Rhode Island Can Afford Health Care for All

Covering Everyone Comprehensively Without Spending More

A Report to the Rhode Island General Assembly

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For the full report, see the Health Reform Program's U.S. Health Reform page at
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SUMMARY

All people concerned about health care in Rhode Island will increasingly have to choose among three things—greater human suffering, soaring spending, and reform. The choice is clear to some but not to others.

Proposals that are politically attractive today are not likely to do much to expand coverage, protect quality, or contain cost. The proposals that would probably work are politically unattractive today. They might look more attractive in a few years, if Rhode Island plunged into a massive medical meltdown, with more hospitals closing, more people losing insurance, and more massive premium increases.

But that would be too late. A time of crisis is the worst time to fix health care. There would be less money, greater problems, and mounting demands to act precipitously. It's easy to make massive mistakes under those conditions. Because it is vital to dig the well before people are thirsty, now is the time for Rhode Island to examine and test the full range of reasonable reform ideas.

This report finds that complete, comprehensive health care for all Rhode Islanders is already affordable. The money is available already, with current Rhode Island health care spending 21.5 percent above the national average, fourth-highest among the states; with per person U.S. health spending itself more than double the Western European average; and with those nations covering all citizens well.

But instead of taking that for granted, this report estimates the cost of insuring all uninsured Rhode Island residents and workers, and of making coverage comprehensive for all, and also estimates the savings achievable with consolidated financing and streamlined delivery. We find that cutting administrative waste, cutting drug prices, preventing some medical problems, and other efficiencies would save enough money to finance full benefits for all the people of Rhode Island.

Failure to win these efficiencies would force Rhode Islanders to make unaffordable and harmful choices between more money for business as usual (without better coverage); expensive efforts to cover more people with small incremental and inefficient programs; and efforts to cut health costs by cutting coverage or asking families to pay more.

Consolidated financing is essential to cutting administrative costs—which is essential to financing comprehensive health care for all. Financing can be consolidated either using the simple single payer approach (in which private insurance simply ends, out-of-pocket payments are virtually eliminated, and taxes are raised to replace the lost revenue), or by pooling all current revenues in one reservoir, which allows the same administrative savings as single payer but requires much smaller tax increases.

But consolidated financing is not enough by itself to ensure affordable medical security for years ahead, as the population ages and costly medical advances are made. For the future, affordable high-quality health care for all Rhode Islanders requires spending

the state's vast but finite health dollars as carefully as possible. Doctors, hospitals, and other caregivers must be paid in financially neutral ways that encourage, liberate, and require them to spend money carefully. "Professionalism within a budget" can help balance the books, getting as much health care as possible to the people who need it.

We find that Rhode Island can provide health care for all of its people and save money—approximately $270 million if reforms had been enacted this year.

The apparent alternatives are not feasible. Financing the same benefits incrementally, without reform, would have cost about $1.0 billion more this year—14 percent more than current spending, and fully 18 percent more than needed for comprehensive, universal care with reform. Waiting for federal action is dangerous and unnecessary. For the years 2002 through 2007, we project these levels of health care spending for Rhode Island residents and workers under various alternative paths:

1. No reform—business as usual	$54,643 million
2. No reform—coverage for all	$62,154
3. Consolidate financing	$50,229
4. Consolidation + professionalism within budget	$47,764

In the approach to universal coverage examined here:

- Caregivers and patients make decisions without bureaucratic interference.
- Trustworthy methods of paying caregivers enhance quality of care.
- Patient cost-sharing would not be required for most services.
- Caregivers gain secure budgets; employers avoid continued premium increases.

The context for reform: Rhode Island health care is in crisis, with high costs and still higher premiums expected; with many people unable to afford the care they need; and with many caregivers facing financial distress despite the high spending. Managed care, price competition, and hospital closings have failed to save money.

Our main findings:

1. Spending less: Rhode Island could provide all necessary care to all its people this year while saving approximately $270 million, or 3.6 percent of current health spending.

2. Covering everyone: Universal, comprehensive care reforms would cover everyone in Rhode Island, providing medical security to people now under-insured and uninsured.

3. More care for less money: Universal health care with streamlined administration, means more care without more cost, with more of each health care dollar used for actual care. Funds for actual physician care alone would rise an estimated 24 percent.

4. Added costs of coverage: The biggest added costs and biggest volume of added services would be filling gaps in coverage for people who are now partly insured. Of $1.03 billion in added costs in 2002, $818 million would go to ending uncovered benefits and patient cost-sharing. These projections allow for use of dental care, for example, to rise 65 percent, and home care use, 17 percent, as a result of ending under-insurance.

5. Administrative savings: Covering everyone in one plan wins large administrative savings—about $750 million, or over one-tenth of total health spending. So that sum can finance care, not paperwork. Over half these savings reflect reduced claims processing and related burdens for caregivers, freeing up their time for patient needs.

6. Ending patient cost-sharing would eliminate about three-quarters of out-of-pocket spending for Rhode Island health care. This "sick tax" deters use of needed care, fails to truly cut costs, often shifts costs to caregivers, and boosts administrative costs.

7. Clinical and other savings: Conservatively, reforms will win an additional $528 million more in non-administrative savings—mainly through more appropriate use of hospital and physician care, bulk purchasing or negotiated price cuts for prescription drugs and medical equipment, and capital budgets.

8. Quality will be enhanced: Covering everyone and ending today's financial pressures on caregivers to do less will protect quality of care, restoring trust.

9. Incrementalism is unaffordable: Incremental coverage improvements are better than none but inevitably cost more. This path to universal, comprehensive coverage would be unaffordable, requiring health spending of at least $8.5 billion in 2002.

10. Benefiting all Rhode Island residents and workers: Insuring the uninsured is one vital gain from such reforms, but many aspects would benefit all the state's people.

11. Delay is dangerous: Rhode Island cannot afford to wait for Congressional action. Nor can the state afford to wait for a deeper crisis. Beginning to plan now for such reforms is essential to avoid great harm to patients, to the trustworthiness of care, and to hospitals, physicians, nursing homes, and other valued health care resources.

Health care for all is affordable, and achieving it can be a win for all parties because current spending is already enough. Rhode Island can have health care security, health care freedom, and lower costs.

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INTRODUCTION

This report finds that complete, comprehensive health care for all Rhode Islanders is already affordable.

- Complete care means coverage for people who lack insurance coverage today.

- Comprehensive care means thorough insurance for prescription drugs, dental care, and other services that are omitted from many insurance policies today.

Why is complete and comprehensive health care for all Rhode Islanders affordable today? For two main reasons:

1. The money is already available. Current health care spending in Rhode Island is fourth highest among the states, 21.5 percent above the U.S. average. And U.S. average spending per person is itself more than double the western European average. Those nations cover all citizens and enjoy better health outcomes than do Americans.

