State of Vermont
Department of Banking, Insurance,
Securities & Health Care Administration

Legislative Report
Division of Health Care Administration

VERMONT HEALTH CARE COST SHIFT ANALYSIS

Submitted to the
Commission on Health Care Reform
In accordance with the
December 2006 Cost Shift
Task Force Report

March 2008

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The Department of Banking, Insurance, Securities, & Health Care Administration has additional information that can be provided upon request. Contact Michael Davis or Peter Santos for this information and with any questions you might have.

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Background

A Cost Shift Task Force was created by Act 191 to recommend changes needed to "ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums." The Task Force met in 2006 and filed a report after completing its work. The report was delivered to the Commission on Health Care Reform in December, 2006 and included a series of recommendations. The recommendations are listed below. This report provides updated information on the cost shift and the recommendations.

The following are Task Force recommendations from December, 2006:

1) Banking, Insurance, Securities, and Health Care Administration (BISHCA) should adopt policies and procedures in the Vermont Community Hospitals' Uniform Reporting Manual to include a definition of (and method for measuring) the cost shift based on the techniques used in the hospital budget review process.

2) BISHCA should measure hospital rates for each hospital to determine the effect of expense changes related to utilization and inflation, operating margin changes, and cost shift changes related to bad debt and free care, Medicaid, and Medicare.

3) BISHCA should instruct the hospitals to make reporting changes to support information needs relating to bad debt and free care in order to better understand the populations served. This includes the need to distinguish Vermont Medicaid revenues from out-of-state Medicaid revenues.

4) BISHCA should prepare an annual report to the legislature detailing its findings related to the hospital cost shift and the rate effects on hospital and insurance rate increases.

Recommendations that will require more time and analysis include:

5) BISHCA should work with the hospitals to determine whether a standard reporting instrument should be prepared to provide better information about the hospital cost shift.

6) BISHCA should work with stakeholders to examine potential information needs and/or changes for health insurance rate review processes needed to monitor the hospital cost shift.

7) BISHCA should prepare a plan and scope of analysis that seeks to measure the effect of the hospital cost shift on premium rates, once it is determined this can be accomplished reasonably.

8) The "science" to measure the cost shift across non-hospital providers needs to be developed in order to monitor changes in the non-hospital cost shift.

9) Any funds appropriated to alleviate cost shifts should be clearly designated so that their impact on the cost shift could potentially be monitored and measured across the Vermont health care system.

10) A feedback mechanism needs to be developed to report how the funds appropriated to reduce the cost shift were used across the health care system.

Recommendations One through Five have been met and the information related to them is in this report. Internal work has begun to examine recommendations Six through Ten. Some of that work is described in the discussion of insurance rates in this report.

Vermont Hospitals' Uncompensated Care & Bad Debt Policies

BISHCA also prepared a report to the Legislature in January, 2007 that reviewed uncompensated care and bad debt policy for Vermont's hospitals. Information in that report included a recommendation to update reporting in the hospital budget process so that more complete information can be applied to BISHCA's review of the cost shift and its impact on hospital and insurance rates. BISHCA is currently working with the Vermont Association of Hospitals and Health Systems to address these recommendations.

Defining the Cost Shift

The term "cost shift" can be easily misunderstood. In its simplest form, one can think of it is a subsidy. The Cost Shift Task Force report stated that from the perspective of a payer of health care costs, the cost shift is defined as:

"The payment of higher prices (above cost) paid by one or more payer groups to offset lower prices (below cost) paid by other payers."[1] In layman's terms, this is often referred to as "charging Peter to pay for Paul".

From the perspective of a hospital, it is a pricing mechanism used to achieve revenues to support services provided to all patients when payments from some payers do not cover the costs incurred by those patients.

Response to the Task Force Recommendations

Recommendations One, Two, and Five from the Cost Shift Task Force report address the need to define how the cost shift will be measured and require an analysis of how the cost shift will affect rate increases in each of the hospital budgets. The efforts were completed as part of the hospital budget review process in 2008. Each individual hospital report included analyses that measured the cost shift for Medicare, Medicaid, and bad debt/free care. In addition, analysis provided an estimate of how much of the rate increase was the result of the cost shift for each hospital budget. (see Appendix G)

Recommendation Three included the need to improve bad debt and free care reporting and the need to distinguish Medicaid revenues that are from other states. It was found that out-of-state Medicaid constitutes about 10% of the Medicaid cost shift for the hospital system – detailed information by hospital can be provided upon request. Efforts to improve bad debt and free care reporting are underway, and new information will be collected this year.

Recommendation Four is addressed in the section that explains the current efforts to understand the relationship of the hospital cost shift and effects on insurance rate increases.

Recommendations Six through Ten all require work to be completed to monitor the cost shift, including reporting improvements for measuring the cost shift, and to expand the analysis to include the cost shift for other health care providers. Over time, information sources of the Vermont Expenditure Analysis could be improved to allow BISHCA to analyze and present the cost shift information in a context that can be reported on an ongoing basis. BISHCA has begun these efforts but improved reporting needs to be developed as well as time dedicated to analyze the new information. Understanding the cost shift for other providers requires knowledge about reimbursement, cost of services, and revenue streams for the different providers. We will

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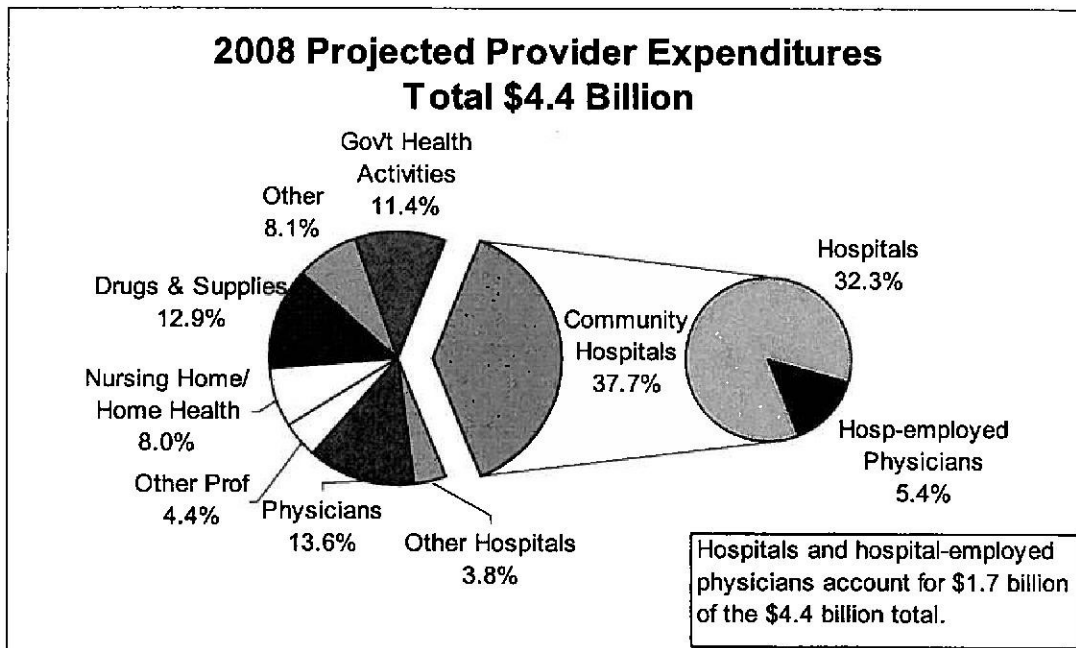
[1] Health Affairs, Jan/Feb 2006, Volume 25

attempt to better understand the cost shift in other industries such as the Vermont Assembly of Home Health Agencies in the coming year.

What Information is Currently Available?

BISHCA is responsible for measuring all health care costs in Vermont. BISHCA recently completed its annual Three-Year Forecast of Health Care Expenditures for the period 2008 –2010. The chart below shows that the community hospital portion of total FY 2008 spending is projected to be $1.7 billion. This includes physicians that the hospitals employ. These dollars represent about 37.7% of the Vermont health care expenditures. The following analysis of the cost shift is focused upon the hospital and physician expenditures distinguished in the chart.

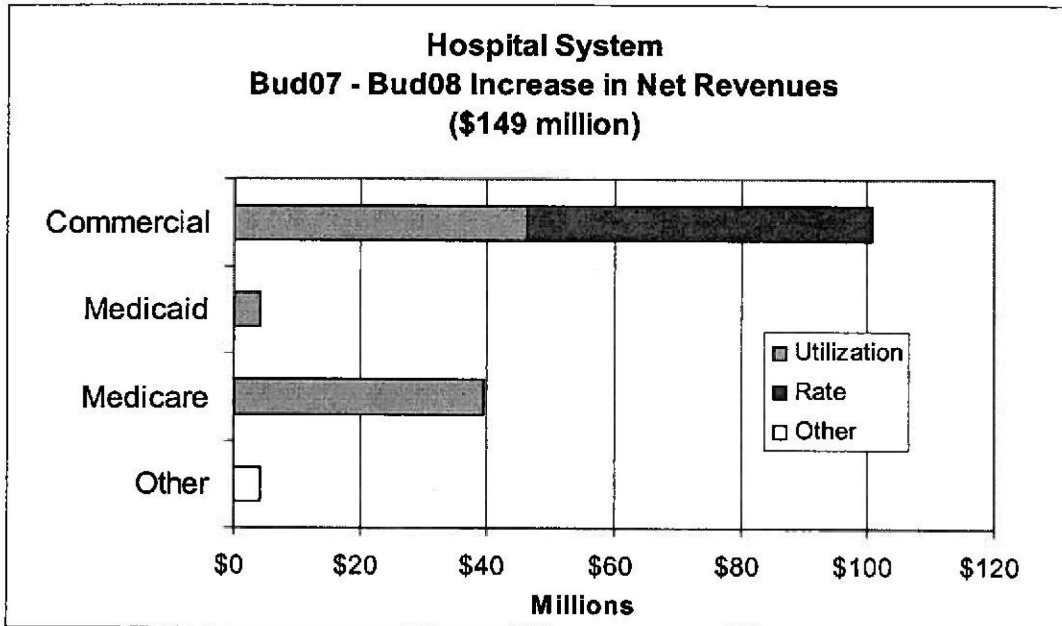


Findings in the FY 2008 Hospital Budget Review Process

BISHCA's methodology for measuring the hospital cost shift by payer is part of the hospital budget review process and has been used since 1989. This methodology can be used to evaluate each individual hospital's cost shift as well as each payer's component of the cost shift. This information is currently used as part of the evaluation of each individual hospital rate request and approval.

The approved FY 2008 budgets found that the hospital system had an increase in net revenues of about $149 million. The increase in revenues will come from increased utilization ($90 million), revenue generated by increased rates ($55 million), and a small

amount from other sources ($4 million). The chart below reflects how much each payer is expected to pay.



Commercial insurers and "self pays" will pay for the entire amount of revenues generated from rates. BISHCA measures the cost shift based upon that assumption. That is because Medicare and Medicaid by and large do not contribute to the hospital rate increases.

As noted above, the revenues earned through increased utilization are expected to be higher in 2008 than those expected from rates. The chart in Appendix F shows the trend of net revenue utilization and rate increases by the hospital system since 2003.

The Cost Shift Measured

Review of the hospital budgets in 2008 finds that the cost shift increased $37.9 million over 2007 budget levels. This is the highest one time increase on record. The increase was the result of lower estimates of reimbursement and larger than normal increases in utilization.

The cumulative hospital cost shift in FY 2008 is measured at $233.6 million. The next table shows a history of the hospital cost shift and reflects how it has changed over the last several years.

Hospital Payers Shifting Costs

in Millions

Hospital Fiscal Year	Medicare	Medicaid	Bad Debt & Free Care	→	Commercial & Other *
ACT 01	($32,228)	($26,448)	($32,706)	equals	$91,382
ACT 02	($42,451)	($35,667)	($33,486)	equals	$111,605
ACT 03	($52,077)	($34,685)	($34,909)	equals	$121,671
ACT 04	($55,670)	($51,655)	($40,878)	equals	$148,204
ACT 05	($54,190)	($57,226)	($40,647)	equals	$152,063
ACT 06	($50,694)	($80,541)	($40,897)	equals	$172,132
BUD 07	($67,941)	($86,809)	($40,937)	equals	$195,687
BUD 08	($91,478)	($94,350)	($47,788)	equals	$233,616
B07- B08 Diff.	($23,537)	($7,541)	($6,851)	equals	$37,930

Numbers are system totals.
The payers values include all hospital and employed Physician services.
Numbers in ( ) reflect the amount of services providers were not compensated for.
* The amount providers shifted to commercial insurance and self pays.

