsin's Uninsured*. Report from Division of Health with Transmittal

Memorandum by Division Administrator Kathryn Morrison. Madison: Department of Health and Social Services, Division of Health, November 1, 1985.

Wisconsin. Department of Health and Social Services, Division of Health, Center for Health Statistics. *The Uninsured and Insured in Wisconsin, 1992: Reference Tables*. Madison: Department of Health and Social Services, Division of Health, October 1993.

Wisconsin. Department of Health and Social Services, Division of Health, Office of Management and Policy. *Wisconsin's State Health Insurance Program (SHIP), A Report to the Legislature Describing Pilot Experience and Findings*. Madison: Department of Health and Social Services, Division of Health, January 1, 1991. 368.6/W7e3.

Wisconsin. Legislative Council. *Health Care and Wisconsin's Uninsured*. Staff Brief 88-2. Madison: Legislative Council, July 20, 1988.

_____. *Legislation on Health Care Services*. Report to the 1989 Legislature, RL 89-9. Madison: Legislative Council, August 1, 1989.

Wisconsin. Office of the Commissioner of Insurance. *Wisconsin Health Insurance Risk Sharing Plan, 1981-1991*. Madison: Office of the Commissioner of Insurance, 1992.

Wisconsin Association of Manufacturers and Commerce. WMC Health Care Cost Management Project, Business and Industry Subcommittee. *Primer on Managing Health Care Costs*. Madison: Wisconsin Association of Manufacturers and Commerce, 1983. 614.02/W751.

Wong, Tim. *Health Access for the Uninsured: A Comparison of the Canadian and Selected State Programs*. Madison: Wisconsin Department of Health and Social Services, Division of Policy and Budget, February 10, 1989, updated December 8, 1989. 368.6/W7e1.

_____. *Proposals to Increase Health Care Access the Uninsured in Wisconsin*. Madison: Wisconsin Department of Health and Social Services, Division of Policy and Budget, September 22, 1989. 368.8/W7e2.

Recent Legislative Reference Bureau Publications

Research Bulletins

- RB-88-1 Childbearing by Contract: Issues in Surrogate Parenting. March 1988
- RB-90-1 Summary of the 1989-90 Wisconsin Legislative Session 1989 Wisconsin Acts 1 to 368. June 1990
- RB-91-1 Chippewa Off-Reservation Treaty Rights: Origins and Issues. December 1991
- RB-92-1 Summary of the 1991-92 Wisconsin Legislative Session, 1991 Wisconsin Acts 1 to 323. July 1992
- RB-93-1 The Evolution of Legalized Gambling in Wisconsin. March 1993
- RB-94-1 A Health Insurance Primer. January 1994

Informational Bulletins

- IB-87-1 The Homeless: A Primer. January 1987
- IB-87-2 The 65 MPH Speed Limit. May 1987
- IB-87-3 The Partial Veto in Wisconsin -- An Update. October 1987, Revised August 1988
- IB-88-1 Drugs in the Workplace: A Discussion of Issues. February 1988, Revised May 1988
- IB-88-3 A Thumbnail History of Wisconsin Veterans' Legislation. August 1988
- IB-88-6 Electronically Monitored Home Confinement: A New Alternative to Imprisonment. December 1988
- IB-89-2 The Ground Rules of a Special Session. October 1989
- IB-90-1 Capital Punishment in Wisconsin and the Nation. January 1990
- IB-90-3 "Let the People Decide"--Initiative and Referendum in Wisconsin and Other States. April 1990, Revised September 1991
- IB-90-4 Financing State Mandates. November 1990
- IB-91-3 Revised Guidelines for Adjusting Municipal Wards Following the 1990 Census. March 1991
- IB-91-4 A Study Guide to the 1991-1992 Wisconsin Blue Book. September 1991
- IB-92-1 Wisconsin's Role in Electing the President. September 1992
- IB-93-1 Ask the LRB. January 1993
- IB-93-2 Constitutional Amendments Given "First Consideration" Approval by the 1991 Wisconsin Legislature. January 1993
- IB-93-3 The Gun Control Debate. May 1993
- IB-93-4 A Study Guide to the 1993-1994 Wisconsin Blue Book. October 1993

Wisconsin Briefs

- Brief 89-5 Wisconsin's Smoke Detector Law. November 1989
- Brief 90-6 An Introduction to Legislative History Research in Wisconsin. June 1990
- Brief 90-8 The Regulation of the Sale and Use of Tobacco in Wisconsin. August 1990 (Revised January 1992)
- Brief 91-2 Wisconsin Women Legislators -- A Historical List. January 1991
- Brief 91-3 The Progress of Executive Budget Bills Through the Wisconsin Legislature. January 1991
- Brief 91-6 Executive Partial Veto of 1991 Assembly Bill 91, Executive Budget Bill Passed by the 1991 Wisconsin Legislature (1991 Wisconsin Act 39). August 1991
- Brief 91-7 Executive Vetoes of Bills Passed by the 1991 Wisconsin Legislature Through July 3, 1991. September 1991
- Brief 92-1 Who are the Candidates? The 1992 Wisconsin Presidential Preference Primary. January 1992
- Brief 92-3 Compensation of Wisconsin Legislators, 1836 through 1991 Legislative Sessions. March 1992
- Brief 92-4 A Summary of the Parental and Family Responsibility Initiative. May 1992
- Brief 92-5 Executive Vetoes of Bills Passed by the 1991 Wisconsin Legislature, October 1, 1991 Through March 17, 1992. May 1992
- Brief 92-6 Legislative Turnover in the 1963-1991 Sessions of the Wisconsin Legislature. May 1992
- Brief 92-7 Senate and Assembly Districts Promulgated for the 1992 Elections by the U.S. District Court for the Western District of Wisconsin. June 1992
- Brief 92-8 Candidates: Primary Election, September 8, 1992. July 1992
- Brief 92-9 Executive Agencies, Boards, Councils, and Commissions Created, Abolished or Altered by the 1991 Legislature (Acts 1-323). July 1992.
- Brief 92-10 Constitutional Amendment to be Considered by Wisconsin Voters November 3, 1992. August 1992
- Brief 92-11 Legislative and Congressional Districts Sorted by County, Municipality, and Ward. August 1992
- Brief 92-12 Candidates: General Election, November 3, 1992. September 1992
- Brief 92-13 1993-1994 Wisconsin State Officers. November 9, 1992
- Brief 92-14 Status of Term Limitations as of November 1992. November 1992
- Brief 93-1 Brief Biographies 1993 Wisconsin Officers. January 5, 1993
- Brief 93-2 Profile of the 1993 Wisconsin Legislature As of January 4, 1993. January 1993
- Brief 93-3 "Mace" and Tear Gas Weapons. February 1993
- Brief 93-4 Constitutional Amendments and Advisory Referenda to be Considered by the Wisconsin Voters April 6, 1993. March 1993
- Brief 93-5 Executive Partial Veto of 1993 Senate Bill 44 Executive Budget Bill Passed by the 1993 Wisconsin Legislature (1993 Wisconsin Act 16). August 1993
- Brief 93-6 An Introduction to Wisconsin. September 1993

Wisconsin Legislative Reference Bureau
Dr. H. Rupert Theobald, Chief

Reference Section (608) 266-0341
Legal Section (608) 266-3561
FAX (608) 266-5648

100 North Hamilton Street
P.O. Box 2037
Madison, Wisconsin 53701-2037