ARIZONA HEALTH FUTURES

WINTER 2004

Arizona CAN!

Coverage and Access Now

"After the darkness, I hope for light."
— Miguel de Cervantes, *Don Quixote*

INSIDE:

St. Luke's Health Initiatives
A Catalyst for Community Health

Health Care Reform:
Prelude to the Future

"To say that we're just going to deal with health insurance [coverage] is sort of ignoring what the elephant is going to look like two or three years from now."

Arizona Resident

When it comes to health care, the attitudes of Americans are nothing if not consistently inconsistent:[1]

- → Most Americans favor some type of national health insurance, financed by taxes.
- ← Most Americans don't want to pay increased taxes themselves.

- → Most Americans think the health care system is badly in need of reform.
- ← Most Americans express satisfaction with their own personal use of the health care system.

- → Most Americans don't trust government to do the right thing.
- ← Most Americans expect government to *do something*.

In the face of these conflicting attitudes, timing is everything.

In 1993, right around the time President Clinton was crafting his plan to provide all Americans with health care coverage, the Arizona Affordable Health Care Foundation (AAHCF) rolled out a plan for Arizona. *The Arizona Model,* a variation of the employer mandate model with a strong emphasis on competition and cost containment, was introduced as a "blueprint for change" that the state might build on to address perennial issues of access, cost and quality in health care.

Not long afterwards, Clinton's plan went down to defeat in the Congress, taking the wind out of the sails of state health care reform efforts with it. In 1995, after calling on the Arizona legislature to increase AHCCCS coverage to 100 percent of poverty and enroll an additional 150,000 uninsured citizens, AAHCF closed its doors after a 10-year run in the health care reform arena.

But the groundwork had been laid. Advocates kept up the pressure, and in 2000 the passage of Proposition 204 increased AHCCCS coverage to 100 percent of poverty.

Today, even with burgeoning AHCCCS enrollments and state population growth to match, almost 1 million Arizonans still lack health insurance. The same call that AAHCF sounded as early as 1985 – the availability of quality, cost-effective health care for all Arizonans – remains.

Arizona as a National Leader

While the national debate continues, states provide a fertile laboratory for the testing and dissemination of new approaches to covering the uninsured and developing a more efficient and equitable system of care. Many are taking practical steps toward reform.

Paradoxically, the *worst* of times – state budget deficits, soaring Medicaid enrollments and health care costs – can create the *best* opportunities for new approaches and thinking outside the status quo.

Twenty-five years ago, Arizona proved to be a catalyst for change when it created the country's first fully managed care Medicaid system. Today, the AHCCCS system is considered to be one of the best in the nation in terms of efficiency and equity, and it has been widely studied and applied in other states.

Twenty-five years ago, Arizona was a leader in setting new directions in health care. Today, managed care is in transition, if not retreat; market forces and a rising tide of consumerism have reduced health care to a commodity; and provider and professional organizations struggle with rising costs, workforce shortages, pervasive discontent, a tangle

of suffocating regulations, shifting roles and relationships, heightened expectations, conflicting incentives and intense competition.

The question is, does this so-called "perfect storm" of conditions also provide a perfect moment for Arizona once again to be a national leader in health reform? Can we take practical steps toward fixing what's broken in our health care system, while building on what's working?

Arizona CAN!

Coverage and Access Now

We explore that question in this *Arizona Health Futures* issue brief. With the full realization that there is no heavier burden than a great opportunity, we introduce the concept of *Arizona CAN – Coverage and Access Now* – which is conceived as a broad-based public education and advocacy effort to increase health insurance coverage and access to affordable, high quality care for all Arizonans. With this report as background, SLHI joins with those who believe that all Arizonans should have access to high quality, cost effective health care.

Arizona CAN Principles

- Arizonans can and should have access to high quality health care that is reasonably available, affordable and culturally appropriate.
- Health coverage matters. People who have health insurance – or the resources to pay for medically necessary care – have better outcomes than those who lack these resources.
- The financing of health care is the responsibility of the public sector, the private sector and the individual.
- Public and private agencies should work together to reduce or eliminate barriers to effective and affordable health care.
- An effective health care system should promote the principles of responsibility, accountability, prevention and wellness, both for communities and individuals.
- There should be policies that respect and protect the rights and privacy of individuals.
- There should be policies that promote the collection and use of relevant information and data across all health care sectors to inform public policy and private choice, and to improve system performance over time.

These principles are hardly exclusive. There is no magic bullet, no final solution to issues of access, cost, quality and choice. We should start from where we are, not from some idealized state of affairs. We should seek improvement and success over the long term, and not be overly concerned with getting everybody into the same boat before we launch off from shore.

A *Flexible* Network

We invite the active engagement of agencies, organizations and individuals with an interest in, and commitment to, increasing access to affordable, high quality health care for all Arizonans.

In light of these principles, SLHI is committed to the nonpartisan, independent analysis of health policy and information; to finding common ground through the facilitation of dialogue across all health care sectors and interest groups; and to the encouragement and promotion of those opportunities that appear to hold the greatest potential to increase access to care.

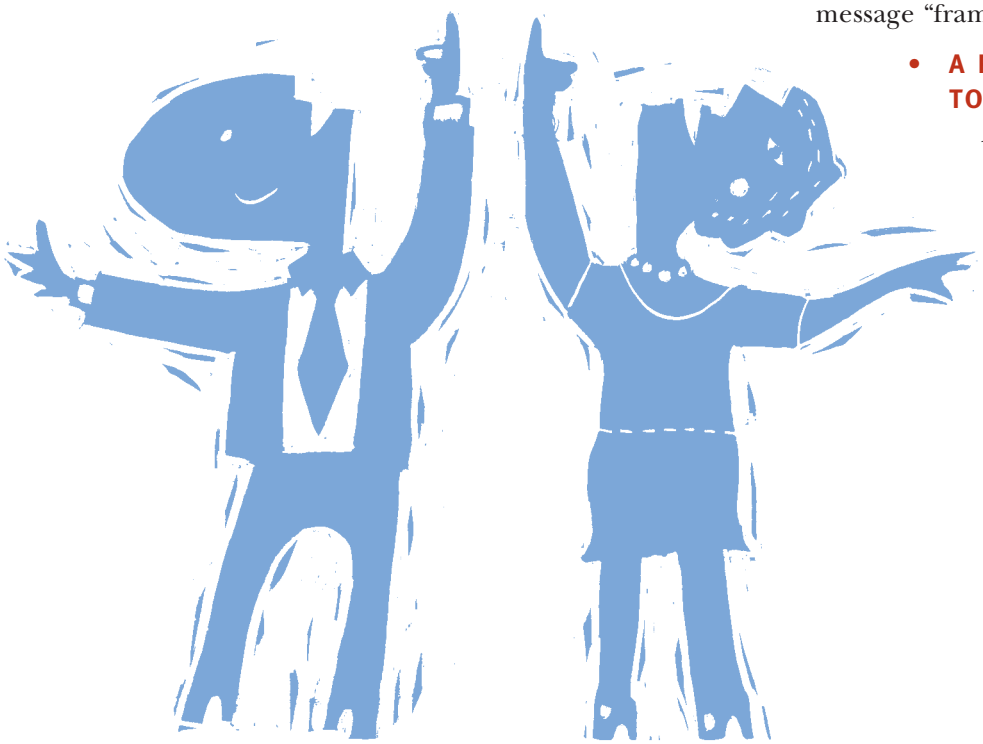
At this point, *Arizona CAN* is envisioned as a flexible communications network rather than a formalized coalition of defined members with a stake in health care issues. Various organizations and communities in Arizona are already actively pursuing issues of access, cost and quality; we seek to encourage these and other activities, whether through ad hoc and temporary relationships or through the established programs of various public and private agencies and groups.

At the same time, we think the time is right to forge new relationships and pursue new opportunities, some of which might conceivably have a genesis in this report.

We invite the active engagement of agencies, organizations and individuals with an interest in, and commitment to, increasing access to affordable, high quality health care for all Arizonans.

To move the discussion forward, we explore four critical aspects of planning in this report:

- **AN ASSESSMENT OF THE PROBLEMS WE FACE.** A recap of the central issues of access, cost, quality and choice that any proposal to improve the health care system must face. Some of these issues are discussed in more detail in previous AHF issue briefs and policy primers.
- **A CONSIDERATION OF IDEAS FOR REFORM.** The development of four models to increase health insurance coverage in Arizona. The models, including financial analysis, are presented not as full blown proposals but as heuristic sketches to frame the tradeoffs inherent in any plan to increase coverage.
- **AN APPRECIATION FOR PUBLIC EXPERIENCE AND OPINION.** Findings from recent SLHI public opinion research on the attitudes and perceptions of Arizonans toward health care and health insurance, and how different message "frames" produce different reactions.
- **A PLAN FOR KEEPING MOMENTUM TOWARD PRACTICAL REFORMS.** A preliminary sketch of what an Arizona CAN initiative might look like: how the principles can be translated into strategies in an action-oriented agenda.



Health Care:
The Historical Context

For the past forty years, American health care has been buffeted by the inherent tension between relentless expansion of medical services for a growing population and the necessity of establishing some control over rising costs:

1960s

The creation of Medicaid and Medicare in the 1960s signals a growing sense of entitlement and access to medical services for a larger share of the population.

1970s

Increased regulation and competing proposals for universal health coverage dominate the national conversation. Concern over inflation, rising medical costs and the value of medical care results in a political stalemate in the mid 70s. Universal health insurance takes a back seat to more pressing financial issues. Regulation continues apace.

1980s

A growing tide of conservatism in politics and economics dominates the late 1970s and the 1980s. Better access and increased efficiency will be achieved with less regulation, more competition and the "reprivatization" of government social welfare functions. The private, for-profit corporate model in health care grows in size and scope; medical expenditures increase, uninsured rate inches upward; so do costs. Regulation continues apace.

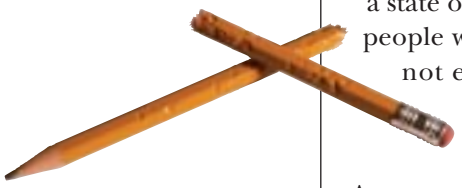
1990s

The Clinton plan for universal health coverage is defeated in the early 1990s. The growth of managed care temporarily reduces rising health care costs, only to see them rise again in the late 90s. The health care industry consolidates through mergers and acquisitions; legislation focuses on curtailing cost increases in Medicare and other public programs. Regulation continues apace.

2000s

The uninsured rate increases in the early 2000s after years of being relatively flat. Health care costs and insurance premiums spike upward. Legislation is passed to increase Medicare benefits (prescription drugs) and take first steps to "reform" Medicare through competition with private health plans. Regulation continues apace…

A *Broken* System?