Bad debt and free care has increased to a cumulative $47.8 million. This is related to more liberal free care policies and higher estimates in 2008 for bad debt expense.

The Medicaid cost shift shows a cumulative total of $94.4 million. For the first time, as part of the budget reporting process in 2008, the hospitals were required to report Vermont Medicaid revenues separately from all other states' Medicaid revenues. Hospitals reported that about $9 million of the $94.4 million cost shift is related to non-Vermont Medicaid.

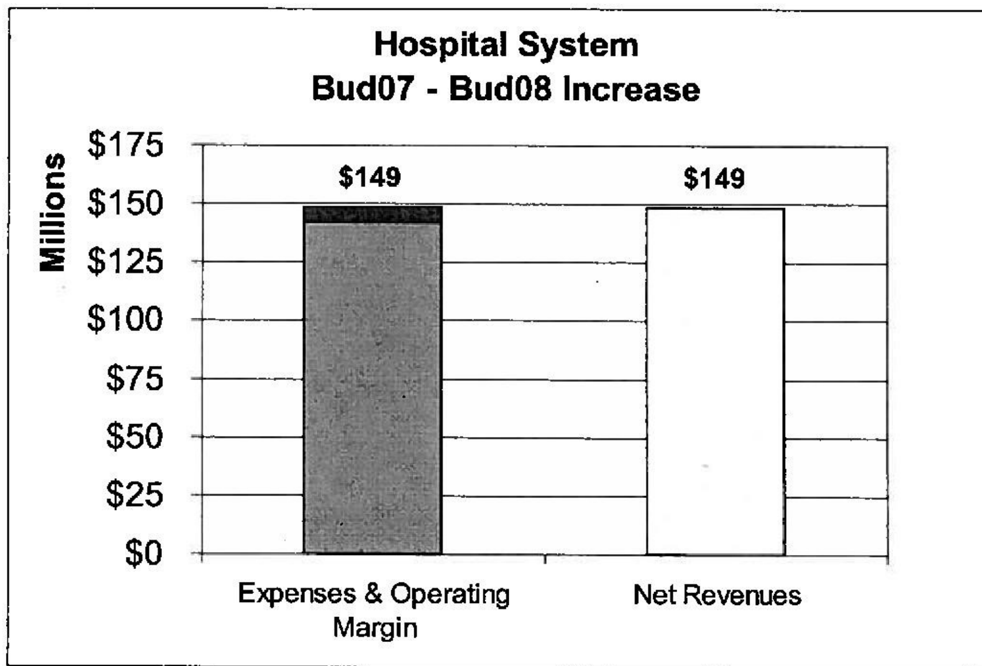
The Medicare cost shift shows a cumulative total of $91.5 million. The increase over 2007 was $23.5 million, or over 25% of the cumulative total. Testimony during the budget hearings revealed great uncertainty about reimbursement in 2008, particularly as it relates to Medicare physician fees.

The chart in Appendix E provides the detail of the cost shift for each hospital. When the cost shift is calculated at the individual hospital level, the sum of the cost shift reflects a slightly higher value than when calculated at the system level. However, that difference is not considered material for purposes of this report.

Cost Shift Relationship to Hospital Budget Rate Requests

The FY 2008 approved budgets for the hospitals show that the hospitals will need an additional $149 million above FY 2007 budgets to pay for services and achieve a slightly higher operating margin. Perhaps the most compelling point should be made here – **regardless of whether there was a cost shift or not, the hospitals would still need $149 million more in FY 2008 to pay expenses and operating margin. The change in the cost shift affects *who* pays; it does not affect the total money the hospitals spend. Let us explain:**[2]

From budget 2007 to budget 2008, the total hospital system expense and operating margin increase equals $149 million. A $149 million increase in net revenues[3] is needed to pay for the $149 million increase in expenses and operating margin.

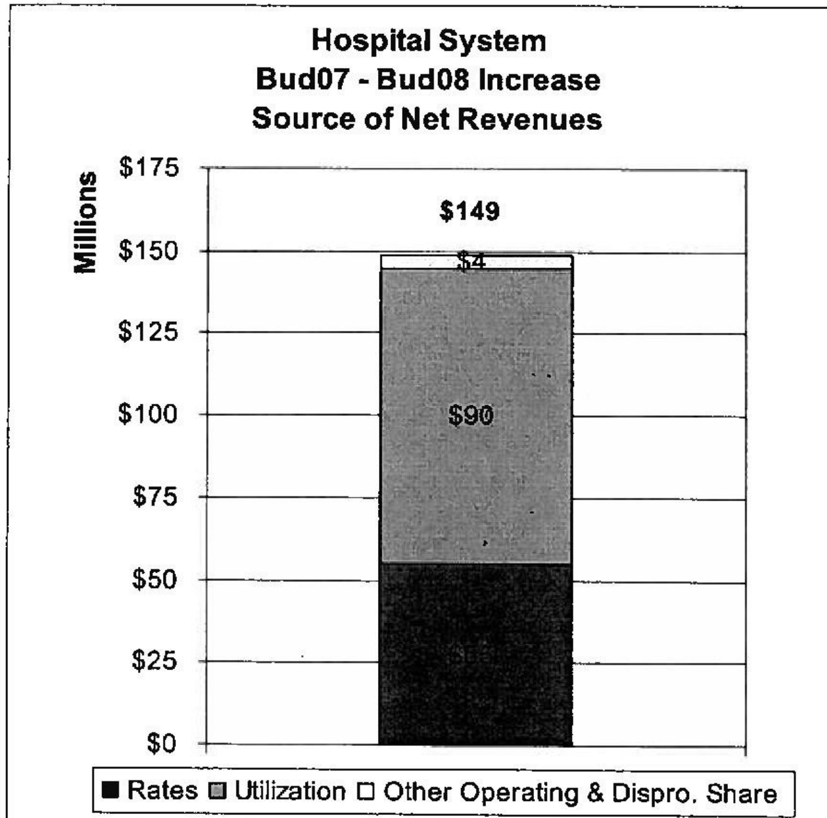


The $149 million increase in net revenues will come from a number of sources: utilization increases (increased use of services and increased demand), increases in other

[2] The following has been edited by BISHCA to present the cost shift in the context of a given year's budget increase (FY 2008). Certain technical considerations were too complex to present at this time. However, though more precise calculations may change some of the values, the overall concept is representative and typical.

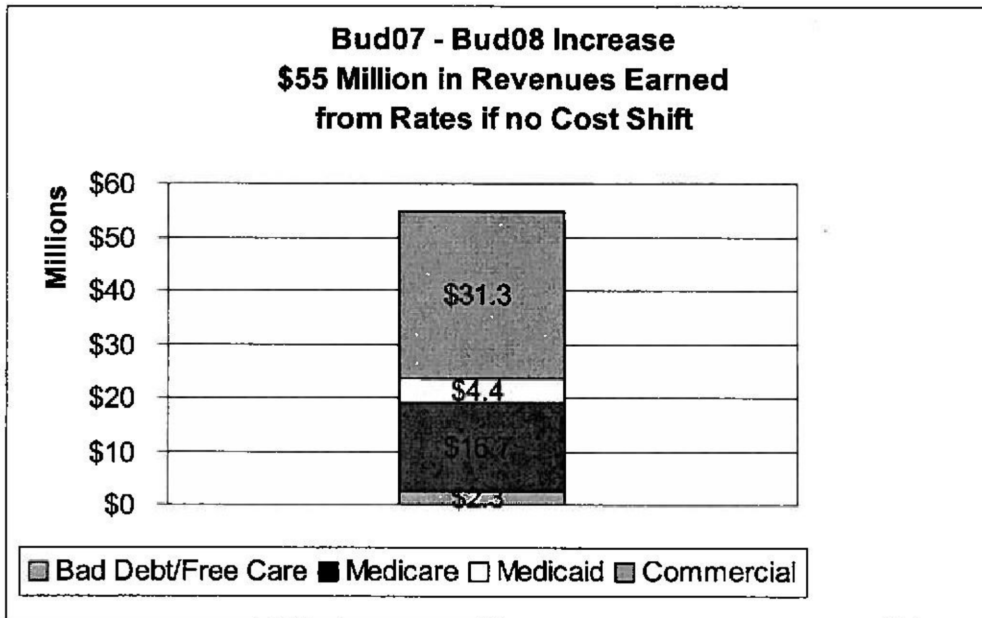
[3] In the world of hospital budgets, "net revenues" does not mean revenues net of expenses, as in the business world. In the hospital budgets, "net revenues" means "revenues net of (after) deductions" such as discounts, write-offs, underpayment, etc. Gross revenue is what is billed; net revenue is what is actually received.

operating revenue (parking, cafeteria, etc.), a change in Disproportionate Share revenue[4], and an increase in rates charged to the payers.



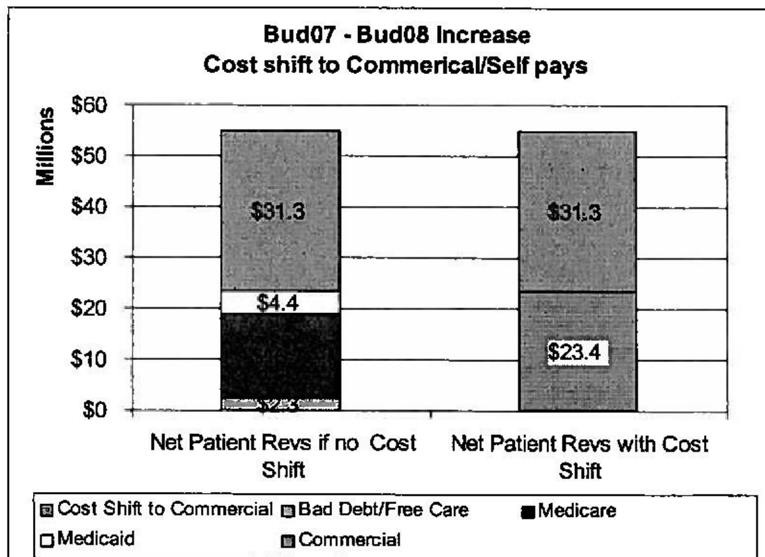
As the chart shows, to achieve the $149 million increase in net revenues, $55 million will need to be raised through rate increases. If every payer paid its proportionate share of the net revenue increase, then the $55 million in net patient revenues would come from Medicare, Medicaid, bad debt and free care, and commercial insurers, as shown on the next chart.

[4] Disproportionate Share is a program administered under Medicaid that provides funding to hospitals based upon the level of their uncompensated care.

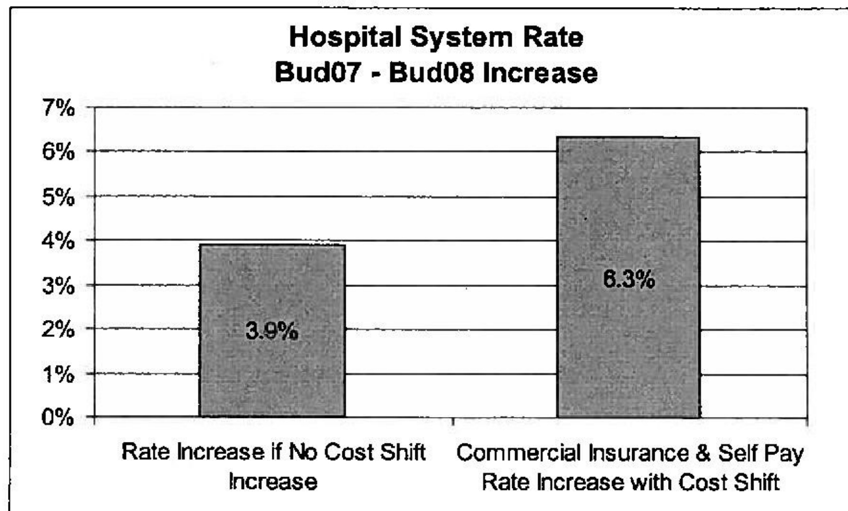


In the above example, if all payers fully participated in an increase in rates, it would require an increase of 3.9% in rates to raise these funds.