2. Cutting administrative waste, cutting drug prices, acting to prevent some medical problems, and other efficiencies would save enough money to finance full coverage for people who are now uninsured or inadequately insured.

This report finds that failure to win these efficiencies would force Rhode Islanders to make unaffordable and harmful choices. These choices include:

- more money for business as usual (without improving coverage),
- expensive efforts to cover more people with small incremental and inefficient programs, and
- efforts to cut health costs by cutting insurance coverage or asking families to pay more.

This report estimates the costs of universal health care in Rhode Island and contrasts those costs with a continuation of the current system. It shows that universal health care for the people of Rhode Island is affordable if certain reforms are made. It offers alarming new evidence that

- ever-higher spending for business as usual in Rhode Island health care is not sustainable for people who pay for it or for people who use it, and that

- business-as-usual is cheating the state's people by wasting huge sums on the private sector's payment bureaucracy at the expense of the care that all Rhode Islanders need.

Consolidated financing is essential to cutting administrative costs. (And cutting those administrative costs is essential to financing comprehensive health care for all.) Financing can be consolidated in one of two ways.

- The first is the simple single payer approach. Here, private insurance simply ends, out-of-pocket payments are virtually eliminated, and taxes are raised to replace the lost revenue. This means big very tax increases. Even though those savings result in a $270 million savings statewide, most people understandably would focus on the higher income, sales, or other taxes they must pay. That's because they would be less aware of the still larger drop in private insurance premiums—because many people wrongly imagine that their private health insurance is provided at no cost to them, essentially a gift from their employer.

- The second approach is to pool all revenues and pay for care from one reservoir. That allows the same administrative savings as single payer but requires much smaller tax increases. This has the advantage of capturing dollars now paid through private health insurance by employers and employees. Today's private insurance payments are frozen in today's dollars. Checks are written to a new health care trust fund, not to private insurers. Increased health costs in future years are covered by public spending. This means much smaller tax increases.[1]

Consolidated financing is essential to financing comprehensive health care for all Rhode Islanders today. Looking ahead, though, it is not enough—by itself—to ensure affordable medical security for years ahead.

That is because health care costs continue to increase as the population ages and as costly new medical advances are made—advances like expensive new drugs, surgical treatments, and transplants.

But what good are these medical advances if Rhode Islanders can't afford them? Rhode Islanders deserve medical security. This first requires deciding what "medical security" really means. It then requires making sure that the state shapes health care—both delivery and financing—to reach this goal. If one doesn't deliberately plan to succeed, one is surely planning to fail.

Ultimately, no state or nation can ever spend enough to win immortality for its citizens. Immortality is not the goal. Rather, the goal should be something like this:

- All Rhode Islanders should be able to get the health care they need—high-quality health care that works—without having to worry about whether they can afford it.

Health care spending in the United States is vast. In the year 2000, health spending in the U.S.A. was more than four times as great as was spending on national defense. And spending in Rhode Island was 21.5 percent above the U.S. average, as noted earlier.

Looking ahead, it is clear that reaching the goal of affordable high-quality health care for all Rhode Islanders requires using the state's vast—but still finite—health care spending as carefully as possible. This, in turn, requires going far beyond the simple but vital step of consolidating financing and thereby cutting administrative waste.

It requires that doctors, hospitals, and other caregivers be paid in financially neutral ways—in ways that encourage, liberate, and require them to spend money as carefully as possible. This means, certainly, that all needed caregivers be paid enough money to allow them to remain in business in Rhode Island—enough money, that is, if they operate efficiently.

It requires, further, that doctors—who make the key decisions about how the great bulk of health care dollars are spent—are particularly empowered to spend money carefully. This should begin by recognizing that doctors traditionally get about one-fifth of the health care dollar. They should be assured this money, to be divided up among them in reasonable proportion to competence, kindness, effort, and other factors.

But doctors also should be encouraged, liberated, and required to allocate the great bulk of the remaining 80 percent of the money (excepting only dollars needed by dentists, public health agencies, researchers, and other independent actors) to provide the care that all Rhode Islanders need. Doctors would have to spend all of that money on their patients, and could not spend more. They could not personally benefit by economizing on care. This approach encourages patients and payers to trust doctors' decisions.

This overall approach has been called "professionalism within a budget." [2] It is one sensible way to balance the books in health care. If a physician does not provide a certain service to a certain patient, the aim would not be to enrich a physician or a for-profit HMO. Rather, the only reason for denying a service would be to make that service available to another patient who needed it more.

This is nothing more than spending money carefully—getting as much health care as possible to the people who need it. This is nothing more than recognizing that all Rhode Islanders need health care but that dollars are always going to be limited. This is nothing more than a way to build trust in Rhode Island health care that offers durably affordable medical security to all residents.

We offer this report in the hope that it will help the public and policy-makers to grapple with the complexity of Rhode Island's health care system, and to identify the benefits of universal access to comprehensive care with simplified administration.

FINDINGS

Rhode Island can provide health care for all its people—and save money.

In the approach to universal coverage examined here:

- Coverage would be comprehensive and secure.
- Patients and payers get a better deal, more care for less money.
- Most of the added care provided would aid people who are now partly insured.
- Cutting administrative waste frees 10% of health dollars to pay for more care.
- Reforms in financing and delivery of care would win other substantial savings.
- About three-quarters of patients' out-of-pocket costs would be eliminated.
- Caregivers and patients make decisions without bureaucratic interference.
- Trustworthy methods of paying caregivers enhance quality of care.
- Caregivers gain secure budgets; employers avoid continued premium increases.
- Replacing most out-of-pocket costs with public funds permits administrative savings.

Reforms this year would have permitted cutting spending on the financial administration of Rhode Island health care by roughly half, or over $750 million. Substantial additional savings are available through other reforms—particularly on prices of drugs and medical equipment, and through clinical efficiencies. As a result, large additional sums could have been devoted to actual care in 2002, to provide comprehensive and complete health coverage to all Rhode Islanders—while saving approximately $270 million, or about 3.6 percent of current spending.