Throughout this period, many observers have pronounced the health care system to be in a state of "crisis:" too expensive, widely varying quality and standards of practice, too many people without health coverage, inequities in access and outcomes, too much regulation, not enough regulation, excessive litigation, corporate hegemony, labor shortages, suffocating administrative overhead, inept bureaucrats, maldistribution of resources, poor planning, insufficient attention to public health.[2]

A core set of issues drives these perceptions:

- **COST.** Whether it's rising Medicare and Medicaid payments, rising health premiums, rising costs for the components of health care (technology, drugs, labor, regulation, etc.) or rising out-of-pocket costs, someone foots the bill. If the bill is too high, it becomes a crisis for the payer. However, rising costs in one part of the system can translate into increased revenue in another. Under a fee-for-service system, providers are incentivized to provide services and increase revenue, not to keep people healthy and out of the system.[3]
- **ACCESS.** People without health insurance or the funds to pay for necessary medical care experience a crisis of access – but only if they don't receive adequate care. Because health care is perceived by a majority of Americans to be a de facto "right," providers are expected – and often required – to provide care for everyone, even people who can't pay for it. The result is cost shifting: A crisis of access fuels a crisis of cost.
- **QUALITY.** In its influential reports, *To Err is Human* and *Crossing the Quality Chasm*, the Institute of Medicine (IOM) makes the case for a crisis of quality in American medicine: too many medical errors, too much indefensible variation in practice; too little evidence-based practice, and the overuse, underuse and misuse of medical care. The blame is placed squarely on a fragmented and inefficient delivery system, misaligned incentives and a woefully inadequate information and communications structure. Quality issues resonate with the public, but not to the same degree as issues of cost and access.[4]
- **CHOICE.** Even if the health care system achieves broad access and high quality at a reasonable cost, it fails the American litmus test of individualism and freedom if it does not also provide choice. Many consumers resist managed care because of a perceived lack of choice of providers and ease of access; many physicians resent the infringement of what they deride as managed "cost" on their professional autonomy to provide choices for patients under their care.

"We work to have private insurance, and then people who get state Medicaid sometimes have better insurance coverage than we do...sometimes it feels like we're being punished because we work."

Arizona Resident

Relentless Growth: *The Drivers*

If the American health care system has allegedly been on the verge of a breakdown for the past thirty years, how has it managed not only to survive, but to grow and even thrive?

Here is a short list of the key drivers:

- **THIRD PARTY, FEE-FOR-SERVICE REIMBURSEMENT.** In 1960, consumer out-of-pocket costs for health care were around 50 percent. Today, they are around 17 percent.[5] Whether it comes from private insurance or government, third party, fee-for-service reimbursement shields both consumers and providers from the true cost of treatment decisions and mitigates the necessity of weighing costs against benefits. This fuels growth of the system on the demand side as consumers avail themselves of services for which they perceive "someone else" is paying. On the supply side, fee-for-service payments grease the wheels of an expanding health care industry that is focused on increasing revenues.

- **THE CONTRADICTIONS OF ACCOMMODATION.**[6] In order to get Medicare and other public programs off the ground in the 1960s and 1970s, government accommodated the interests of physicians, hospitals and other health care sectors that understandably sought to maintain and extend their sphere of control. But this accommodation contained its own contradictions. As medical costs began to escalate, government, employers and other payers distinguished their interests from those of the health care industry. This led to further attempts to control costs, which in turn fueled more pressure to roll back restraints, which led to more pressure to control costs – a repeating cycle of accommodation through which public demand and political pressure by the health care industry have yielded substantial gains in growth ($73 billion, or 7 percent of GDP in 1970 compared to $1.6 trillion, or 15 percent of GDP in 2002). The recent passage of the Medicare "reform" Act in late 2003 is a textbook example of the politics and contradictions of accommodation.

- **HEALTH CARE AS A RIGHT.** Even though U.S. law doesn't recognize any general "right" to health care, actual practice and public attitudes over the past several decades have reinforced access to health care as a de facto right. Hospitals are expected – and even required in some cases – to provide care; the passage of EMTALA in the mid-1980s is but one example. This growing sense of entitlement, coupled with cost shifting and the dominance of a third party financial reimbursement mechanism, fuels more outpatient services, prescription drugs, physician visits and emergency room use. Without any effective "braking" mechanism on demand, the system feeds on itself in a self-referential loop.

- **SYSTEM FRAGMENTATION.**[7] Just as medical science has advanced over the recent past through ever more specialized research and technology, so has a growing reliance on the dominant "business" model of private industry in health care encouraged the pursuit of profit and efficiency through targeted market segmentation and product lines. Ironically, even "integrated" health services (e.g., chronic disease management) become just another "specialty" in this "niche" approach to health care, the model for which has increasingly come to dominate every facet of American life. Americans avail themselves of more specialized physician services and technologies through more fragmented and specialized facilities and plans – all of which are heavily promoted to induce demand. So long as the money keeps coming in today – even if it means saddling others with a huge debt tomorrow – the system grows in scope and size.

- **THE ADMINISTERED WORLD.** The American health care system is a decentralized quilt of many public and private pieces stitched together with layer upon layer of administrative and regulatory thread. The *process* of connecting these pieces in any semblance of coherent function and form is the purview of a vast army of administrators, regulators, litigators and various third-party brokers – all of whom don't provide care themselves but add to the total cost of the system. While it's common to criticize the system for its excessive administrative costs compared to other industrialized nations, one has to acknowledge that these system costs translate into literally millions of jobs and billions of dollars in revenue, which take a seat at the political table of accommodation alongside the other players. Someone's waste and inefficiency is someone else's livelihood. In a real sense, the growth of the health care sector over the past several decades has been a jobs program for America.

IT'S THE SYSTEM, STUPID

This cursory summary of the historical context and key factors driving system dysfunction in American health care underscores the important point that the tensions and contradictions fanning the flames of public discontent are built into the system itself, and are not the result of any one issue, group or set of discrete circumstances alone.

The contradictions of the system, in turn, arise out of the tension between what we value *in common* as part of the public good and what value *apart* as private individuals pursuing our interests in a dynamic market of goods and services.[8] If health care is just another commodity, what do we care if some people get it and others don't? Why be concerned with questions of access at all?

Increasing health insurance coverage – the central focus of the following models and discussion – is a necessary but hardly sufficient condition of improving the health of all Arizonans, and especially those who are most in need of care. If all we do is focus on insurance coverage and aren't also engaged in addressing system performance issues of cost, quality and choice, then we really aren't doing much except arranging the deck chairs on the Titanic.

We start and end with a systems perspective in which each of us has a stake. In the words of Benjamin Franklin at the signing of the Declaration of Independence, "We must all hang together, or assuredly we shall all hang separately."

Model Development: Preliminary Distinctions

In developing four models to increase health insurance coverage in Arizona, we made the following choices on what to include and – what is perhaps even more important – what *not* to include:

1. We focus less on *who* the uninsured in Arizona are and more on *where* they are, and *why* they are uninsured.[9] The situations in which all people find themselves – employed, between jobs, unemployed, living in rural areas with poor access to health care, faced with a sudden and catastrophic illness, not having enough money to make premium payments – increasingly determine whether they have access to affordable health care. Here, we choose to characterize the uninsured as a market segment in its own right and then break down that segment into various *secondary markets* for purposes of assigning, analyzing and projecting financial costs. Attributes such as citizenship, age and health status are reflected in aggregate in total historical claims experience of each *secondary market*, but we do not break out those attributes separately and assign financial costs/projections to each.

2. In developing the models, we choose to base the financial analysis on one standard comprehensive benefits package similar to what one would typically find under a large employer health benefit. Long term care and dental benefits are excluded. The reason for doing this is to compare "apples to apples" across the models, but we readily admit that by manipulating benefits rather than eligibility, one could arrive at a much different place. Indeed, positing a typical comprehensive benefits package is merely the start of the discussion, not the end. Where we need to go as a state and nation is to consider the relative health benefits of various services when allocating limited public resources to the system. What people choose to buy with their own nickel is one thing; what we choose to pay for with public dollars is another.

3. The central thrust of the models is to increase coverage within the existing health care provider delivery system, especially in terms of continuity and stability, and not necessarily to control costs. That doesn't mean that we are less concerned with costs; clearly if we can lower costs, more people will be able to afford coverage. In the financial analysis of national models to increase health insurance coverage, proponents of particular approaches (vouchers, single

The Mercer Model Study

The financial analysis portion of the four models presented here is the work of Mercer Government Human Services Consulting (Mercer) through a contract with SLHI.

All charts, graphs and analytical work from this study are hereafter referenced as the *Mercer Model Study (2003)*.

Mercer established estimated 2004 calendar year (CY) baseline cost and population estimates by pre-defined insurance market segments under the current health care delivery model. Baseline cost estimates were further delineated by major product type and key category or service. From those estimates, the impact of each proposed model was developed and presented in terms of the number of Arizonans who would be covered by public and private health insurance and the costs of extending coverage.

Estimates and assumptions were derived from published literature, public data sets and Mercer's proprietary data sets.

payer, etc.) often point out that analysts fail to consider how the underlying dynamics of the health system will change as new configurations and incentives are created in response to such things as chronic disease management, a focus on prevention, better consumer choices based on readily available information on quality and cost, and so on.[10] This may well be true – we hope so – but to investigate the projected dynamics of any one model in new configurations of care would require a more detailed analysis than can be presented here.[11] We do, however, suggest ways in which system dynamics could change under different scenarios, and how to optimally link issues of access, cost, quality and choice under a dynamic systems model.

4. For all of these reasons, the models are presented as prototypes that represent a family of approaches to increasing health coverage rather than representing fully developed proposals themselves. For example, the model focused on using tax credits is generally representative of a family of approaches that is often characterized as "free market" or "consumer choice" plans; the public utility model is representative of what is often referred to as "single-payer, universal coverage" approaches. We set it up this way in order to compare and contrast various systems features; clearly the level of description and financial analysis of the models as presented at this early stage is insufficient to argue for the adoption of any particular approach. In effect, each model might appeal to different populations or people in different circumstances – employees of small businesses might find one more appealing; early retirees or persons with chronic conditions might favor another.[12] In that sense, the models are intended to invite further inquiry.

"I think that if you're willing to work hard and look at it [health care] and fight for it....it's out there to be found."

Arizona Resident

The Models Defined

"We continue to pay more and more and tax and tax and tax, and more people will be insured and cost will go up. What about the other side of the coin that says what's fair market value? Why does a transplant cost $150,000?"

Arizona Resident

A review of efforts at both the national and state levels to increase health insurance coverage reveals an array of different approaches that might be characterized as variations on four central themes:[13]

1. **UNIVERSAL, SINGLE-PAYER.** The development of mandated, universal coverage that is primarily funded by one source. The prevalent example is the creation of a new national health system funded and regulated – but not necessarily administered – by the federal government. Others tout national, single-payer systems using free market mechanisms (a voucher for everybody, etc.).