However, neither Medicare nor Medicaid usually pay providers based on the providers' charges. Instead, Medicare and Medicaid set their own payment rates, which are largely unaffected by increases in hospitals' charges. Bad debt and free care individuals do not and cannot meet rate increases. The result is that all of the $55 million in additional revenues needed from payers has to come from commercial carriers – not just the $31.3 million that is commercial's proportionate share. In other words, bad debt and free care ($2.3 million), and government's $21.1 million share of the increased revenues has to be "cost shifted" to commercial carriers. Therefore, the rate increase necessary to raise the $55 million from commercial carriers will need to be 6.3% instead of 3.9%.



As noted earlier, if all payers were to pay their proportionate share of the increased revenues, a 3.9% increase in rates would raise the $55 million in net revenues needed by the hospitals. However, because Medicare and Medicaid are largely unaffected by any increases in rates, the remaining payer, commercial insurance, has to be charged a higher rate. In this case, the hospital rate becomes 6.3%.



As noted earlier, the total cost shift increase in 2008 was $38 million. That's because in addition to the cost shift from rates, there is a cost shift from new utilization as well. For every Medicare, Medicaid, or non-paying patient who adds new utilization to the hospital system, commercial insurance will pay for the Medicare and Medicaid non-payment shortfalls. This utilization cost shift of $15 million, along with the rate cost shift of $23 million, explains the overall increase of $38 million.

How do We Reduce the Cost Shift?

The cost shift can only be reduced one of two ways – increase revenues or decrease expenses. For example, the hospital cost shift can be reduced if the hospitals lowered their input costs for salaries, supplies, capital costs, etc. The cost shift would be lowered assuming expenses were reduced without a reduction in services **and** assuming no reduction in reimbursement. For every dollar of reduced spending, a dollar of the cost shift would be reduced if all other things (such as operating surplus) remained the same.

The other option would be to increase revenues from other sources. Taxes or other revenue sources would need to be increased in order to provide higher reimbursement for those in government programs. Most of the cost shift would be eliminated if government payers paid all costs of services incurred by providers. A cost shift would remain, however, to cover both bad debt and free care services.

For hospitals, every 1% in rates generates approximately $8.5 million in revenues. Therefore, every increase in revenues of that amount could lower hospital rates to commercial and "self pays" by about 1%.

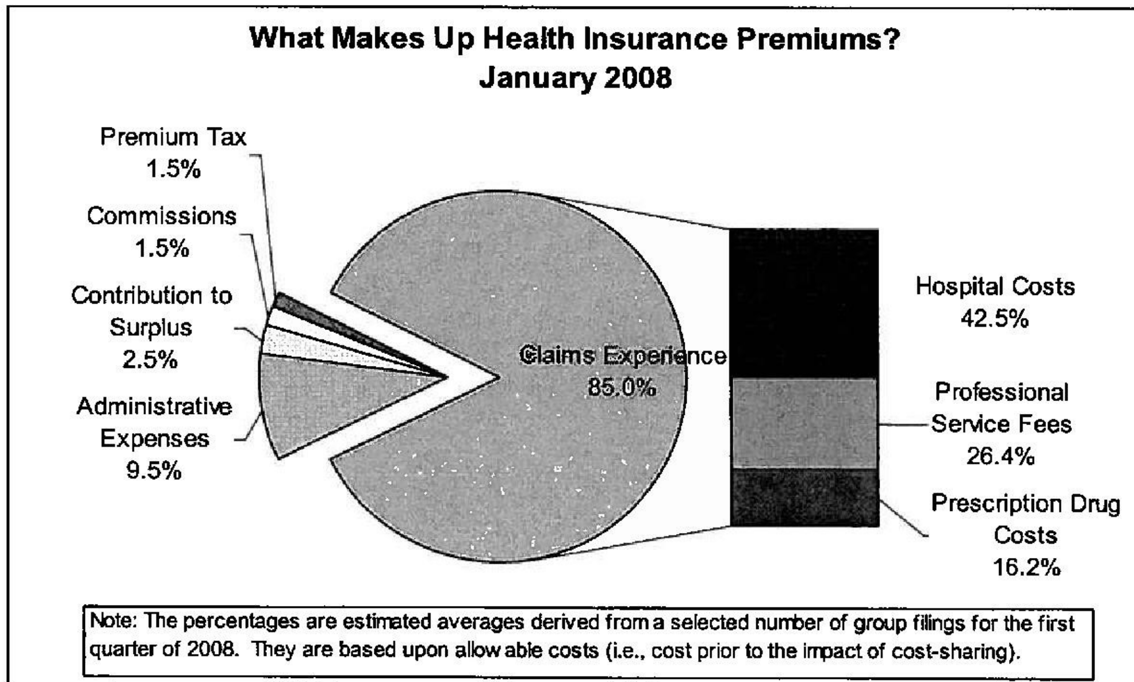
Since the hospital rate increases to commercial insurers show up in claims filed with insurers, this will have an impact on insurance rates. However, it should be noted that there is not a direct one-to-one relationship to insurance rates. This is explained in the next section.

Hospital Rate Increases Relationship to Health Insurance Rates

Pursuant to 8 V.S.A. § 4062, insurance carriers must submit proposed health insurance premiums for Vermonters to BISHCA for review and approval.

The carriers' actuaries prepare the insurers' rate filings, seeking BISHCA approval of the proposed rates. Included in the rate development are the analyses of actual incurred and paid claims, completion factors, estimated claims outstanding, reinsurance costs, cost trend factors, and other data.

A number of different elements make up a health insurance premium, including reported claims experience, administrative expenses, contribution to surplus, commissions and premium tax. Although each filing is different, the following chart sets forth the approximate percentages that these components contribute to rate premiums for group comprehensive major medical products:



As you can see, reported claims experience accounts for a significant percentage of insurance premiums. Claims experience can be further broken down into hospital costs, professional service fees, and prescription drug costs as reported by carriers. For example, the chart conveys that 42.5% of a premium is due to overall hospital costs.

Some carriers use the hospital rate increases approved through the hospital budget process to predict hospital trend factors and other carriers only use the hospital rates as a guide. Carriers generally develop hospital trends based on the carriers' actual past hospital cost experience analyzed over time and in the context of likely future market conditions. Again, it is important to recognize that hospital costs are only a portion of the many factors that go into premium rate development.

Insurance rate development is also impacted by a carrier's negotiations with its participating providers. This additional complication must be considered in developing a model to measure cost shift effects. Differences in payment methodologies, discount amounts, and contract design can all affect the charges from those providers, and thus the premium rates that are established with each plan. The "cost shift" is included in the premium when the commercial insurers pay rates to providers who have priced services to include costs not paid for by other payers. Thus, to capture any reduced cost shift, insurers would need to factor the cost shift into their contract negotiations when providers receive more revenue from government payers. This additional step, among others, must also be considered in developing a model to measure and monitor cost shift effects.

Currently, the insurance rate review process does not allow BISHCA to precisely track the hospital cost shift and its effect on insurance rates. Part of the challenge is that the taxonomies are different for each of the processes. While it is evident that hospital costs and claims are included in insurer rate development, the ability to quantify the specific amount of hospital claims for each plan may require much more additional data from the carriers. BISHCA continues to develop and improve its reporting to enable a better understanding of hospital rates and insurance rate impacts.

Appendices

A. **ACT 191 Cost Shift Legislation - 2006**

B. **Act 191 Cost Shift Task Force Members – 2006**

C. **Hospital Cost Shift Calculation Methodology**

D. **Flow of Dollars from Hospitals to Commercial Plans**

E. **Hospital Payers Shifting Costs**

F. **Trends in Vermont Hospital Budgets**

G. **Cost Shift Impact on Hospital Rate Increases**

Appendix A

ACT 191 COST SHIFT LEGISLATION – 2006

Sec. 26. COST SHIFT TASK FORCE

Increases in Medicaid rates, reductions in private insurance claims through the nongroup market security trust, a decrease in the number of individuals without insurance, and the provision of minimum preventive services through Catamount Health should reduce the cost shift. The department of banking, insurance, securities, and health care administration shall convene a task force of health care professionals, insurers, hospitals, employers offering private health insurance, the state auditor or designee, a representative of the office of Vermont health access, and other interested parties to determine how to ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums. The task force shall make written recommendations to the commission on health care reform no later than December 1, 2006 regarding statutory or administrative changes needed to ensure that a reduction in the cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums.

Appendix B

ACT 191 COST SHIFT TASK FORCE MEMBERS

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Central Vermont Medical Center
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Insurer Representative

Gregory Peters
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Appendix C

HOSPITAL COST SHIFT CALCULATION METHODOLOGY

Division of Health Care Administration
November 2006

Background:

This report has been prepared by the Division of Health Care Administration (DHCA) to document the calculation methodology of the "cost shift" in Vermont hospitals. The basic methodology was originally developed by the Vermont Hospital Data Council and Blue Cross/Blue Shield and is now used by DHCA. The methodology has changed slightly over time due to better reporting through the hospital budget process.

Methodology:

Revenues:

1. The distribution of hospital gross patient revenues is reported by payer: Commercial insurance, Medicare, Medicaid, and Bad Debt/Free Care (BD/FC). BD/FC is considered a payer though their actual payments are nil.
2. Hospital-employed physician gross patient revenues, by payer, are added to the hospital gross revenues for each payer.
3. Deductions from gross revenue for each payer are deducted resulting in the net patient revenue for each payer. Disproportionate share payments are not included and are eliminated from consideration.
4. Other operating revenues are then distributed, allocated to the payers by the gross revenue percentage distribution of each payer.
5. The result is the total net revenues that each payer contributes for the total services (gross revenues) that have been billed (the net revenue amount also includes the other operating revenue).

Expenses:

6. Total operating expenses less the Provider Tax (a tax levied on hospital revenues) are then allocated by payer by the gross revenue percentage distribution.
7. The calculated total operating margin (revenue calculation total minus expense calculation total) is allocated by payer by the gross revenue percentage distribution.

8. This distributed operating margin by payer is added to operating expenses by payer.
9. This result is the total cost that each payer is considered responsible – their share of expenses and operating margin.

Cost Shift calculation:

10. Expenses for each payer are then subtracted from the net revenues for each payer. If the result is less than zero, then that payer has a shifted cost to another payer. If the revenues less expenses are greater than zero, then that payer contributes to offset the cost shift.
11. The total of the revenues minus expenses across all payers equals zero, with some payers cost shifting and some payers offsetting the cost shift.