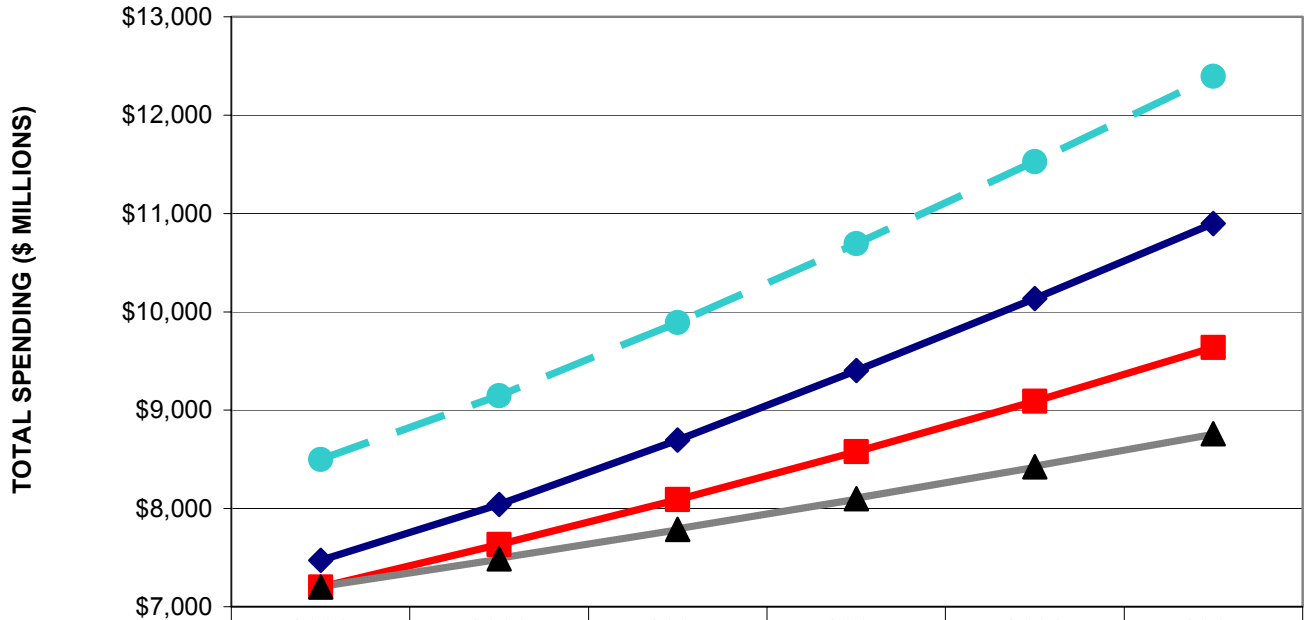
The apparent alternatives are not feasible:

- Incremental strategies simply increase spending and fail to find administrative, clinical, and other savings.

- As shown in Exhibit 1, on the following page, financing the same comprehensive benefits for all incrementally—simply buying all Rhode Island residents and workers comprehensive coverage in today's system without reform—would have cost about $1.0 billion more this year. That is 14 percent more than current spending, and fully 18 percent more than the cost of comprehensive universal coverage with financing and delivery reforms.

- Waiting for federal action is dangerous and unnecessary. Rhode Island can afford coverage for all. The time to start planning is now.

Exhibit 1
PROJECTED RHODE ISLAND HEALTH COSTS, WITH AND WITHOUT REFORM, 2002 - 2007, $ Millions



	2002	2003	2004	2005	2006	2007
NO REFORM	$7,472	$8,041	$8,697	$9,401	$10,135	$10,898
CONSOLIDATE FINANCING	$7,201	$7,633	$8,091	$8,577	$9,091	$9,637
ADD PROFESSIONALISM WITHIN A BUDGET	$7,201	$7,489	$7,789	$8,100	$8,424	$8,761
INCREMENTAL ACCESS BUT NO REFORM	$8,499	9,146	9,892	10,693	11,528	12,396

To summarize:

The costs of health care in Rhode Island under the four alternatives are dramatically different. These are the total costs from 2002 through 2007 (six years):

1. No reform—business as usual	$54,643 million
2. No reform—coverage for all	$62,154
3. Consolidate financing	$50,229
4. Consolidation + professionalism within budget	$47,764

1. Option 1, no reform with business as usual, would mean higher costs simply for services currently available, with no improvement in which services are covered or how many people have insurance. These projections assume that Rhode Island health care spending increases are in line with those projected nationally by experts at the Office of the Actuary, Centers for Medicare and Medicaid Services.[3]

2. Option 2, no reform but coverage for all, reflects our estimates of the costs of comprehensive care for all Rhode Islanders, without reform in financing or delivery of care. Costs rise at the same rate as in option 1, but start from 2002 costs that include the $1,027 million estimated cost of covering all Rhode Islanders with comprehensive care, without cost savings from consolidated financing.

3. Option 3 would consolidate financing and win some savings through lower drug prices, reducing duplication of services, and avoiding some care needs through prevention. It reflects 2002 costs of comprehensive care for all Rhode Islanders and savings won through consolidated financing, reduced drug prices, prevention of problems through adequate primary care, and other steps. Costs are projected to rise at 6 percent annually, slightly below the rate used in options 1 and 2.

4. Option 4 would build on the savings from consolidation of financing and other steps in option 3. Its aim would be to squeeze out clinical waste through various reforms in the organization and delivery of health care. This expectation rests on the very common research finding that a very large share of current health care spending and services are unnecessary—for example, that perhaps "one-fourth of hospital days, one-fourth of procedures, and two-fifths of medications could be done without." [4]

Option 4 would provide for an overall health care budget and ask doctors to make the decisions that would spend the available dollars as carefully as possible. In option 4, costs are projected to rise at 4 percent annually, still well above overall inflation, which is projected to rise at roughly 2.5 percent annually, but below the 6 percent annual increase assumed in option 3. Professionalism within a budget, described earlier, is expected to result in this level of economies.

The context—Rhode Island health care is in crisis.

- Rhode Island's health costs are fourth highest in the nation, 21.5 percent above the national average per person.

- Despite this high spending, many people are unable to afford the care they need—such as prescription drugs, home care, dental care, and more. Many people are also at risk because of managed care's financial incentives to provide fewer services. Still others are at risk because of HMOs' unstable relations with hospitals and doctors.

- Although spending was already high, HMO premiums nationally have risen by 12 to 15 percent or more annually in recent years. Some employers and patients have suffered far bigger increases. Substantial further increases are expected for 2003.

- Despite high spending, many caregivers—hospitals, nursing homes, and home health agencies—face financial distress.

- Despite high spending, HMOs have also faced financial stress in the past few years.

- Despite high spending, less money goes to actual care than many people realize. We estimate that about one-fifth of each Rhode Island health care dollar today goes to administration.

- The private health insurance market has failed to make insurance affordable. Only the past decade's substantial expansions of government programs and extraordinary economic boom prevented the number of uninsured people in the state from soaring.

One response to Rhode Island's health problems would be to boost spending on health care. But this will also boost financial burdens on all who live, work, and do business in the state. More money for business as usual is not affordable.

Our analyses indicate that, while managed care, price competition, and hospital closings have failed to save money, alternative methods of cutting administrative and clinical waste are likely to succeed.

Critics of reform have failed to put forward proposals to contain costs, protect quality, and enhance coverage. Some of these critics instead seem to lean toward advocating more money for business as usual.

We predict that those who advocate more money for business as usual and who reject reform will lead Rhode Island medicine toward medical meltdown. That will mean more hospitals closing, more people without insurance, and more employers bailing out of offering health coverage in favor of making only defined contributions toward health benefits. And it will mean more instability, more insecurity, more distrust in Rhode Island health care.