2. **EMPLOYER-BASED.** The further expansion and refinement of America's predominant method of providing health insurance coverage through employers. Some would mandate employer coverage, others would develop associations for small businesses to offer affordable coverage; still others would allow certain businesses to provide coverage through the Federal Employees Health Benefits Program (FEHBP), etc.

3. **EXPAND PUBLIC PROGRAMS.** The expansion, refinement and/or reconfiguration of existing public programs such as Medicaid, Medicare, SCHIP, FEHBP, etc. This might also include the creation of new public programs, such as high risk pools.

4. **MARKET-BASED.** The development and application of such funding methods as tax credits, vouchers, medical savings accounts and other approaches to provide individuals with the means and incentives to arrange for their own health care in a dynamic market of goods and services.

These themes are hardly exclusive. Many proposals combine different approaches in a multi-prong plan, while others stress various approaches in incremental stages. Some focus on specific populations (children, high risk, small employers), while others champion approaches that stress particular benefits or areas of health focus (prescription drugs, prevention, chronic diseases).

Instead of offering one particular model for consideration and drilling down into its benefits and costs, we start with four models that are representative of each of the four themes. Two are based on mandatory coverage, and two are voluntary:

MANDATORY	VOLUNTARY
PUBLIC AZ MODEL UTILITY **Universal, Single-Payer**	SLIDING AZ MODEL SCALE **Expand Public Programs**
EMPLOYER AZ MODEL MANDATE **Employer-Based**	TAX AZ MODEL CREDIT **Market-Based**

In a departure from the prevailing public utility structure, *AZ Public Utility* would not own the assets of the delivery system itself. The per person cost of the benefit package/service level would be determined in an actuarially sound manner, and existing insurance companies and managed care organizations (MCOs) would be invited to participate as administrative entities and/or in the provision of services, similar to the current health care system.

Although the delivery system would depart from the typical public utility model, the governance structure would not. A publicly elected Board would assume responsibility and provide oversight for establishing covered services within a comprehensive benefit package typical of plans provided by large employer MCOs. Board members would presumably be representative of consumers of health care services, and not necessarily of various providers of services or related interest groups. The mission of the Board of *AZ Public Utility* would be to ensure access to comprehensive health care benefits with the highest quality of care for all Arizonans at a reasonable cost.

In this model, health care is provided to all Arizona citizens through a centralized administrative structure – a public utility – similar to the provision of electricity, water and public safety.

Considerations

MANDATORY COVERAGE. Compared to the other models outlined here, coverage would be mandatory for all non-Medicaid recipients and *passive* – everyone needs only complete some form of registration to access services. Assuming the continued presence of existing federal programs, *AZ Public Utility* would utilize Medicaid funds and provide coverage up until the age of Medicare eligibility, when individuals would transition to that program. Within this scenario, it is possible to imagine a time when both Medicaid and Medicare funding would be allocated to *AZ Public Utility* based on a per capita formula.

FINANCING. Funding might be provided through a variety of public and private sources, relying primarily on income-based contributions and patient co-payments. Existing state and federal support for AHCCCS would continue to support care for low-income and indigent persons. Both the personal income tax and co-payments would be pro-rated in order to balance financial capability and patients' obligation to utilize services responsibly. In recognition of the financial break for employers that would result from the decoupling of health insurance and employment, the program might also derive funding through a commercial sales tax based on gross corporate revenue.

COMPREHENSIVE CARE. While each of the models presumes a basic, comprehensive benefit package such as might be found under a large employer plan, *AZ Public Utility* anticipates a concerted effort to allocate more resources to improved delivery of preventive and primary care, rather than acute care and heroic measures at the end of life. For example, the governing Board could conceivably establish guidelines for outcome-based quality adjusted life years (QALYs) gained in determining to what degree the benefit package would cover high-cost procedures. This may well result in lower overall medical costs; however, the financial analysis of *AZ Public Utility* in the Mercer Model Study makes no such assumptions.

ADMINISTRATIVE SAVINGS. What the Mercer Model Study *does* include in its analysis of *AZ Public Utility* are (a) adjustments in medical expenses to reflect differences in plan benefits, savings from coordination of care and some nominal savings from provider contracting; (b) savings from the elimination of broker commissions, which are not required under this model; and (c) a net savings of 10 percent in non-commission administrative expenses to reflect lower underwriting and claims processing costs, and increased member education expenses. Non-commission administrative expenses in the modeling are never expected to be less than current AHCCCS administrative expenses.

This model is most easily conceptualized as the expansion of the AHCCCS program. We refer to it as AZ Sliding Scale to distinguish it from AHCCCS itself and to highlight its central feature.

Essentially, this model allows Arizonans to voluntarily "buy" into the AHCCCS program (which could be modified in any number of interesting ways) on a sliding scale basis: The higher your income, the more of the full premium cost you pay; the lower your income, the more the premium is offset by a public subsidy.

The benefit package would presumably mirror the AHCCCS package and be determined through the legislative process, where ultimate oversight and responsibility would also rest. *AZ Sliding Scale* would contract with insurance carriers and MCOs for the actual provision of services, and provider rates would continue to be based on actuarial analysis.

Considerations

VOLUNTARY COVERAGE. This program would be open to all groups and individuals regardless of health status and the availability of health insurance through another venue. Mirroring the experience of expanded public insurance programs in other states, *AZ Sliding Scale* primarily targets lower-income residents; thus participation rates would be expected to decrease as income increases.

FINANCING. Like most programs of this type, financing would come from participant premiums with public subsidies for low income persons, not unlike the financing mechanism of Arizona's former Premium Share program. Premiums would be based on income, with those above 100 percent of the federal poverty level (FPL) paying an amount pro-rated to their income and established on a sliding fee scale. The cost difference for low income persons/families would be subsidized through a combination of Medicaid and state funds, the latter of which would presumably come from the general fund, tobacco taxes or other sources specifically earmarked for this purpose.[14] Again, we stress that while the models all presume some type of public financing, the analysis does not specify a particular source.

COMPREHENSIVE CARE. The benefit package would combine primary and acute medical care, behavioral health services and prescription medications in a comprehensive delivery system. Limits on benefits may be imposed by the legislature, which would assume responsibility for establishing covered services. In the economic analysis of this model, the cost of the comprehensive benefit package is reflected in total medical costs and out-of-pocket costs paid by enrollees. Just as in *AZ Public Utility*, the benefit package could be modified to focus on such issues as prevention and chronic disease management, resulting in a different utilization and cost mix. These options are not modeled here.

THE "CROWD OUT" ISSUE. One of the standard concerns of public health insurance programs of this type is that they run the risk of "crowding out" employer-based coverage, as employers would have less incentive to continue to provide health insurance for their low-income workers, who might sign up with *AZ Sliding Scale* if they could pay lower premiums than through their employer. Essentially, costs for low-income workers would shift from the private sector to the public sector as the latter "crowds out" the former. Research on this issue has produced mixed results.[15]

THE "ADVERSE SELECTION" ISSUE. Another concern is that public insurance programs tend to attract less healthy persons, which creates a pool of sicker people who drive up costs for the program. This is referred to as 'adverse selection.' Again, the research is mixed, underscoring the point that issues of "crowd out" and "adverse selection" are too complicated to be reduced to summary judgments.[16]

Mandating coverage would likely require more substantive regulation of insurance company rates and premiums in order to maintain a competitive market and avoid unreasonable escalation of costs. Beyond regulation of rates, governance under *AZ Employer Mandate* would include legislative oversight of the terms and conditions of employer participation and corporate oversight at the insurance carrier and employer levels.

Considerations

MANDATORY COVERAGE. All employer groups (a minimum of two employees or more) would be required to provide coverage to full-time employees, defined as persons who work 25+ hours per week, and their dependents. This would include governmental employees as well, but would exclude the part-time, individual and early retiree market segments. Clearly, there are some thorny issues here, especially in the area of what constitutes 'dependents' and 'part-time' employees. *AZ Employer Mandate* primarily targets uninsured workers, the majority of whom work for small businesses; hence the mandatory coverage for employers in that category (2-50 employees). The Mercer Model study breaks down the secondary market into large and small employers, however, so it is possible to determine what coverage numbers would look like if the model were modified to exclude mandatory coverage for small businesses. For people between jobs, insurance coverage would continue under existing COBRA laws.

FINANCING. Notwithstanding current efforts to establish limited coverage options for small employers, *AZ Employer Mandate* takes a 'play or pay' approach, in which employers who do not 'play' by providing health insurance coverage to their employees would be required to 'pay' an additional payroll tax that would be used to cover their workers. Employer-sponsored programs would likely remain with the private insurance market for administration and underwriting, while the proposed payroll tax could be administered through existing private markets or through public insurance programs. Employers would continue to receive the government subsidy that benefits employer-based health insurance programs under existing tax laws.

COMPREHENSIVE CARE. While the modeling assumes a comprehensive benefits package similar to what might be offered through a current large employer program, there is no reason to suppose that it would be limited to the standard mix of primary and acute care – or even ought to be. There is growing evidence to suggest that when employers view the health of their employees as an *investment* and not a *cost* (a focus on prevention, wellness, mental health, chronic diseases), there is a direct payoff in terms of increased productivity, lower absenteeism and lower health care costs overall.[17] Indeed, this is a point that needs to be stressed in all of the models.

COST SHIFTING AND OTHER ISSUES. A concern with the employer-based health insurance model is that as health care costs rise, employers tend to shift more of the premium costs to workers, many of whom are low income and find it to be a financial burden. In a mandatory model such as described here, this is potentially a major problem, especially in the small business market segment. It would conceivably encourage more premium rate regulation at the state level, which brings with it another set of issues we don't investigate here. Also, under the *AZ Employer Mandate* model, some employers might be incentivized to shift workers to part-time or temporary status, thus making them ineligible for benefits. Finally, the financial burden on employers might negatively impact their ability to compete in national and global markets, potentially harming the state's economy in the process.

AZ Employer Mandate is the most familiar of the models presented here, as it is an extension of the predominant method of providing coverage in Arizona and the rest of the nation. The difference – and it's a big one – is that employer-provided coverage is no longer voluntary, but is mandatory. This is often referred to as the "play or pay" approach.

This model utilizes a voluntary approach to coverage by creating a tax-related benefit that would be provided to individuals to purchase health insurance coverage themselves in the private market.

This model is often taken to be representative of "free market" solutions, because it presumably relies on market forces of supply and demand in a free exchange of goods and services.[18]

Considerations

VOLUNTARY COVERAGE. The AZ Tax Credit Model is developed on the assumption that the State would want to retain current tax levels rather than increase them to provide a tax deduction. The model assumes that, on average, between a two and five percent marginal tax rate at 100 percent FPL would be subsidized for those participating in the voluntary program.[19] Plans could be purchased either through employers or through brokers/plans in the marketplace. The target market is lower- and middle-income individuals and families who are currently uninsured, typically those making more than 100 percent of FPL (more realistically, those above 200 percent FPL), as experience has shown that participation increases as income relative to FPL increases. Marginal tax rates for those in financial need are in the two to five percent range, and those who are in "true" financial need (at least as defined by federal poverty standards) are eligible for public programs and charity care regardless of participation.

FINANCING. Although modeling is based on an individual tax credit and assumes a minimal subsidy, this approach could also utilize a refundable tax credit (a credit in excess of tax liability), a direct voucher or some other type of tax-related benefit, the amount and scope of which could dramatically affect participation rates. Here, we assume financing would come from some combination of federal and state revenues, as well as individual premium and out-of-pocket payments. Proponents of market-based approaches to health reform also tout the benefits of medical savings accounts, health reimbursement arrangements (HRAs) and similar approaches, but since these could conceivably be incorporated into all of the projected models if so desired (as could tax credits/vouchers), we don't discuss them specifically here.

COMPREHENSIVE CARE. As in the other models, we assume a comprehensive health benefits package across the board. The projected growth of consumer-directed/consumer-choice health plans, coupled with an individual tax credit, would presumably encourage more direct consumer involvement in purchasing and utilization decisions, resulting in innovations in plan design and benefits, as well as better information on health care quality and cost factors. What is an appropriate and necessary level of care for a healthy adult, however, may not be adequate for someone with a chronic and expensive condition; without some way to pool risks or otherwise provide affordable care to those in the latter category, *AZ Tax Credit* might not be an attractive alternative for them.

THE COST EFFICIENCY ISSUE. On the positive side, *AZ Tax Credit* would provide incentive for consumers to utilize more cost effective care. If one is responsible for purchasing one's own health care, one wants to know what things cost, what works and what doesn't, and what represents the best value for the money. On the negative side, in order to be attractive, the tax credit must cover at least 50-75 percent of the premium, and this is hard to achieve in the small group and individual markets, at least at the present time.[20] The upshot is that the government's cost for a tax credit sufficiently large enough to purchase a comprehensive benefits package in the private marketplace may be higher than the tax liability of most low income individuals. For consumers, why would they choose to accept a tax credit that couldn't purchase what they need? For the government, what is the public policy argument for funding an expensive tax credit when it may be less expensive to provide health insurance directly through one or more existing public programs?

The Arizona Health Insurance Market

In order to establish a context for the coverage and financial analysis of the four models, we link every Arizonan to an *insurance market segment*. Those who have conditions or are in situations that result in no health coverage constitute a market segment in their own right – the uninsured. The Mercer Model Study further breaks out the uninsured into secondary markets in order to clearly see the projected impact of particular models. All projections are for calendar year (CY) 2004.

As **Figure 1** illustrates, a total projected population of 5,763,000 people is broken out into Medicare (12%) and non-Medicare (88%) segments. We show Medicare at the outset to indicate its portion of the total, but we will no longer be concerned with it in this analysis, since Medicare is presumed to remain intact.

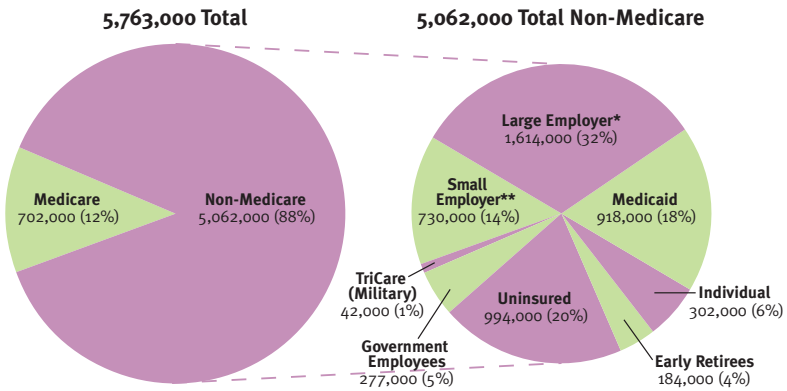
The 5,062,000 non-Medicare population – the focus of our attention – is further broken into insurance market segments as indicated. While the uninsured (994,000) represent about 17% of the total state population, they represent 20% of the total non-Medicare population. If one excludes government employees and early retirees, less than half of Arizona's population (46%) is covered by private health insurance offered through an employer.

Figure 2 assigns projected dollar amounts spent in each market segment. Dollars include medical, administrative and out-of-pocket expenses. Not surprisingly, expenditures associated with an insurance market segment are not necessarily correlated with the population of that segment:

- Medicare is 12% of the total population, but 29% of the expenditures.
- Medicaid (AHCCCS) is 18% of the non-Medicare population, but 12% of the expenditures.
- Small business is 14% of the non-Medicare population, but 23% of the expenditures.
- The uninsured are 20% of the non-Medicare population, but 13% of the expenditures.

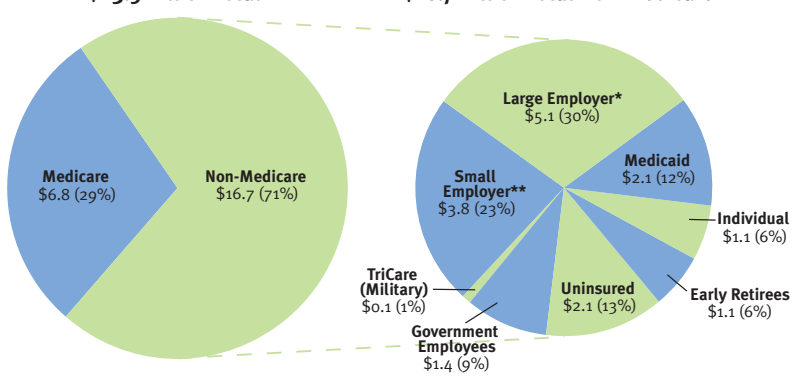
While exploring the relationship between population and expenditures in any depth is beyond the scope of this report, we note in the case of the uninsured – the primary focus of the analysis – the role health insurance plays in gaining access to care. If one doesn't have it, one receives less care, and health status is adversely affected.[21]

FIGURE 1: Arizona Population by Insurance Market Segment



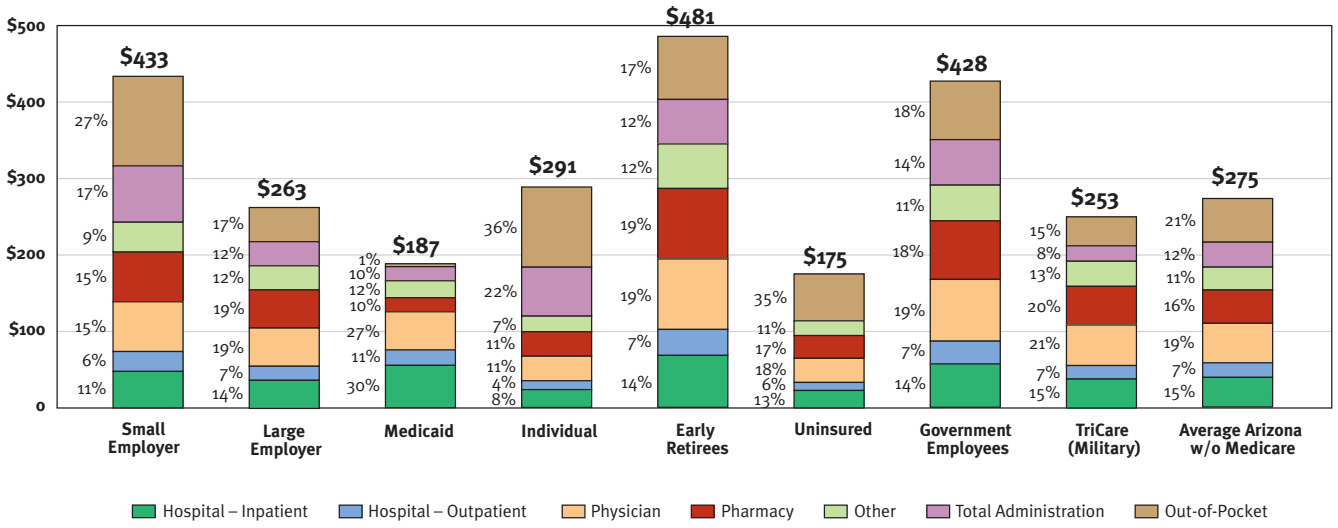
To Nearest Thousand. *51+ Eligible Employees. **2-50 Eligible Employees.

FIGURE 2: Arizona Health Care Dollars by Insurance Market Segment



In Billions. Includes Medical, Administrative and Out-of-Pocket Expenses.
*51+ Eligible Employees. **2-50 Eligible Employees.

FIGURE 3: Arizona PM/PM Expenditures by Insurance Market Segment and Category of Service



Includes Medical, Administrative and Out-of-Pocket Expenses.

"Our resources are drained by a lot of illegal aliens and immigrants because they get health care regardless, if they are willing to go and show up for it."

Arizona Resident

Not only are there differences between expenditures associated with different insurance market segments, but there are also significant differences in how these expenditures break out between medical care expenditures (hospital, physician, pharmacy, other), administrative expenditures and out-of-pocket expenses. One method of comparison is to look at the average expenditure per person (member) per month – or PM/PM. This is illustrated in **Figure 3**.

A few highlights:

- The highest average PM/PM health care expenditures are for early retirees ($481), employees of small businesses ($433) and government employees ($428) – all exceeding $5,000 annually.
- The lowest PM/PM market segments include the uninsured – who still average $175 PM/PM – followed closely by AHCCCS (Medicaid) at $187 PM/PM. Dollars spent by the uninsured or on their behalf are already in the system.
- Non out-of-pocket medical expenditures account for just 41% of total monthly expenditures for those in the individual insurance market compared to 89% in AHCCCS and 71% in large employer.
- Administrative percentages are highest for the individual (22%) and small employer markets (17%), where they add $64 and $74 PM/PM respectively. Compare this to administrative expenditures for AHCCCS, at 10% ($19 PM/PM).
- Out-of pocket expenditures range from a high of $117 PM/PM for people covered through small employers to a low of $2 PM/PM for low-income people covered by AHCCCS. People in the individual insurance market also pay some of the highest out-of-pocket expenditures, averaging $105 PM/PM.

FIGURE 4: Arizona Uninsured by Secondary Market

Secondary Market Attachment	Under 100% FPL*	100-199% FPL	200%+ FPL	Total
Small Employer	146,000 15%	121,000 12%	108,000 11%	374,000 38%
Large Employer	75,000 8%	63,000 6%	56,000 6%	194,000 19%
Governmental Employees	13,000 1%	11,000 1%	10,000 1%	33,000 3%
Early Retirees	9,000 1%	7,000 1%	6,000 1%	22,000 2%
Individual	75,000 8%	63,000 6%	55,000 6%	193,000 19%
Do Not Work	69,000 7%	58,000 6%	51,000 5%	178,000 18%
TOTAL	386,000 39%	322,000 32%	286,000 29%	994,000 100%

To Nearest Thousand. *Federal Poverty Level.