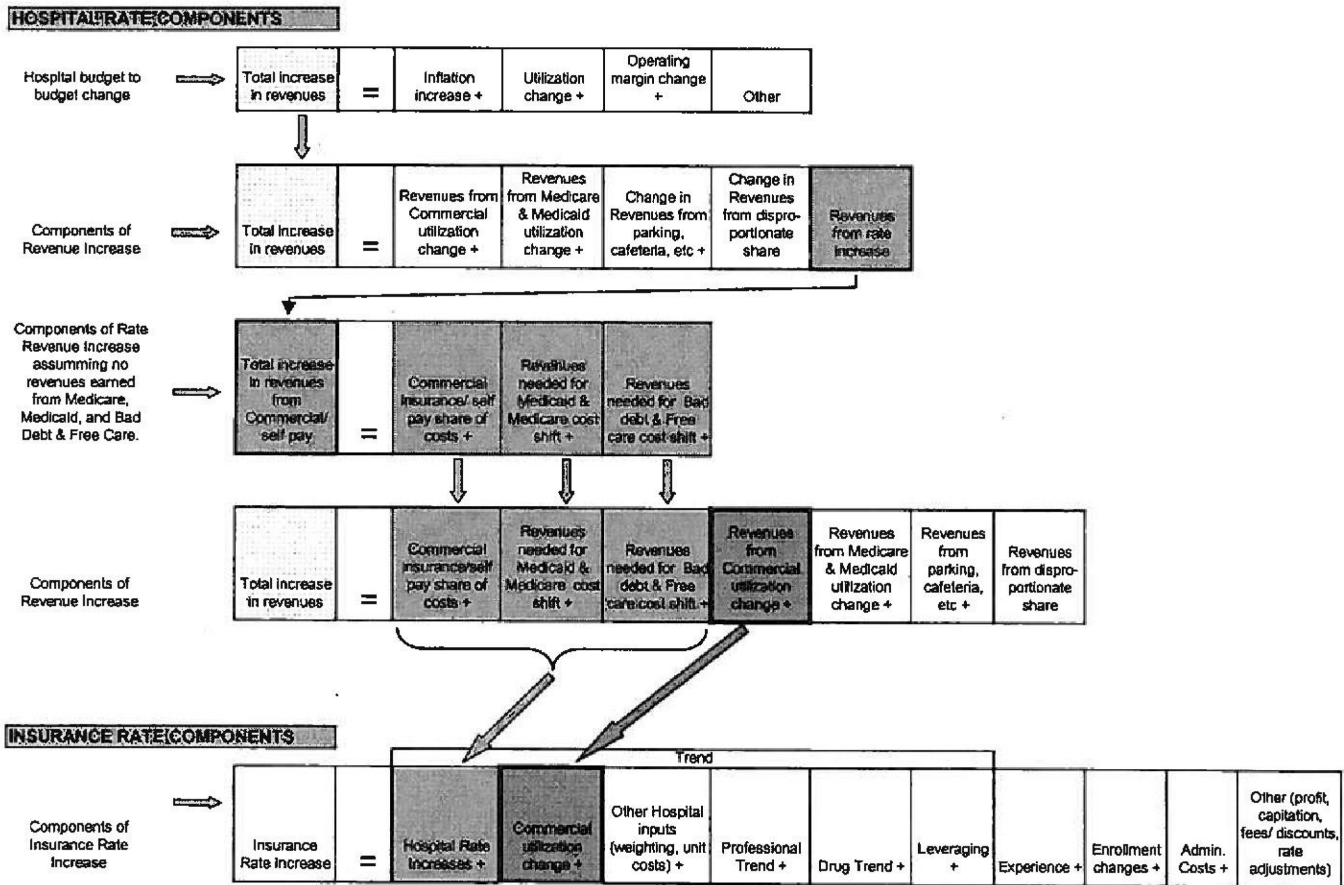
Assumptions:

1. All patients contribute equally to the cost of providing care. For example, costs for a Medicare patient are assumed to be the same as a Medicaid patient for similar services.
2. Other operating revenues are allocated on a relative basis, i.e.; if a payer has 10% of the gross revenues, then they are allocated 10% of the other operating revenues.
3. Likewise, all payers are considered to contribute to the operating surplus on a relative basis, i.e.; if a payer has 10% of the gross revenues, then they pay for 10% of the surplus.
4. Medicaid reported dollars in the hospital budgets are accrued, not paid dollars.
5. No adjustment for patient severity has been applied.
6. Disproportionate Share revenues and Provider Tax expenses are not included in the methodology.
7. Non-operating funds that are part of the Total Margin are not included in the analysis.

Appendix D

Flow of Dollars from Hospitals to Commercial Plans

Note: This is a schematic of hospital budget revenue increases and how some of the revenue increases are passed on to the commercial insurance companies.



Appendix E

Hospital Payers Shifting Costs

Hospital Fiscal year		Medicare		Medicaid	Bad Debt & Free Care			Commercial & Other *
Brattleboro	$	(4,863,808)	$	(2,832,123)	($1,890,931)	equals	$	9,586,862
Central Vermont	$	(10,275,363)	$	(4,194,758)	($3,245,230)	equals	$	17,715,351
Copley	$	26,377	$	(3,454,016)	($1,709,409)	equals	$	5,137,047
Fletcher Allen	$	(31,204,758)	$	(51,210,875)	($19,001,331)	equals	$	101,416,964
Gifford	$	(3,276,839)	$	(1,865,207)	($1,666,747)	equals	$	6,808,794
Grace Cottage	$	946,188	$	(292,050)	($276,654)	equals	$	(377,484)
Mount Ascutney	$	(551,713)	$	(1,094,061)	($1,246,389)	equals	$	2,892,163
North Country	$	(2,800,523)	$	(5,674,218)	($2,041,017)	equals	$	10,515,758
Northeastern	$	(2,525,219)	$	(3,807,850)	($1,767,709)	equals	$	8,100,778
Northwestern	$	(3,695,124)	$	(3,912,696)	($2,387,514)	equals	$	9,995,335
Porter	$	(673,209)	$	(3,101,974)	($1,997,469)	equals	$	5,772,651
Rutland	$	(21,575,309)	$	(7,528,789)	($5,708,416)	equals	$	34,812,514
Southwestern	$	(12,420,721)	$	(5,133,905)	($2,988,592)	equals	$	20,543,218
Springfield	$	(1,764,313)	$	(1,977,753)	($2,702,792)	equals	$	6,444,858
Sum	$	(94,654,334)	$	(96,080,276)	($48,630,200)	equals	$	239,364,810
Hospital System Calculation	$	(91,477,993)	$	(94,350,096)	($47,788,307)	equals	$	233,616,396

The sum of the individual hospitals is higher than the system totals because of weighting.
The payers values include all hospital and employed Physician services.
Numbers in ( ) reflect the amount of services providers were not compensated for.
* The amount providers shifted to commercial insurance and self pays.

Appendix F

Trends in Vermont Hospital Budgets

in Millions

Budget to Budget change	Hospital Net Revenue Increase	Generated from Rates	Generated from Utilization	Generated from Other
Bud 03 Bud 04	$89.5	$48.4	$32.0	$9.1
Bud 04 Bud 05	$89.0	$46.0	$34.0	$9.0
Bud 05 Bud 06	$72.5	$56.2	$14.9	$1.3
Bud 06 Bud 07	$135.4	$58.2	$45.5	$31.7
Bud 07 Bud 08	$148.8	$54.7	$89.7	$4.4

Numbers are based upon the budgets submitted that year.
Other includes disproportionate share change and other non-direct patient services like parking or cafeteria.
Individual hospital detail available upon request

Appendix G

Vermont Community Hospitals

Cost Shift Impact on Hospital Rate Increases

	Approved overall rate Increase	Rate Due to Cost Shift	Rate to meet all other Needs
Brattleboro Memorial Hospital	6.3%	2.2%	4.1%
Central Vermont Hospital	8.0%	2.4%	5.6%
Copley Hospital	4.5%	0.2%	4.3%
Fletcher Allen Health Care	5.5%	2.2%	3.3%
Gifford Memorial Hospital	6.4%	3.5%	2.9%
Grace Cottage Hospital	8.7%	0.0%	8.7%
Mount Ascutney Hospital	5.3%	0.7%	4.6%
North Country Hospital	6.5%	2.0%	4.5%
Northeastern VT Regional Hospital	6.5%	1.7%	4.8%
Northwestern Medical Center	10.5%	3.8%	6.7%
Porter Medical Center	8.3%	0.6%	7.7%
Rutland Regional Medical Center	8.5%	1.8%	6.7%
Southwestern Vermont Medical Center	7.0%	1.8%	5.2%
Springfield Hospital	4.3%	3.6%	0.7%
System	6.3%	2.4%	3.9%

Notes: Analysis built on Budget to Budget change
System analysis completed separately from individual hospital analysis
Other operating revenue, disproportionate share, and provider tax not considered
Differing impacts due to utilization change, reimbursement change, and payer mix change

Pennsylvania Association of Health Underwriters

PHC4 Testimony Synopsis
House Insurance Committee
August 12, 2008

On behalf of the Pennsylvania Association of Health Underwriters, I encourage you to reauthorize PHC4 permanently. PHC4 is uniquely qualified to conduct the due diligence that will be required before any major changes in health care policy can be made. Because of the critical nature of PHC4's work, I recommend that the legislature consider the reauthorization on its own and not attach other proposals or legislation to it.

PHC4 is needed to examine the cost drivers and report their unbiased finding for the record in order analyze the cost drivers behind health care's crippling inflation and its resulting impact on health insurance premiums. This in turn will help determine the effective, responsible and reasonable approach that Pennsylvania should take to address the health care needs of its citizens. By focusing on what I believe are the two major areas of concern -- cost structure and utilization -- PHC4 can make it a priority to determine a realistic cost for health care. I am happy to take follow up questions on those two areas at your convenience.

Thanks in large part to adultBasic and CHIP, Pennsylvania has been recognized as being one of the best states for the lowest number of uninsured, according to the 2005 CRS Report for Congress. PHC4 will be crucial as we work to build on our successes and work to avoid adding Pennsylvania to the growing list of states with failing or failed health care programs.

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CRS Report for Congress
Received through the CRS Web

Health Insurance: Uninsured by State, 2005

Chris L. Peterson
Specialist in Social Legislation
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Summary

An estimated 15.9% of the noninstitutionalized U.S. population lacked health insurance coverage in 2005. When examined by state, estimates of the percentage uninsured ranged from a low of 8.4% in Minnesota to a high of 24.2% in Texas. Generally, states in the Midwest and New England have lower rates of uninsured, while states in the southern portion of the nation have higher shares of their populations without coverage.

These state-level estimates are based on the March 2006 Current Population Survey (CPS) and must be interpreted with caution because they are based on a sample of the population. When sampling variation is taken into account, the uninsured rate in 13 states is not different statistically from the uninsured rate nationwide. The uninsured rate is statistically lower than the national rate in 27 states and the District of Columbia, and statistically higher in the remaining 10 states. In addition to estimates of uninsurance, this report also presents state-level estimates of people's coverage through private health insurance and public health insurance.

This report will be updated every fall, when new data become available.

Estimates of Health Insurance Coverage by State

An estimated 15.9% of the noninstitutionalized U.S. population lacked health insurance coverage in 2005. **Table 1** shows that the estimated percentage of each state's population that lacked health insurance coverage in 2005 ranged from a low of 8.4% in Minnesota to a high of 24.2% in Texas. Three states (Minnesota, Iowa and Hawaii) had estimated uninsured rates of less than 10%. Four states (Texas, Florida, New Mexico and Arizona) had uninsurance rates of 20% or more. Generally, states with the lowest rates of uninsurance were located in the Midwest and Northeast; states with the highest rates were in the southern portion of the country (**Figure 1**).

Table 1 also ranks[1] states according to which has the lowest percentage of private health insurance,[2] public health insurance,[3] and uninsurance. The far right-hand column of the table also shows whether the state's uninsurance rate is significantly lower (shown with a "-") or significantly higher (shown with a "+") than the national average of 15.9%.

Both private and public health insurance impact a state's uninsurance rate. For example, Minnesota and Maine have similarly low uninsurance rates.[4] Minnesota's uninsurance rate is low because it ranks as having the highest rate of private health insurance in the country (80.7%), even though it ranks as the fifth *lowest* in its public health insurance rate (22.6%). On the other hand, Maine's rate of private coverage (66.5%) is significantly lower than Minnesota's and ranks as 19th lowest in the country, as shown in **Table 1**. However, Maine ranks as having the highest *public* coverage rate in the country (35.4%). Thus, even though there are significant differences regarding whether people in Maine and Minnesota obtain private or public health insurance, the impact is that both have similarly low uninsurance rates.

The states with the highest-ranking uninsurance rates, led by Texas with nearly a quarter of its population uninsured, have some of the lowest rankings for private coverage. The 10 states with the highest uninsured rates, shown in the last 10 rows of **Table 1**, rank in the lowest dozen states in terms of their private coverage. Interestingly, the state ranked as having the *lowest* private-coverage rate (Mississippi, 56.4%) was not among the states with the highest uninsured rates.[5] This is because Mississippi, along with Maine, had a rate of public coverage (35.4%) that ranked as highest in the nation. Thus, even though Mississippi and Texas had similar rates of private coverage, Mississippi's much higher rate of public coverage led to its much lower rate of uninsurance.

Estimates' 95% Confidence Intervals. The estimates of health insurance coverage in this report are based on data from the March supplement of the 2006 Current Population Survey (CPS).[6] The CPS is representative of the civilian, noninstitutionalized population and is designed to produce reliable estimates at the national, regional and state level.

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[1] Rankings do not connote statistically significant differences with other states.

[2] "Private health insurance" consists of insurance obtained through an employer or purchased directly from a private insurer.

[3] "Public health insurance" consists of Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and other government-provided health insurance, as well as health insurance related to employment in the military.

[4] Their uninsurance rates are significantly below the national average and are not significantly different from each other.

[5] Mississippi's uninsurance rate (17.4%) is not significantly different than the national average of 15.9%.

[6] Because the supplement is now fielded from February through April, it has been officially renamed the Annual Social and Economic supplement (ASEC) to the CPS, though many analysts continue to refer to it by its traditional name.