It now seems clear that the cost control tools of recent years—managed care, price competition, and hospital closings—have not worked remotely as well as their proponents claimed. For these and other reasons, Rhode Island has some of the world's most expensive health care, with many caregivers facing financial distress, and with growing concern that quality is suffering.

Spending on health care in Rhode Island is already enough to finance and deliver the care that works for all the people who need it, we conclude. So ever-higher spending is not the answer.

The challenge is to make health care for all durably affordable, while protecting quality of care and the doctors, hospitals, and other caregivers whose efforts ensure quality.

Meeting this challenge requires well-designed and carefully implemented public action. Given the impossibility of anything approaching genuine free market competition in health care, the only alternative to careful government action is medical anarchy.

The evidence points to a recent and striking government success in Rhode Island health care. Public program expansions have helped to substantially reduce the number of people without insurance. Market competition, by contrast, has failed to contain costs or to protect needed hospitals, nursing homes, home health agencies, physicians, and other caregivers.

This report's analyses of Rhode Island health care indicate that public action can attain durably affordable and high-quality health care for all without increasing spending. These are our main findings:

1. *Spending less: Rhode Island can afford to provide all necessary care to all its people while spending less.*

- Pooling, re-channeling, and better use of existing spending would have permitted saving an estimated $270 million from the approximately $7.2 billion in total payments for Rhode Island health care in 2002, even while covering everyone comprehensively.

- The savings winnable with reform would likely be even higher in future years, as Exhibit 1 (above) shows, because health costs are rising sharply without reform. But with reform, Rhode Island payors can avoid the expected rise in premiums. For the six years from 2002 through 2007, we project Rhode Island health costs at $54.6 billion without reform, and $47.8 billion with the reforms modeled here.

- Today's strategies of managed care, price competition, and moving care out of hospitals are not containing costs, even though Rhode Island is near the top among states in the share of its people in HMOs, and even though the number of hospital beds per thousand citizens is well below the national average (2.3 per thousand

residents as compared with 2.9 per thousand nationally, in 2000).[5] All who pay for care in the state face big cost increases.

- Comprehensive coverage for all without health care financing and delivery reforms would require far higher spending in Rhode Island, totaling an estimated $8.5 billion for 2002. That is 14 percent above current spending—and 18 percent above the spending level needed with reforms to win administrative, clinical, and other savings.

Table 1
Impact of Different Reform Strategies on
Cost of Rhode Island Health Care

In 2002, for Rhode Island residents and workers:	
Baseline cost of current health care system and policies	$7.47 billion
Cost of care with universal, comprehensive coverage under current financing and care delivery policies	$8.50 billion
Cost of care with universal, comprehensive coverage, with financing and care delivery reforms	**$7.20 billion**

2. ***Covering everyone: Universal, comprehensive care reforms would cover everyone in Rhode Island—guaranteeing all-inclusive care, to aid today's under-insured and uninsured people. This will give all of Rhode Island's people medical security.***

- Rhode Island can act from both compassion and competence in covering all of the state's people comprehensively and affordably.

- Most citizens of Rhode Island are under-insured today because they are unprotected against costs of long-term care and often other vital care as well. Many seniors, who are deemed "insured" because they have Medicare, in fact face huge financial barriers to obtaining needed care, including prescription drugs.

- Many are in managed care plans that give financial incentives to provide less care.

- People will feel secure with guaranteed coverage. It will reduce stress, bankruptcies, job lock, and fear of job loss.

3. More care for less money: Universal, comprehensive health care, with streamlined administration, means more care without more cost, with more of each health care dollar actually going for care.

- Because health care dollars can be shifted from paper-processing to actual care, reform will permit the people of Rhode Island to receive substantial additional services while still saving money. Each health care dollar will go farther. A substantial portion of spending within physicians' offices, for example, could be reallocated from billing staff to nursing assistants or other clinical personnel.

- The real (marginal) cost of serving added people is less than today's average, since caregivers can accommodate them without huge new fixed costs.

- With comprehensive coverage, we project substantially higher use of physician care, prescription drugs, dental care, home care, and other health services.

- Funds for actual physician care alone would rise an estimated 24 percent, for example, and funds for actual dental care are projected to rise approximately 60 percent.

- Payors, caregivers, and patients would each be getting a better deal than today.

4. Added costs of coverage: The biggest added costs and biggest volume of added services would go to fill the gaps in coverage for people who are already partly insured.

- To be conservative, we use an estimate that 8 percent of Rhode Island residents are uninsured in 2002, slightly above the latest Census Bureau estimate, from 2001. Recent job losses and premium increases likely mean a rise in the number of people without coverage or with inadequate coverage.

- The added costs of universal access to comprehensive benefits include an estimated $128 million to cover all uninsured residents and workers, bringing per person spending on uninsured Rhode Islanders up to the level of people who are insured. We use an estimate that current health spending for the average uninsured person is 41.8 percent of spending on those who are privately insured.[6] Another way to look at this is that the $128 million figure reflects a rise in the health care resources used for uninsured individuals, on average, to 2.4 times their current level.

- But a far larger cost of reform goes to addressing the needs of the great majority of Rhode Island residents and workers whose coverage leaves gaps in access to care. About $818 million—over six times the sum needed to insure the uninsured— would go to eliminate under-insurance. This would provide comprehensive benefits to all with no patient cost-sharing for most services.

- The $1.03 billion in total added costs for expanding coverage would be more than offset by the savings available in a universal system with simplified administration.

- Ending under-insurance—eliminating patient cost-sharing and uncovered benefits—is projected to raise use of physicians' and other professionals' services by 17 percent[7] (some of which is offset by changes in practice patterns, as noted later). We estimate separately that comprehensive coverage would raise use of dental care by fully 65 percent, addressing enormous unmet need.

Table 2

PROJECTED 2002 R.I. HEALTH CARE COSTS, WITHOUT AND WITH REFORM	**($ billions)**
∗ BASELINE: 2002 cost of care for Rhode Island beneficiaries (residents plus workers from out of state), without major reform or policy changes	**$7.47**
With reform: • with comprehensive coverage for all, • without insurance companies, • without patient cost-sharing, • with reforms in financing and delivery of health care	
ADDED COSTS: $1.03 billion in new costs with reform	
Bring uninsured to average service use rates for people without public coverage	+ $ 0.13
Added service use for all when fill gaps in benefits and end patient cost-sharing	+ $ 0.82
Better care coordination, services for people with disabilities, and data collection	+ $ 0.08
Total of added costs	+ $ 1.03
Total cost for adding full coverage for all, without reforms to achieve savings	$8.51
SUBTRACTED SAVINGS: $1.31 billion in new savings with reform	
Savings in administration of coverage	- $ 0.31
Savings in caregiver administration	- $ 0.45
More appropriate use of hospital and physician care	- $ 0.21
Negotiating prescription drug and medical equipment prices	- $ 0.27
Budgeting construction and equipment, and other savings	- $ 0.06
Total of subtracted savings	- $ 1.31
∗ Total cost of care for Rhode Island beneficiaries after reform	**$7.20**
Change from baseline without reform (- 3.6%)	**- $ 0.27**

(Note: Numbers may not add exactly to totals because of rounding.)

Table 3

Change in Spending in Major Health Sectors with a Universal, Comprehensive Health Care Delivery System, and with Simplified Administration

Major areas of expenditure (health sector)	Estimated 2002 expenditures if no reform for Rhode Island residents ($ billion)	Estimated 2002 expenditures with universal access and simplified administration for RI residents and workers ($ billion)	Percent change *
Areas of rising expenditure			
Prescription Drugs and Medical Non-Durables	$0.92	$0.98	6.3%
Physician and Other Professional Services	$1.57	$1.70	8.1%
Other Personal Health Care	$0.57	$0.63	10.5%
Home Health Care and new care for people with disabilities[8]	$0.17	$0.25	46.7%
Dental Services	$0.31	$0.49	54.5%
Areas of declining expenditure			
Hospital Care	$2.17	$1.87	** -14.0%
Program Admin. and Net Cost of Private Health Insurance ***	$0.47	$0.21	-55.3%
OTHER: Areas of stable expenditure			
Nursing Home Care	$0.59	$0.61	
Vision Products and Durable Equipment	$0.05	$0.07	
Research	$0.14	$0.15	
Government Public Health Activities	$0.26	$0.27	
Care of non-resident workers/dependents	$0.26		
TOTAL	$7.47	$7.20	-3.6%

Notes:

* In data on type of care, population served before reform is Rhode Island residents only; after reform, data on type of care include service to non-resident workers in Rhode Island and their dependents. In "Before" column, the $0.26 billion for their care is only in "Total."

** Savings on hospital administration are $0.27 billion, as shown in Table 4, so hospitals can provide essentially the same level of services despite the drop in total hospital spending.

*** This includes the cost of administering private and public coverage, and insurors' profits.

- Medicare does not cover long-term care. As a result, most Americans are underinsured for long term care, but long term care use rates in Rhode Island are already far above the U.S. average. These projections allow for home care use to rise substantially—17.4 percent—even though its use in Rhode Island is already well above the U.S. average; recently, for example, 44 percent more Medicare enrollees in Rhode Island were receiving home care services than in the average state.[9] Because nursing home use is already so high,[10] however, and because the state has been working hard to substitute community-based services for reliance on nursing home care, we project no net rise in use of nursing home care in Rhode Island.

- Since Rhode Island has substantial physician and hospital bed supplies, adding services for more people would not cost as much, per person, as the average for those now insured.

5. Administrative savings: Covering everyone in one plan would win very substantial administrative savings— about $750 million, over one-tenth of health spending.

- As administrative costs plunge from over $1.47 billion in Rhode Island today, down to about $720 million, vast resources could be reallocated from the payment bureaucracy to care—from fat to bone and muscle.

- Using a single or pooled financing source for all care would, for example, eliminate the need to process millions of claims, and the need to screen out patients to avoid costly ones. Under comprehensive reforms, knowing that everyone is covered and that payment is secure, caregivers could drop several huge tasks:

  - determining patient eligibility,
  - determining patient benefits under many different plans, and
  - seeking reimbursement from insurors and patients through billing and collections.

- Such simplification would have saved an estimated $314 million on administering coverage (insurance overhead) this year in Rhode Island, we estimate. This reflects the U.S. General Accounting Office finding that using a single payor could cut the cost of administering coverage by 79 percent.[11] (Some of these savings would be offset by new costs, added earlier, of data collection and better care coordination.)

- But the savings from simplification and streamlining of health care financing are even greater on the caregiver side. Administrative costs for Rhode Island hospitals alone are approximately $583 million for 2002—26.8 percent of total hospital expenses.[12] We estimate that eliminating most claims processing, and the related paperwork burdens of systems with hundreds or even thousands of different plans

paying caregivers, could save about $273 million on hospital financial administration.[13]

- We estimate that $381 million is being spent on financial administration of physician services alone this year,[14] and that 42.5 percent of that ($162 million) could be saved through the more efficient administration achievable with consolidated financing.[15] That would also free up doctors' and support staff's time for patient needs. It would mean saving fully 10 percent of current spending on physicians—and permitting that sum to be devoted to care, rather than paperwork. These and other savings mean, as noted earlier, that funds for actual physician care in Rhode Island could rise by 24 percent after reform while still saving money system-wide.

Table 4

Spending for Actual Care and Administration in Major Health Care Sectors without and with Reform

Major areas of expenditure (health sector)	Estimated 2002 expenditures if no reform for Rhode Island residents ($ billion)		Estimated 2002 expenditures with universal access and simplified administration for RI residents and workers ($ billion)		Percent change in funds for actual care *	Percent change in funds for admini-stration *
	CARE	ADMIN.	CARE	ADMIN.		
Physician Services	$1.19	$0.38	$1.48	$0.22	+24.3%	-42.1%
Nursing Home Care	$0.51	$0.09	$0.54	$0.08	+5.9%	-11.1%
Hospital Care	$1.59	$0.58	$1.56	$0.31	-1.9%	-46.6%

Note:

* Population served changes after reform, to include Rhode Island workers (and their families) who live outside the state.

6. Ending patient cost-sharing would help people by eliminating about three-quarters of out-of-pocket spending for Rhode Island health care.

- Patient cost-sharing amounts to a sick tax which most heavily burdens people with chronic or serious illnesses or lower incomes. It deters use of needed care, fails to target the true causes of high costs, and often shifts costs to caregivers as well as patients.

- Out-of-pocket costs for Rhode Island patients would drop from about $867 million this year (absent reform) to an estimated $227 million with comprehensive coverage. In the reforms modeled here, patient cost-sharing would continue in only two sectors: spending on non-medical (room and meal) costs for long nursing home stays,[16] and covering the costs of over-the-counter drugs and medical supplies.

- Aiding under-insured people by providing comprehensive benefits and ending deductibles, co-payments, and most other out-of-pocket spending are both affordable and very important for cutting administrative costs.

- Retaining patient cost-sharing requirements would mean perpetuating today's inefficient billing bureaucracies, and a financing system that deters needed care and shifts costs. All these problems would raise costs:

  - The need to handle cash and partial payments creates an administrative system that is both expensive and unfriendly to patients.

  - Continuing patient cost-sharing would oblige wasteful and costly record-keeping to bill patients and track payments towards deductibles. It also would prompt demand for supplemental insurance to cover out-of-pocket costs.

  - Most important, requiring patients to pay at the point of service discourages use of services. And cost-sharing is as likely to cut out essential services as unnecessary or marginal ones.[17] Therefore, if cost-sharing requirements persist, patients will continue needing to use costly hospital care after failing to get appropriate care at earlier stages of their illnesses.

7. Clinical and other savings: Conservatively, reforms will win an additional $528 million more in <u>non</u>-administrative savings— mainly through more appropriate use of hospital and physician care, bulk purchasing or negotiated price cuts for prescription drugs and medical equipment, and capital budgets.

- As shown in Table 2 above, total savings of $1.3 billion more than offset the added cost of new coverage. Savings from streamlining administration combined with

moderate clinical and other savings can, when captured and recycled, amply finance needed care for all.

- Rhode Island can expect modest savings from reduced hospitalizations for conditions treated in more timely fashion when residents gain coverage.

- We estimate the costs of a large expansion of prescription drug use under a package deal (a drug price "peace treaty") with drug makers. Rhode Island would protect drug makers' current profit levels and ability to finance research, in return for purchasing the higher volume of needed medications at the low actual cost of making and dispensing those pills.

- We also project substantial savings on durable medical equipment through price negotiations.

- While these savings are expected, system-wide budgets will operate as a back-up to ensure that costs stay within desired limits.

- Caregivers will be paid in ways that make the budgets real, while allowing patients to trust that caregivers' decisions reflect not personal or organizational financial incentives but the best ways to make use of inevitably finite resources. Thus, care would be shaped by "professionalism within a budget."

8. Quality will be enhanced: Covering everyone and ending today's financial pressures on caregivers to do less will protect quality of care, restoring trust.

While caregivers will have to spend carefully, $7 billion is ample in Rhode Island to finance all the care that works for all the people who need it.

9. Incrementalism is unaffordable: Incremental coverage improvements are better than none— much better— but inevitably cost more money. Incremental measures to achieve universal, comprehensive coverage would be unaffordable, requiring health spending of at least $8.5 billion in 2002 in Rhode Island.

- Thus, buying the uninsured and underinsured into the current system (without reforms to permit system-wide savings) would cost at least $1.3 billion above what Rhode Island needs to spend to win coverage for all.

- That is fully 18 percent higher spending than under universal coverage with streamlined financing and delivery system reform.

10. Benefiting all Rhode Island residents and workers: Insuring the uninsured is just one vital gain that comprehensive reforms would bring. Many aspects of such reform would benefit all the people of Rhode Island.

- Everyone would be able to receive more care at lower cost.

- Cutting health care costs will free up money in family, business, charitable, and government budgets to meet many other pressing needs. And having healthier people will strengthen Rhode Island in countless ways.

- Durably affordable prescription drug coverage would benefit all Rhode Islanders.

11. Delay is dangerous: Rhode Island cannot afford to wait for Congressional action. Nor can the state afford to wait for a crisis. Beginning to plan now for such comprehensive reforms is essential to avoid great harm to the state's people, to the trustworthiness of care, and to hospitals, physicians, nursing homes, home health agencies, and other valued health care resources.

- Today's cost control strategies are failing. More money for business as usual is not affordable.

- Higher costs will mean more cuts in coverage.

- Caregiver financial distress is growing.

- Delay is unnecessarily costly.

- Congress will not soon legislate health care for all and cost control— in part because states' economies, health costs and delivery, and share uninsured vary so widely.

- This state should not and cannot wait for unlikely Congressional action, since state-level reforms to cover everyone are clearly feasible without spending a penny more.

- State reform is the only likely path to universal coverage and cost control for years to come.

In summary, health care for all is affordable, and achieving it can be a win for all parties because current spending is already enough. Rhode Island can have health care security, health care freedom, and lower costs.

<u>Security</u>
- for patients and families, knowing that needed care is covered, and that caregivers no longer are rewarded for giving too much care or too little care
- for employers and employees, knowing that costs are capped and predictable
- for needed caregivers, knowing that their revenue budgets are stable, fair, and sufficient.

Freedom

- for patients, to select the caregivers they choose
- for caregivers and patients, to choose care without bureaucratic interference
- for workers, to choose their jobs without worrying that they will lose coverage
- for employers, to focus on running their business, not on searching for health plans.

Lower costs

- cuts in administrative waste and other reasonable savings are enough to offset the cost of expanded coverage and to reduce health care spending overall
- developers of cost-reducing medical technologies would rewarded
- advocates of higher health care spending must compete with advocates of other good things—including many others that are also vital to improving the health of citizens of Rhode Island.

Conclusion

A state-level effort to cover all people is vitally needed in Rhode Island, and this analysis shows it is feasible.

Those who pay for health care in Rhode Island spend far more than payors do in most other states, 21.5 percent above the national per capita average. The same federal government data show that spending on the state's caregivers in 1998, per resident, was 65 percent higher in Rhode Island than in Idaho— the fourth highest and the lowest cost states, respectively.[18]

Further, an analysis that combined spending on care in-state and out-of-state care for each state's residents found that spending was still 19.6 percent higher, per capita, in Rhode Island than the national average.[19]

The state's extraordinarily high spending levels are long-standing. And they prevail even though Rhode Island, as recently as 1999, ranked third highest among the states in rate of HMO penetration.[20]

So current strategies for cost-control and coverage are clearly not working. State action is urgently needed.

But analysis of the cost of insuring the uninsured and filling today's gaps in coverage for everyone— along with the opportunities for saving with streamlined administration and trustworthy, equitable coverage— shows that Rhode Island can do the job without spending a penny more.

Note on Authorship

This analysis of the feasibility of universal, comprehensive health care for Rhode Island was conducted by the Health Reform Program at the Boston University School of Public Health (Boston University School of Public Health) in collaboration with Solutions for Progress (SfP), of Philadelphia.

The study is built on a core model conceptualized by Robert Brand, of SfP, with computer modeling developed largely by David Ford, also of SfP.

Alan Sager, of BUSPH, took the lead in designing the particular reform plan modeled for Rhode Island.

The report was written primarily by Sager and Deborah Socolar, of BUSPH, with the explanation of the findings and model mainly by Socolar.

Estimates of Rhode Island's baseline 2002 health care spending were developed largely by Ford. Research on Rhode Island data for analyzing the effects of reform was conducted primarily by Ford and Socolar.

Appendix I

HIGHLIGHTS AND OUTLINE OF MODEL AND ESTIMATES

We summarize here the major steps involved in reaching our bottom line conclusion—that Rhode Island can win comprehensive health care for all while saving money. These highlights of our estimates offer a few examples of the evidence and assumptions used, to convey a sense of the types of issues involved. [21]

This material intentionally overlaps that presented in the Findings, but offers a different look, emphasizing the way the analysis was done as much as its results.

A brief comment on precision: Cost and savings estimates are presented in billions of dollars and tenths of billions— $0.6 billion, for example, or the equivalent, $600 million. Often, individual estimates and their components were calculated using available data in millions of dollars. But because of the incompleteness and approximate nature of many health care cost data, we wish to avoid over-stating the precision of these estimates. We therefore round here to the nearest $10 million. While $10 million is certainly a large sum, it is less than two-tenths of one percent (0.13 percent) of the estimated $7.47 billion in health spending for Rhode Island residents and workers in 2002.

What coverage is proposed?

This plan would provide all Rhode Island residents and workers with comprehensive, equal health care benefits, including dental and long-term care. Besides insuring people who are now uninsured, this plan fills in the gaps in coverage for today's insured, giving substantial new benefits to all.

It would cover the cost of all medically necessary health care, excluding only non-prescription drugs and non-durable medical supplies (unless prescribed), and some of the housing costs of nursing home care.

By filling gaps in benefits and ending most patient cost-sharing requirements, this plan would eliminate over three-fourths of out-of-pocket costs. The plan gives patients free choice of doctors, hospitals, and other caregivers. And it frees patients and caregivers from bureaucratic interference with decisions about the appropriate course of care.

This coverage would rest on a system of health care financing without insurance companies, in which all caregivers are paid from one pool of funds. This could be either a traditional single-payor design or a "pooled multi-payor system." In the latter, varied funding streams are combined to permit consistent, equitable caregiver payment

methods, budgeting and cost control instead of cost shifting, gaining many of the benefits of traditional single payor.

This coverage plan also includes a range of financing and delivery reforms that would cut administrative and other waste. These will enable the people of Rhode Island to get much more care, while saving money.

Who will be covered?

The plan analyzed here would cover all Rhode Island residents and also out-of-staters who work in Rhode Island. This report refers to these groups, together, as "Rhode Island beneficiaries."

So all of the over one million people who live in Rhode Island would have coverage. In addition, our estimates assume that, for simplicity, efficiency, and workplace equity, the roughly 39,000 people who work in Rhode Island but live outside the state[22] (and their dependents) would get the same coverage that Rhode Island residents receive.

We also note that about one-seventh of working Rhode Island residents are employed outside the state.[23] While the scope of this report does not permit addressing the various options for raising the money to finance universal coverage, we assume that many out-of-state employers would contribute to the state plan since that may well prove less costly than buying private insurance. (With such a large share of the workforce employed outside Rhode Island, the state might hope to raise $400 million or more in employer contributions from out of state.) Also available from outside of Rhode Island, we project, would be some limited additional federal funding, mainly because Medicare patients would use more care after removal of the access barriers now posed by requirements to pay deductibles and co-insurance.

Ending under-insurance

Many discussions of universal health insurance focus solely on the goal of providing some coverage to all. But besides insuring the uninsured, this plan is designed to eliminate the diverse problems of under-insurance, such as these.

- As shown by the current debate over drug coverage for seniors and the lack of long-term care coverage for many who need it, people with today's Medicare coverage are often among the under-insured. A recent national survey found that medical costs and premiums *actually* consumed at least 10 percent of income for *fully half* of families headed by seniors.[24]

- The same survey showed that medical costs and premiums *actually* consumed at least 10 percent of income for one-sixth of households headed by people under age 65.

- Some analysts[25] consider people to be under-insured if the gaps in their coverage leave them *at risk* of having to pay health costs out-of-pocket (excluding premiums) amounting to more than 10 percent of their family income. This is a broader definition because people need not have actually been sick enough to incur large bills to be deemed under-insured.

Yet even this definition may be too restrictive. There are good reasons to consider far more of Rhode Island's population under-insured:

- Costs amounting to less than 10 percent of income may well keep many people from getting needed care.

- Managed care plans' incentives to limit care mean that most people risk having difficulty getting coverage for needed care.

- Definitions of the under-insured which emphasize people incurring high costs or unable to obtain needed care fail to include the countless people with meager benefits who did not happen to fall ill in the year studied. A solution for the problems of the under-insured cannot target only those who will get sick, because that is not predictable.

Thus, providing protection against the costs of care for everyone is manifestly the only way to fill the gaps for the under-insured people of Rhode Island.

Outline of model

- We first estimate the costs of care in 2002 absent reform—total health care spending, personal health care spending, and spending for each major type of care. (Details of how we have prepared those estimates are not presented here.)

- Next, we estimate the costs of
  a) bringing uninsured people's care to the private average, and
  b) filling gaps in benefits and eliminating cost-sharing for all patients.

- We then estimate savings from
  a) administrative simplification, and
  b) financing and delivery reforms,
  to determine the post-reform cost of care.

- Finally, we compare the costs of care for Rhode Island residents and workers after reform to today's costs, and also to the cost of providing expanded coverage without reform.

NOTES

[1] Tax increases would be needed only to cover current out-of-pocket costs, less any continued out-of-pocket costs and also less the savings winnable with reform. For more detailed treatment of these issues in a similar analysis, see A. Sager, D. Socolar, R. Brand, and D. Ford, *Massachusetts Can Afford Health Care for All,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 November 2000, www.healthreformprogram.org

[2] See Joseph White, "Markets, Budgets, and Health Care Cost Control," *Health Affairs*, Vol. 13, No. 3 (fall 1993), pp. 44-57.

[3] Stephen Heffler, Sheila Smith, Greg Won, and others, "Health Spending Projections for 2001-2011: The Latest Outlook," *Health Affairs,* Vol. 21, No. 2 (March – April 2002), pp. 207-218.

[4] Robert H. Brook, "Practice Guidelines and Practicing Medicine," *Journal of the American Medical Association,* Vol. 262 (1989), pp. 3027ff., cited in Thomas S. Bodenheimer and Kevin Grumbach, *Understanding Health Policy: A Clinical Approach,* 3rd edition, New York: Lange, 2002, p. 2

[5] National Center for Health Statistics, *Health, United States, 2002*, Hyattsville, Maryland, 2002, Table 109, http://www.cdc.gov/nchs/products/pubs/pubd/hus/tables/2002/02hus109.pdf

[6] Ratio calculated from 1998 percent with expense and mean spending per person with expense, Health Care Expenses in the U.S. Civilian Non-Institutionalized Population, 1998, Agency for Healthcare Research and Quality, Rockville, MD, June 2002, Table 1, from www.meps.ahrq.gov/CompendiumTables/98Ch2/98PDFTables.htm

[7] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 67. The estimate is that physician service use would rise 17 percent when full benefits are established and out-of-pocket costs eliminated. This estimate, used by the GAO and in our model, represents the average of the Rand Health Insurance Experiment estimate (31%) and Canada's experience.

[8] Under home health care, the figure for spending after reform in this table reflects a very substantial expansion of home care and other types of care for people with disabilities, including not only attendant care but also assistive technology and rehabilitation services (which are tabulated here for simplicity).

[9] Medicare home health service data show that Rhode Island had the highest 1998 rate of persons served per 1000 Medicare enrollees, with 138 receiving visits as compared to the U.S. average of 96. And Rhode Island Medicare patients receiving home care had slightly more visits per patient than the U.S. average (53 to 51). See Medicare data on Kaiser Family Foundation, State Health Facts, www.kff.org (accessed August 2002). We assume that the same relationship to the national average prevails for all home care, and that a use rate 75 percent above the U.S. average is reasonable to address substantial unmet human need. (See, for example, Charlene Harrington and others, "A National Long-term Care Program for the United States, *JAMA,* 266: 21, p. 3025.) Assuming use in Rhode Island is 49 percent above the

U.S. average ([138*53] / [96*51] = 1.49), then to reach 75 percent above the U.S. average, Rhode Island needs another 17.4 percent rise in home visits from the current level. The need for home care, however, may be seen as potentially limitless within the relevant range. It may be subject to the softest estimates of any health care sector, in part because home health care may be hard to distinguish from homemaker, personal care, and social services, which all may serve to maintain health as well as quality of life.

[10] For the U.S. as a whole, Charlene Harrington and others ("A National Long-term Care Program for the United States, *JAMA,* 266: 21, p. 3025) suggested that "[l]ong-term care insurance could legitimately result in a 20 percent increase in nursing home utilization." In 1999, compared to the U.S. average, Rhode Island already had about 21.9 percent more nursing home residents per 1000 persons aged 85 and up, the age group most likely to use nursing homes (436.3 in Rhode Island, 358 for the U.S.), according to data reported in National Center for Health Statistics, *Health, United States, 2001*, Hyattsville, Maryland, 2001, Table 112, http://www.cdc.gov/nchs/data/hus/hus01.pdf

[11] United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 65; United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 8.

[12] Methods used to estimate hospital administrative costs were from Steffie Woolhandler et al., "Administrative Costs in U.S. Hospitals," New England Journal of Medicine, Vol. 329, No. 6 (5 August 1993), p. 402. As corrected in Steffie Woolhandler and David U. Himmelstein, letter, New England Journal of Medicine, Vol. 331, No. 5 (4 August 1994), p. 336. This estimate assumed that the administrative share in Rhode Island is similar to that in Massachusetts.

[13] Savings estimates rest in part on findings of United States General Accounting Office, *Canadian Health Insurance: Lessons for the United States*, GAO/HRD-91-90, p. 65; United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 8. Details available on request.

[14] Estimate reflects ratios derived from analysis of Medical Group Management Association data (analysis available on request), and is confirmed by recent information from within the industry. See also, for example, "The Challenges of Practice Management: An Interview with James L. Heffernan," *Healthcare Financial Management,* Vol.. 54, No. 10 (October 2000), pp. 75-78.

[15] The GAO, in comparing physicians' administrative costs in the United State and in Ontario, Canada, concluded that under a Canadian-style system, physicians' administrative costs could be reduced by 10.3 percent of total physicians services expenditures. United States General Accounting Office, *Canadian Health Insurance: Estimating Costs and Savings for the United States*, GAO/HRD-92-83, p. 12.

[16] These contributions for the non-medical—room and board—costs of nursing home care, substituting for the same costs that patients would have had at home, are modeled using an estimate of $50 per day for 2002, or about $18,000 per year. It is also assumed that only those patients in nursing homes longer than two months would be charged. Federal Medicaid funds would continue to flow to the state to contribute to covering those costs for patients whose Social Security and other income and savings would not suffice. With this lower annual cost to patients, people in nursing homes would deplete their savings more slowly than they do today. The patient cost-sharing revenues counted here reflect the equivalent (combining those who

could not contribute at all and those who could contribute less than $18,000 per year) of 10 percent of long-stay patients contributing nothing towards room and meal costs.

[17] See, for example, Kathleen Lohr et al., "Use of medical care in the Rand Health Insurance Experiment: diagnosis and service-specific analyses in a randomized controlled trial," *Medical Care* (September 1986), Supplement, p. S72, S 78; Gregory E. Simon, et al., "Impact of Visit Copayments on Outpatient Mental Health Utilization by Members of a Health Maintenance Organization," *American Journal of Psychiatry*, Vol. 153, No. 3 (March 1996), pp. 331-8; C.E. Reeder and Arthur A. Nelson, "The Differential Impact of Copayment on Drug Use in a Medicaid Population," *Inquiry*, Vol. 22 (Winter 1985), pp. 396-403; Brian L. Harris et al., "The Effect of Drug Co-Payments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization," *Medical Care*, Vol. 28, No. 10 (October 1990), pp. 907-917; Morris Barer et al., *Lies, Damned Lies, and Health Care Zombies: Discredited Ideas that Will Not Die*, Houston: University of Texas Health Policy Institute, Discussion Paper 10, March 1998, pp. 21-31.

[18] Calculations from United States Health Care Financing Administration, 1980-1998 State Health Care Expenditures Estimates, 29 September 2000, http://www.hcfa.gov/stats/nhe-oact/stateestimates/.

[19] See Anne Martin and others, "Health Care Spending During 1991-1998: A Fifty-State Review," Health Affairs, Vol. 21, No. 4 (July-Aug 2002).

[20] Aventis Pharmaceuticals, *Managed Care Digest 2000*, Kansas City, MO, 2001, p. 18.

[21] For more detailed treatment in a similar analysis, see A. Sager, D. Socolar, R. Brand, and D. Ford, *Massachusetts Can Afford Health Care for All,* Boston: Access and Affordability Monitoring Project, Boston University School of Public Health, 2 November 2000, www.healthreformprogram.org. See also Solutions for Progress and Access and Affordability Monitoring Project, *Universal Comprehensive Coverage: A Report to the Massachusetts Medical Society*, December 1998, http://www.massmed.org/pages/2lewin.pdf.

[22] Census data are not yet available for 2000 on this point, so our estimate assumes that 7.6 percent of the state work force is non-residents, as was the case in 1990. (Journey-to-work and Migration Statistics, Population Division, U.S. Census Bureau.)

[23] Census data indicate that, in 2000, about 14.4 percent of working Rhode Island residents were employed outside the state (Journey-to-work and Migration Statistics, Population Division, U.S. Census Bureau), or more than 73,000 people if the same ratio prevailed in 2002.

[24] Gail Shearer, *The Health Care Divide: Unfair Financial Burdens*, Washington, D.C.: Consumers Union, 10 August 2000, http://www.consumersunion.org/health/divide/divide.htm. See also press release at http://www.consumersunion.org/health/dividepr.htm

[25] See, for example, Pamela Farley Short and Jessica S. Banthin, "New Estimates of the Underinsured Younger Than 65 Years," *JAMA*, Vol. 274 (25 October 1995), pp. 1302-1306.