People without health insurance can be viewed as a market segment in their own right, but they are hardly some amorphous "other" group. They are, in fact, everyday people like the rest of us – people with jobs, people between jobs and looking for work, people in good health and poor health, our co-workers, family and friends. Any of us, at anytime, anywhere could be in similar situations and counted among the uninsured.

In **Figure 4** we break out the primary market of 994,000 people without health insurance into the different "secondary" markets found in Figures 1-3. We further classify these secondary markets by those under 100% of the FPL, 100-199% FPL and 200%+ FPL (see accompanying chart).

Some highlights:

- 80% of the uninsured in Arizona are employed. By far the largest portion (38%) fall into the small employer market – employers who generally might like to offer health insurance but often cannot afford to do so.
- Fully 267,000 people in the small employer market – 71% of the total – make under 200% FPL. That's $17,960 for an individual, or $36,800 for a family of four. Even if they are offered health insurance, they can't always afford their portion of the premiums.
- Looking at the uninsured by income level alone, 386,000 – 39% – earn less than 100% FPL and are conceivably eligible for public insurance programs under Prop. 204. Some portion of the 322,000 people who earn between 100-200% of the FPL might also be eligible under more targeted health insurance programs such as SCHIP.

"For every 16 cents that you spend in preventive medicine, you're going to have a savings of 84 cents in curative medicine.... If we can get a wellness state of mind, in the long run everyone is healthier, and the entire system benefits by far less problems."

Arizona Resident

Increasing Coverage: The Four Models Applied

Within the context of Arizona's health insurance market as described, and applying the eligibility criteria and other factors of the four proposed models previously outlined, the Mercer Model Study projects the number of people currently without health insurance who could be covered within existing insurance market segments.

FIGURE 5: AZ Tax Credit and AZ Sliding Scale

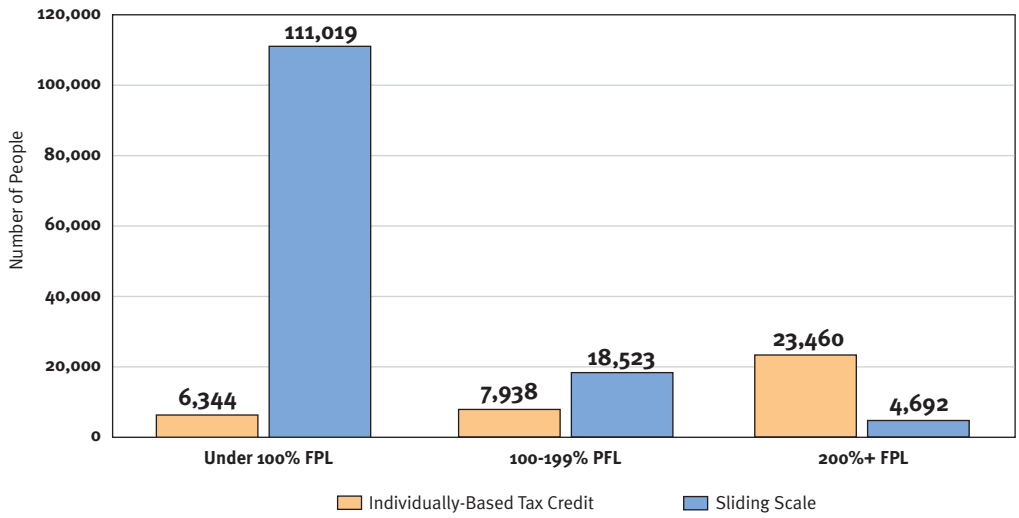


Figure 5 projects the number of additional persons who would be covered under the *AZ Tax Credit* and *AZ Sliding Scale* models, broken down by FPL income segments.

TAX AZ MODEL CREDIT

- AZ Tax Credit is projected to expand coverage by a net total of 37,742 persons – about 4% of the total uninsured. This is the smallest expansion of the four models. Voluntary participation rate estimates are based on a study by the Center on Budget and Policy Priorities.
- The limited expansion is due in part to the well documented net effect of a loss in employer-based coverage, as more individuals would be able to purchase insurance in the individual market, and employers would have less incentive to offer coverage.
- Research shows that the take-up rate is heavily dependent upon the amount of the tax credit, which must cover at least 50 percent of the premium before it becomes an economically feasible choice for most people.[22] This is reflected in Figure 5, which shows higher participation as the income level increases.

- *AZ Sliding Scale* is projected to expand coverage by a total of 134,234 persons – about 14% of the total uninsured population in Arizona.
- Participation rate estimates are based upon a participation function developed by the Urban Institute (Washington, D.C.) and reflect data from Washington, Hawaii and Minnesota. As predicted, enrollment rates decrease as income increases – the reverse of *AZ Tax Credit*.
- As Figure 5 shows, the majority of those projected to enroll (111,019) may already be eligible for AHCCCS but not enrolled; this number also includes people whose annual income may be less than 100% FPL, but who do not qualify for other reasons such as ownership of a home or other assets.
- There is an overlap between *AZ Sliding Scale* and *AZ Tax Credit* at more moderate income levels, where people would be able to purchase individual or group insurance with a subsidy provided either through a tax credit or discounting the premium.

2003 Federal Poverty Level (FPL) Guidelines in Arizona

Size of Family Unit	100% FPL	200% FPL
1	$8,980	$17,960
2	$12,120	$24,240
3	$15,260	$30,520
4	$18,400	$36,800

"What ever happened to your doctor spending time with you?"

Arizona Resident

FIGURE 6: **Estimated Working Uninsured by Secondary Market**

Secondary Market Attachment	Estimated Uninsured Impacted by Employer Mandate	Estimated Full-Time-to-Part-Time Employees*	Part-Time Workers	Individual
Small Employer	292,000	32,000	50,000	
	29%	3%	5%	
Large Employer	159,000	8,000	26,000	193,000
	16%	1%	3%	19%
Government	28,000	2,000	4,000	
Employees	3%	0%	0%	
	TOTAL 479,000 48%			
	ELIGIBLE UNINSURED 601,000			
	WORKING UNINSURED 794,000			

To Nearest Thousand. *Employees potentially converted from full-time to part-time status as a result of employer mandate.

"I'm going to give you nothing for as much as I can, which is what they [health insurance companies] are trying to do."

Arizona Resident

Figure 6 shows the number projected to be covered by *AZ Employer Mandate*. Out of the 80 percent (794,000) of those without health insurance who work, mandated coverage is projected for 479,000 of them – 48% of the total uninsured population of 994,000.

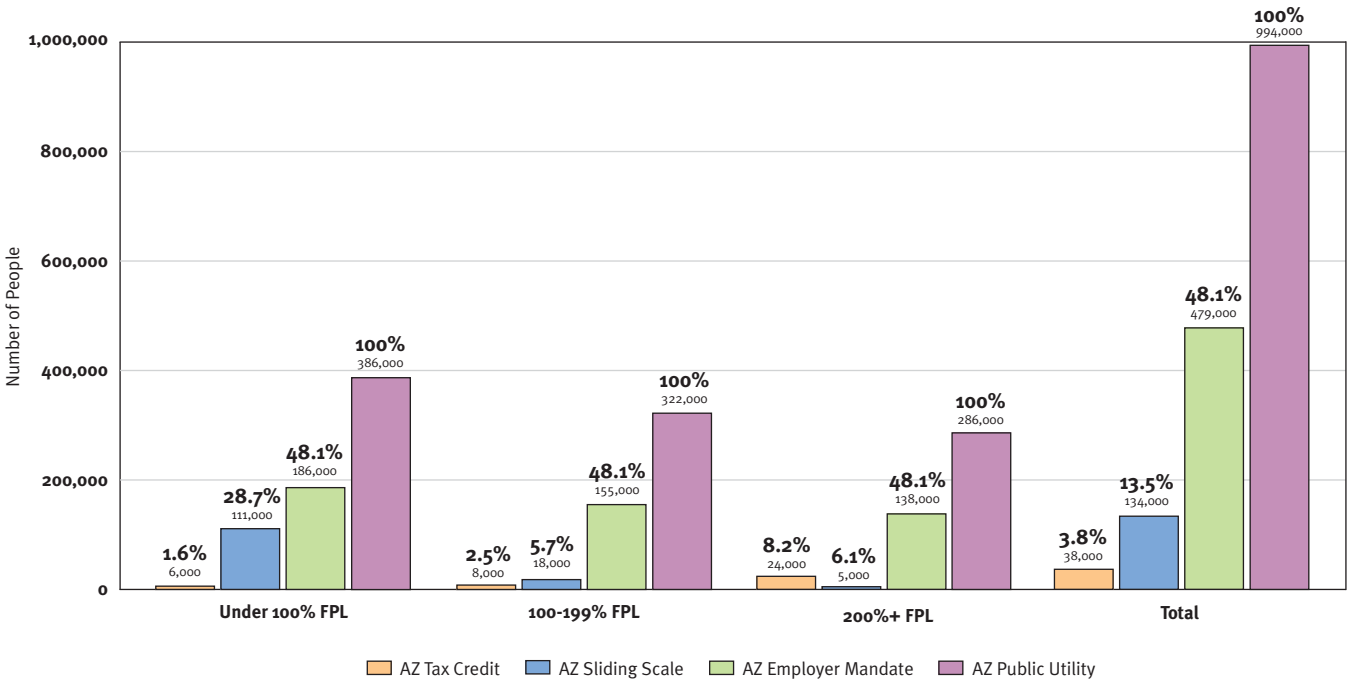
- Small businesses (50 employees or less) account for 94% of all businesses in Arizona but only 26 percent of all employees. About 60% of those projected to be covered under *AZ Employer Mandate* would come from the small business segment (292,000).
- About 315,000 uninsured – roughly 32% of the total uninsured population – are either part-time workers (less than 25 hours per week) or individuals in the private market. They would not be covered by *AZ Employer Mandate*.
- If one were to modify *AZ Employer Mandate* to exclude small business (similar to legislation recently passed in California), only an additional 187,000 people would be covered – 19% of the total uninsured population compared to 48% under the model that includes small businesses.

No surprise here. *AZ Public Utility* covers everyone. In this model, health care is defined as a public good, and of benefit to everyone in society. Therefore, everyone is provided access.

While some public goods are provided directly by governments, others are provided by quasi-governmental organizations such as public utilities; still others can be provided by private businesses and nonprofit organizations under contractual or other legal arrangements. We chose a public utility model to illustrate certain cost and delivery benefits, but there are compelling reasons for choosing other arrangements.

Coverage and Cost:
The Four Models Compared

FIGURE 7: Arizona Newly Insured by Delivery Model and by Federal Poverty Level Shown with Percentage Change from Current



To Nearest Thousand.

Coverage

By way of summary, **Figure 7** compares the four models on the criterion of increasing health insurance for Arizonans, considered in total and broken out in FPL categories.

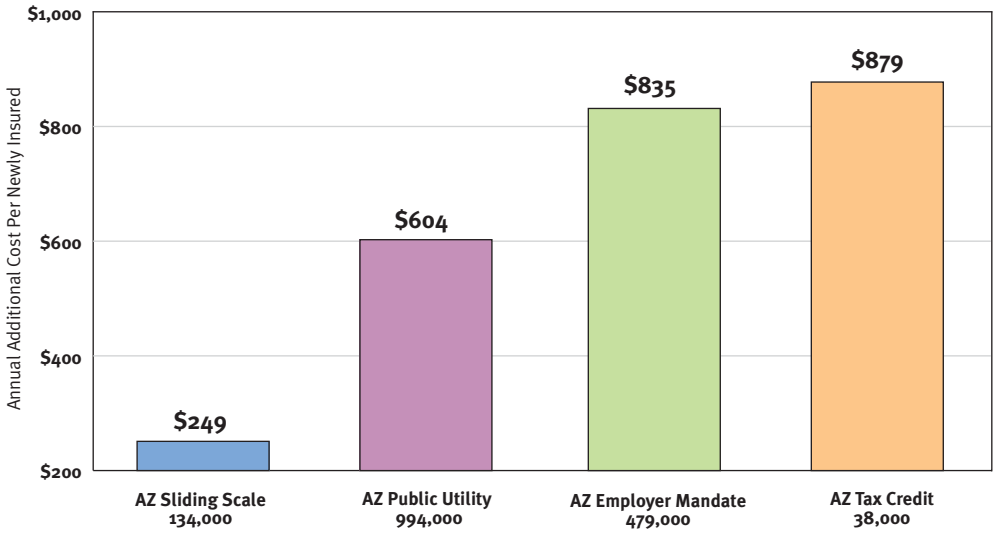
- If the primary goal is to provide more Arizonans with health insurance, then by definition the mandatory models outperform the voluntary ones: *AZ Public Utility* provides 100% coverage, and *AZ Employer Mandate* covers an additional 479,000 persons (48%), leaving 515,000 still uninsured. The voluntary approaches in *AZ Sliding Scale* and *AZ Tax Credit* increase coverage for approximately 134,000 (14%) and 38,000 (4%) respectively.
- On the voluntary side, *AZ Tax Credit* is a more attractive option for moderate and higher income people, while *AZ Sliding Scale* is more attractive for those in the lower income category. The major difference is at the very low income category (under 100% FPL), where *AZ Sliding Scale* picks up 111,000 people compared to 6,000 for *AZ Tax Credit*. The coverage differences are less extreme in the other income categories.

"Talk to the nurse, pay for the doctor."

Arizona Resident

FIGURE 8: Overall Program Dollars by Delivery Model

FIGURE 9: Model Cost-Benefit Analysis



Cost

Figure 8 provides a comparison of the four models on the basis of total costs. **Figure 9** combines cost data with coverage data from Figure 7 to arrive at a preliminary *cost-benefit* analysis of each model.

- Currently Arizona has a $16.7 billion health care expenditure with 994,000 uninsured. This works out to an annual per person expenditure of about $3,300 (excluding Medicare).

- *AZ Tax Credit* and *AZ Sliding Scale* each add approximately $33.4 million in additional annual costs to the current non-Medicare system (.2%). *AZ Employer Mandate* and *AZ Public Utility* add about $400 million (2.7%) and $600 million (3.5%) in additional annual costs respectively.
- The cost-benefit analysis in Figure 9 is calculated by dividing the additional funding required for each model by the total amount of the projected take-up rate for each. This results in a projected additional annual cost per person. Considering this factor alone, *AZ Sliding Scale* is the most cost-efficient of the four models at $249 per new enrollee; *AZ Tax Credit* is the least cost-efficient at $879 per new enrollee.
- *AZ Public Utility* manages to cover every Arizonan at an additional cost of $600 million annually, or 3.5% higher than the current outlay – with 994,000 people uninsured. From a cost efficiency view alone, it's second to *AZ Sliding Scale,* and better than *AZ Employer Mandate* and *AZ Tax Credit.*

A cost-benefit analysis is one of several criteria to consider, but system efficiency has never been a first order criterion for most Americans. If it were, we wouldn't have the fragmented, expensive and over-administered health care system we have in the United States today.

First Order *Questions*

The first order questions for public discussion are these:

? Do Arizonans want to fix the health care system so everyone can have access to high quality, cost effective care?

? Is the provision of health insurance for all Arizonans the best way to begin to address system reform issues?

? If health care for all Arizonans is desirable, how do we calculate the balance between public cost and public benefit?

? How do we reconcile public costs and benefits with the multitude of vocal and often competing interests in a privatized health care delivery system?

Research Methodology

The FrameWorks Institute is a nonprofit organization whose purpose is to advance the nonprofit sector's communication capacity by identifying, modeling and translating relevant research to more effectively frame public discourse about social problems.

Using an approach called *strategic frame analysis*, developed with its research partners such as the Center for Communications and Community (UCLA), Cultural Logic (www.culturallogic.com) and Public Knowledge, The FrameWorks Institute designs, conducts and evaluates communications campaigns on health care, school reform, youth development and other social issues.

For its work with SLHI, The FrameWorks Institute and its partners conducted a series of six focus groups in Arizona during Fall 2003, comprised of a representative mix of "engaged" citizens (those who are registered to vote, read the newspaper frequently, are involved in community organizations and have recently contacted a public official or spoken out on an issue). Quotes from focus group participants are found throughout this report.

Researchers also conducted a statewide public opinion survey (800 interviews) on health care and related issues in November-December 2003. Residents of rural areas and Hispanic residents were over sampled and weighted to reflect their proportion of the population.

The Arizona work builds on similar research recently completed in New Hampshire, California and other states.

Here, we summarize selected findings of this research, particularly as they relate to Arizonans' perception of health care issues generally and the four coverage models specifically.

WWW.FRAMEWORKSINSTITUTE.ORG

Message Frames:
A Window on Health Care

In a highly pluralistic and advanced technological society like the United States, the media are the chief sources of information about public affairs and shape, unconsciously or not, how all of us "see" complicated and contentious issues like health care, education and tax policy, where we must weigh public benefits with private interests and perceived "needs."

Competing interests seek to *frame* their messages – imbue them with a defined construct of images, concepts, values and messengers – in ways that resonate with the corresponding internalized *frames* of their intended target audience and influence how that audience perceives – and acts on – the message.

As used here, *frame* is both a noun and a verb: It is the perceived construct of the message itself, and the way the message is manipulated to trigger the desired meaning.[23]

When communication is effective, people can look beyond – or into – the dominant frames of the moment and consider different perspectives (other frames) on an issue. When communication isn't effective, we tend to resort to "default" frames – those shorthand and comfortable sets of assumptions, values and images we use to make sense of the everyday world, often without a great deal of thought.

Frames and Framing in Health Care

As part of our long-term goal to increase access to affordable, high quality health care for all Arizonans, SLHI sought the perspective of the FrameWorks Institute and its partner organizations (see box) to investigate the following:

- How do Arizonans think about health care and the health care system?
- Are there dominant frames and default frames that Arizonans use to interpret health care?
- How do these frames affect public policy choices?
- How are the frames reinforced or otherwise manipulated in the media?
- How can issues like access, cost, quality and choice be *reframed* to improve policy choices in health care?

Working closely with SLHI, FrameWorks conducted a series of research projects on how Arizonans view the health care system in general, how they might react to different approaches to increase health insurance coverage (the four models previously outlined), and what communications and framing strategies might prove most effective in moving a policy agenda forward.

Snapshot!
Arizonans on Health Care

1. Health care is clearly among the front burner issues for most Arizonans.

What kind of priority should the state legislature give to the following issues (ranked 1-10, with 10 as highest priority)?

Improving education and the schools	8.6
Strengthening the state economy	8.2
Reforming health care	8.0
Improving conditions for the poor	7.4
Lowering taxes	6.7

2. Arizonans believe all levels of government should be involved in reforming health care.

What levels of government (federal, state, local) should be primarily responsible for reforming health care?

All levels equally	65%
Federal	20%
State	11%
Local	3%

3. While they expect and support a government role in reforming health care, Arizonans are also cautious about government responsibility for health care compared to other issues.

State government should have a lot of responsibility for:

Improving education	75%
Strengthening the state economy	67%
Lowering taxes	58%
Reforming health care	57%
Improving conditions for the poor	50%

4. Arizonans want to see health care reformed, but they don't think the system is so broken it needs to be completely rebuilt.

Which of these statements is closest to your view about the health care system in Arizona?

There are some good things in our health care system, but fundamental changes are needed to make it work better.	54%
The health care system has so much wrong with it that we need to completely rebuild it.	23%
The health care system works pretty well, and only minor changes are necessary to make it work better.	19%

5. Cost — and cost coupled with access — is the top priority for most Arizonans when it comes to health care.

When it comes to health care, where should the state legislature place its priorities (1-10 scale)?

Making sure treatment is not limited because of cost	8.2
Holding down the cost of health care	8.1
Addressing medical errors	7.9
Dealing with insurance company bureaucracy and inconvenience	7.8
Providing coverage for people without health insurance	7.7

6. Still, there is a large single segment that would prioritize coverage for the uninsured. If just one goal can be accomplished, a plurality prioritize the uninsured.

Which one of these priorities (in Question 5) would you most like the Arizona legislature to address?

Providing coverage for people without health insurance	30%
Holding down the cost of health care	25%
Making sure treatment is not limited because of cost	20%
Dealing with insurance company bureaucracy and inconvenience	13%
Addressing medical errors	6%

7. Outside of their experience with physicians and other health care professionals, Arizonans are dissatisfied with the current health care system.

Are you generally satisfied or dissatisfied with these issues in Arizona?

	Satisfied	Dissatisfied
The cost of health care	29%	69%
The state's efforts to reduce the number of uninsured	34%	58%
The state's efforts to make sure the needs of patients come before the economic interests of the health industry	39%	55%
The ability to get approval for health care services	44%	48%
The time doctors spend with patients	53%	44%
The experience and qualifications of doctors and other health care professionals	78%	19%

8. Arizonans support making a major effort to provide health coverage for the uninsured.

Which of these statements come closest to what you think state government should do for people who don't have health insurance?

Make a major effort to provide health insurance for most uninsured	63%
Make a limited effort to provide health insurance for some uninsured	27%
Keep things as they are now	8%

9. Most Arizonans support making a major effort to increase coverage even when told it would require an increase in state taxes.

If providing health coverage for the uninsured would require an increase in state taxes, what should state government do?

Make a major effort to provide health insurance for most uninsured	55%
Make a limited effort to provide health insurance for some uninsured	28%
Keep things as they are now	15%

10. Even with a tax increase, a slight majority of Arizonans think the state would be better off with a major effort to provide coverage for the uninsured.

Do you think Arizona would be better off, worse off, or wouldn't feel much of an effect if state government made a major effort to increase coverage for the uninsured, which might require a tax increase?

Better off	51%
Worse off	26%
Not much effect	19%

Default Frames: *How Arizonans Perceive Health Care*

The Consumer Product Frame is not the only frame that resonates with people (see sidebar). Before we get to that, however, we summarize selected findings from the Arizona focus groups:

HEALTH CARE ISSUES ARE TOP OF MIND

Arizonans recognize that health care is among the most important issues facing the state, but, unlike what researchers found in California, they do not perceive the system as being in crisis, nor do they think it is completely broken.

COST IS THE CHIEF CONCERN

It's easy to engage Arizonans on the health care system as a whole and the implications of various proposed reforms, but the conversation quickly devolves into a litany of personal horror stories about rising costs. Affordability, far more than access and quality, drives the energy on this topic. If system reform focuses on cost first, then the "product" will become more affordable. This, in turn, will "solve" the access problem.

INSURANCE COMPANIES WEAR THE BLACK HAT

For many Arizonans, health insurance companies are replacing cigarette manufacturers as the *bete noire* of American capitalism. The chief complaint is the perception that insurance companies, not physicians, are now making health care decisions and "running the industry." People also worry about medical bankruptcy and the adequacy of plans to cover catastrophic expenses. We note in passing that while people are quick to bash the health insurance industry as a whole, they often express satisfaction with their own health insurance plan. This same phenomenon is seen in public education.

SERVICE QUALITY IS DECLINING

Despite the fact that a majority of Arizonans express satisfaction with their own experience in the health care system, they pick up on what they read in the media: It's difficult to find or see a doctor, and even when you do, they don't spend enough time with you; a shortage of nurses is affecting quality of care; people in small towns and rural areas lack access to specialists and modern technology; there are too many medical errors, too many lawsuits, etc. In this climate of perceived malaise, getting more people signed up with health insurance will simply add more people to an already dysfunctional system and won't "solve" the issue of access.

Consumer Logic

This is how Cultural Logic, one of The Framework Institute's research partners, describes the logic of the Consumer Product Frame when it comes to addressing the uninsured:

> "The Consumer Stance [Consumer Product Frame] largely preempts a moral perspective on the problem of the uninsured. From the perspective of a consumer, the fact that some people do not have health insurance loses much of its moral force. Not everyone has access to a given consumer good, for a variety of reasons, prominently including *Individual Choice and Responsibility* [another 'frame' – italics added] – if you really want to buy something, you do what it takes (saving, working hard) to buy it. And by the logic of the Consumer Stance, if you don't have a particular good, it's either because it wasn't a priority for you, or it was a luxury beyond your means."[24]

Results of SLHI-sponsored research with Arizona focus groups underscore the results from other focus groups across the nation. When it comes to health care, the dominant default frame for most Americans is the *Consumer Product Frame*:

- People are consumers first, citizens second.
- Health care is perceived as a commodity.
- The power to purchase the commodity is paramount. Cost is the problem.
- Individual security in access trumps collective security.
- The uninsured are not a first concern. They aren't perceived as consumers.
- System reform is a zero-sum game. Improvement or expansion comes at someone's expense.

The Consumer Product Frame is the reason many of us engage in dubious reasoning when we try to come to grips with the complexities and problems of the health care system. With its focus on individual consumers and products, it masks what we *share in common within one system*, and why the system cannot be reduced to a zero-sum model.

"What's important to me is cost. I don't make enough money as it is...I'd have to work two jobs just to pay for my insurance."

Arizona Resident

ARIZONA IS MORE VULNERABLE THAN OTHER STATES

Arizonans believe that the high cost of health care is due in part to large numbers of senior citizens, illegal immigrants, a transient population and the state's rapid growth. While Arizona is in fact not all that unique when it comes to high health care costs, there is a tendency to blame certain populations and situations – especially illegal immigrants – as the dominant "cause" of health care woes. This fuels resentment and makes it harder for people to see the advantages of risk sharing and cost sharing across one common pool. Indeed, Arizonans mirror what researchers find in other states: there is little understanding of linked fate beyond the negative.

DISPARITIES IN ACCESS COME DOWN TO PERSONAL RESPONSIBILITY

Any discussion of disparities in health care among population segments is quickly associated with a discussion of race and ethnicity. Even ethnic community leaders expressed the view that most people had access to health care, but they lacked motivation and responsibility to get it. In this frame of mind, "both information and motivation are perceived as explanations for lack of access, as opposed to more structural and systemic problems such as part-time jobs or declining family benefit packages."[25]

FOCUSING ON THE UNINSURED WILL SOLVE LITTLE

While survey research indicates that a majority of Arizonans express support for a major state initiative to cover the uninsured, focus group participants expressed the view that health insurance isn't the major problem confronting the health care system, and will do little to address their top issues of cost and value for services rendered. In the Consumer Product frame, "people's innate desire to 'do the right thing' on this issue [covering the uninsured] is easily trumped by the reasoning that….lack of coverage is explained by bad choices made by people or lack of discipline and responsibility in saving to afford health care."[26]

ARIZONA IS A NATIONAL MODEL, BUT GOVERNMENT ISN'T THE ANSWER

Arizonans take pride in the state's Medicaid system (AHCCCS) as a model for other states to follow. At the same time, they associate government involvement in health care with inefficiency. While they think government might want to "do the right thing," they don't trust government to "do things right." Focus group participants thought they had a Hobbesian choice between "greedy insurance companies" at one pole and inept government at the other. They long for reform – for someone to advocate for the best interests of the public – but they are reluctant to trust either government or the private sector alone with that responsibility.

ARIZONANS ARE OPEN TO REFORM

Despite the pessimism and cynicism evident in much of the attitudes of Arizonans about the state of the health care system, they are receptive to "putting together a good long-term plan" to improve health care in the state. After reviewing the four proposed models to increase health insurance coverage, many participants expressed optimism that the views of citizens were "being taken seriously" by public officials, and that the state should press forward with a responsible and effective plan to address issues of access, cost, quality and choice. Attitudes and perceptions began to change during the course of the conversation. Participants saw it as a beginning, not an end.

Public Perception:
The Four Models

SLHI's research partners used the focus groups and opinion polling to test public perception of the four models to increase health insurance coverage in Arizona. The results are intended to inform the work of individuals and organizations that seek to implement successful communication strategies in the areas of health care access, cost, quality and choice.

Compared to the other models, Arizonans do not necessarily see the benefit of *AZ Public Utility* as covering the uninsured. Instead, most believe the central goal of the model is to oversee the health care industry in order to reduce costs and "reform" the system. While they support that goal, they are confused about possible funding sources and express reservation about the wisdom of having a publicly elected board make decisions about health care. They also associate *AZ Public Utility* with more direct government involvement in health care, which was a concern.

Of all the models tested, *AZ Sliding Scale* was the best received on an initial basis. Most Arizonans support the recommendation to allow people to buy into public insurance on a sliding scale basis, and they see relatively few downsides to the general approach. On the other hand, this model brought out several perceptions of the "poor" that could potentially undermine future support. Many perceive that the poor are irresponsible for not having health insurance, and resent that the poor seem to get better health care than they do.

Arizonans clearly understand that the goal of *AZ Employer Mandate* is to expand coverage among the uninsured. However, many believe it is simply an expansion of the current "flawed" system, plus it also presents some additional problems. Continuing to tie health insurance to employment leaves the unemployed out of the system. They also express significant reservations about the cost consequences of mandating coverage for small businesses. They predict that this approach will lead to small business bankruptcy, increased costs for services and pressure to lower wages.

Most Arizonans believe that the central goal of *AZ Tax Credit* is to place more responsibility for the cost of health care in the hands of individuals. Many are unclear just how such a system of tax credits/vouchers would work, and they believe this approach has significant potential for abuse, both by consumers and by businesses. In addition to worrying about how government can afford to hand out tax credits/vouchers when "they can't even balance the budget," they worry about the fate of individuals with major health problems under this model, who they believe would "fall through the cracks."

PERCEPTUAL BARRIERS ACROSS THE MODELS

Certain perceptual barriers were consistent across all four models.[27] Without a clear understanding of where the system is broken, people default to established ways of thinking. In brief, Arizonans:

- Worry that government intervention will make health care worse, not better.
- Know that additional funding may be necessary, but hesitate to support additional taxes.
- Are insistent that small businesses will be harmed by any sort of a mandate, and that this will have major repercussions for the state's economy.
- Want the poor to demonstrate responsibility by contributing to the cost of their care, but do not want this cost to be burdensome.

Framing Health Care Reform

Researchers also tested a series of message frames around health care issues to determine which, if any, resonated with the public, and with what types of groups as sorted by various demographic and economic factors. Here we present a short synopsis of each frame[28] and make a few initial observations:

Public Utility Frame

Just like electricity, water or public education, this approach to health care would ensure that all Arizona residents have access to health care. Health care should be treated like any other public utility, managed for the good of all residents and accessible to all residents.

Observation: Most effective when it is used to reinforce the public nature of health care – for the "good of all."

Situation Frame

There are many situations that result in people being uninsured – working for employers who don't offer coverage, having a pre-existent condition, divorce, early retirement, etc. This approach stresses that coverage should be extended to people in these and similar situations.

Observation: People easily identify with these situations. Very effective.

Prevention Frame

Quality health insurance that includes check ups, immunizations, prenatal care and other preventive care pays for itself in the long run and results in healthier communities.

Observation: Arizonans firmly believe in and support a focus on prevention in any plan to increase coverage.

Fair Share Frame

For health care to run smoothly, everyone should have to contribute their fair share. This approach stresses that everyone in the state has to participate so health care will be more efficient.

Observation: Big questions on what constitutes a "fair share" for the rich, the poor, the homeless, etc.

Small Business Frame

Small businesses would like to offer their employees health insurance but can't always afford to. Those that do provide coverage are being priced out of the market by those that don't. This approach will level the playing field for all businesses.

Observation: This frame was poisoned by reactions to the Employer Mandate Model, which was viewed as bad for small business, and therefore bad for Arizona.

Working Uninsured Frame

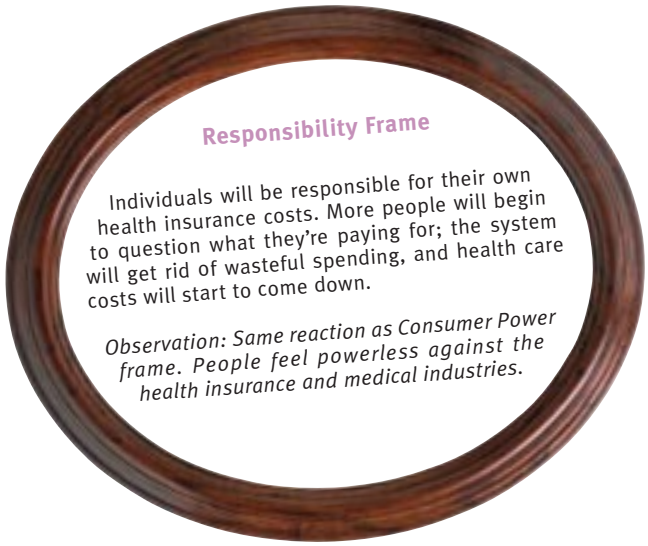
There are thousands of Arizonans who work for employers who don't offer health insurance, and who earn too much to qualify for public insurance but not enough to purchase insurance on their own. This approach will help them get coverage and become more secure.

Observation: This frame raises questions of individual worth and effort and often results in an emphasis on individual responsibility, as opposed to fixing the system to address common problems.

Community Health Frame

When people lack health insurance, they delay going to the doctor and don't get the preventive care they need. This results in more preventable diseases and affects us all. This approach would expand health coverage and improve the health of our communities.

Observation: Any message that stresses prevention is attractive to the public.



Build It Up

Building something up is much harder than tearing something down. The history of health care reform is replete with examples of successful opposition media campaigns focused on stereotypes, government bashing and playing on the fears and prejudices of carefully targeted audiences.

But health care reform is a long-term proposition, and if our research teaches us anything, it's that Arizonans yearn for a more positive vision and want to be involved in creating it.

Using lessons learned from the framing of health care messages and issues, we can all work together to create that vision and make it a reality.

"It's been an eye opener to see the [health care] situation more as not just for myself personally and my family, but moreover as a whole... to learn about other problems and situations, to take that into effect." Arizona Resident

Lessons of Reform

What can we learn from the experience of the Arizona Affordable Health Care Foundation and reform efforts in other states? Here is a short list of points to consider:

- Reconciling opposing interests and reform agendas is extremely difficult in any kind of formal "coalition-building" process. The "politics of accommodation" is just as active at the state level as it is at the federal level.
- Maintaining and enhancing a coalition of all the stakeholders in health care reform is never sufficient by itself for success, and sometimes it may not even be necessary – or the wisest thing to do. A great deal depends on timing and the political winds of the moment.
- Some people are willing to march in a parade, but only if they lead it. The old adage rings true: It's amazing what you can accomplish if you don't care who takes credit for it.
- Leadership at the top is vital. A strong governor and political will can change everything.
- Incremental reform isn't necessarily a goal, but it is often an effective strategy. Perseverance furthers.

Research

Develop

Test

Disseminate

Advocate

Evaluate

Strategies to Move Forward

As a broad-based public education and advocacy effort focused on the goal of ensuring that all Arizonans have access to high quality, cost-effective health care, the *Arizona CAN* initiative should employ the following strategies:

- **RESEARCH** promising ways to increase access to affordable, high quality health care in Arizona.
- **DEVELOP** models and ideas for possible application.
- **TEST** model(s) viability and application.
- **DISSEMINATE** information to increase public awareness and inform public policy choices concerning issues of health access, cost, quality and choice.
- **ADVOCATE** through targeted communication strategies for *Arizona CAN* principles and goals.
- **EVALUATE** results continuously.

The Windmills of Change

Timing is everything. The challenges of America's health care system now cut a wide swath into the middle class, small and large businesses, an aging population and a growing chorus of providers of care concerned with the way medicine is practiced today. These issues have been with us for a long time, but their scope – and the public tab for their expansion – has grown exponentially over the past 30 years.

The political battle is joined. Health care reform is a front burner issue with politicians and citizens across the country, and is likely to remain so for the foreseeable future.

Once again we ride out to tilt with the windmills of change. It's a long and proud tradition – and a necessary one. Citizens *are* the wind. We must attempt to direct the way the windmill moves, and choose a more positive future rather than resign ourselves to feelings of powerlessness in the face of forces we think are beyond our control.

The system is broken, but it can be fixed – one step at a time. It's not an impossible dream – people are working together on it today all across the country.

Arizona CAN! Grab your lance, hop on your horse and ride out!

Acknowledgements

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Finally, this report has its genesis in a series of informal conversations with a number of seasoned observers and participants in the Arizona health policy scene. We wish to thank Susan Gerard, Monte DuVal, M.D., Michael Powers, M.D., Phyllis Biedess, Leonard Kirschner, M.D. and Don Schaller, M.D. for their insights into the history of Arizona health care reform and health care issues generally.

As always, responsibility for errors and the sins of omission and commission remains our own.

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1 Blendon, Robert; Benson, John, "Americans' Views on Health Policy: A Fifty-Year Historical Perspective," *Health Affairs*, March/April 2001, pp. 33-46.

2 See Starr, Paul, *The Social Transformation of American Medicine*, NY, Basic Books, 1982, chapters 4-5 for an excellent history of health care up through the early 80s. The rhetoric of "crisis" in the early 1970s, for example, is strikingly similar to the rhetoric today.

3 See *Sticker Shock, The Future of Health Care Costs*, an SLHI Arizona Health Futures issue brief, Winter, 2001 for more on this issue.

4 See *Got Quality? The Search for Perfection in an Imperfect Health Care System*, an Arizona Health Futures issue brief, Spring, 2001 for a discussion of quality issues.

5 This is an average out-of-pocket cost figure across all populations. As one might expect, insurance status dramatically impacts out-of-pocket costs. Medicaid patients, for example, pay about one percent of their own money for care; those in the individual insurance market can pay as much as 40 percent.

6 See Starr, op. cit., pp. 381-388 for more on the contradictions of accommodation in health care.

7 For more on the history of system fragmentation, with a focus on behavioral health specifically, see *The Humpty Dumpty Syndrome: Integration and Behavioral Health*, an Arizona Health Futures issue brief, Winter, 2003, pp. 6-7.

8 *Building a Public Health Movement in Arizona*, an Arizona Health Futures Issue Brief, Fall, 2002 discusses this distinction in a public health context.

9 Attributes of the uninsured such as race, age, sex, citizenship, income and health status are obviously important, and there is a growing body of relevant information available in Arizona and elsewhere. One comprehensive source of information is *Health Care Coverage in Arizona*, University of Arizona Health Sciences Center, 2002. See also Wm. C. Mercer, *Faces of the Uninsured and State Strategies to Meet Their Needs: A Briefing Paper*, prepared for the Arizona Health Care Cost Containment System, July 2001. The Kaiser Family Foundation also maintains a wealth of national and state-specific information on health insurance coverage and related health care issues (www.kff.org).

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11 One Arizona example of the level of analysis that such a projection might require is *The Financial Impact of the Arizona Affordable Health Care Foundation's Emerging Model* (unpublished), prepared by William M. Mercer, Inc., March 1993.

12 See, for example, Cunningham, Peter J. and Kemper, Peter, "Ability to Obtain Medical Care for the Uninsured: How Much Does it Vary Across Communities?" *Journal of the American Medical Association*, 1998, 280 (10), 921-927. Also, Neuschler, Edward and Curtis, Rick, "The Use of Subsidies to Low-Income People for Coverage Through Small Employers," *Health Affairs Web Exclusives*, Jan-Jun 2003, W3-227-236.

13 These themes are similar to those outlined in the recent January 2004 report calling for universal health insurance issued by the Institute of Medicine (IOM), and were posited for purposes of our research in advance of release of the IOM report. There are, of course, other ways to slice health insurance proposals. In one study, the authors analyze ten national proposals in five general categories: incremental reforms, voluntary insurance pools, employer mandate ("pay or play"), tax credits and a tax-financed health care system. See Shields, op. cit., p. 1.

14 SLHI plans to review potential funding sources for an expansion of health care coverage in Arizona in a future report.

15 See Cunningham, Peter, "Declining Employer-Sponsored Coverage: the Role of Public Programs and Implications for Care," *Medical Care Research and Review*, 2002, Vol. 59 (1).

16 For a discussion of these issues, see Long, Stephen H. and Marquis, Susan, "Participation in a Public Insurance Program: Subsidies, Crowd Out and Adverse Selection," *Inquiry*, 2002, Vol. 39. Available at http://www.milbank.org/quarterly/8101feat.html.

17 See O'Brien, Ellen, "Employers Benefit from Workers Health Insurance," *The Milbank Quarterly*, Vol. 81, No. 1, 2003.

18 We say 'presumably' because one can argue that there is nothing particularly "free" about free markets in health care. A few relevant distinctions can be found in *Sticker Shock*, op. cit., p. 3.

19 This is a minimal subsidy. The math roughly translates into a subsidy of $235 (2.5% x $9,400), which equals approximately one month's premium, or 1/12th of total annual cost of purchasing health coverage. Clearly that is not sufficient to equal 50-75 percent of premium coverage, which most analysts say is necessary for some type of tax credit/voucher plan to be attractive enough to work. We could have posited a much more generous subsidy, and therefore increased the projected take-up rate, but of course at a much greater cost to the state.

20 For more on the feasibility and applications of tax credits, see Garrett, Bowen, et. al., "Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?" Found in the *Community Voices: Healthcare for the Underserved* project. October 2001, http://communityvoices.org/PolicyBriefs.aspx.

21 There is a wealth of information on this issue. See, for example, Cunningham, op. cit. Also, Davis, Karen, "The Cost and Consequences of Being Uninsured," *The Commonwealth Fund*, publication #266, www.cmwf.org.

22 Garrett, op.cit. Most proponents of tax credits and similar funding mechanism believe that the credits must be not only large relative to the premium, but should be refundable as well. They also discuss guarantee issue, community rating and purchasing pools, none of which we discuss here.

23 The idea of deconstructing frames by the use of frame elements is unique to The FrameWorks Institute. They have this to say about framing: "Framing refers to the construct of a communication — its language, visuals and messengers — and the way it signals to the listener or observer how to interpret and classify new information. By framing, we mean how messages are encoded with meaning so that they can be efficiently interpreted in relationship to existing beliefs or ideas. Frames trigger meaning." www.FrameWorksinstitute.org/strategicanalysis/perspectives.html.

24 Quoted in "Framing Health Insurance Reform in Arizona for Public Understanding and Support," *The FrameWorks Institute*, December 2003. SLHI internal document.

25 Op. cit.

26 Op. cit.

27 Op. cit.

28 Excerpted in part from op. cit.

Our Mission

To improve the health of people and their communities in Arizona, with an emphasis on helping people in need and building the capacity of communities to help themselves.

The purpose of *Arizona Health Futures* is to unravel an important health policy topic of relevance to Arizonans, provide a general summary of the critical issues, background information and different perspectives on approaches to the topic; tap into the expertise of informed citizens, and suggest strategies for action.

Arizona Health Futures is available through our mailing list and also on our web site at **www.slhi.org**. If you would like to receive extra copies or be added to the list, please call 602.385.6500 or email us at info@slhi.org.

ARIZONA HEALTH FUTURES

Comments and suggestions for future issues, as always, are welcome.

St. Luke's Health Initiatives is a public foundation formed through the sale of the St. Luke's Health System in 1995. Our resources are directed toward service, public education and advocacy that improve access to health care and improve health outcomes for all Arizonans, especially those in need.

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