The small sample sizes available from the CPS for many states make it prudent to consider state-level estimates in terms of a range of values. Like **Table 1**, **Table 2** shows the best point estimates, or single values, for the numbers of people covered and not covered by health insurance. The table also reports a range in values — the 95% confidence interval — for these estimates. The size of the range depends primarily upon the sample size. A 95% confidence interval means that if repeated samples were collected under essentially the same conditions and their confidence intervals calculated, in the long run about 95% of those intervals would contain the true number of people with (or without) health insurance.

Reasons for Differences in the Percent Uninsured

Figure 1 indicates that residents of the southern United States are more likely to lack health insurance, and residents of the Midwest and New England are more likely to be covered. Various characteristics of a state's population may account for these differences. Nationwide, the percent uninsured is related to age, race and ethnicity, employment, and a number of other factors.[7] The prevalence of particular population and employer characteristics may account for some of the regional or state variation in percentages of uninsured. Some factors related to the percent of a state's population that is uninsured may be affected by each state's policies, such as eligibility criteria for the state's Medicaid program or the State Children's Health Insurance Program (SCHIP).

Table 1. Estimates of the Number, Percentage and State Ranking of People With and Without Various Forms of Health Insurance, 2005

Sorted by uninsured ranking (numbers in thousands)

	Total	Private health insurance			Public health insurance			Uninsured		
	population	Number	Percent	Rank	Number	Percent	Rank	Number	Percent	Rank
U.S.	**293,834**	**198,901**	**67.7%**		**80,249**	**27.3%**		**46,577**	**15.9%**	
Minnesota	5,129	4,139	80.7%	51	1,159	22.6%	5	431	8.4%	1
Iowa	2,909	2,323	79.9%	50	738	25.4%	13	251	8.6%	2
Hawaii	1,279	940	73.5%	39	417	32.6%	42	116	9.1%	3
Wisconsin	5,447	4,189	76.9%	46	1,422	26.1%	16	534	9.8%	4
Massachusetts	6,328	4,684	74.0%	40	1,701	26.9%	23	618	9.8%	5
New Hampshire	1,301	1,027	79.0%	49	285	21.9%	4	135	10.3%	6
Pennsylvania	12,281	9,357	76.2%	44	3,307	26.9%	24	1,287	10.5%	7
Kansas	2,695	2,075	77.0%	47	703	26.1%	17	290	10.8%	8
Maine	1,320	878	66.5%	19	467	35.4%	51	143	10.8%	9
Connecticut	3,487	2,662	76.4%	45	841	24.1%	8	394	11.3%	10
Michigan	9,982	7,435	74.5%	42	2,635	26.4%	18	1,133	11.4%	11
Vermont	622	426	68.5%	23	209	33.7%	47	73	11.7%	12
Nebraska	1,766	1,320	74.7%	43	461	26.1%	15	208	11.8%	13
Rhode Island	1,054	753	71.5%	33	315	29.9%	36	125	11.8%	14
Missouri	5,710	4,080	71.5%	31	1,570	27.5%	27	691	12.1%	15
North Dakota	626	483	77.2%	48	158	25.3%	12	76	12.2%	16
Ohio	11,334	8,240	72.7%	36	3,006	26.5%	19	1,394	12.3%	17
South Dakota	768	563	73.2%	38	221	28.8%	31	95	12.4%	18
Kentucky	4,052	2,775	68.5%	22	1,236	30.5%	38	514	12.7%	19
Delaware	844	602	71.3%	29	239	28.3%	29	110	13.0%	20
New York	19,022	12,822	67.4%	20	5,864	30.8%	39	2,559	13.5%	21

[7] For additional information, see CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2005*, by Chris L. Peterson.

	Total	Private health insurance			Public health insurance			Uninsured			
	population	Number	Percent	Rank	Number	Percent	Rank	Number	Percent	Rank	
DC	540	341	63.1%	13	179	33.2%	45	73	13.5%	22	-
Virginia	7,454	5,387	72.3%	35	1,981	26.6%	20	1,011	13.6%	23	-
Washington	6,250	4,462	71.4%	30	1,667	26.7%	21	866	13.8%	24	-
Indiana	6,141	4,369	71.1%	27	1,472	24.0%	7	871	14.2%	25	-
Maryland	5,569	4,054	72.8%	37	1,371	24.6%	11	788	14.2%	26	-
Tennessee	5,867	3,734	63.6%	14	1,966	33.5%	46	836	14.2%	27	-
Illinois	12,608	9,069	71.9%	34	3,060	24.3%	9	1,802	14.3%	28	-
New Jersey	8,725	6,471	74.2%	41	1,748	20.0%	1	1,324	15.2%	29	
Idaho	1,442	1,003	69.6%	26	352	24.4%	10	222	15.4%	30	
Alabama	4,524	2,956	65.3%	17	1,497	33.1%	44	696	15.4%	31	
Oregon	3,627	2,495	68.8%	24	983	27.1%	25	579	16.0%	32	
North Carolina	8,561	5,652	66.0%	18	2,532	29.6%	35	1,371	16.0%	33	
Wyoming	511	348	68.1%	21	141	27.6%	28	82	16.1%	34	
Utah	2,524	1,798	71.3%	28	535	21.2%	3	420	16.6%	35	
Colorado	4,641	3,317	71.5%	32	948	20.4%	2	788	17.0%	36	
Nevada	2,448	1,686	68.9%	25	579	23.7%	6	425	17.4%	37	
Montana	928	606	65.2%	16	273	29.4%	33	162	17.4%	38	
Mississippi	2,854	1,610	56.4%	1	1,009	35.4%	50	495	17.4%	39	
South Carolina	4,181	2,657	63.6%	15	1,228	29.4%	32	741	17.7%	40	
Alaska	659	401	60.9%	5	218	33.1%	43	117	17.7%	41	
Arkansas	2,760	1,717	62.2%	8	873	31.6%	40	494	17.9%	42	+
West Virginia	1,799	1,127	62.7%	11	609	33.8%	48	322	17.9%	43	+
Oklahoma	3,505	2,189	62.5%	10	1,120	32.0%	41	647	18.4%	44	+
Louisiana	4,088	2,564	62.7%	12	1,163	28.5%	30	767	18.8%	45	+
Georgia	9,045	5,612	62.0%	6	2,460	27.2%	26	1,709	18.9%	46	+
California	35,940	22,307	62.1%	7	9,669	26.9%	22	6,961	19.4%	47	+
Arizona	6,047	3,576	59.1%	4	1,837	30.4%	37	1,219	20.2%	48	+
New Mexico	1,938	1,114	57.5%	2	662	34.2%	49	396	20.4%	49	+
Florida	17,886	11,152	62.4%	9	5,295	29.6%	34	3,703	20.7%	50	+
Texas	22,819	13,354	58.5%	3	5,866	25.7%	14	5,516	24.2%	51	+

Source: U.S. Census Bureau's March 2006 Current Population Survey, at [http://pubdb3.census.gov/macro/032006/health/h05_000.htm]. Rankings and significance testing computed by the Congressional Research Service.

Notes: Rankings do not connote statistically significant differences with other states. In the far right-hand column of the table, "-" indicates percent uninsured is statistically lower than the national rate and "+" indicates percent u ninsured is statistically higher than the national rate, at the 5% level of significance.

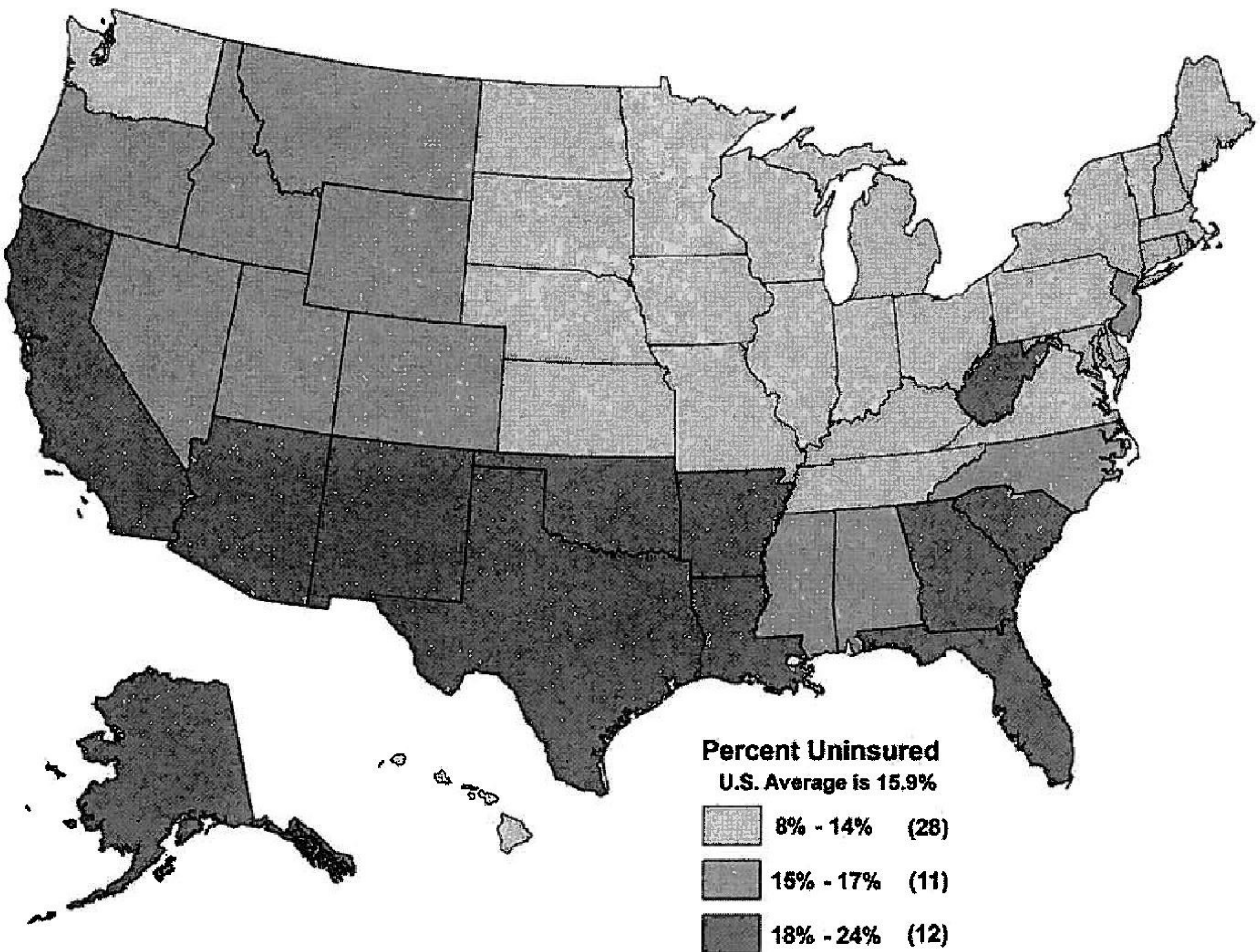
Table 2. Estimates of Number and Percentage of People With and Without Various Forms of Health Insurance, with 95% Confidence Intervals, 2005

(numbers in thousands)

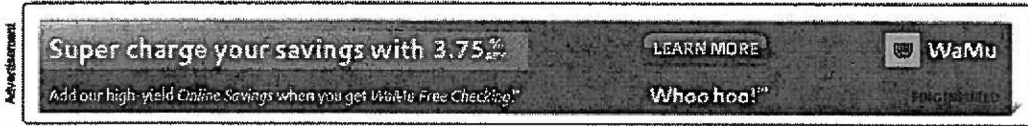
	Private health insurance		Public health insurance		Uninsured	
	Number	Percentage	Number	Percentage	Number	Percentage
U.S.	**198,901 ± 811**	**67.7% ± 0.2%**	**80,249 ± 772**	**27.3% ± 0.2%**	**46,577 ± 631**	**15.9% ± 0.2%**
Alabama	2,956 ± 104	65.3% ± 2.4%	1,497 ± 104	33.1% ± 2.4%	696 ± 78	15.4% ± 1.8%
Alaska	401 ± 18	60.9% ± 2.5%	218 ± 16	33.1% ± 2.5%	117 ± 14	17.7% ± 2.0%
Arizona	3,576 ± 135	59.1% ± 2.2%	1,837 ± 125	30.4% ± 2.2%	1,219 ± 110	20.2% ± 1.8%
Arkansas	1,717 ± 67	62.2% ± 2.4%	873 ± 65	31.6% ± 2.4%	494 ± 53	17.9% ± 2.0%
California	22,307 ± 325	62.1% ± 1.0%	9,669 ± 300	26.9% ± 0.8%	6,961 ± 267	19.4% ± 0.8%
Colorado	3,317 ± 108	71.5% ± 2.4%	948 ± 96	20.4% ± 2.2%	788 ± 90	17.0% ± 2.0%
Connecticut	2,662 ± 74	76.4% ± 2.2%	841 ± 76	24.1% ± 2.2%	394 ± 57	11.3% ± 1.6%
Delaware	602 ± 20	71.3% ± 2.4%	239 ± 20	28.3% ± 2.4%	110 ± 14	13.0% ± 1.8%
DC	341 ± 16	63.1% ± 2.7%	179 ± 16	33.2% ± 2.7%	73 ± 12	13.5% ± 2.0%
Florida	11,152 ± 218	62.4% ± 1.2%	5,295 ± 206	29.6% ± 1.2%	3,703 ± 182	20.7% ± 1.0%
Georgia	5,612 ± 153	62.0% ± 1.8%	2,460 ± 141	27.2% ± 1.6%	1,709 ± 123	18.9% ± 1.4%
Hawaii	940 ± 25	73.5% ± 2.2%	417 ± 29	32.6% ± 2.2%	116 ± 18	9.1% ± 1.4%
Idaho	1,003 ± 33	69.6% ± 2.4%	352 ± 31	24.4% ± 2.2%	222 ± 25	15.4% ± 1.8%
Illinois	9,069 ± 171	71.9% ± 1.4%	3,060 ± 163	24.3% ± 1.4%	1,802 ± 133	14.3% ± 1.0%
Indiana	4,369 ± 120	71.1% ± 2.0%	1,472 ± 112	24.0% ± 1.8%	871 ± 90	14.2% ± 1.6%
Iowa	2,323 ± 61	79.9% ± 2.2%	738 ± 67	25.4% ± 2.4%	251 ± 43	8.6% ± 1.4%
Kansas	2,075 ± 59	77.0% ± 2.2%	703 ± 63	26.1% ± 2.4%	290 ± 43	10.8% ± 1.6%
Kentucky	2,775 ± 98	68.5% ± 2.4%	1,236 ± 96	30.5% ± 2.4%	514 ± 69	12.7% ± 1.8%
Louisiana	2,564 ± 102	62.7% ± 2.5%	1,163 ± 94	28.5% ± 2.4%	767 ± 82	18.8% ± 2.0%
Maine	878 ± 33	66.5% ± 2.5%	467 ± 35	35.4% ± 2.5%	143 ± 22	10.8% ± 1.8%
Maryland	4,054 ± 112	72.8% ± 2.0%	1,371 ± 110	24.6% ± 2.0%	788 ± 88	14.2% ± 1.6%
Massachusetts	4,684 ± 114	74.0% ± 1.8%	1,701 ± 116	26.9% ± 1.8%	618 ± 78	9.8% ± 1.2%
Michigan	7,435 ± 145	74.5% ± 1.4%	2,635 ± 147	26.4% ± 1.6%	1,133 ± 106	11.4% ± 1.0%
Minnesota	4,139 ± 92	80.7% ± 1.8%	1,159 ± 98	22.6% ± 2.0%	431 ± 65	8.4% ± 1.4%
Mississippi	1,610 ± 71	56.4% ± 2.5%	1,009 ± 69	35.4% ± 2.4%	495 ± 55	17.4% ± 2.0%
Missouri	4,080 ± 116	71.5% ± 2.0%	1,570 ± 114	27.5% ± 2.0%	691 ± 82	12.1% ± 1.4%
Montana	606 ± 24	65.2% ± 2.4%	273 ± 22	29.4% ± 2.4%	162 ± 18	17.4% ± 2.0%
Nebraska	1,320 ± 39	74.7% ± 2.2%	461 ± 39	26.1% ± 2.4%	208 ± 29	11.8% ± 1.6%
Nevada	1,686 ± 59	68.9% ± 2.4%	579 ± 55	23.7% ± 2.2%	425 ± 49	17.4% ± 2.0%
New Hampshire	1,027 ± 27	79.0% ± 2.2%	285 ± 27	21.9% ± 2.2%	135 ± 20	10.3% ± 1.6%
New Jersey	6,471 ± 135	74.2% ± 1.6%	1,748 ± 125	20.0% ± 1.4%	1,324 ± 114	15.2% ± 1.4%
New Mexico	1,114 ± 53	57.5% ± 2.7%	662 ± 51	34.2% ± 2.5%	396 ± 43	20.4% ± 2.2%
New York	12,822 ± 221	67.4% ± 1.2%	5,864 ± 220	30.8% ± 1.2%	2,559 ± 163	13.5% ± 0.8%
North Carolina	5,652 ± 147	66.0% ± 1.8%	2,532 ± 141	29.6% ± 1.6%	1,371 ± 114	16.0% ± 1.4%
North Dakota	483 ± 14	77.2% ± 2.2%	158 ± 14	25.3% ± 2.2%	76 ± 10	12.2% ± 1.8%
Ohio	8,240 ± 157	72.7% ± 1.4%	3,006 ± 157	26.5% ± 1.4%	1,394 ± 116	12.3% ± 1.0%
Oklahoma	2,189 ± 86	62.5% ± 2.5%	1,120 ± 84	32.0% ± 2.4%	647 ± 71	18.4% ± 2.0%
Oregon	2,495 ± 90	68.8% ± 2.5%	983 ± 86	27.1% ± 2.4%	579 ± 71	16.0% ± 2.0%
Pennsylvania	9,357 ± 157	76.2% ± 1.4%	3,307 ± 165	26.9% ± 1.4%	1,287 ± 114	10.5% ± 1.0%
Rhode Island	753 ± 25	71.5% ± 2.4%	315 ± 25	29.9% ± 2.5%	125 ± 18	11.8% ± 1.8%
South Carolina	2,657 ± 102	63.6% ± 2.4%	1,228 ± 96	29.4% ± 2.4%	741 ± 80	17.7% ± 2.0%
South Dakota	563 ± 16	73.2% ± 2.2%	221 ± 16	28.8% ± 2.2%	95 ± 12	12.4% ± 1.6%
Tennessee	3,734 ± 123	63.6% ± 2.2%	1,966 ± 120	33.5% ± 2.0%	836 ± 88	14.2% ± 1.6%
Texas	13,354 ± 269	58.5% ± 1.2%	5,866 ± 239	25.7% ± 1.0%	5,516 ± 233	24.2% ± 1.0%
Utah	1,798 ± 53	71.3% ± 2.2%	535 ± 47	21.2% ± 2.0%	420 ± 43	16.6% ± 1.8%
Vermont	426 ± 16	68.5% ± 2.5%	209 ± 16	33.7% ± 2.5%	73 ± 12	11.7% ± 1.7%
Virginia	5,387 ± 127	72.3% ± 1.8%	1,981 ± 125	26.6% ± 1.8%	1,011 ± 98	13.6% ± 1.4%
Washington	4,462 ± 122	71.4% ± 2.0%	1,667 ± 120	26.7% ± 2.0%	866 ± 94	13.8% ± 1.6%
West Virginia	1,127 ± 41	62.7% ± 2.4%	609 ± 39	33.8% ± 2.2%	322 ± 33	17.9% ± 1.8%
Wisconsin	4,189 ± 106	76.9% ± 2.0%	1,422 ± 108	26.1% ± 2.0%	534 ± 73	9.8% ± 1.4%
Wyoming	348 ± 14	68.1% ± 2.5%	141 ± 12	27.6% ± 2.4%	82 ± 10	16.1% ± 2.0%

Source: U.S. Census Bureau's March 2006 Current Population Survey (CPS), at [http://pubdb3.census.gov/macro/032006/health/h05_000.htm]. Confidence intervals computed by the Congressional Research Service.

Figure 1. Percentage of U.S. Population Without Health Insurance, by State, 2005



Source: U.S. Census Bureau's March 2006 Current Population Survey (CPS), at [http://pubdb3.census.gov/macro/032006/health/h05_000.htm].



Mass. pioneering health plan turns 1

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Enlarge By Josh T. Reynolds for USA TODAY

Wendy Rodriguez, of Jamaica Plain, Mass., sits with her her nephew Jason Portillo, 10 and her 23-month-old daughter Shahana Ahmed in the waiting room before her daughter's appointment at the Revere Family Health Center. July 1 marks a year since all residents of Massachusetts were to have signed up for health insurance coverage, which has signed up many low-income uninsured residents, but has seen higher than projected costs.

Enlarge By Josh T. Reynolds for USA TODAY

Dr. Assad Sayah, right, consults with nurse Sue McMahon in the emergency department of the Cambridge Hospital's Cambridge Street Campus in Cambridge, Mass.

By Julie Appleby, USA TODAY

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CAMBRIDGE, Mass. — Self-employed Patricia Pelletier says she has better health insurance than she did before Massachusetts became the first state to require almost all residents have coverage, but it's costing her more.

The plan she now buys, through a system set up by the state, covers more, she says, but her monthly premium is going up from $422 to $615 in August.

"I almost fell on the floor," says Pelletier, 55, of Newbury. "Costs are getting out of control."

Tuesday marks the one-year anniversary of the deadline for most Massachusetts residents to carry health coverage. Those who don't face tax penalties. Since the program began, the percentage of uninsured adults has dropped by nearly half, from 13% to 7%, according to studies cited by the state.

Yet the Massachusetts experiment, enacted in 2006 by a Republican governor in a Democratic state, still faces a huge challenge — costs.

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Most of the newly insured are lower income residents who qualify for low- or no-cost coverage through the state and there were more uninsured than the state anticipated. Both factors pushed costs to $625 million the first year, up from estimates of $472 million, according to figures from the state agency overseeing the program.

In the fiscal year that starts Tuesday, the governor has requested $869 million for the program, up from 2006 estimates of $725 million.

Monthly premiums for those who qualify for the partially subsidized program went up an average of 9.4% going into the second year of the program, state figures show. For higher income residents who buy coverage without a state subsidy, such as Pelletier, the average premium increase was 5.1%.

As both presidential candidates outline their own health proposals — and several states consider insurance expansion efforts — Massachusetts' health care law is both touted as an example to copy nationally and criticized as a model to avoid.

"Some will say it's an overwhelming success story. Others will say it has cost somewhat more than expected, so we can't afford to expand coverage," says Drew Altman, president of the non-partisan Kaiser Family Foundation, which studies health policy. "The truth is somewhere in the middle."

A boost in preventive care

The new insurance law in Massachusetts is being felt keenly in hospitals, doctor's offices and clinics, like the Revere Family Health Center, about 15 minutes from Cambridge. Cambridge Health Alliance, which runs this center and 20 others, says their

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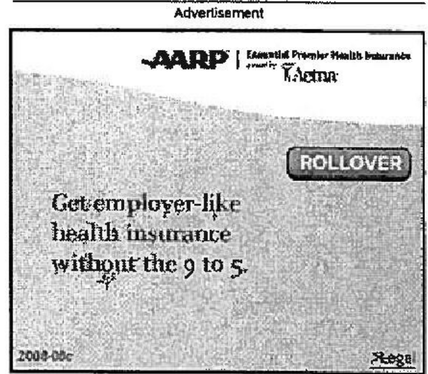

clinics have seen a 16% increase in visits since the expanded program helped many patients get insurance.

Center Director Somava Stout says insured patients are more likely to come in for preventive care. For some, insurance has meant survival.

Kathleen Richard, who is battling thyroid cancer, is among them. "She would not be alive today if she didn't have insurance," says Stout.

Without insurance, Stout says, it would have been difficult, if not impossible, to get Richard the complex surgery she needed. Until she became ill, Richard, 55, always worked and had insurance. Her illness caused her to lose her job and her coverage.

Her cancer was discovered after an emergency visit in 2005 to Cambridge Hospital, which has since helped Richard sign up for several different types of subsidized coverage through the state.

"When you go from having insurance, then having nothing, it's very frightening," says Richard, whose cancer is now in remission. "It's such a plus not to have to worry about insurance."

'A heroic commitment'

The first priority of the Massachusetts effort was to broaden coverage so that residents such as Richard could be insured, says Jon Kingsdale, head of the independent state agency that oversees the program. Tackling costs would come later.

"The way to do this is to make the moral commitment to cover everybody," Kingsdale says. That forces "the political leadership, doctors, hospitals and health insurers to grapple with how to make this affordable. I don't know any other way to get America to confront this very tough problem."

The state has 355,000 newly insured residents, as of April, according to the journal *Health Affairs*, a leading chronicle of health policy, which recently outlined the success and challenges of the effort.

January figures cited by the state show most of the newly insured qualify for help: 37% are eligible for free state-subsidized coverage, 17% are in an expanded Medicaid program, and 14% only pay for part of their coverage.

Only 7% of the newly insured bought it on their own without a subsidy. The remaining 25% signed up through their jobs.

A bill before the state Legislature aims to save money through a variety of efforts, Kingsdale says, including increasing the use of electronic medical records.

"The state made a great commitment, a heroic commitment," says Assaad Sayah, chief of emergency medicine at Cambridge Hospital. "Is it perfect? No. I'm not sure any system in the world is perfect. But it's better than what we had before."

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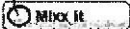

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The Mick wrote: 7/1/2008 3:23:07 PM

Are there any reliable studies on how much insurance companies profit from government run programs vs private programs. The $615 per month, though, may not be high - we're not told what's covered. My pension's total health insurance premium is $565/month (80% employer paid) and that includes an excellent plan for health-vision-dental with low max. ($15) prescriptions and a $500 annual max on major care. Most of my friends envy that plan: but it would be even cheaper through

Courant.com

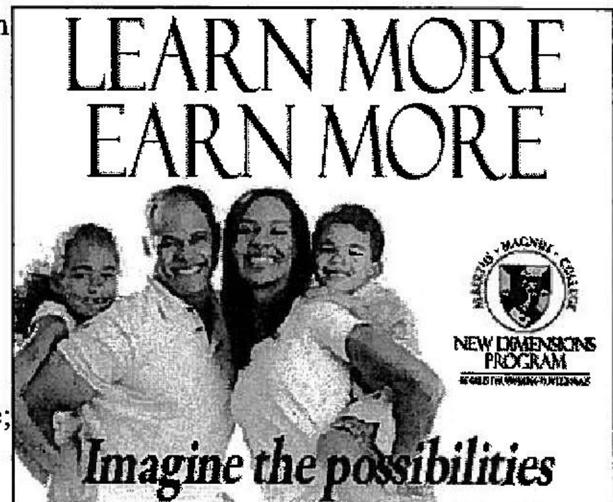
New State Program For The Uninsured Off To Slow Start

By ANN MARIE SOMMA

Courant Staff Writer

July 31, 2008

Gov. M. Jodi Rell's much-touted Charter Oak Health Plan for uninsured adults has gotten off to a slow start, as administrators struggle to build up a comprehensive network of doctors and hospitals willing to participate.



The three private insurers who have contracted with the state — Aetna Better Health, AmeriChoice of Connecticut and Community Health Network of Connecticut — have signed on less than 3,000 primary care providers and only one hospital.

"This program was supposed to be a safety net for people; it's shaping up to be more like a sieve," said state Sen. Jonathan Harris, D- West Hartford, co-chairman of the legislature's human services committee.

Some medical providers say the lower-than-expected reimbursement rates offered under the plan, coupled with additional administrative costs, are keeping them from signing on.

"Our physicians aren't sure they can take on a deluge of new patients under the rates being offered. We don't want to over-promise and under-deliver," said Cheryl Lescarbeau, vice president of marketing at the Farmington-based ProHealth Physicians Group, the state's largest group practice of primary care doctors.

Since the state-subsidized health plan was launched on July 1, more than 16,000 people have flooded the state's hot line with questions about the plan. To date, 5,351 people have applied up for coverage that offers premiums ranging from $75 to $259, based on income levels.

On Wednesday, state lawmakers grilled Michael Starkowski, commissioner of the state Department of Social Services, on whether a viable network will be in place for the 19,000 residents the plan will ultimately serve. Today, 24 residents will be first to receive coverage under one of Charter Oak's three health plans.

Starkowski told members of the state's appropriations committee that providers are signing on daily and that rates are being negotiated with hospitals and providers. He did say that some hospitals are less than enthusiastic about the reimbursement rates for their services. The plans are negotiated with providers' rates that fall between commercial insurance and Medicaid rates.

"Some providers will be fine with Medicaid rates, some will want something in between, some will hold out," Starkowski said.

So far, only the Hospital of St. Raphael in New Haven has signed on to contract with Aetna Better Health. And not exactly with overabundant enthusiasm.

"The Hospital of St. Raphael is participating as a good faith effort to support the community, the governor and for Aetna, which is an organization we contract with on other plans. However, we are concerned about the reimbursement rates," said Rick Scavetta, a hospital spokesman.

Stephen A. Frayne, senior vice president of the Connecticut Hospital Association, which represents 29 hospitals in the state, said reimbursement rates remain a sticking point. "The question is: 'How do you make it work for everybody?'" Frayne said.

Kevin P. Lembo, who runs the state's Office of Healthcare Advocate, which represents consumers, said the questions raised about reimbursement and network adequacy are huge.

"Just because someone has an insurance card doesn't mean anything. That insurance card has to get you something. At a minimum, it has to get you a visit from a doctor," said Lembo, whose office is prepared to take complaints and help consumers find doctors.

The slow number of sign-ups is a concern for lawmakers and child advocates who fear the 320,000 low-income children and adults enrolled in the HUSKY health plan will have fewer pediatricians to choose from. Beginning Sept. 1, HUSKY members will be phased in to one of the three plans offered under Charter Oak.

Sheldon Toubman, a New Haven legal aid lawyer who opposed merging HUSKY with Charter Oak, said only a small number of doctors who currently accept HUSKY patients have signed on to Charter Oak.

"We shouldn't address the problem of the uninsured on the backs of poor children," Toubman said

Steve Holland, an emergency room physician at St. Mary's Hospital in Waterbury, said that if the number of pediatricians doesn't increase under Charter Oak, children covered under HUSKY will end up in emergency rooms for care.

Contact Ann Marie Somma at asomma@courant.com.

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Olympia Business Watch

The Association of Washington Business blog reviewing the news and events shaping business and politics.

July 16, 2008

Massachusetts "Connector" Health Plan May Not Be Connecting----Be Careful Washington

Before Washington legislators leap head-on into adopting the Massachusetts "connector" state sponsor health care program, they need to do the math and connect all of the dots---VERY CAREFULLY.

Grace-Marie Turner, president of the Galen Institute, a health-care think-tank, is closely monitoring the Massachusetts model and raises some large red flags.

Here are some of her findings so far:

1. The majority of the newly covered are heavily subsidized by taxpayers. Of the 330,000 new enrollees, at least 232,000 are getting free or heavily subsidized coverage.
2. The plan is a strain on the state budget in Massachusetts. Gov. Deval Patrick (D) has asked for $869 million next year to fund the plan, but budget writers say the true costs are likely to be $1.1 billion. On top of that, the state is bracing for another 30,000-40,000 who have job based coverage now but could be added to the subsidy rolls as well.
3. Health insurance rates continue to rise. The state just approved a 12% rate increase for next year. That alone could drive more people to seek state subsidized coverage which, in turn, will have a snowballing impact on the state budget.
4. Some safety-net hospitals are threatened with bankruptcy because they are still treating large numbers of uninsured people. The problem is their compensation rates have been cut by the reforms.
5. The state is having a hard time convincing people who don't get the subsidy to buy insurance especially as rates go up. The government is even telling people what they can and cannot afford and threatens fines as much as $1,824 for a couple who don't buy the mandated insurance. For example, if your family income in Massachusetts is $70,001, the state says you can afford to spend $550 a month, or $6,600 a year, for health insurance. Try spending that much if a family has three or four children. Again, if you don't buy it or don't get a waiver, you fork over $1,824 in fines, which will increase next year.

Is the grand Massachusetts government scheme reducing the number of uninsured? Check our Grace-Marie's link for the answer.

AWB wants people to have affordable access to health care and insurance. That's why we, and other associations, negotiated an association health plan bill which overwhelmingly passed the legislature with bi-partisan support in 1995 and with the strong blessing of then Gov. Mike Lowry (D). They are working and covering over a half-million people in our state of which 40% could not afford health care before. They are part of what is working in Washington and target small businesses who employ around five people.

In surveying our members, we found that well over 9 in 10 private sector job-provides who belong to the Association of Washington Business want to continue to provide health coverage for the people who work for them. Health insurance and good benefits are keys to keeping good workers.

There is a role for government and a role for insurers in providing health care. Finding the proper balance is key. We need to build on what is working and fix what is not. Legislators need to look back and remember the massive

landslide set off by the last round of state directed universal reforms. That year was 1993 and there are lessons learned that should not be repeated.

Do the math and connect the dots. Grand schemes for universal care are complex and costly. They tend to collapse on their own weight. Just check out what is happening in California.

Don C. Brunell (DonB@awb.org)

Posted by Don Brunell on July 16, 2008 at 09:10 AM | Permalink

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Tarren Bragdon: Dirigo Health experimentwell-intentioned failure

By BDN Staff
Thursday, April 03, 2008 - Bangor Daily News

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Let's face it: Gov. John Baldacci's Dirigo Health plan, a state-funded program that was supposed to provide subsidized health coverage to some 128,000 Maine people without insurance, is a costly failure. After four years and nearly $164 million committed to this program, less than 4 percent of Maine's previously uninsured people have Dirigo coverage. An experiment that doesn't even reach 4 percent of its goal after four years is clearly a failure.

When that failed experiment promised health coverage to the uninsured people in Maine, it's much worse than a laboratory experiment or business venture that doesn't work out. After four years and lackluster enrollment, there are still some 122,000 Maine people without health coverage. For the most part, these uninsured are working people who do not qualify for Medicaid, do not have health insurance through their jobs, or are self-employed and cannot afford the incredible cost of individual health insurance plans in Maine.

When it started in 2003, Dirigo Health promised to cover all the uninsured people in Maine with a self-funding program by the current (2008-09) budget cycle. Instead, only an estimated 4,500 previously uninsured people have health coverage through this state program. With a total enrollment of only 14,400, seven in 10 of these subsidized policies cover people who already had insurance.

Dirigo Health has consumed $53 million in federal budget relief funds plus another $110.8 million in savings offset payment and Dirigo tax money — $163.8 million so far. Maine families and businesses have had their health insurance costs increased by $110.8 million over the last three years for the Dirigo Health experiment. This is a counterproductive way of attempting to legislate more "affordable" health insurance for Maine people.

Unbelievably, legislative Democrats want to increase tobacco taxes, including another 50 cents per pack on cigarettes for a cost of more than $28 million a year, to continue throwing good money after bad at the failed Dirigo experiment. Additional taxes include a 1.8 percent tax on health insurance claims paid, which will make health insurance plans more expensive. The taxes on Maine people are too high already and spending another $28 million a year to cover less than 4 percent of Maine's uninsured people is an indefensible waste of tax dollars and an irrational reason to raise taxes.

The insurance "reforms" in the latest Dirigo bill are costly, unproven and unlikely to have a significant impact on premiums for Maine's small businesses, sole proprietors, and individuals buying insurance outside their employer. This proposal attempts to subsidize Maine's poor insurance regulations with an uncertain reinsurance scheme while not fundamentally changing Maine's guaranteed issue regulation. Only four other states — Massachusetts, New York, New Jersey and Vermont — have guaranteed issue laws like Maine's, and that's for a reason.

The latest Dirigo bill is a fundamentally flawed bill seeking to fix a fundamentally flawed program. Dirigo Health should be ended, not mended. Maine's insurance laws should be reformed with proven patient-centered regulations shown to reduce costs, increase choices and expand competition.

We need to look no further than New Hampshire to see effective health insurance regulation. New Hampshire's premiums are a fraction of Maine's for those buying insurance outside their employer. New Hampshire's small businesses have a dozen different insurance companies to choose from while Maine has four.

"Dirigo," our state motto, means "I lead." This clearly provided motivation, and a great name, to the governor's desire to provide affordable health insurance to 128,000 people without coverage. Maine moved in a new direction to address this problem, but unfortunately, it was the wrong direction. It's time to lead again, and stop funding an expensive experiment that is moving into its fifth year without ever coming close to meeting any of its goals. Dirigo's time has passed. Dirigo should be Dirigone.

Tarren Bragdon is the CEO of The Maine Heritage Policy Center. His studies of Dirigo Health can be viewed at www.MainePolicy.org. He can be reached at tbragdon@MainePolicy.org.

Reader Comments

Submit your comments and photos (photos optional)

Ann of Boston, MA - 04/05/08
For years I have spent time in Maine every summer and have dears friends who live in Maine. I am a nurse in Boston and have followed both the Dirigo Plan and Dirigo Politics closely. I would like to comment on these statements of Mr. Bragdon's: Only four other states ? Massachusetts, New York, New Jersey and Vermont ? have guaranteed issue laws like Maine?s, and that?s for a reason. - Yes, the reason for this is that the good people of these states have at least partially prevailed over the greed and political influence of insurance companies and have passed laws that require insurance companies to sell their product to people who will pay the going price. Denying a person the ability to buy insurance b/c they have been sick in the past should be illegal - thankfully a few civilized states recognize this and have guaranteed issue laws. Kudos to these states! -- The latest Dirigo bill is a fundamentally flawed bill seeking to fix a fundamentally flawed program. ... Maine?s insurance laws should be reformed with proven patient-centered regulations Absolutely! And state administered social insurance with streamlined single payer financing is clearly the optimal reform if the goals are to achieve the most cost-savings and to establish guaranteed coverage in an equitable manner so that all Mainers have health security into the future. Maine People's Alliance is doing great work on this and on other health care reform legislation and they could use your help. Learn more and get involved at http://www.mainepeoplesalliance.org/healthcare/healthcare_legislation.html

Health care is for people not for profits!□

Vernon of Bangor, Maine - 04/04/08
Maine Citizen of Somewhere, ME Top notch thinking on the taxable income angle sir. I hadnt considered that. As I figure my own reduction of taxable income over the last 10 years from excessive premiums the state of Maine has lost about $900 of tax revenue from me alone in 2007 compared to premium rates in other states. When you figure a couple hundred thousand folks in similar tax situations you can estimate the state has lost about $100 million dollars in tax revenue because of higher premiums at a conservative estimate.... The telling tale about Dirigo is simply when the people who a program was designed for reject it wholesale as unworkable for them... Its time to close the book on it.

Maine Citizen of Somewhere, ME - 04/03/08
It probably does not help the numbers when people who have insurance offered by their employer but do not see the point in paying the increasing premiums anymore for less coverage and have dropped coverage all together.

Also, as the costs of insurance premiums go up to compensate for the costs in this state less income can be taxed by the state and federal government. Since those costs are tax deductible, the state and federal government are losing money to budget, more people make less money, and more people may be closer to qualifying for services or qualify for services.

Kurt of Bangor, ME - 04/03/08
and all of God's people said AMEN!...

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Friday, December 24, 1999

Editor's Notebook

TennCare's troubling history

Nashville Business Journal - by Bill Lewis

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If good intentions were dollars, TennCare would be turning a profit instead of failing in its financial and moral responsibilities to the people of Tennessee.

After all, TennCare provides access to health care for the weakest and most vulnerable Tennesseans. It insures 850,000 people who are classified by the federal government as poor and therefore unable to provide health care for themselves and their families. Another 500,000 recipients of TennCare benefits are supposedly unable to buy insurance in the open market, so they buy it through TennCare.

TennCare replaced Tennessee's Medicaid program in 1994 with the promise of bringing free-market, managed care discipline to that runaway government program. Tennessee's business community, nervous about higher taxes to feed Medicaid, was happy. Advocates for the poor were happy, particularly since TennCare opened the door to universal health insurance. Members of the Legislature were happy because TennCare shifted millions of dollars of expenses to the federal government.

The only people not happy were doctors and hospital administrators, since they believed, correctly, that they were being grossly underpaid. Since they were accused of enriching themselves on the misery of the sick and at the expense of taxpayers, no one cared.

With one-quarter of Tennessee's population on its rolls, and with that kind of broad support, it seemed TennCare could not fail.

But it did.

The largest TennCare insurer, Blue Cross Blue Shield of Tennessee, says it will leave the program at the end of June. The company is losing money on TennCare, and so many doctors and hospitals are leaving the program that Blue Cross might not have a network of providers.

That would be the end of TennCare. The Chattanooga-based not-for-profit insures 645,000 TennCare beneficiaries. Other TennCare managed care organizations have suffered financial difficulty or left the program, as well.

Blue Cross' announcement was an especially damning vote of no-confidence, especially when you remember that Blue Cross had a seat at the table when TennCare was created behind closed doors under Gov. Ned McWherter.

Six years later, there's plenty of blame to go around for TennCare's failure.

Let's start with the idea behind the program. It saved money for the state by shifting costs to the federal government. That's a notion only a bureaucrat could love, since all of the government's money comes from one place -- taxpayers. In any case, that cost shift was only temporary. Each year, the state has to pay for a greater share. Now TennCare has become an IOU signed by every taxpayer in Tennessee.

Next, blame any business that does not provide health insurance and encourages employees to sign up for TennCare.

Blame insurance companies for declaring individuals with pre-existing conditions to be "uninsurable" and shifting them into TennCare. Insurance is supposed to share risk, not

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Blame any TennCare managed care organization that paid its bills slowly, or not at all, and was unresponsive to the scared, sick and poor people it insured.

Then blame the entitlement industry that has grown up around TennCare like weeds choking a garden. These strident advocates believe they have the right to reach into our pockets and take as much money as they need to turn TennCare into what they want it to be -- universal insurance -- instead of what it is supposed to be -- a safety net.

All of this leads us to the final bit of blame -- the administration of Gov. Don Sundquist. His administration has been more interested in covering up TennCare's problems than in solving them. That's why we taxpayers paid to insure thousands of dead people. Administration officials say they may have wasted millions of dollars by not properly auditing TennCare. But they aren't sure, so it isn't fair to criticize them.

Just be quiet and pay the income tax that will probably be proposed, again, in January. The administration has decided it's easier to raise taxes than to fix TennCare.

Reach Lewis, editor of Nashville Business Journal, at blewis@amcity.com or 615-248-2222, ext. 139.

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Health Insurance Coverage of the Total Population, states (2005-2006), U.S. (2006)

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Rank by: Uninsured View by: # | %

Rank Order:

Rank		Employer	Individual	Medicaid	Medicare	Other Public	Uninsured	Total
	United States	53.5%	4.9%	12.8%	11.8%	1.0%	15.9%	100.0%
1	Minnesota	61.2%	6.9%	10.5%	12.3%	0.6%	8.6%	100.0%
2	Hawaii	60.4%	3.9%	10.4%	12.9%	3.5%	8.9%	100.0%
3	Wisconsin	60.5%	5.2%	11.8%	12.5%	0.9%	9.1%	100.0%
4	Iowa	59.2%	6.0%	12.5%	12.3%	0.5%	9.4%	100.0%
5	Maine	52.8%	4.6%	18.7%	12.7%	1.5%	9.8%	100.0%
6	Massachusetts	59.9%	4.3%	13.4%	12.2%	0.3%	9.8%	100.0%
7	Pennsylvania	58.3%	5.6%	11.6%	14.5%	0.2%	9.9%	100.0%
8	Rhode Island	56.1%	3.8%	19.1%	9.9%	1.0%	10.1%	100.0%
9	Connecticut	61.3%	3.9%	10.6%	13.3%	0.7%	10.2%	100.0%
10	Michigan	59.2%	3.9%	13.4%	12.7%	0.4%	10.4%	100.0%
11	New Hampshire	64.5%	4.5%	6.3%	13.5%	0.6%	10.6%	100.0%
12	Ohio	58.7%	3.9%	13.2%	12.6%	0.8%	10.7%	100.0%
13	Vermont	53.6%	4.0%	19.2%	11.6%	0.7%	10.9%	100.0%
14	Nebraska	58.5%	7.5%	9.4%	11.6%	1.5%	11.4%	100.0%
15	Kansas	57.1%	6.5%	11.0%	13.0%	1.0%	11.4%	100.0%
16	North Dakota	56.5%	9.3%	8.2%	13.2%	1.2%	11.7%	100.0%
17	South Dakota	52.7%	8.8%	10.6%	14.1%	2.1%	11.8%	100.0%
18	Delaware	59.5%	2.8%	10.2%	14.1%	1.1%	12.2%	100.0%
19	District of Columbia	50.3%	5.6%	21.2%	9.9%	0.5%	12.4%	100.0%
20	Missouri	54.9%	5.9%	12.3%	13.5%	0.8%	12.5%	100.0%
21	Washington	57.4%	5.1%	11.3%	11.4%	2.2%	12.6%	100.0%
22	Indiana	60.4%	4.3%	10.9%	11.4%	0.3%	12.7%	100.0%
23	Virginia	60.9%	3.6%	7.5%	11.3%	3.4%	13.2%	100.0%
24	New York	52.3%	4.0%	18.4%	11.5%	0.3%	13.5%	100.0%
25	Tennessee	50.6%	4.9%	15.2%	13.5%	2.1%	13.7%	100.0%
26	Maryland	61.1%	3.8%	8.9%	11.5%	1.0%	13.7%	100.0%
27	Illinois	59.1%	4.2%	10.9%	11.5%	0.4%	13.9%	100.0%
28	Kentucky	54.3%	3.6%	14.5%	12.7%	0.9%	14.0%	100.0%
29	Wyoming	53.7%	6.8%	9.8%	13.1%	1.9%	14.7%	100.0%
30	Alabama	52.7%	3.5%	14.7%	13.1%	1.1%	14.9%	100.0%
31	New Jersey	62.5%	2.9%	7.6%	11.7%	0.3%	15.0%	100.0%
32	Idaho	54.4%	6.1%	12.0%	11.5%	0.9%	15.1%	100.0%
33	West Virginia	50.0%	1.7%	15.8%	16.1%	1.2%	15.2%	100.0%

34	Montana	48.1%	8.3%	11.0%	13.8%	2.3%	16.5%	100.0%
35	South Carolina	51.2%	3.9%	14.1%	12.7%	1.6%	16.6%	100.0%
36	North Carolina	51.3%	5.0%	13.3%	12.3%	1.4%	16.7%	100.0%
37	Oregon	52.6%	5.6%	11.7%	12.3%	1.0%	16.8%	100.0%
38	Utah	57.4%	6.4%	10.0%	8.3%	0.9%	17.0%	100.0%
39	Colorado	56.8%	7.1%	8.2%	8.8%	2.1%	17.0%	100.0%
40	Alaska	52.8%	3.8%	14.4%	6.4%	5.4%	17.2%	100.0%
41	Georgia	53.8%	3.9%	12.8%	9.3%	2.1%	18.1%	100.0%
42	Arkansas	46.4%	5.2%	14.7%	13.6%	1.9%	18.2%	100.0%
43	Nevada	56.1%	4.4%	7.1%	12.5%	1.5%	18.4%	100.0%
44	Oklahoma	48.2%	4.1%	13.2%	13.6%	2.3%	18.6%	100.0%
45	California	48.5%	6.9%	15.9%	9.0%	0.9%	18.8%	100.0%
46	Mississippi	45.3%	4.4%	19.0%	11.2%	1.1%	18.9%	100.0%
47	Louisiana	46.6%	5.2%	14.6%	13.3%	0.5%	19.9%	100.0%
48	Arizona	47.0%	3.9%	16.2%	11.5%	1.1%	20.3%	100.0%
49	Florida	46.9%	5.2%	10.1%	15.5%	1.5%	20.8%	100.0%
50	New Mexico	43.2%	4.0%	16.5%	12.9%	1.6%	21.7%	100.0%
51	Texas	47.5%	4.4%	12.2%	10.5%	1.2%	24.2%	100.0%

Notes: Percentages may not sum to 100% due to rounding effects.
For current Medicaid and Medicare enrollment figures, please refer to the Medicaid & SCHIP and "Medicare" sections, respectively, which report enrollment data from the Centers for Medicare and Medicaid Services (CMS).
Dual eligibles are included under Medicaid.
For more details, see "Notes to Topics Based on the Current Population Survey (CPS)" at http://www.statehealthfacts.kff.org/methodology.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements).