HB
409
File No. 2


SHARMAN HALEY

THE IMPLICATIONS OF STATE-INITIATED CATASTROPHIC-COMPREHENSIVE HEALTH INSURANCE PLANS

A Seminar Sponsored by

Georgetown University Health Policy Center

Sheraton-Carlton Hotel
Mount Vernon Room

Friday, September 16, 1977

Health Policy Center
Georgetown University
3520 Prospect Street, N. W.
Washington, D. C. 20007
202-625-3092

AGENDA

9:00 a.m. WELCOME AND OPENING REMARKS

Verne Horn - Director, Health Policy Center
Jordan Braverman - Conference Coordinator
Lewis Butler - Moderator

9:30 a.m. CROSSING THE LEGISLATIVE HURDLE: POLITICS AND PLANNING FOR STATE HEALTH INSURANCE

- Determining the need
- Assessing state capabilities
- Developing the benefits
- Establishing eligibility standards
- Analyzing the costs
- Reassuring friends and placating foes

PANEL:

The Honorable Donald D. H. Ching, Majority Leader, Hawaii State Senate and sponsor of Hawaii's health plan.

Keven McKenna, Attorney-at-Law and former aide to Governor Philip Noel during passage of Rhode Island's plan.

Larry Fredrickson, Counsel, Minnesota Senate Health, Welfare and Corrections Committee and chief drafter of Minnesota's plan.

The Honorable Sam A. McConnell, Jr., Chairman, House Rules Committee and sponsor of catastrophic health insurance in Arizona.

Joseph McLean, Research Director of Joint Committee on Health Benefits and Health Services in Massachusetts State Legislature and involved in unsuccessful attempts to enact a state health plan.

11:30 a.m. IMPLEMENTATION AND ADMINISTRATION: MAKING A STATE HEALTH INSURANCE PLAN WORK

- Finding the right agency
- Hiring the staff and finding the experts
- Integrating with other departments
- Determining eligibility
- Controlling quality and costs
- Assessing the impact

PANEL:

Brian Keeler, Chief, Division of Health Insurance, Rhode Island Department of Health.

John Fickett, Director, Medical Assistance Division and Catastrophic Illness Program, Maine Department of Human Resources.

Joseph C. Mike, Commissioner of Insurance, State of Connecticut.

Paul Farseth, Outgoing Supervisor of Minnesota Catastrophic Health Expense Program, Department of Public Welfare.

The Honorable Donald D. H. Ching, Majority Leader, Hawaii State Senate.

1:00 p.m. LUNCH

2:00 p.m. WHAT DOES IT ALL MEAN?: THE IMPLICATIONS OF RECENT STATE ACTIVITY IN MEDICAID AND CATASTROPHIC ILLNESS PROTECTION

- Providing protection in the absence of a federal commitment
- Administrative innovations
- Financial and administrative pitfalls
- National policy and state discretion
- Practical problems

PANEL:

The Honorable John G. Veneman, former Counselor to Vice President Rockefeller, Under Secretary of DHEW, and California State Assemblyman.

Keven McKenna, Attorney-at-Law, Providence, Rhode Island.

Keith Weikel, Administrator, Medicaid Division, Health Care Financing Administration.

Beverlee Myers, Professional Staff Member, Subcommittee on Antitrust and Monopoly, United States Senate.

Bonnie Lefkowitz, Office of the Assistant Secretary for Planning and Evaluation, DHEW.

4:00 p.m. CLOSING REMARKS

Georgetown University
Health Policy Center Publications

(A) Health Programs in the States: A Survey. Published in cooperation with the Eagleton Institute of Politics, this report discusses and documents provisions and procedures of health care programs in the 50 states (40 pages; $3.25).

(B) Paper Victories and Hard Realities. This legal and programmatic analysis of the landmark Supreme Court decision, *O'Connor v. Donaldson*, resulted from a working conference held by the Health Policy Center. It covers: the decision, establishing the right to liberty for mentally ill persons who can live safely outside an institution; "right to treatment"; alternate systems for mental health care; civil commitment statutes; "dangerousness"; and federal mental health programs (144 pages; $4.25).

(C) State Health News. A bi-weekly publication, this newsletter reports developments, innovations and problems in state health legislation. Special issues focus on particular issues of significance to state and local health policymakers: e.g., the proposed Michigan Health Planning Code, Certificate of Need Regulations, etc. (4-6 pages; $10/year).

(D) The Legal Status of Physician Extenders in Thirteen Southern States. This study conducted by the East Tennessee Research Corporation examines the laws, regulations and guidelines governing physician assistants and nurse practitioners. Discussion of each state's legislative provisions is followed by analysis and recommendations (61 pages; $2.00).

(E) A Legislator's Guide to the Medical Malpractice Issue. Published jointly with the National Conference of State Legislatures, this booklet contains: an analysis of state and federal legislative activity, five state case studies, and papers from various interest groups (88 pages; $3.25).

(F) Catalogue: Washington Health Newsletters. This compilation lists 40 Washington-based newsletters by title, publisher, frequency of publication, price, subject, and unique features (6 pages; $1.00).

(G) Strategies for Long-Term Care. This paper surveys financing, administration, and institutions, community-based facilities, and individual home settings. It addresses characteristics and needs of the population at risk, inter-governmental relationships, and includes recommendations for action (38 pages; $2.00).

(H) Death and Dying: An Examination of Legislative and Policy Issues. This report is based on a conference co-sponsored with the American Association for the Advancement of Science. It explores the legislative, ethical, demographic, medical and public policy ramifications of death and dying issues (68 pages; $3.50).

(I) Model Medical Practice Act. This model act is designed to ensure physician competency. Originally developed by the Health Policy Center, the act was refined at a conference co-sponsored with the Bureau of Health Manpower, DHEW. Representatives of various federal agencies participated in the meeting (22 pages; Free).

(J) Health Expenditures by State Governments. This report examines information on state health spending compiled largely by the Bureau of the Census. It shows that the percentage of overall state health expenditures compares favorably with the percentage of overall federal health expenditures (23 pages; $2.25).

(K) Drug and Alcohol Abuse Programs in the States. This survey examines the pros and cons of state legislative activity surrounding ten major drug/alcohol abuse issues. The book is scheduled for publication in August 1977.

(L) Implementing Protection and Advocacy Systems for the Developmentally Disabled. This forthcoming report grew out of a conference designed to consider how best states can meet federal protection and advocacy requirements.

(M) State-Initiated Catastrophic/Comprehensive Health Insurance Plans. A forthcoming conference proceedings, this report will review the implications of such plans for both the private and public sectors.

(N) Medicaid Reimbursement of Primary Health Clinics. This forthcoming report is based on a nationwide survey of state Medicaid clinic reimbursement practices. An analysis of the findings is due for publication in August 1977.

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THE IMPLICATIONS OF STATE-INITIATED CATASTROPHIC/ COMPREHENSIVE HEALTH INSURANCE PLANS

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SPEAKERS

The Honorable Donald D. H. Ching is the Majority Leader of the Senate of the State of Hawaii. He is a graduate of the University of Hawaii and the George Washington University Law School. Since 1967 he has been on the Senate Health Committee, first as Chairman, then Vice Chairman and presently as a member. He is also presently Chairman of the Military and Civil Defense Committee and Vice Chairman of the Transportation Committee in the Hawaii Senate. In addition to his legislative duties, Senator Ching serves as a Director of the Hawaii Medical Service Association.

Brian E. Keeler is presently Chief of the Division of Health Insurance, Rhode Island Department of Health and is responsible for the administration of the Rhode Island Catastrophic Health Insurance Plan. The Division also regulates health maintenance organizations and acts as a clearinghouse for health insurance information. Mr. Keeler, a graduate of Siena College in New York State, was associated with the Aetna Life and Casualty Company for ten years prior to assuming his present position and served as chairman of the Health Care Committee of the Health Insurance Association of America in the formulation and promotion of a national health insurance plan.

Larry Fredrickson is Counsel to the Senate Health, Welfare and Corrections Committee in the Minnesota State Legislature. Mr. Fredrickson, a graduate of Macalester College and New York University Law School, prior to his present position, was engaged in private law practice, worked with Interstudy as research attorney in Minneapolis and served as Director of Minority Research in the Minnesota State Senate. He was intimately involved in formulating the state health insurance law that became effective in Minnesota in January 1977.

PANELISTS

Sam A. McConnell, Jr. is Chairman of the Rules Committee in the Arizona House of Representatives and serves as a member of the House Banking and Insurance, Health, and Appropriations Committees. A pharmacist by profession and graduate of Butler University in Indiana, Mr. McConnell is a member of the Health Insurance Benefits Advisory Council of the Department of Health, Education, and Welfare, an advisor to the Secretary of HEW on Medicare and Medicaid and a former member of the Governor's Committee on Problems of the Aged. He is presently serving his sixth term in the Arizona House of Representatives and is President-elect of the National Association of Retail Druggists.

Joseph P. McLean is Research Director of the Joint Committee on Health Benefits and Health Services in the Massachusetts State Legislature. He also serves as Legislative Director to Senator Daniel J. Foley, Chairman of the Insurance Committee in the Massachusetts Senate. A graduate of Siena College in New York State, Mr. McLain has also served as Legislative Director in the Offices of the Massachusetts Senate President and Senate Majority Whip. Author of various health care statutes in Massachusetts, Mr. McLain presently is a lecturer at the Institute for Governmental Science at the University of Massachusetts and a member of the University of Massachusetts Health Policy Growth Study Committee.

John E. Fickett is Director of the Medical Assistance Program (Medicaid) and the Catastrophic Illness Program in the Department of Human Resources of the State of Maine. A graduate of the Gordon Divinity School, both on the bachelor and master's levels, Mr. Fickett also has a master's degree in Social Work from Boston College. A former minister, Mr. Fickett is a member of the American Society for Public Administration and is listed in Who's Who in the East, Who's Who in Government, Who's Who in Religion and in the Dictionary of International Biography.

Joseph C. Mike is the Commissioner of Insurance for the State of Connecticut. Prior to his present appointment, he served as Deputy Commissioner of Insurance from April 1975 to May 1977. A graduate of Providence College, Commissioner Mike has also been associated with the Aetna Life and Casualty Company and also

served two terms from 1971 to 1975, as Councilman-at-Large for the City of Bristol, Connecticut. He has been a member of various city boards including the Bristol Veterans Committee, Bristol Retirement Board, City Council Salary Committee, Council on Human Needs, Bristol Day Care Center and the Bristol Jaycees. On a statewide basis, Commissioner Mike has served on the Connecticut Commission for Hospitals and Health Care and on the Teachers Retirement Board and has been responsible for the regulation of Connecticut's Health Maintenance Organizations and the implementation of Connecticut's Health Care Act. He also serves on the Commission for Hospital and Health Care Malpractice Task Force and the Product Liability Tort Reform Task Force. He has also been on the Board of Directors of the Connecticut Association of Local Legislators and various organizations that assist in the activities of teenagers. Mr. Mike is a member of the Bristol Young Democrats and a member of a Military Intelligence Detachment of the U. S. Army Reserve.

John G. Veneman is Vice President and Manager of the Washington office of Braun and Co. as well as Executive Advisor to the Georgetown University Health Policy Center. His past experience in government has included serving as Counselor to Vice President Nelson A. Rockefeller, Under Secretary of HEW during the Nixon Administration, member of the California Assembly as well as Chairman of the Assembly's Committee on Revenue and Taxation, and a member of various standing Assembly committees including Finance and Insurance, Social Welfare and Agriculture. In 1967 he was selected as the Most Outstanding Legislator in the Assembly by the Capitol Press Corp. Mr. Veneman has served on the Board of Trustees of the Urban Institute, the American Social Health Association, the Citizens Conference on State Legislatures and the San Francisco Public Schools Commission.

MODERATOR

Lewis Butler is Co-Director of the Health Policy Program at the University of California at San Francisco as well as an Adjunct Professor of Health Policy at the University. A graduate of Princeton University and Stanford University Law School, Mr. Butler has served as an HEW Assistant Secretary for Planning and Evaluation from 1969 to 1971 in the Nixon Administration, as Visiting Faculty member at the School of Law and Earl Warren Legal Institute at the University of California at Berkeley, as a Director of the Peace Corps in Malaysia as well as an attorney engaged in the private practice of law. He is a member of the Institute of Medicine of the National Academy of Sciences, a member of the Advisory Panel on National Health Insurance to the Subcommittee on Health of the House Committee on Ways and Means, Chairman of the Advisory Board, HEW Fund for the Improvement of Post-Secondary Education and Director or Trustee of the John Hay Whitney Foundation, Abelard Foundation and California Tomorrow as well as President of the Rosenberg Foundation. He has also served on the San Francisco Public Schools Commission, the Technical Advisory Committee of the Carnegie Commission on Higher Education, and was Founding Director and President of the Planning and Conservation League.

Georgetown University Health Policy Center

AN OVERVIEW OF THE HEALTH POLICY CENTER

AN OVERVIEW

OF THE

HEALTH POLICY CENTER

GEORGETOWN UNIVERSITY

WASHINGTON, D. C. 20057

MAY 1977

This overview is designed to summarize activities in each of the major operational areas of the Health Policy Center:

- Research
- Seminars, Workshops and Conferences
- Network of Correspondents
- Library and Other Documentary Resources
- Publications

Information on Center personnel concludes the document.

GEORGETOWN UNIVERSITY HEALTH POLICY CENTER

The Georgetown University Health Policy Center (HPC) was established in January 1975 through a grant from the Robert Wood Johnson Foundation to assist state, county and municipal governments in formulating and implementing health care policies. The Center provides for the improvement of national health policy development by focusing on the needs, capacities, activities, and problems of state and local governments in carrying out health programs. Its constituency includes: local, state and national legislators, health care officials at all levels, professional health care associations, and private groups concerned with state interests in health policymaking.

RESEARCH

The Center undertakes both short and long term research in response to current pressing state health policy concerns and requests from individuals and organizations in the health policy-making community. In selecting issues for study, we consider such factors as: upcoming state and national health legislation; the volume and nature of requests for technical assistance; issues voiced by the Center's Network of Correspondents; the possibility of impact on developing legislation; the uniqueness of the issue; and the type of attention the issue is receiving elsewhere.

Research is planned to provide states and localities with practical timely information that they cannot or do not receive from other organizations and agencies. Thus our research and policy analysis efforts focus on: analyzing innovative state health programs; examining the impact of proposed federal legislation on state and local governments; reviewing and comparing existing state health programs and proposals; drafting model state legislation; and developing policy position papers discussing alternative approaches to critical health care issues. Most studies lead to workshops, conferences and/or publications.

Research efforts have dealt with such topics as:

- The implications of alternative national health insurance proposals for state and local governments
- Medical malpractice
- Implications of the MAC drug program
- Developmental disability legislation
- A Model Medical Practice Act
- The Health Maintenance Organization Amendments of 1976
- Primary health care delivery
- Quality assurance programs
- Rural health care
- Mental health legislation
- Litigation and the mentally disabled
- State perspectives on health block grants for personal services
- Long-term care
- Medicaid reform
- Death and dying legislation
- Abortion
- State health planning
- Mid-level medical personnel

Current research efforts include:

- A study of Reimbursement of Primary Health Clinics under State Medicaid Programs involving a nationwide survey of state Medicaid directors. The study is aimed at determining whether and if so how states reimburse primary health clinics as independent health care providers. It also seeks data on the reimbursement of primary health practitioners. Generated by an increasing number of requests from state and federal policymakers concerning this type of direct Medicaid reimbursement and the serious lack of reliable information in this area, the study was also fueled by recent Congressional hearings on clinic reimbursement under Medicare. An analysis and report of the findings are due for publication in August 1977.

- An evaluation of State Standards for the Delivery of Public Health Services. This study involves: (1) the collection and comparative analysis of existing or developing state standards; (2) an in-depth survey of 10-12 carefully selected health departments and (3) a seminar for representative public health providers and consumers focusing on proposed federal standards for the delivery of local public health services, and the capacity of local governments to provide such services. Concern over the setting of federal standards governing public health programs, the relationship between these programs and national health insurance, and the strong interests of state and local health officers motivated this research project.

- A survey of Drug and Alcohol Abuse Programs in the States. This study surveys state legislative activity in response to the following drug/alcohol abuse issues: Organization of State Drug/Alcohol Abuse Efforts; Alcohol and Highway Safety; Legal Drinking Age; Decriminalization of Marijuana and Public Intoxication; Credentialing of Drug and Alcohol Abuse Programs and Personnel; Mandatory Health Insurance Coverage for Drug Abuse and Alcoholism Treatment; Earmarked Alcoholic Beverage Tax; Implications of Title XX for Drug/Alcohol Abuse Programming. An additional chapter in the forthcoming publication of this study deals with the extent and nature of the drug/alcohol abuse problem in the United States, and major federal legislation in the area. The issues were selected on the basis of their importance to upcoming state legislation. Each is discussed in terms of the significance of the issue, the need for legislation, and the pros and cons of alternative courses of legislative action. The study is due for publication in July 1977.

- An analysis of The Legal Framework in which the Developmental Disability Protection and Advocacy Systems Required by States Must Operate. The paper examines the Developmental Disabilities Assistance and Bill of Rights Act of 1975, the legislative history of relevant sections, and the regulations, guidelines, and legal opinions issued by the Department of Health, Education and Welfare on implementing these protection and advocacy systems.

- An examination of State Catastrophic and Comprehensive Health Insurance Plans. Prepared for participants at a Health Policy Center seminar, this paper examines the political organizations, and administrative experiences of the five states that have adopted plans: Hawaii, Rhode Island, Connecticut, Maine and Minnesota. The paper covers: benefit coverage and eligibility, administration and financing as well as the history, characteristics, and problems of definition associated with "catastrophic" health plans.

- Participation in the New Coalition Task Force on Medicaid Reform, which has involved: (1) Preparation of a policy option paper summarizing major ideas and research on Medicaid and presenting policy alternatives for intergovernmental financing of Medicaid. The paper, "Federal/State Financing of Medicaid," exploring such concepts as equity, program rationale (health or welfare), ability of various levels of government to pay intergovernmental relations and centralization vs. decentralization, was presented to the Task Force in January 1977. (2) Preparation of a cost analysis of options presented in the paper. (3) Participation in a seminar convened to review and analyze federal proposals on cost containment. A summary of contents and recommendations was provided to DHEW. (4) Review and editing for the Task Force of papers dealing with eligibility and institutional reimbursement. The New Coalition is a group composed og voernors, mayors, state legislators, and county elected officials.

Other recent studies prompted by national debate over issues that will inevitably impact on state and local jurisdictions include the following.

- Comprehensive Health Insurance: Initiatives by State Government. This study surveys types of state health insurance plans already enacted and discusses the rationale for the state movement, the proposals of leading organizations on this issue (the National Association of Insurance

Commissioners and the Conference of Insurance Legislators), cost control measures, and the future of state plans.

- The MAC Drug Program. Implications for State Governments. This analysis of the maximum allowable costs controversy surrounding the establishment of cost limits on prescription drugs clarifies the issues of this potentially far-reaching program. The aims, implementation problems, advantages, disadvantages, and implications of the MAC program for state and local government are examined.

- Aerosols and the Earth's Ozone Layer: Issues for State Governments. The background and present issues surrounding legislation banning aerosol sprays propelled by fluorocarbons are discussed in this study. It covers federal legislation initiated as a result of the findings and recommendations of the National Academy of Sciences and discusses legislative options available to state governments.

- Health Maintenance Organization Amendments of 1976: Implications for State and Local Governments. This report covers the history, objectives, and provisions of the 1973 HMO Act and the HMO Amendments of 1976. A summary of the implications of these Amendments for state and local governments is included.

- Community Mental Health Centers: Implications for State and Local Government. This study examines the present status and future implications of community mental health centers as they will impact on state and local government. In view of President Carter's establishment of a national Mental Health Commission, community centers may receive renewed impetus and importance in the delivery of health care services and this paper examines the historical background of the issue, analyzes the impact of the Community Mental Health Center Act itself, examines the scope of the mental illness problem, public financing of such centers, and their implications for local and state governments.

- National Health Insurance Bills of the 94th Congress: Implications for State and Local Government. This series of papers examines key national health insurance bills that were introduced in the 94th Congress by such organizations as the AFL-CIO, the American Medical Association, the American Hospital Association, the Health Insurance Association of America and Senators Long and Ribicoff's Catastrophic Health Insurance Bill. Those aspects of the bills that impact on state and local government are noted and analyzed.

SEMINARS, WORKSHOPS AND CONFERENCES

To air the variety of viewpoints concerning health policy and program developments, the Center sponsors a number of meetings each year. Meeting size and composition vary, according to the purpose of the meeting. Seminars range from small working sessions designed to explore policy options and/or define state legislative interests, to large forums designed to communicate policy concerns to a wide audience. And, when there is a commonality of interests, sponsorship is shared with other organizations and agencies.

Whether large or small, most meetings are characterized by a "how-to" theme. One area in which the Center is uniquely capable of providing a practical service is the identification of federal legislation requiring states to meet certain standards as a condition for receiving federal funding. It has been our experience that, all too often, little technical assistance is offered to states to assist in compliance. Our upcoming seminar on the implementation of state advocacy systems for the developmentally disabled is one example of how the Center can fill this void and provide a much-needed service to states.

Scheduled for May 27, 1977, this meeting deals with The Implications of State Protection and Advocacy Systems Designed to Protect the Rights of the Developmentally Disabled. This one-day seminar will bring together federal and state policymakers, as well as consumers, to discuss the best means of implementing these systems. Designed to safeguard the human and civil rights of the developmentally disabled (DD), the systems are required to be "in effect" by October 1, 1977, if states are to continue receiving federal DD moneys following that date. The shortage of time and federal technical assistance, however, has made state compliance with this requirement especially difficult.

The seminar is therefore timely and will produce findings and recommendations designed to be of immediate practical value to the states. The proceedings are scheduled for publication and distribution in August 1977, and will include an analysis of the relevant federal legislation, regulations, and guidelines; a study of what forms advocacy can and should take; a paper on what should constitute compliance with the federal legislation; and a case study of how an advocacy system actually is implemented and functions on the state level. Speakers/authors include:

- Jim Stearns, Policy Analyst and developmental disabilities specialist for the Georgetown University Health Policy Center.
- Stanley Herr, Visiting Scholar at Harvard Law School, specializing in disability law and the mentally retarded with emphasis on advocacy issues.
- Neil Mickenburg, Director of Vermont's Developmental Disabilities Advocacy Project and past Director of Minnesota's Developmental Disabilities Advocacy Project.

- Ronald Neufeld, Director of Developmental Disabilities Technical Assistance System, University of North Carolina

- James Paul, Director of Training, Developmental Disabilities Technical Assistance System, University of North Carolina

In July 1977 the Center plans to hold a seminar on State-Initiated Catastrophic/Comprehensive Insurance Plans. Dealing with an issue of growing importance in the area of health care financing, this conference will examine the growth and implications of state-enacted comprehensive insurance programs for the private sector--such as the health insurance industry--and the public sector. The implications for federal national health insurance plans will be of particular interest. The proceedings of the seminar will be published in the fall of 1977. Speakers/authors will include:

- The Honorable Donald D. H. Ching, Majority Leader of the Hawaii State Senate

- Brian E. Keeler, Chief of the Division of Health Insurance, Rhode Island Department of Health and Administrator of Rhode Island Catastrophic Health Insurance Plan

- Larry Fredrickson, Counsel to Senate Health, Welfare and Corrections Committee, Minnesota State Legislature

Past Health Policy Center conferences have been concerned with the following topics:

- MEDICAL MALPRACTICE: Held in May 1975, in Washington, D. C., in conjunction with the National Conference of State Legislatures, this seminar attracted a number of state legislators and other public officials from across the country to address the critical issue of availability of malpractice insurance coverage. During three days of activity, the participants addressed the value of federally mandated malpractice legislation, reviewed case studies of malpractice legislation introduced in California, Idaho, Indiana, New York, and Wisconsin, and analyzed the presentations of physicians, lawyers, insurance commissioners, and consumer advocates concerned with resolution of this crisis.

- HEALTH ISSUES OF 1976: Recognizing the increasing responsibilities imposed on state and local governments in the health policy field, the Georgetown University Health Policy Center sponsored this seminar to determine the immediate health care issues facing states and localities. The Health Issues of 1976 Seminar, held in Palm Beach, Florida, on November 9-12, assembled a number of state,

local and federal officials to identity issues and evaluate alternate approaches and/or solutions. In addition to targeting issues, this conference represented an attempt to review and analyze the changing role of government in health care and the magnitude of the problems being addressed by state and local expenditures.

- LITIGATION AND THE MENTALLY DISABLED: On June 26, 1975, the Supreme Court decided the case of O'Connor v. Donaldson proclaiming a constitutional right to liberty for mentally ill individuals. The Court ruled that mentally disabled persons cannot be confined involuntarily if they are not dangerous and can live safely in the outside world. The Health Policy Center, on December 8, 1975, sponsored a one-day working session focusing on the effect of the decision upon state and local programs for the mentally disabled. The participants developed analyses of the legal and programmatic effects of the case. In attendance were state legislators, county supervisors, and city councilmen as well as program administrators from the three levels of government. A major publication, "Paper Victories and Hard Realities," resulted from the meeting.

- MEDICAID AND RELATED STATE HEALTH ISSUES: Held in December in Phoenix, Arizona, and co-sponsored by the National Conference of State Legislatures and the Public Services Laboratory of Georgetown University, this seminar presented to over one hundred state legislators various facets of state-federal relationships and government financing mechanisms for medical care.

- COMPETENCE, RELICENSURE AND CONTINUING MEDICAL EDUCATION: On January 16, 1976, the Health Policy Center convened an "Issue of the Month" round table discussion to discuss issues related to continuing medical education.

- WORKING SESSION TO DRAFT A MODEL MEDICAL PRACTICE ACT: This working session in Febraury 1976 grew out of the Center's concern over the absence of any ongoing physician competence assurance, and the need to develop more satisfactory legislation to assure physician competence.

- A HEALTH BLOCK GRANT FOR PERSONAL SERVICES: THE STATE PERSPECTIVE: In February 1977, a seminar was convened to discuss the Ford Administration's proposal to consolidate federally funded health programs into a single block grant, and examine its implication for the states.

- MEDICAID: A STATE AND LOCAL PROBLEM: In March 1976, a seminar was convened to review the background and objectives of Medicaid and its status 10 years later. The paper that resulted from this seminar includes a summary of major Medicaid issues and suggested reforms.

- COMPETENCY IN THE MEDICAL PROFESSION: A joint conference, sponsored by the Health Policy Center, in cooperation with the Department of Health, Education and Welfare Bureau of Health Manpower, was held to refine a Model Medical Practice Act, which had been developed earlier by the Center.

- STRATEGIES FOR LONG-TERM CARE: In May 1976, a seminar was convened to discuss one of the major current public policy problems in the human services area: how to finance, administer, and provide long-term care services in large institutions, community-based facilities and individual home settings. The paper that resulted from the conference addresses characteristics and needs of the population at risk, long-term care financing, and intergovernmental relationships, and includes recommendations for action.

- DEATH AND DYING: AN EXAMINATION OF LEGISLATIVE AND POLICY ISSUES: Held in June 1976, this joint conference was sponsored by the American Association for the Advancement of Science and the Health Policy Center. The speakers included: Dr. Conrad Taeuber, Director of the Center for Population Research, Kennedy Institute; Mr. Sidney Rosoff, Director of the Society for the Right to Die; Dr. Robert Veatch, Senior Associate of the Institute of Society, Ethics and the Life Sciences; and Dr. Andre Hellegers, Director of the Joseph and Rose Kennedy Institute for the Study of Human Reproduction and Bioethics. The participants examined demographic, legal, public policy, and ethical aspects of death and dying issues.

NETWORK OF CORRESPONDENTS

The Network of Correspondents consists of an individual in each state selected on the basis of his/her knowledgeability of state health care developments and position in the state health structure. On retainer with the Center, the Correspondents supply up-to-date information on proposed health legislation, legislative and study committee reports, municipal and state budgets, judicial and executive activity, key state people in health policy formulation, and other pertinent health care developments. In turn, the Center provides the Correspondent with the Center's newsletter, STATE HEALTH NEWS, various Center reports and papers, and technical assistance on a variety of issues. Members of the Network of Correspondents include: legislative leaders and staff, program and bureau directors, local health program officers, health media representatives, and academically based health researchers.

The Network has been used to provide the Center with a broad sample of state and local reaction to President Ford's health block grant proposal. Correspondents were also used to provide state and local reaction to some of the pressing problems with the Medicaid program, and to 1976 legislation in the U. S. Senate (S. 3205) aimed at solving fraud and abuse problems in Medicaid.

More recently, the Correspondents have provided a broad sample of state reactions to proposed regulations under Section 504 of the Rehabilitation Act; to the Administration's hospital cost containment proposal; and to newly established federal regulations pertaining to certificate of need under P. L. 93-641. They have also provided the names of resource persons in community health care around the country; identified persons in their state who were particularly knowledgeable about rural health care; identified state programs to provide better rural health care; and determined for the Health Policy Center whether their state licensed community health clinics.

In the fall of 1976, the Network of Correspondents division began focusing attention on publication of the Center's newsletter--STATE HEALTH NEWS. This publication is an effort to communicate to Correspondents and many others some of the significant and innovative developments in health at the state level. Previously, no convenient vehicle had existed for the Health Policy Center to share the information collected from interested groups and individuals across the country. Reactions to this new publication have been extremely favorable. The format calls for most news items to be covered in short articles. Those items warranting more lengthy treatment are presented in "Special Feature' issues.

LIBRARY AND OTHER DOCUMENTARY RESOURCES

The Library of the Health Policy Center contains a unique collection of some 600 books and 100 periodicals concerned with health policy formulation and implementation. A full-time Librarian maintains this up-to-date resource--circulating timely information to the staff, assisting in Center research efforts, and providing reference services to numerous organizations and people outside the Center. The Library is open to the public as well as the staff.

Another resource is a comprehensive collection of state health legislation, obtained on an ongoing basis through a contract with Commerce Clearinghouse. While the sheer bulk of this resource is staggering--estimates call for more than 8,000 health bills to be introduced around the country in 1977--it is an excellent barometer of emerging state and local health concerns. The immediate availability of the actual text, moreover, has enabled the Center to provide its constituents with reliable and complete information on new legislation. For ease of retrieval, bills are filed according to topic, state, house of origin, and date of introduction. This resource, too, is open to the interested public.

PUBLICATIONS

Publications are guided by a concern for the practical. The fact that the genesis of many Center activities is a request, or pattern of requests, for insight into the effects of particular health policies reinforces this concern. Special papers, books, directories, and our newsletter, STATE HEALTH NEWS, are all aimed at providing timely and informative answers to such questions as: What works? What doesn't work? Why? How can states use this? Where can we turn to find out more about the issue?

Our publications list includes the following titles:

Health Programs in the States: A Survey. Published in cooperation with the Eagleton Institute of Politics, this report discusses and documents provisions and procedures of health care programs in the 50 states (40 pages; $3.25).

Paper Victories and Hard Realities. This legal and programmatic analysis of the landmark Supreme Court decision, O'Connor v. Donaldson, resulted from a working conference held by the Health Policy Center. It covers: the decision, establishing the right to liberty for mentally ill persons who can live safely outside an institution; "right to treatment"; alternate systems for mental health care; civil commitment statutes; "dangerousness"; and federal mental health programs (144 pages; $4.25).

State Health News. A bi-weekly publication, this newsletter reports developments, innovations and problems in state health legislation. Special issues focus on particular issues of significance to state and local health policymakers: e.g., the proposed Michigan Health Planning Code, Certificate of Need Regulations, etc. (4-6 pages; $10/year).

The Legal Status of Physician Extenders in Thirteen Southern States. This study conducted by the East Tennessee Research Corporation examines the laws, regulations and guidelines governing physician assistants and nurse practitioners. Discussion of each state's legislative provisions is followed by analysis and recommendations (61 pages; $2.00).

A Legislator's Guide to the Medical Malpractice Issue. Published jointly with the National Conference of State Legislatures, this booklet contains: an analysis of state and federal legislative activity, five state case studies, and papers from various interest groups (88 pages; $3.25).

Catalogue: Washington Health Newsletters. This compilation lists 40 Washington-based newsletters by title, publisher, frequency of publication, price, subject, and unique features (6 pages; $1.00).

Strategies for Long-Term Care. This paper surveys financing, administration, and institutions, community-based facilities, and individual home settings. It addresses characteristics and needs of the population at risk, intergovernmental relationships, and includes recommendations for action (38 pages; $2.00).

Death and Dying: An Examination of Legislative and Policy Issues. This report is based on a conference co-sponsored with the American Association for the Advancement of Science. It explores the legislative, ethical, demographic, medical and public policy ramifications of death and dying issues (68 pages; $3.50).

Medicaid: A State and Local Problem. A review of Medicaid and its status ten years later, the paper summarizes major Medicaid issues and suggested reforms (9 pages; $2.00).

Model Medical Practice Act. This model act is designed to ensure physician competency. Originally developed by the Health Policy Center, the act was refined at a conference co-sponsored with the Bureau of Health Manpower, DHEW. Representatives of various federal agencies participated in the meeting (22 pages; Free).

A Health Block Grant for Personal Health Services: The State Perspective. This paper describes the Ford Administration's proposal to consolidate federally funded health programs into a single block grant, and examines implications for the states. Seven possible state positions are outlined (16 pages; $2.00).

Health Expenditures by State Governments. This report examines information on state health spending compiled largely by the Bureau of the Census. It shows that the percentage of overall state health expenditures compares favorably with the percentage of overall federal health expenditures (23 pages; $2.25).

Drug and Alcohol Abuse Programs in the States. This survey examines the pros and cons of state legislative activity surrounding ten major drug/alcohol abuse issues. The book is scheduled for publication in August 1977.

Implementing Protection and Advocacy Systems for the Developmentally Disabled. This forthcoming report grew out of a conference designed to consider how best states can meet federal protection and advocacy requirements.

State-Initiated Catastrophic/Comprehensive Health Insurance Plans. A forthcoming conference proceedings, this report will review the implications of such plans for both the private and public sectors.

Medicaid Reimbursement of Primary Health Clinics. This forthcoming report is based on a nationwide survey of state Medicaid clinic reimbursement practices. An analysis of the findings is due for publication in August 1977.

PERSONNEL

Center staff members combine an overall understanding of health policy issues with in-depth knowledge of particular health areas. All have extensive backgrounds in research, writing, policy analysis and/or health project administration, as the attached resumes will indicate.

The full-time Center staff is supplemented by part-time Research Associates, work-study students, Summer Interns, and Consultants.

The Research Associates are top-level graduate students who have academic and/or professional backgrounds in health. They work a minimum of 15 hours a week and provide the major back-up support for Center program activities.

Work-study students for Georgetown University assist in carrying out essential routine work of the Center.

Summer Interns are generally advanced students seeking work experience in a health policy-related organization or agency. Drawn from institutions across the United States, the Summer Interns receive academic credit for their work. A weekly seminar is offered, providing interns with an opportunity to meet and exchange views with health policymakers.

Policy guidance is provided by an Executive Committee composed of national leaders in health policy formulation:

- Jack Veneman, former Under Secretary of the U. S. Department of Health, Education, and Welfare, and recently Special Assistant to Vice President Nelson D. Rockefeller. Mr. Veneman now serves as a Consultant for Braun and Company.
- Robert Ball, Senior Scholar of Institute of Medicine, National Academy of Sciences, former Director of Social Security Administration
- Larry Lewin, President of Lewin and Associates, health and welfare specialist
- The Honorable John Milton, State Senator from Minnesota
- Arthur F. Quern, Acting Director of the Illinois Department of Public Aid
- William R. Roy, MD, St. Francis Hospital, former Congressman from Kansas

VERNE HORN

Verne Horn is Director of the Georgetown University Health Policy Center, a national service organization sponsored by the Robert Wood Johnson Foundation to assist state and local governments in formulating and implementing health policies and programs. The Center's program includes publication of reports, directories, books and a newsletter; provision of technical assistance to health policymakers; maintenance of a Network of Correspondents in all states, and the organization of conferences and workshops on health policy issues.

Prior to his present position, Mr. Horn served as:

- Consultant to the California State Senate Office of Research and San Diego County, responsible for participating in a comprehensive review of tax-supported health programs in San Diego County.

- Project Director of an Office of Economic Opportunity sponsored project to provide technical assistance to neighborhood health centers throughout the country. His overall administrative responsibilities included direction of a bi-lingual clearinghouse program and development of national conferences on health care issues.

- Executive Director of the Neighborhood Health Organization of Southeast San Diego, where he assisted in developing an innovative plan of pre-paid health insurance through collaborative efforts by a consumer-oriented non-profit corporation and private physicians, and increased health training opportunities for community residents.

- Assistant Director, Field Operations, for the National Urban Coalition, responsible for organizing community health task forces and non-profit advisory boards, organizing group practice facilities, improving insurance procedures and coordinating federal health services.

- Western Regional Field Director, American Public Welfare Association, responsible for reviewing state welfare plans to determine eligibility standards and procedures, developing management information systems for state and county welfare departments, and developing pilot programs emphasizing outreach, evaluation, and eligibility of marginal income recipients.

- Community Action Consultant for California State Office of Economic Opportunity, responsible for coordinating program resources, providing staff training, and management reorganizations.

Mr. Horn earned a BS in Political Science from Loyola University, Los Angeles, an MPH in Health Administration and Planning from the University of California, Berkeley, and has done additional graduate work in public administration, finance and economics at the University of Southern California.

DEBORAH JANE CARR

Deborah Carr serves the Georgetown University Health Policy Center as Director of Program Services. Her responsibilities include assessing requests and administering responses for technical assistance, conference planning and management, liaison activities, conducting health policy research, and providing consultation in a variety of health policy and program areas.

Ms. Carr's previous positions include:

- Assistant Project Director of a nationwide technical assistance project sponsored by the Office of Health Affairs, Office of Economic Opportunity. She was responsible for assessing and assigning specialists to respond to technical assistance requests from neighborhood health centers in such areas as: comprehensive health care, program planning and development, and information and fiscal management. In addition, she planned and conducted health conferences and assisted in founding and operating a health information clearinghouse and bi-lingual services facility.

- Senior Technical Assistance Specialist on a Department of Health, Education and Welfare project to provide technical assistance in administration and training to Region III Work Incentive Programs.

- Assistant Project Director of a technical assistance project to develop and implement internship programs for administrators of 20 Black colleges. Designed to enhance institutional fund-raising capabilities, the program was conducted with Florida A&M University.

- Consultant to the Director of Sign of the Times, a unique creative arts community center serving Northeast Washington. Ms. Carr developed and carried out a fund-raising program, developed administrative controls, and provided overall policymaking and management assistance.

- Assistant Project Director of a Department of Labor evaluation of an employer-sponsored day care center, where she conducted background research and planned the evaluation and analysis effort.

- VISTA Volunteer Trainer, assigned to organize the Great Lakes Region VISTA Training Center and help design the curriculum serving 1300 trainees. Ms. Carr's duties included: teaching Volunteers, conducting staff and trainee orientations, developing special materials, evaluating candidates for community agency placement, and preparing administrative and financial reports.

- Intern with the Manpower Assistance Project, sponsored by the Ford Foundation to provide training to community action people in manpower development.

Ms. Carr earned a BA in History from Newton College, and did postgraduate work at Harvard University, Austro-American Institute, Massachusetts College of Art, and Boston Museum School of Art.

GARY JAMES CLARKE

Gary Clarke is Director of the Georgetown University Health Policy Center's Network of Correspondents and Editor of State Health News. In addition to reorganizing and coordinating the Network information system consisting of health policy specialists in each state and publishing a bi-weekly newsletter, Mr. Clarke conducts research on health programs and legislation and has administered three projects aimed at evaluating state legislature health committee staffing.

Prior to joining the Health Policy Center staff, Mr. Clarke was:

- Instructor with the Eagleton Institute of Politics, Rutgers University, and staff member of a Ford Foundation funded project to assist five state legislatures in researching, drafting, holding public hearings, testifying, and writing committee reports on health legislation. Major work was done in the areas of health manpower regulation, certificate of need, rate regulation, genetic disorders, lead poisoning, and home health needs of the elderly.

- Assistant Administrative Analyst with the Office of the Legislative Analyst, California State Legislature, where he was responsible for reviewing and writing budget and legislative analyses of all state-sponsored health and retirement programs for state, county, and municipal employees and other minor state agencies. He testified on these matters before the Senate Finance and Assembly Ways and Means Committee.

- Consultant to the National Governor's Conference on health planning and national health insurance legislation. His work included analysis of the effect of this legislation on state governments and drafting of statements for Governors' testimony. Mr. Clarke drafted an alternate bill (HR 15908) representing the position of a coalition of state, county, and city interests in health planning legislation.

- Consultant to TransCentury Corporation for the evaluation of the Experimental Health Services Delivery Systems (EHSDS).

- Author of numerous publications and articles on state health planning and health care (see attached listing).

Mr. Clarke received his AB in Economics and Political Science from the University of California; his MA in Political Science from Rutgers University; and is presently studying law at the National Law Center, George Washington University.

G. J. Clarke

PUBLICATIONS

State Health News. Georgetown University Health Policy Center (Washington, D. C.: October, 1976, continuing).

"State Health and Mental Health Programs," in The Book of the States - 1976-77, Volume XXI, Council of State Governments (Lexington, Kentucky, July, 1976).

Paper Victories and Hard Realities: The Implementation of the Legal and Constitutional Rights of the Mentally Disabled, (co-editor); Health Policy Center, Georgetown University (Washington, D. C., July, 1976).

"Some Obstacles to State Legislative Staffing: Real or Illusory?" with Charles R. Grezlak, National Civic Review (June, 1976).

"Health Expenditures by State Governments," Georgetown University Health Policy Center (Washington, D. C., May, 1976).

"Improving Health Planning and Service Delivery" in States' Responsibilities to Local Governments: An Action Agenda; Center for Policy Research and Analysis, National Governors' Conference (Washington, D. C., October, 1975).

Health Programs in the States: A Survey. Eagleton Institute of Politics (New Brunswick, New Jersey March, 1975), 40 pp.

Explanatory statement and suggested legislation for "Hereditary Disorders Act," Suggested State Legislation - 1974 Edition, Council of State Governments (Lexington, Kentucky, October, 1973).

"Report of the Subcommittee on Occupational Licensing," in Report of the Legislative Research Committee, State Capitol, Augusta, Maine, November, 1972).

Various sections in Analysis of the Budget Bill, Joint Legislative Finance Committee, Office of the Legislative Analyst, California State Legislature (Sacramento, 1971).

"Some Aspects of the Appropriations Process," in Studies of the New Jersey Legislature, The Eagleton Institute of Politics, Rutgers University, New Brunswick, New Jersey, September, 1970).

"Health Policy Experts in State Legislatures: A Comparative View," with Charles R. Grezlak (submitted for publication).

"Utility-Like Regulation of Health Facilities by the States," working paper, Intergovernmental Relations Committee, Task Force on Health, National Legislative Conference (Washington, D. C., December, 1973).

"Regulation of Health Manpower - Problems and Prospects," Veterans Administration Hospital (Tuscaloosa, Albama, July, 1972).

JORDAN BRAVERMAN

Jordan Braverman is Director of the Division of Legislative and Policy Analysis for the Georgetown University Health Policy Center. He is responsible for reviewing and analyzing health policy/program issues and developments generated by the federal government, Congress, state and local governments, trade associations, public interest groups, etc., with an emphasis on their implications for state and local health policy-making. His work has resulted in a series of papers on proposed and current health legislation.

Prior to this position, Mr. Braverman was:

- Director of Public Policy Research for the Pharmaceutical Manufacturers Association, where he was responsible for preparing staff position papers on domestic and international socioeconomic issues affecting the American pharmaceutical industry, and maintaining liaison with government agencies, commissions and private organizations concerned with the pharmaceutical industry.

- Research Associate and Assistant to the Director of the American Pharmaceutical Association, responsible for writing staff papers on such topics as health insurance, population, hunger and malnutrition, the environment, manpower problems, hospital care, nursing homes, neighborhood health centers, community mental health centers, health maintenance organizations, Medicare, Medicaid, Model Cities, and comprehensive health planning and regional medical programs.

- Economist for the Public Health Service, Department of Health, Education and Welfare, where he prepared special studies for the Division of Medical Care Administration and the Health Economics Branch on health care institutions and planning.

- Economist, National Blue Cross Association, where he directed a nationwide study on private and public financing of as well as quality of care in long-term institutions. As a member of an advisory committee to the Council on State Governments, Mr. Braverman helped formulate a model state health care act.

- Management Consultant to EBS Management Consultants, Inc. and Herbert L. Bogen, responsible for special studies on federal revenue-sharing programs and analyzed socioeconomic data related to urban problems.

- Planning Assistant to the City Government of Quincy, Mass., where he prepared an economic base study on "The Economy of Quincy, Massachusetts."

Mr. Braverman earned an AB in Social Relations from Harvard University, an MS in National and International Economics from Georgetown University, and an MPH in Medical Care Administration from Yale University. A list of his publications is attached.

J. Braverman

PUBLICATIONS

Articles

"National Health Insurance: Yesterday's Theory--Tomorrow's Reality," Journal of the American Pharmaceutical Association, May, 1970.

"A Comparative Summary of Major National Health Insurance Proposals-1971," Journal of the American Pharmaceutical Association, June, 1971.

"Group Practice Prepayment Plans: Universities Give New Impetus to Old Concept," Journal of the American Pharmaceutical Association, November, 19569.

"Changes in American Health Care: Evolutionary to Revolutionary," American Journal of Pharmaceutical Education, December, 1970.

"Subprofessionals in Pharmacy: An International Perspective," Journal of the American Pharmaceutical Association, June, 1969.

Books

Nursing Home Standards: A Tragic Dilemma in American Health, American Pharmaceutical Association, Washington, D. C., March, 1970.

Pharmaceutical Payment Plans - An Overview, Pharmaceutical Manufacturers Association, Washington, D. C., 1973.

American Medicine: The Coming Revolution, (Unpublished manuscript, completed, 1977).

JAMES C. STEARNS

James Stearns serves the Georgetown University Health Policy Center as Health Policy Analyst. He is involved in analyzing the impact of federal legislation on state and local governments and conducting investigative research on major health policy issues. He has provided extensive consultation to the Carter Transition Team on developmental disability issues, and continues to provide technical assistance to the Department of Health, Education, and Welfare as Vice-Chairman of the National Advisory Council for the Developmentally Disabled. In addition, Mr. Stearns serves on the Government Affairs Committee of the United Cerebral Palsy Association and the Committee to Further Careers for Disabled Scientists of the American Academy for the Advancement of Science.

Mr. Stearns' previous positions include:

- Law Clerk for the Georgetown University Health Policy Center, responsible for preparing memoranda to aid states in complying with federal court decisions delineating the rights of the mentally ill and retarded.

- Law Clerk with the Office of Employee Benefit Security, Department of Labor, where he was responsible for preparing issue papers on proposed regulations designed to implement the Employee Retirement Income Security Act.

- Researcher for the Presidential Task Force on Workers' Compensation, responsible for recommending ways in which attorneys could assist clients in recovering benefits without litigation.

- Co-Founder and Student Director of a Youth Counseling Center in Laconia, New Hampshire, with administrative duties including fund raising; representing the Center before state and local agencies; serving as liaison with law enforcement officials, and counseling clients, mainly drug users and runaways.

- Press Aide to U. S. Senator Thomas J. McIntyre (D-NH), responsible for drafting press releases and editing campaign publications.

Mr. Stearns earned an AB in Government from Dartmouth College, where his work as a Senior Fellow on the impact of federal programs on the physically disabled resulted in his testimony before a Senate Subcommittee. He also received an MA in Government from Victoria University of Manchester, England; and a JD from the Georgetown University Law Center.

JANET LEE DINSMORE

Janet Dinsmore serves the Georgetown University Health Policy Center as Editor/Writer, responsible for editing and designing all Center publications, including policy position papers, conference reports, brochures, special studies, annual reports, etc. She also conducts research and assists in providing technical assistance.

Prior to joining the Center, Ms. Dinsmore was:

- Senior Research Associate for (1) an Office of Education study on black leaders' attitudes toward vocational education; and (2) a project involving provision of instructional media and graphic design assistance to the Department of Labor, Region II. The projects involved research, writing, and the publication of training materials. Other responsibilities included preparation of company reports, proposals and publications.

- Proposal Writer for the national office of the U. S. League of Women Voters, responsible for writing proposals to the federal government, foundations, corporations, unions and individuals on: energy, land use, housing, campaign financing, government and election processes, environmental quality, public interest litigation, and urban problems.

- Technica Writer for A. L. Nellum and Associates, where she wrote or edited proposals and reports on: health services, Medicaid, manpower development, housing, corrections, community action, and youth training programs.

- Editor/Research Associate of the ERIC Clearinghouse on Higher Education, where she administered all research and writing activities; trained abstractors and research assistants; and edited or conducted original studies on a broad range of issues affecting colleges and universities.

- Associate Editor of Educational Record, quarterly professional journal of the American Council on Education, a national research and service association devoted to higher education administration. Responsibilities included reviewing all manuscripts, editing the publication, and a book resulting from Council's annual conference, Whose Goals for American Higher Education? She also served on the Council's Commission on Academic Affairs.

- Assistant Editor of Middle East Journal, a scholarly journal concerned with the Middle East. In addition to editing and doing production work, she wrote a chronology of social, economic and political events in 26 countries for each issue.

- Writing Consultant to federal government and private agencies.

Janet Dinsmore received a BA in English from American University. A list of her publications is attached.

PUBLICATIONS

"Student-Initiated Change in the Academic Curriculum," chapter in Handbook on Contemporary Education. New York: R. R. Bowker Co., 1976. Originally published as a monograph by ERIC Clearinghouse on Higher Education, George Washington University, 1972.

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Youth Action to Improve Housing. Washington, D C.: A. L. Nellum and Associates, 1973.

"All About National Fundraising." Washington, D. C.: U. S. League of Women Voters, 1974.

"Personal Protective Equipment: How and When to Use It." Occupational Health and Safety Administration, Department of Labor, 1975.

Public Service Employment: A Summary of Three Conferences. Washington, D. C.: A. L. Nellum and Associates, 1975.

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Educational Record. Associate Editor. Washington, D. C.: American Council on Education, March 1967-October 1968.

Middle East Journal. Assistant Editor. Washington, D. C.: Middle East Institute, August 1965-February 1967.

Death and Dying: An Examination of Legislative and Policy Issues (Editor). Washington, D. C.: Health Policy Center, Georgetown University, 1977.

PAMELA DAWN DECKER

Pamela Decker is Administrative Assistant to the Director of the Network of Correspondents, and also serves as Assistant Editor of the Health Policy Center's newsletter STATE HEALTH NEWS. She is responsible for coordinating information-gathering activities of the Network, and assisting in the overall production of the newsletter--from planning and design to writing, editing, printing, and distribution.

Previously, Ms. Decker was:

- Research Assistant for the Health Policy Center on a "Model Committee Staff Project." Ms. Decker wrote and edited major portions of the Final Evaluation Report, and analyzed health legislation from 1970-1976 in 16 states. As Research Assistant for a Legislative Professional Staffing Project, she analyzed state legislative responses to drug and alcohol issues and assisted in writing a forthcoming publication on state drug/alcohol abuse programs.

- Assistant Coordinator and Reporter for the Patriot-News Publishing Co., Harrisburg, Pa., responsible for analyzing legislation, interviewing public officials, writing public affairs articles, and conducting public opinion surveys. Ms. Decker also coordinated public service projects, and assisted in promotional activities, advertising design, brochure preparation, and filmstrip production.

- Staff Assistant to the Capital Area Youth Forum, Harrisburg, Pa., where she organized a conference for 1000 senior high school students from 35 schools modeled on the 1960 White House Conference on Children and Youth. Responsibilities included interviews, news reporting, and a variety of public relations assignments.

- Author of research studies and publications in public affairs (see attached listing).

Ms. Decker earned a BA in English/Journalism from Shippensburg State College, and an MA in American Government and Political Science from Georgetown University.

P. D. Decker

PUBLICATIONS

State Health News. (Assistant Editor) Georgetown University Health Policy Center (Washington, D. C.: October, 1976, continuing)

Newspaper in the Classroom: It's Elementary!, a teacher's handbook for using the newspaper in the elementary classroom, published by the Patriot-News Co., 1974.

"Greatest tool to help students become better informed citizens," feature article in PNPA Press (Pennsylvania Newspaper Publishers Association magazine), 1974.

General and feature news articles for the Patriot, the Evening News, and the Sunday Patriot News, Patriot-News Co., 1972-1974.

Special assignment reporter to the International Science and Engineering Fair, Notre Dame University, South Bend, Indiana, 1974.

MARY PATRICIA O'DELL

Patricia O'Dell is the Librarian for the Georgetown University Health Policy Center. She is responsible for maintaining a specialized collection of approximately 400 books and 90 periodicals on aspects of federal, state, and local health policymaking; preparing bibliographies on new acquisitions; and assisting staff research efforts.

Ms. O'Dell previously served as:

- Law Librarian for the Georgetown University Law Center Library, where she supervised up to 30 assistants in addition to performing normal duties associated with the administration of a specialized library.

- Library Intern with The American Banker's Association Library, responsible for cataloging a special collection dealing with banking law and history.

- Teacher of English with the Robert Frost Intermediate School and with the Fairfax County Public Schools.

- Administrative Assistant to the Director of the Speech and Hearing Center, The George Washington University, responsible for maintaining financial records, monitoring preparation of federal grant proposals, and supervising schedules of graduate students.

- Program Director of U. S. Army Service Clubs, APO Europe, responsible for planning and coordinating service club activities and supervising personnel.

Ms. O'Dell earned a BA in English from American University and an MLS from the College of Library and Information Services, University of Maryland.

CAROLYN BROOKS POWELL

Technical Assistance/Seminar Coordinator

As Technical Assistance/Seminar Coordinator, Carolyn Powell participates in the coordination and administration of support services for the Center's activities. She was formerly Technical Assistance Coordinator for a nationwide comprehensive health technical assistance project, a position involving maintaining close liaison with health specialists, varied reporting requirements; and administrative support to the Project Director. Ms. Powell was Administrative Assistant to the Executive Vice President of A. L. Nellum and Associates, a management consulting firm, and served the firm as Assistant Technical Assistance Coordinator of a Department of Labor Welfare Incentive Program.

Ms. Powell received a BS in Business Education from North Carolina Central University.

SALLY T. HOLLAND

Executive Assistant/Office Manager

The Center's Executive Assistant/Office Manager, Sally Holland is responsible for coordinating administrative support services and ensuring that the office runs efficiently. She formerly served as Office Manager and Administrative Assistant of a social and economic consulting firm, where she performed a variety of technical and administrative functions, including the coordination of services delivered to Peace Corps trainees and their families in Malawi, Africa. Ms. Holland was an Executive Secretary with the National Medical Association Foundation, Galaxy, Inc., and various offices of the Navy Department.

Ms. Holland received a BA in English from Howard University.

1977 RESEARCH ASSOCIATES

Patricia Kalmans is assigned to the Division of Legislative and Policy Analysis. Prior to joining the Center, Ms. Kalmans worked with the East Tennessee Research Corporation providing legal and technical assistance to community organizations on the development of health care programs. She also served as a member of the Advisory Panel on National Health Insurance to the House Ways and Means Committee, U.S. Congress; the Regional Advisory Group of the Tennessee Mid-South Regional Medical Program; and as a consultant to the Bureau of Community Health Services, DHEW. Working with the Vanderbilt Health Law Project, she analyzed state and federal health legislation. During her tenure as Family Advocacy Specialist for Family and Children's Services, Nashville, Ms. Kalmans organized a successful move to modify the Tennessee Food Stamp Law; organized the first mid-South conference on child abuse; and initiated an alternative juvenile justice program and continuing education program for paraprofessionals.

Ms. Kalmans received her BA in Political Science from Vanderbilt University; and is presently enrolled in the Georgetown University Law Center.

Ellen Miyasato is a Research Associate in the Division of Program Services, assisting in research and analysis of health policy issues affecting state and local legislation, as well as in program activities such as conferences, seminars, and technical assistance services. She formerly worked as Research Associate with the Population Law Center in San Francisco where she was responsible for assembling background information on litigation involving intergovernmental aspects of the health care system. Her focus there was on the impact of federal health laws on hospitals.

Ms. Miyasato has pursued study on the legal ramifications of the health care system on both the undergraduate and graduate levels. She received a BA in Government from Wesleyan University and is currently pursuing study in state and local health policies as a student in the Georgetown University Law Center.

Assigned to the Network of Correspondents, Sandra Manners is responsible for facilitating interaction among state health policymakers through the identification and reporting of emerging health policy issues. Before joining the Center, she conducted research on health legislation as a Law Clerk. She previously worked as a Medical Reference Librarian for George Washington University; as a Staff Research Associate in the Bio-Engineering Department, Medical School, University of California, San Diego; and as a

Pre-Medical College Aide with Columbia-Presbyterian Hospital, New York. Ms. Manners also managed the Women's Clinic and worked as a full-time Community Board Member of the Beach Area Free Medical Clinic--a position including active involvement in both the medical and administrative activities of the Clinic.

Ms. Manners received her BA in Biology from New York University; took pre-doctoral work in Physiology from George Washington University; and is presently enrolled in the Georgetown University Law Center.

1977 SUMMER INTERNS

John Luehrs is a PhD candidate in Political Science, Washington University, St. Louis, Missouri. His general field of study is political science, with a concentration on public policy formulation and analysis. Mr. Luehr's background includes experience in research methods and analytical techniques, primarily statistics, and the application of statistical analysis to public policy issues.

John Ragland is sponsored by Duke University Health Policy Internship Program, and the Association of American Medical Colleges. He will work at the Center from May 23 to July 29, 1977. Mr. Ragland's area of concentration at Duke was public policy sciences. His particular interest is legislative policy development.

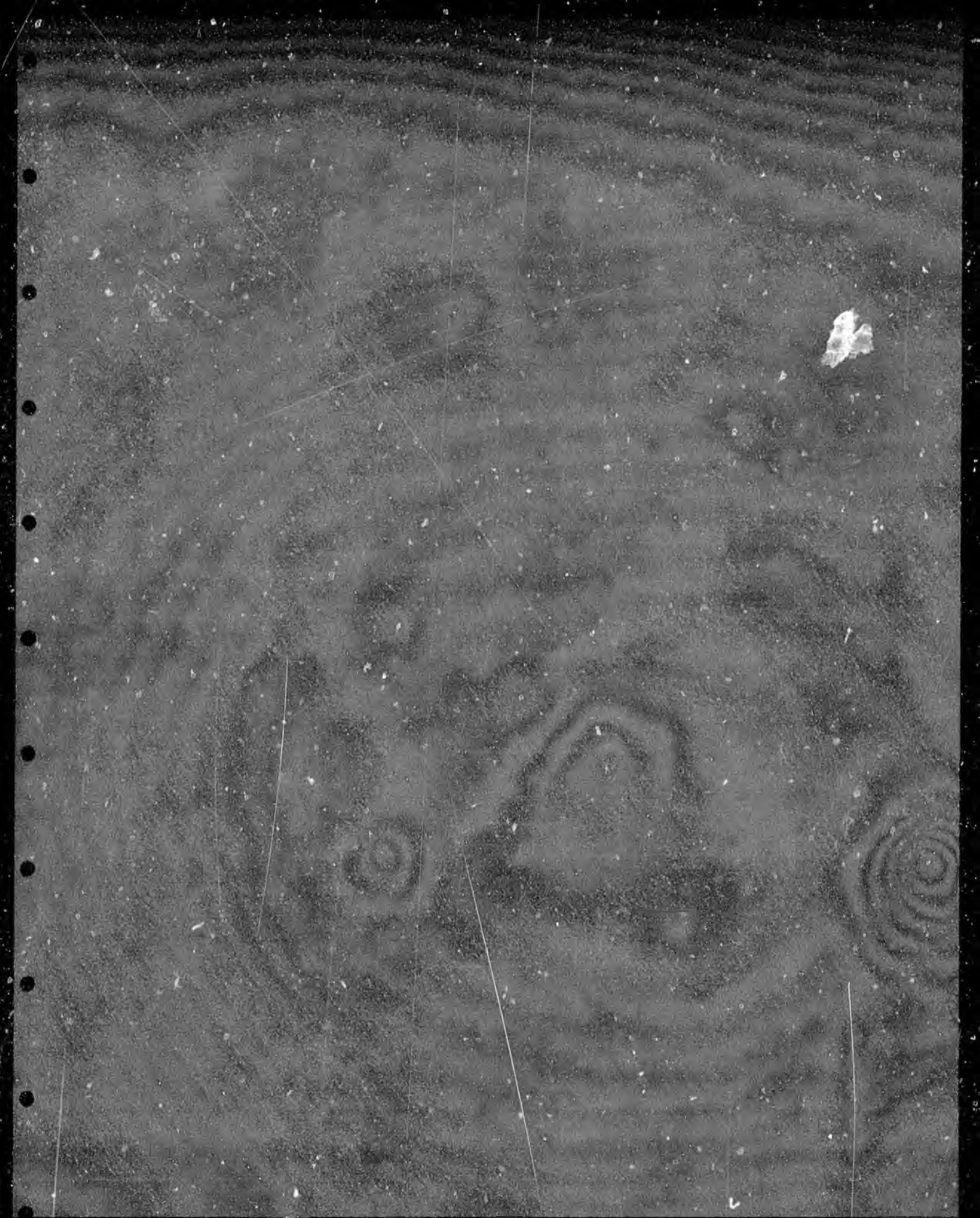
HEALTH POLICY CENTER CONSULTANTS

Valerie J. Bradley is President of the Human Resources Research Institute, a consulting firm specializing in state and federal health/mental health issues. Ms. Bradley was formerly Vice President and Director of Policy Development for Arthur Bolton Associates where she worked extensively with state governments in evaluating their mental health and mental retardation programs. Her legislative background includes work for the California State Assembly Office of Research and Legislative Reference Service; and for the New Jersey Legislature. Ms. Bradley has lectured for the Centers for Training in Community Psychiatry, Los Angeles; the McGeorge School of Law; California Hospital Association; National Association for Mental Health; and the New Jersey Association of Mental Health. She has served as a consultant to numerous state legislatures, and authored some 15 legislative analyses on health policies and children's issues for state agencies and legislatures.

Melvin L. Bergheim has served as Director of the Energy Staff of the National League of Cities and U. S. Conference of Mayors since 1976 and as a senior policy analyst for NLC and USCM since 1969. He was previously Deputy Executive Director of the U. S. Conference of City Health Officers; Vice Mayor and City Councilman for six years of Alexandria, Virginia; Director of Research on Civil Disorders; and Project Director for Urban America, the Potomac Institute, and Governmental Affairs Institute. Mr. Bergheim has been a reporter for the Washington Post, The Providence Journal-Bulletin and Congressional Quarterly, and published a number of studies on local government issues.

Patricia Kelley Gualtieri is presently completing a study of Drug and Alcohol Abuse Programs in the states for publication by the Health Policy Center. Formerly, she served as Associate Director of Evaluation for a long-term comparative study of staffing on legislative committees. Ms. Gualtieri was first Assistant, then Deputy Director of the Bureau of Drug Rehabilitation for the Commonwealth of Virginia. As one of the five participants in the Governor's Intern Program, Ms. Gualtieri worked with the Commonwealth's Department of Mental Health and Mental Retardation, Bureau of Drug Rehabilitation, and Governor's Council on Narcotics and Drug Abuse. She has been a consultant to the National Institute on Drug Abuse and the White House Counference on the Handicapped.

Harry S. Freeman currently directs an NIMH contract project to provide technical and financial management assistance regarding third-party reimbursement to Community Mental Health Centers. He also assists the Health Policy Center in budget planning and management. Mr. Freeman previously provided financial management assistance to Comprehensive Health Centers under an OEO Office of Health Affairs contract, and directed several SBA and OMBE projects aimed at improving the management of small businesses throughout the United States. He served as Vice President of the Greater Washington Business Center, and Assistant Director of the Washington Council for Equal Business Opportunity.



SURVEY OF EXISTING STATE HEALTH INSURANCE PLANS

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**Not available for distribution

SURVEY OF EXISTING HEALTH INSURANCE PLANS

I. BACKGROUND

Both federal and state consideration have been given to the need to provide better and more comprehensive health insurance coverage to the American public. As of the end of 1975, only five states had passed legislation addressing this problem, although it is reported that 12 other states have considered bills. At the federal level, there are a number of national health insurance plans under consideration but the immediate prospect of passage is considered poor unless a compromise is achieved.

In National Health Insurance: Benefits, Costs, and Consequences (Brookings Institution, 1975; probably the best and clearest book on the subject), Karen Davis suggests three primary goals for a health insurance system:

(1) ensuring access to care;
(2) eliminating financial hardship; and
(3) limiting the rise in health care costs.

In addition she sees three supplementary goals which are requisites of any acceptable plan:

(1) equitable financing;
(2) easy to understand and administer; and
(3) acceptable to providers and the public.

Within the structures of these six fairly clear-cut goals, there are a multiplicity of approaches that might be successful. For example, more than 20 bills have been introduced in the last two Congresses for the implementation of a national health insurance plan. To properly evaluate a plan, recognizing cognizable alternatives and necessary tradeoffs, Ms. Davis identifies eight basic questions in the provision of national (or state) health insurance:

(1) Who should be covered?
(2) What should be covered?
(3) Should patients share in costs?
(4) How should the plan be financed?
(5) What role should private insurers and government have?
(6) What role should consumers have?
(7) How should hospitals, physicians, and other providers be paid?
(8) How should the plan change over time?

It is clear that these questions cannot be answered for the nation or any state without reference to considerable amounts of evaluative and informational data. Chief among these would be analysis of the effects of past programs, an honest evaluation of the strengths and weaknesses of the current health system, and data on health needs. There is also a need to evaluate the basic public policy behind extensions of health insurance, to determine which goals are most important to the state and its citizens. Finally concern must be shown, not just for the most desirable program, but also for the ability of the federal or state governments to sustain an adequate level of financing over a period of years. No matter how favorable the public benefits derived from a plan, the spector of later cutbacks or elimination for fiscal reasons holds an enormous threat to any comprehensive plan.

From this multiplicity of options, a recent conference paper (see Attachment A: New Jersey State Health Insurance Conference Background Documents) initially singled out five that seemed representative of directions possible plans might take:

(1) Minimum specified benefits and other standardization of health insurance policies--This is the easiest to regulate and least expensive to implement and may result in cost savings, but could also be regressive in that it might make it more difficult for the poor and near-poor to obtain insurance and result in downgrading of present policies to the minimum;

(2) Mandatory insurance pool--A pool of all insurers would be required to offer benefits at specified premiums to individuals and groups unable to obtain coverage. While this is a potentially expensive method (subsidies might be required), it is a possible mechanism for extending coverage to high risk or low income groups through the existing private industry structure;

(3) Catastrophic insurance--While providing coverage only against extraorderinary expenses, this type of plan can provide relief for the most ruinous health care situations of prolonged illnesses and accidents. Eligibility may be determined by a set expense level or by a floating measure based on income and assets. One problem is the apparent tradeoff between administrative costs and regressive sources of financing (administrative problems are largest for a catastrophic plan tied to income levels, which would be the most progressive and equitable);

(4) Extensions of Medicaid--At a reasonable administrative cost, Medicaid coverage could be extended to selected additional groups such as the unemployed. Other costs (depending on availability of federal matching funds) might be high and only certain groups could be helped through this type of program.

(5) Comprehensive state supported health insurance system--This would provide maximum coverage, and better coordination and control of the health care system, but costs are much higher than other approaches and implementation would probably be more difficult.

These five options do not exhaust the possibilities but are representative of different plans being considered.

II. NATIONAL HEALTH INSURANCE (NHI)

NHI has been under consideration for several years and numerous bills have been introduced (for a comparative survey of provisions of major bills introduced in the last Congress, see the Davis book referred to above). Prospects for passage of any bill this session are considered uncertain at best. This is attributed to the lack of Congressional consensus on any particular plan and President Ford's threatened veto of any health insurance programs likely to increase the federal budget.

As an alternative the President has suggested a catastrophic health insurance plan for the elderly which would be administered through Medicare. The program would place an upper limit on personal expenses of $500 per year on hospital charges and $250 on physicians' services. However, co-insurance charges and higher deductibles up to these maximums would mean most elderly persons would spend as much or more on health care. Consequently, the program has been sharply attacked as a cost saving program at the expense of the elderly sick ($2 billion is "saved" while only about $500 million in new expenses will be incurred, the difference will be paid by the recipients on previously covered medical services) which would benefit only one out of every thousand Medicare recipients (see Attachment B: Comments of Senator

Kennedy, Congressional Record, January 21, 1976, S 278.) Prospects for passage of the Ford plan are not considered good.

III. STATE HEALTH INSURANCE

As noted, five states have adopted some form of state health insurance. The programs vary considerably in approach and format and have met with mixed success in implementation. (See Attachment C.)

A. ARIZONA (plan repealed by Legislature after this paper was written)

The original Arizona plan, passed in 1974, required companies writing health insurance policies to provide coverage for catastrophic medical costs, unless the insured declines such coverage. Catastrophic insurance would cover unreimbursed medical costs exceeding five thousand dollars incurred during a two-year period. However, this plan was never implemented because of serious deficiencies in the structure and details of the Act. Reportedly new efforts are underway in Arizona to pass a revised bill along the same lines.

The advantages of a plan such as this are its coverage (all residents willing to pay a 1975-estimated premium cost of about $10 per month for a family of three or four), its administrative simplicity, and its ability to combat the most ruinous health care expenses. However, the plan's weakness is its limited benefits (only about 6,000 out of 2.2 million persons will ever spend $5,000 on medical costs of one illness), and its failure to increase access to health care (a deductible of $5,000, even if $4,000 of insurance payments are included as in the 1975 bill, is too high). (Figures cited are from Attachment D: Arizona Republic, 2/24/75, page 1, discussing the bills introduced in 1975.)

B. CONNECTICUT

In July 1975, Connecticut enacted a Comprehensive Health Care Act. This plan requires insurers to make available to all persons under 65 a standardized comprehensive health insurance policy covering specified minimum benefits. Included benefits are hospital services, physicians' services, prescription drugs, part payment for treatment of mental conditions, skilled nursing facility care, home health agency visits, and numerous other lesser benefits. Three deductible levels are available and a 20% co-payment provision will be in all plans. However, a ceiling on cost sharing expenditures is set at $1,000 per person and $2,000 per family.

The Act was to become effective April 1, 1976, but technical inconsistencies (such as no authority to draft regulations prior to the effective date) will delay implementation (new legislation is before the legislature to correct these deficiencies). The program provides no new benefits, but rather requires the availability of certain types of coverage for those able to pay. The required package is very comprehensive, but will probably not seriously alter coverage for anyone already on a good group coverage plan. Thus, it is expected that demand for the new policies will be primarily from individuals or small-employer groups. Further, the cost of the premium will probably be high, making it out of the reach of unemployed and low-income persons not already covered by health insurance.

Because of Connecticut's fiscal situation, this program was considered to be the extent of action possible at this time. Certainly an advantage of this approach is its lack of cost and its ability to improve health insurance coverage for a segment of the population. On the other hand, significant portions of the population will still not be able to afford adequate health insurance and the program does nothing to attack rising health care costs.

C. HAWAII (See Attachment E: Congressional Record)

The program in Hawaii mandates health insurance coverage for nearly all employed persons. However, it does not cover dependents. While deductibles, co-insurance, and other cost-saving devices are permissible, the law requires thorough and near-total coverage of basic and catastrophic health costs. The program is to be employment-based with costs to be paid by the employer or shared with the employee. The employee portion of the cost is limited to half the premium cost, not to exceed 1.5 percent of wages. Provisions are made for state subsidization of those small employers who would be heavily burdened by the costs of this program. The law specifies that passage of a mandatory NHI, or a voluntary NHI with substantially similar benefits, will terminate the program.

The advantages of such a program are its coverage of a broad segment of the population, its comprehensive benefits, and its potential for improved health planning and more efficient delivery of health care services. However, employment-based plans leave a significant population unserved that may not be covered by other programs. In addition, employer/employee premium payments, especially when mandatory, are a highly regressive form of financing since the employee will ultimately bear the burden of costs: either by lower cash wages or smaller than expected raises. This represents a much higher share of income for low income workers and is thus regressive. Further, in marginal industries and for minimum wage workers the effect can be to reduce total employment.

The Hawaii program has been in effect since January 1, 1975, and appears to be working fairly well. The main problems appear to be occasional employer non-conformance and negotiating whether out-of-state plans (from insurers with branch offices in Hawaii) are in substantial conformity with the Act's requirements. The base-line plans for evaluating conformity have been in Hawaii Medical Services Association #4 plan and the Kaiser #1 plan.

D. MAINE

The Maine program establishes a "catastrophic medical expense fund," partially funded through a cigarette tax, to aid all persons suffering catastrophic medical expenses and not otherwise eligible for aid through federal programs. The state will provide assistance for additional medical costs in excess of $1,000 after the following resources have been exhausted:

(1) any health insurance coverage;
(2) 20% of the family's net income before taxes;
(3) 10% of the excess of the family's net worth over $20,000.

Reimbursement is directly to the provider and no federal funding is provided for the program.

This is an extremely limited program because of the high deductibles. However, this is also why opposition to the program has apparently been low--the rationale being offered that eligibility standards being so high means that only those clearly in trouble are aided. Further the program does fill two "holes" under the federal SSI program by potentially covering major but less than year-long disabilities and preventing total "wipe-out" of families with small total assets. The main disadvantage of the program is readily apparent--inadequate coverage because of high deductibles. Clearly many persons suffering disastrous medical losses are not covered.

E. RHODE ISLAND

The Rhode Island plan, effective January 1, 1975, provides for a state catastrophic health insurance fund to pay excessive unreimbursed health care costs. Eligibility for payments is based on a sliding scale designed to encourage persons to maximize their private insurance coverage.

Type of Coverage	To Be Reimbursed Individual Expenses Must Be the Larger of:
(1) Qualified plans, to include Basic Hospitalization and Major Medical	$500 or 10% of Income
(2) Qualified Basic Plan, but no Major Medical	$1,250 or 25% of Income
(3) Not a qualified plan	$5,000 or 50% of Income

Insurers must make available qualified plans for all individuals and employers must make a qualified plan an option under any health benefits provided. Rates for the minimum qualified plan are to be regulated by the State. Insurers may form a reinsurance pool for the coverage of qualified health policies. The catastrophic payments are to be funded out of general revenues.

The Rhode Island program (CHIP) is the most sophisticated of the state efforts. The program was geared to provide support for the average working person with about $10,000 income and it has apparently been successful in this regard. The poor are not generally eligible because they would "spend down" their income to the Medicaid level before they would qualify for the state program. An ancillary success of the program is the referral structure required by the Act. Originally intended as a screening program so that CHIP would be the bottom-line payor of last resort, it has expanded into a social services placement service with referrals to programs such as food stamps and vocational rehabilitation.

On the other hand, CHIP is partly regressive in its financing. While the state financing is from general revenues, it is still up to employers/employees to pay for most of the insurance coverage. This has the same weakness as the Hawaii plan. The plan also anticipates future budgeting troubles because of certain coverage areas (e.g., Psychiatric benefits are about 19% of payments and this is expected to increase) and some technical

problems (e.g., apparently patients in state mental hospitals can switch to private hospitals and have CHIP pay the bills).

F. OTHER STATES

A number of other states have considered bills implementing some form of state health insurance. In many cases these bills are modeled after one of the five state plans described above or the National Association of Insurance Commissioners' proposed model bill (see Attachment F) or the Conference of Insurance Legislators' model bill (there were two drafts; for the later one see Attachment G). In some cases the bills were introduced but no serious consideration was given to them. Reportedly 12 states had bills introduced in 1975 (excluding Connecticut which enacted its plan in 1975): California, Florida, Massachusetts, Minnesota, New Mexico, Ohio, Oklahoma, Oregon, Texas, Washington, and Wisconsin.

Of these states considerable effort has been expended in Minnesota to pass a bill. The first effort was made in 1973 and bills have been refined since then. The Governor backed a catastrophic bill on the Rhode Island model last year, but is taking no position this year. There are three bills being considered, the most comprehensive being the House bill, HF 1910. This Bill has four major provisions covering: (1) types of health insurance policies which must be written; (2) establishment of a poor risk state pool; (3) creation of initial state regulation of hospital and insurance rates; (4) provision of catastrophic coverage for medical expenses with a high deductible (expected to primarily benefit families in the $10,000-$13,000 income bracket). There is generally less concern about coverage of the poor because Minnesota has fairly liberal Medicaid eligibility provisions and also provides general relief benefits to persons with income a fixed percentage over Medicaid.

The advantages of the Minnesota bill will be greater standardization and availability of insurance policies. Opposition from the insurance industry focuses on their preference for a voluntary risk sharing pool: from the labor unions on their belief that cost controls are needed; and from the business community because of the additional costs involved. Prospects for the bill are uncertain--it has the strong support of the leadership but the 1975 legislative session is a short one. (Minnesota bill passed in 1976).

IV. CONCLUSIONS

Until the principles of full-scale health coverage are universalized in a national program, it is important that state efforts be cognizable in terms of the most important state health needs as well as the available resources. There is probably no single "correct" approach for a state to take.

How then should a state proceed? The goals and basic questions considered by Karen Davis (and briefly discussed earlier) are a good starting place. Consensus on the application of these goals is important although it may not be possible for a state (as opposed to the federal government) to maximize the Davis goals. It is likely that state policies and constraints will require further modification. The same applies to the basic questions she poses, although these may help to focus on two or three general approaches most appropriate to particular state needs.

On a more practical level, a conversation with Mr. Brain Keeler, Head of the Rhode Island CHIP Program, suggested a number of important planning considerations.

(1) Identify the strengths and weaknesses of the present state health system and plan accordingly. The adoption of model plans or other states' plans is likely to result in fundamental weaknesses in implementation. The preparation of a comprehensive program based on evaluation of present needs and future directions can also serve as a legitimizing force in implementing the final plan.

(2) Carefully identify revenue resources to assure that a health insurance plan can be maintained. Public expectations can build up quickly and make it very difficult to cutback or eliminate a program the state cannot afford. Consideration should be given to funding all or part of the program out of special revenues, such as the Maine tax on cigarettes.

(3) Incremental phasing-in of the program may be called for. Not only does this avoid problems of expectations, but it improves the chances for sound fiscal planning, good management, and smooth operation. For example, it might be preferable to start with day or dollar limits or caps on certain types of benefits until the real costs of higher or non-existent limits can be more firmly established and unintended inclusions can be eliminated.

(4) The importance of technical details in a state health insurance program cannot be overestimated. Not only usual details like oversight authority must be considered, but also questions of interlock with Medicare and Medicaid, possibilities of unexpected costs, and problems of cost and quality controls.

STATE GOVERNMENT AND MODEL HEALTH INSURANCE PLANS AS OF NOVEMBER, 1976

Plan	National Assn. of Insurance Commissioners (NAIC)	Council of Insurance Legislators (COIL)	Connecticut	Hawaii	Maine	Rhode Island	Minnesota
Coverage	Comprehensive	Comprehensive	Same as COIL plan, with one substantive difference: Instead of flat $200 deductible, individuals given choice of three: $250, $500, and $750.	Comprehensive	Catastrophic	Essentially catastrophic	Comprehensive catastrophic
Availability	All employers and private health insurers must offer state plan as alternative; firms must insure those who can't get or aren't eligible for private insurance	All insurers required to offer state plan as an option, through state insurance pool if necessary		All employers must make health insurance available to meet basic minimum coverage standards	All state residents covered; extent of coverage based on whether individual has private insurance policy	All state residents covered; extent of coverage based on whether individual has private insurance policy	State association of private insurers must make coverage available to anyone rejected by two private firms; state-funded catastrophic plan also; all employers with more than 10 employes must make coverage available.
Deductible	Option 1: $200 per person. Option 2: Choice of $200, $400, or $750 per person	$200 per person		According to private policies	When individual's out of-pocket health expenses exceed 20% of gross adjusted income, state pays rest.	From $500 to $5,000, depending on whether or not individual has private insurance.	[illegible] "levels" of deductibles to be [illegible] on gradually
Funding	Premiums	Premiums		Premiums	State cigaret tax; no premium	State revenues	Comprehensive coverage paid by premium; catastrophic by state
Co-payment	Option 1: 20% co-payment. Option 2: No co-payment. Both options provide that when policy holders' out-of-pocket expenses equal 10% of gross adjusted income, insurance will pay all additional health expenses	20% of costs over deductible, up to maximum of $1,000 out of pocket expenses per person		According to private policies	None	None	Private carriers will determine with approval of state.
Structure	Insurance conducted by private carriers under guidelines of "state health care commission" with broad representation. Commission required to review hospital costs; if unsatisfactory, commission has option of enacting review rules for physicians' costs	Coverage for uncompensated hospital care by state assessment of private insurers to pool reimbursement costs. Some mechanism established to review hospital costs; peer review, as currently exists, required for physicians.		Not really state health insurance, but a set of legal requirements to expand the private insurance market to all employed persons	Run by state government	Run by state government	Private insurers must submit comprehensive plan; state will handle catastrophic coverage

Source: "State Health Insurance Plans: Tiptoeing In Back Door", American Medical News, November 8, 1976, p.9

STATE GOVERNMENT AND MODEL HEALTH INSURANCE PLANS AS OF NOVEMBER, 1976

Plan	National Assn. of Insurance Commissioners (NAIC)	Council of Insurance Legislators (COIL)	Connecticut	Hawaii	Maine	Rhode Island	Minnesota
Coverage	Comprehensive	Comprehensive	Same as COIL plan, with one substantive difference: Instead of flat $200 deductible, individuals given choice of three: $250, $500, and $750.	Comprehensive	Catastrophic	Essentially catastrophic	Comprehensive-catastrophic
Availability	All employers and private health insurers must offer state plan as alternative; firms must insure those who can't get or aren't eligible for private insurance.	All insurers required to offer state plan as an option, through state insurance pool if necessary		All employers must make health insurance available to meet basic minimum coverage standards.	All state residents covered.	All state residents covered; extent of coverage based on whether individual has private insurance policy.	State association of private insurers must make coverage available to anyone rejected by two private firms; state-funded catastrophic plan also. All employers with more than 10 employes must make coverage available.
Deductible	Option 1: $1000 per person. Option 2: Choice of $500, $400, or $750 per person	$200 per person.		According to private policies	When individual's out-of-pocket health expenses exceed 20% of gross adjusted income, state pays rest.	From $500 to $5,000, depending on whether or not individual has private insurance.	Three "levels" of deductibles to be phased in gradually.
Funding	Premiums	Premiums		Premiums	State cigaret tax; no premium	State revenues	Comprehensive coverage paid by premiums; catastrophic by state
Copayment	Option 1: 20% co-payment. Option 2: No co-payment. Both options provide that when policyholder's out-of-pocket expenses equal 10% of gross adjusted income, insurance will pay all additional health expenses	20% of costs over deductible, up to maximum of $1,000 out of pocket expenses per person.		According to private policies.	None	None	Private carriers will determine with approval of state.
Structure	Insurance conducted by private sector, under guidelines of "state health care commission" with broad representation. Commission required to review hospital costs; insurance commissioner has option of enacting review rules for physician costs	Coverage for uninsurables handled by state association of private insurers to pool reinsurance costs. Some mechanism established to review hospital costs, peer review, as currently exists, required for physicians.		Not really state health insurance but a set of legal requirements to expand the private insurance market to all employed persons	Run by state government	Run by state government	Private insurers must handle comprehensive plan; state will handle catastrophic umbrella coverage

Source: "State Health Insurance Plans: Tiptoeing In Back Door", American Medical News, November 8, 1976, p.9

THE COST OF STATE HEALTH INSURANCE PROGRAMS

By
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The cost of state health insurance plans to the jurisdictions which enacted them is only now becoming discernable. Knowledge is still minimal due to the relative newness of some programs and the legal structure in which others have been framed. For example, there is a minimal of state administrative expense and no state beneficiary payments in Hawaii and Connecticut since these programs are not operated by the states. Rather, the health insurance laws in these two states mandate that private health insurers must offer all or certain segments of the resident population health insurance benefits according to the criteria established by state law after certain requirements on the part of the residents are met in terms of health care expenses and other guidelines. Hence, most of the state's program costs, except assuring that the private health insurers are adhering to the law, are absorbed by the private carriers. Minnesota's program, effective on January 1, 1977, did not become operational till July, 1977 so that no cost experience is as yet available from that state. Although the Minnesota Department of Public Welfare requested $23 million for state payment of catastrophic health insurance expenses, estimates by other state officials indicated that the biennial cost of the state health insurance plan would be lower. The Minnesota State Legislature eventually approved a biennial budget of $17 million for the program. Consequently, the states that can offer utilization

experiences, however minimal they may be, are limited to Maine, whose program became effective in 1974 and Rhode Island, whose program became effective in 1975.

The state legislature in Maine has appropriated $800,000 per year for its state health insurance program, part of which is financed by a state cigarette tax. The program's standards were designed to match the public funds appropriated. As of October, 1976, Maine had 244 eligible recipients and another 306 individuals were in the process of becoming eligible.

As far as Rhode Island is concerned, benefit payments were 69 percent higher in the second year of the state's catastrophic health insurance plan (CHIP) than in the first. During 1976, the state paid $858,565 in benefits to 150 families. Emotional disorders led the list of disabilities. Claimants received state health plan aid for cerebrovascular disorders, cancers, cardiac and kidney conditions. The state health department stated that 43 percent of the families aided by the state health plan were Medicaid recipients. Although the average expenditure for Medicaid patients was lower than the overall average, they qualified earlier for state health plan benefits because they were required to make smaller out-of-pocket expenditures. The state noted that 57 families who received state health plan aid in 1976 had Blue Cross coverage, 65 had Medicare coverage, 14 had commercial insurance and 14 had no insurance. In 1975, the plan paid benefits for 189 individuals. The average expenditure was $4,544, about 16 percent above 1975 when 114 persons received benefits.

Although no sweeping conclusions can be drawn from the cost data available, it would appear that as these state health insurance programs progress more people will continue to qualify for them at ever increasing expense to the state. Only time will be the ultimate judge as to whether or not a state will be able to continue to pay for such costs in addition to all of its other social responsibilities if no national solution is found for bringing health care costs under control.

STATE COMPREHENSIVE/CATASTROPHIC HEALTH INSURANCE PLANS: AN OVERVIEW

by
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For almost a decade, the establishment of a national health insurance program in the United States has dominated our health dialogue. Yet, in terms of Congressional action, national health insurance has remained only a dialogue. With the convening of the 95th Congress in January 1977, a whole gamut of national health insurance plans has been or will be reintroduced, ranging in philosophy and intent from a catastrophic illness concept to a mixed public-private approach to a wholly public program.

Meanwhile, the costs of health care continue to escalate. During fiscal 1976, 8.6 percent of our Gross National Product or $139 billion was spent on health care services--an amount exceeding the expenditures of every other nation in the world for this same social service. The costs of financial protection against the incidence of ill health are now beyond the means of millions of Americans, especially those whose income is less than $10,000 per year.

As the federal government continues to study and debate the issue of national health insurance, states have begun to assume the initiative by enacting their own health insurance programs for those living within their political jurisdictions. So far, five states have enacted health insurance plans of varying scope: Hawaii,

Rhode Island, Minnesota, Maine, and Connecticut. Some plans are designated as "comprehensive" in character, while others are more limited and catastrophic in their intent. In addition, other states are considering similar legislation. Thus, it is possible to foresee that one day instead of there being one uniform national health insurance plan covering all citizens in all states, there may be 50 diverse plans in each of our 50 jurisdictions. Thus, it is the purpose of this paper to explore the problem of state health insurance plans, especially catastrophic insurance and the various problem areas attendant to their creation including their administration, organization, financing, eligibility and benefit determination, to name but a few topics. However, before examining these various issues, it may be of interest to briefly describe their historical evolution.

BACKGROUND

Much has been written in recent years about the enactment of state health insurance programs in Hawaii, Rhode Island, Minnesota, Maine, and Connecticut, and the possibility that similar legislation may be enacted by other state governments. These activities are not really new initiatives. Rather, they represent an extension of state government into the traditional preserve of private industry--an intrustion that can be traced as far back as the 1950s.

Traditionally, states have confined themselves to scrutinizing insurance rates; determining whether insurers have adequate capitalization and reserves; setting taxes and exemptions for the industry; and performing similar functions. Policy benefits were of concern only to the insurer and the insured. But beginning with Massachusetts in 1956, states have gradually assumed the role of informing insurers what their health policies must include, and to whom benefits must be provided, sometimes with little thought given to two questions: what will it cost, and how can it be reasonably administered?

State involvement in health insurance has increased steadily over the years. Twenty years ago, for example, the Massachusetts legislature ruled that coverage of physicially handicapped and mentally retarded dependents must extend beyond the health contract's age limitations. In 1965, the state of New York followed Massachusetts with extended dependent coverage, and by 1970, 14 other states had taken similar courses of action with about one-half of the jurisdictions requiring extended coverage for the physically handicapped and the mentally retarded. California, Louisiana, North Carolina, and Texas led the vanguard of states requiring coverage of newborn infants from the moment of birth. Most of this legislation was passed in the early 1970s, with more than two-thirds of the states now beginning such coverage.

Many states now stipulate that if a policy covers specialized services (dental restorations following accidents, emergency eye

care, psychiatric treatment) when provided by a medical doctor, the policy must also pay for the same services when they are administered by a health specialist operating within the scope of his license (i.e., an optometrist, dentist, or psychologist). In addition, about 11 states now require coverage for the treatment of mental or nervous conditions--coverage that varies widely. Even the issue of unemployment has not been overlooked; states like Oklahoma, Illinois and Minnesota now require health insurance coverage for terminated employees to continue for varying periods of time.[1/]

In some instances, state laws apply only to commercial insurance coverage, specifically excluding Blue Cross and Blue Shield contracts. Other laws add requirements to Blue Cross and Blue Shield enabling acts or charters. Still others apply equally to commercial carriers and Blue Cross plans.[2/] Thus, in view of the historical involvement of state government and the slowness of federal activity in the national health insurance area, it is not surprising that a few states have begun mandating catastrophic or comprehensive state health insurance payments to place a lid on their residents' health payments.

Mandated state health benefits, however, have caused considerable controversy among various groups. Many insurers, for example, are concerned that mandated benefits will drastically increase the number of providers eligible for payment, and the level of payments to all providers. They argue that additional rate hikes will be forced on a public already concerned with high health care costs.

Private corporations, unions, and the federal government itself are also beginning to realize that benefits established in a patchwork nature may seriously affect the administration of regional and national health plans that may not include all the benefits required by individual states.

Unions, for example, believe that such actions are the responsibility of the bargaining table, not the state legislative assembly. While many group contracts cover individuals living in one state--subject to one set of mandated benefits--some very large groups (i.e., auto workers or steelworkers) negotiate health contracts on a regional or national basis. Such contracts may exclude benefits that a state requires in all contracts within its particular jurisdiction, or, conversely, include Michigan or Pittsburgh home-office-state-requirements that are not characteristic of other states. To minimize such problems, a general understanding (albeit with exceptions) has evolved that conventional multi-state group coverage is regulated by a single state--the one in which the master policy is delivered. Thus, an auto worker's policy that delivers services in Michigan would conform to Michigan requirements, even if the covered workers live and work in Ohio and California. However, a few states do impose specific requirements regardless of where the master contract is delivered.

These are just some of the issues raised by state mandated health benefits. However, before discussing additional specific problems raised by these mandated programs and the five

state health insurance plans presently in existence, it may be of interest to examine briefly the concept of catastrophic health insurance and some of the problems associated with that concept.[3/]

CATASTROPHIC HEALTH INSURANCE--A DEFINITIONAL PROBLEM

The term "catastrophic" as it applies to health insurance has rasied many perplexing questions. As one example, a grave medical expense problem for one individual may not be any problem at all for an individual at a different income level. According to a recently published study by the U. S. Congressional Budget Office, two measures have been most frequently used to define and delimit a catastrophic expense. One measure has been large absolute expenditures; the other has been expenditures that are large in relation to an individual's income.[4/] The first definition is used in traditional private insurance plans and in a number of public programs modeled on private insurance. The second standard of measurement--expenditures that are large relative to an individual's income--has been used only by government. This is the basis for allowing federal tax deductions for those medical expenses exceeding three percent of adjusted gross income.[5/]

While there are three major sources of financial assistance available to consumers in helping them meet their medical needs--namely private health insurance, public programs and tax subsidies--significant coverage problems still remain. The most outstanding include: (1) uneven coverage (an estimated 18 million Americans are totally unprotected); (2) the failure of private and public

EXHIBIT 1

Status of catastrophic coverage in the U.S. (for fiscal 1978)

1. Unprotected	18 million people—uninsured, not eligible for aid from noninsurance sources
2. Least adequate protection	19 million people—families with incomes of less than $10,000 holding only individual private policies
3. Less than adequate protection	26 million people—the aged and disabled on Medicare
4. Less than adequate protection	38 million people with basic hospital coverage, no major medical insurance
5. Adequate protection	24 million people—covered by Medicaid
6. Good Protection	103 million people—major medical, comprehensive major medical, members of HMOs

(Categories 2,3,4 overlap)

—Source: Congressional Budget Office

insurance plans to include certain types of services or to insure them adequately; (3) the inadequacy of some insurance plans in covering high expenses (an estimated 37 million Americans have plans that do not adequately cover high expenses or long hospital stays); and (4) the ineffectiveness of tax subsidies in assisting low-income families.[6/]

The lack of adequate basic insurance coverage for almost one-third of the families whose incomes are below the national median and the failure of both public and private health insurance programs to cover certain types of services have resulted in two kinds of catastrophic out-of-pocket expenses: the cost of long-term care for the aged; and average or normal expenses that consume an unreasonable proportion of a low-income family's resources.[7/] Although 103 million persons have major medical insurance, and programs such as Medicare and Medicaid cover part of the costs incurred by the elderly and the medically indigent, both groups still experience high out-of-pocket expenses for non-hospital services, as well as for those aspects of their hospitalization not covered by private insurance or public medical care programs.[8/]

These are some of the issues, along with the failure of the federal government to enact thus far a national health insurance plan, which have prompted states to enact their own insurance plans. This paper will now examine the experiences of the five states that have enacted such programs.

CHARACTERISTICS OF STATE HEALTH PLANS

In deciding to adopt a state health insurance plan for its residents, a state government must consider many questions. First, how does it initially determine the need for a state health insurance program? What kinds of criteria should be used to decide whether a plan should be limited to catastrophic illness costs or be more comprehensive in scope? How does it decide whether a plan should be mandatory or voluntary for its citizens? And if the plan is voluntary, how does the state proceed in marketing it to the public?

Another question that arises deals with the relationship of the state plan to private insurance carriers such as Blue Cross, Blue Shield, and commercial insurers, as well as to HMOs and Medicaid and Medicare beneficiaries. In addition, what effect will any potential national health insurance program have upon the state plan? What if the state plan is broader in scope than the initial national health insurance program? Will the state plan just supplement those benefits not covered by the national health insurance plan? What if the state plan is narrower than any initial national health insurance program? Will the state dissolve its own plan in favor of the national health insurance program? And what kind of legislative obstacles must be overcome to get such a plan enacted in the first instance?

Thus far, it would appear that at least five states have answered some of these questions to their own satisfaction. They

Plan	National Assn. of Insurance Commissioners	Council of Insurance Legislators (COIL)	Connecticut	Hawaii	Maine	Rhode Island	Minnesota
Coverage	Comprehensive	Comprehensive	Same as COIL plan, with one substantive difference: Instead of flat $200 deductible, individuals given choice of three: $250, $500, and $750.	Comprehensive	Catastrophic	Essentially catastrophic	Comprehensive/ catastrophic
Availability	All employers and private health insurers must offer state plan as alternative; firms must insure those who can't get or aren't eligible for private insurance.	All insurers required to offer state plan as an option, through state insurance pool if necessary.		All employers must make health insurance available to meet basic minimum coverage standards.	All state residents covered.	All state residents covered; extent of coverage based on whether individual has private insurance policy.	State association of private insurers must make coverage available to anyone rejected by two private firms; state-funded catastrophic plan also. All employers with more than 10 employes must make coverage available.
Deductible	Option 1: $200 per person. Option 2: Choice of $200, $400, or $750 per person.	$200 per person.		According to private policies.	When individual's out-of-pocket health expenses exceed 20% of gross adjusted income, state pays rest.	From $500 to $5,000, depending on whether or not individual has private insurance.	Three "levels" of deductibles to be phased in gradually.
Funding	Premiums	Premiums		Premiums	State cigaret tax; no premium	State revenues	Comprehensive coverage paid by premiums; catastrophic by state
Co-payment	Option 1: 20% co-payment. Option 2: No co-payment. Both options provide that when policyholder's out-of-pocket expenses equal 10% of gross adjusted income, insurance will pay all additional health expenses.	20% of costs over deductible, up to maximum of $1,000 out-of-pocket expenses per person.		According to private policies.	None	None	Private carriers will determine, with approval of state.
Structure	Insurance conducted by private sector, under guidelines of "state health care commission" with broad representation. Commission required to review hospital costs; insurance commissioner has option of enacting review rules for physician costs.	Coverage for uninsurables handled by state association of private insurers to pool reinsurance costs. Some mechanism established to review hospital costs; peer review, as currently exists, required for physicians.		Not really state health insurance, but a set of legal requirements to expand the private insurance market to all employed persons.	Run by state government.	Run by state government.	Private insurers must handle comprehensive plan; state will handle catastrophic umbrella coverage.

Source: "State Health Insurance Plans: Tiptoeing in Back Door," American Medical News, November 8, 1976, p. 8.

include Maine, Rhode Island and Minnesota which have enacted catastrophic health insurance programs, and Hawaii and Connecticut which have enacted plans that are more comprehensive than the catastrophic illness approach.

RHODE ISLAND

The state of Rhode Island decided in April 1974 that a catastrophic health insurance plan was needed for the average working person whose income was about $10,000 per year. Under the program, effective January, 1975, Rhode Island pays the costs of eligible health services after a person has incurred a specified amount of medical expenses. The program encourages the purchase of private health insurance including that of major medical whether it be from Blue Cross and Blue Shield, commercial insurers or through Health Maintenance Organizations. This encouragement is fostered by varying the amount of the deductible that the individual must meet prior to the state plan becoming effective. The amount of the deductible is tied to the kind of private health insurance that an individual purchases. Thus, the deductible would be smallest for an individual or family with qualified health insurance coverage that also includes major medical, larger for the individual or family which has qualified health insurance coverage without major medical and largest for an individual who does not have qualified health insurance coverage at all. The same incentives apply to Medicare beneficiaries who purchase private health insurance as supplementary coverage to Medicare benefits. The program requires

all insurance carriers to offer a qualified policy that meets minimum standards and minimum benefits as specified by the state. The rates for such insurance must be approved by the state as well. The program provides for the establishment of a reinsurance pool and all carriers writing qualified health insurance policies may participate in the pool. There is also mandatory participation in the pool if the insurance commissioner deems such participation to be necessary.[9/]

MAINE

In distinct contrast to Rhode Island, the state of Maine in 1974 merely established a catastrophic medical expense fund that was partially financed through a cigarette tax to aid all persons who were experiencing catastrophic medical expenses and who were not otherwise eligible for aid through federal programs. The plan has a very high deductible that must be met prior to its assisting those in need and opposition to the state program has been small on the theory that the eligibility standards are very high and that only those truly in trouble will be aided. The program covers major but less than one-year long disabilities and prevents the total wipe out of families with small assets. The plan terminates when any similar program on the federal governmental level becomes effective.[10/]

CONNECTICUT

Connecticut, on the other hand, has enacted a more comprehensive health insurance program than either Maine or Rhode Island and the plan became effective on April 1, 1976. The plan requires private

insurers to offer Connecticut residents a wide range of benefits, including protection for catastrophic illness with a lifetime maximum of $1 million per individual. A choice of three deductibles--$200, $500, and $750--is available to individuals and groups. A Health Reinsurance Association insurance pool for hign risk insureds is included. The plan guarantees that no one in the state has to pay more than $1,000 per year in out-of-pocket medical expenses as a covered individual or $2,000 per year as a covered family.[11/]

HAWAII

Like Connecticut, the state of Hawaii also enacted a comprehensive health insurance plan but back in 1974. Unlike Connecticut, the Hawaii plan only pertains to those who are employed in the state rather than to all of the state residents. The law requires that companies offer workers acceptable prepaid health care plans similar to Kaiser or Blue Shield programs. Employers must pay at least 50 percent of the costs; employee contributions are limited to a percentage of their wages. The Hawaii Department of Labor and Industrial Relations administers the program. A seven man advisory council--appointed by the Director of the Department--assists in determining whether a prepaid health care plan qualifies. The council members represent the medical and public health professions, consumer interests and the prepaid health care field. The law specifies that the new program will terminate upon the passage of a federal voluntary health insurance program that provides for health care on a basis that is at least as favorable as that provided by the state program.[12/]

MINNESOTA

The latest state health insurance plan to have become operational is that of Minnesota, effective January 1, 1977. Employers in this state must include qualified catastrophic protection in the health insurance programs which their companies offer. Following a $150 deductible, the qualified basic plan pays 80 percent of the first $3,000 per year and 100 percent thereafter, to a lifetime maximum of $250,000. Starting March 1, 1977 the state welfare department will pay 90 percent of yearly medical costs for any person whose incurred expenses exceed 40 percent of household income up to $15,000, plus 50 percent of that between $15,000 and $25,000, plus 60 percent of that over $25,000 or $2,500, whichever is greater.[13/]

BENEFIT COVERAGE AND ELIGIBILITY

In considering the scope of benefit coverage and program eligibility, a state must examine various alternatives and options in terms of the financing available and the capability of administering the program as well as the goals it seeks to attain through the program's establishment. For example, one important question relates to the scope of benefit coverage. Should such coverage be limited to specific age groups, be univeral for all state residents, or be delimited by income range or personal asset valuation? Should the benefit coverage include categorical welfare groups, the unemployed, uninsurables, employer groups, Medicaid and Medicare recipients or beneficiaries of other federal health

programs such as military personnel and their dependents. What about benefit coverage for state residents who work outside the state and out-of-state residents who work within the state? After eligibility determination, the state must decide if it wishes to limit its program to those benefits that embrace the cost of catastrophic illness or establish a program that is much broader in scope than that kind of insurance, as already noted. In the latter case, how does the state determine the kind, priority and extent of benefit coverage?

In answering some of these questions several states adopted the following regulations. The state of Rhode Island's catastrophic health insurance plan covers persons who have resided in the state for at least three months but excludes anyone who moved to the state primarily to obtain benefits. In addition, state benefits to otherwise eligible persons are payable, generally, only if services are not available under other programs. Applicants for benefits are screened to determine possible eligibility for other benefits. The law specifically gives precedence to benefits provided under federal programs such as those for military personnel and for the aged, poor and indigent. The state Medicaid program also takes precedence. The law does not specify the types of services that are reimbursable under the catastrophic program but does note that some services will be excluded or covered only under given conditions or to a limited extent. The restrictions cover such services and items as prescription drugs, chiropractic care, psychological therapy and social

counseling only if they are prescribed as being medically necessary; and cover only up to 50 percent of the costs for outpatient psychiatry care; covers dental care and optometry only if they are required because of an injury or serious illness; covers eyeglasses, hearing aids and related aids only if they are medically necessary for rehabilitation; covers cosmetic surgery only if it is needed to repair an injury; and excludes custodial and domiciliary care and non-prescription drugs.[14/]

In view of the recent advent of state health insurance plans, Rhode Island is one of the very few states to obtain any utilization experience. During 1976, the state paid $858,565 in benefits to 150 families. Emotional disorders led the list of disabilities. Claimants also received state aid for cerebrovascular disorders, cancers and cardiac and kidney conditions. The state health department notes that 65 of the families (43 percent) aided by the state plan were Medicare recipients. The department also stated that 57 families who received state aid in 1976 had Blue Cross, 14 had commercial insurance and 14 had no insurance. Under the Rhode Island plan, a family qualifies as a unit and the catastrophic definition is determined by financial loss rather than by type of illness. Once a family has qualified for the state plan more than one person can get state assistance benefits. Benefits are only available after the claimant has exhausted all health insurance coverage and met certain levels of out-of-pocket expenditures. After qualifying, a claimant can maintain eligibility by incurring out-of-pocket

medical expenses that equal or exceed 25 percent of the first year deductible. In 1976 the plan paid benefits to 189 individuals. The average expenditure was $4,544, about 16 percent above the 1975 expenditure when 114 persons received benefits.[15/]

In order to qualify for the Rhode Island Catastrophic Health Insurance Plan, a person who has private health coverage which has been certified as a qualified program must have accumulated out-of-pocket expenses totaling either $500 or 10 percent of their allowable income, whichever is greater. Medicare beneficiaries with a qualified plan must meet a flat $500 deductible. Persons with less coverage than provided by a qualified program will have to make a larger out-of-pocket expenditure in order to receive state financial coverage. For example, a person with no health insurance must spend either $5,000 or 50 percent of his allowable income, whichever is greater, before becoming eligible. Any benefit that is covered under a qualified program, as defined in the CHIP Act, would be covered under the state financial coverage in full. Thus, it would appear, as in the case of Rhode Island, that those who might not be able to afford the purchase of health insurance must meet the highest form of deductible in order to qualify for the state's health insurance program and in this sense deductibles are regressive since individuals who may need to be protected the most against health care costs through insurance must also bear the greatest personal cost burden before the state's plan becomes effective for them.

On the other hand, a person in Maine must incur medical bills in excess of the following deductibles in order to qualify for benefits through the state's catastrophic illness program:

(1) $1,000

(2) 20 percent of annual income before taxes

(3) 10 percent of net worth over $20,000 if the excess over $20,000 is in the form of cashable assets

The individual is responsible for bills up to the previous amount. Costs in excess of this amount are payable by the Maine Department of Human Services. Eligibility for the Catastrophic Illness program is for a period of a year and can be retroactive for up to 12 months. Out-of-state providers of medical care within 15 miles of the Maine/New Hampshire border and within five miles of the Maine/Canada border are routinely reimbursed. This helps people living in these areas to maintain their usual pattern of health care services. Persons visiting Maine or temporarily from out-of-state are covered for emergency services. All other out-of-state medical services require prior authorization. The Catastrophic Illness program will pay for the following services when medically necessary. These include ambulance services, durable medical equipment, inhalation services, inpatient hospital services, laboratory and x-ray services, outpatient hospital services, ophthalmologist services, physical therapy, physician services, prescription drugs, and skilled nursing services.[16/]

In Hawaii the state mandated health insurance plan is compulsory and workers cannot waive the protection provided by the law. A worker is covered as soon as he has had four or more consecutive weeks of employment. If an employee is not able to work because he is sick, protection continues for three months following the month in which he became ill. All employers with one or more regular employees are covered by the law except the following: government employees, agricultural seasonal employees, employees who work less than 20 hours a week or whose monthly wages are less than 86.67 times the prevailing state minimum hourly wage, employees covered by a federal program or receiving public assistance, individuals who depend on prayer or spiritual means for healing, individuals in family employment, and insurance and real estate salesmen or brokers paid solely on commission.

If an individual works concurrently for more than one employer, the one who pays the most wages will be the principal employer and will be responsible for providing health care coverage. The employee, however, may select a different principal employer if he works at least 35 hours weekly for an employer who does not pay the most wages. If he works for a government agency and a private employer, the former will be deemed the principal employer. If an employee's dependents are themselves employed, they may choose to be covered under the plan at their own place of employment. As far as benefits are concerned, the employer's prepaid group health plan meets the requirements of the law if it provides health care benefits equal to, or medically

reasonably substitutable for, the benefits offered by prepaid health plans of the basic types, such as the Kaiser Foundation Health Plan, commercial insurers or non-profit plans such as the Hawaii Medical Services Association--plans that have the largest number of subscribers in the state, as already has been noted.

The Director of the Department of Labor and Industrial Relations, with the advice of an advisory group, determines whether a plan complies with these standards. Exceptions are permitted when the plan is deemed to provide sound health benefits at a premium commensurate with the benefits after taking into account coinsurance features, deductibles, limitations on reimbursability, and dependents' benefits.

The plan's protection must include hospital benefits of at least 120 days confinement in each calendar year; outpatient hospital care; surgical and diagnostic benefits; home, office, and hospital visits by a physician; and maternity benefits (applicable to employees with at least nine months' coverage before delivery).

Employees are free to bargain collectively for different prepaid health care coverage or for a different allocation of the costs. Employers are in compliance with the law if they provide health care services under a collective bargaining agreement and if the services are provided for employees not covered by such an agreement.[17/]

As far as the state of Connecticut is concerned, its comprehensive health care plan requires insurers to make available to all persons under 65 a standardized health insurance policy covering specified minimum benefits. Included benefits are hospital services, physician services, prescription drugs, partial payment for treatment of mental conditions, skilled nursing home facility care, home health agency visits such as ambulance services, physical therapy, oxygen, anesthetics, diagnostic x-rays and laboratory tests and other lesser benefits. Three deductible levels are available--$200, $500 and $750 as already has been noted--and a 20 percent co-payment provision will be in all the plans. However, a ceiling on cost sharing per year is set at $1,000 per individual and $2,000 per family. However, although a person is eligible for the various benefits under the state health plan, benefits for pre-existing conditions that exist within six months of effective date of the plan coverage and pregnancies that exist on the effective date of the plan are not covered.[18/]

The state of Minnesota has four plans available under its comprehensive state health insurance program and three of the plans are tied to variable out-of-pocket expenses and the fourth plan is concerned with Medicare beneficiaries. In addition, Health Maintenance Organizations may be used in those areas of the state where an HMO has agreed to make coverage available and has been selected as a writing carrier. A plan is certified as a number one plan if it meets the requirements established by the laws of the

state and provides for payment of 80 percent of the covered expense in excess of a deductible which does not exceed $1,000 per person. A health coverage plan shall be certified as a number two plan if it meets the requirements of the state of Minnesota and provides payment of 80 percent of the covered expenses in excess of a deductible which does not exceed $500 per person. Any plan which provides benefits to persons age 65 years or more may be certified as qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deductible and co-payment required under Medicare and 50 percent of the charges for services covered under the state plan which are not covered by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000. A number three plan is certified as such when the minimum benefits are equal at least to 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this plan. The coverage may be subject to a maximum lifetime benefit of not less than $250,000. Covered expenses as in the case of number one and two plans shall be the usual and customary charges for the following services and articles when prescribed by a physician. These include such benefits as hospital services, prescription

drugs, limited nursing homes services, home health agency services of 180 visits per year, oxygen, anesthetics, protheses, rental or purchase of durable medical equipment, diagnostic x-rays and laboratory tests, physical therapy services, oral surgery, physician services, other than outpatient mental or dental, for diagnosis and treatment of injuries or illnesses, and beginning in 1980, subject to appropriate deductibles, coinsurance and maximum lifetime limitation provisions, services for well-baby care, physician services for routine checks and annual physicals, and multiphasic screening and other diagnostic testing.[19/]

ADMINISTRATION AND FINANCING OF STATE HEALTH INSURANCE PLANS

In considering the administration and financing of any state health insurance plan, state government must consider many questions. First, does the government have the ability and capacity in terms of finances and manpower to operate such a program, as already noted? What kind of cost and quality controls should be incorporated into the program to make it economically feasible and manageable? What kind of audit and accountability procedures should be included in the program so as to avoid the kind of fraud and abuse problems that presently plague Medicaid and Medicare? Should the financing of benefit coverage be phased in by legislative schedule or by the executive branch's administrative decision, if the program is initially limited in its benefit scope? What are the advantages and disadvantages of each of the latter choices? What kind of reimbursement methods are most equitable under the program and how is the method equitably

determined for the providers of health care services who are participating in the program? These are some of the important questions that arise when considering the establishment, administration and financing of a state health insurance program.

In answering some of these questions, the state of Maine, as already noted, established a catastrophic medical expense plan that was partially funded through a one mill cigarette tax increase. An annual minimum amount of $800,000 per year was appropriated for the program by the state government. All participating providers of medical service and supplies agree to accept the payment received from the Maine Catastrophic Illness Program as full reimbursement for services rendered according to state program requirements. No additional charge is to be demanded from the program's beneficiaries for a service or supply covered by the program.[20/]

As far as the state of Rhode Island is concerned, catastrophic illness payments are made out of general revenues. The Rhode Island Department of Health Administration administers the program with private health insurers serving as fiscal intermediaries for the payment of benefits. However, despite the use of general revenues to fund the program, it is still up to employers/employees to pay for most of the insurance coverage. The State Department of Business Reuglation establishes the minimum standards--applicable to all health insurance contracts in the state--that are designed to standardize and simplify benefits; eliminate misleading or confusing provisions and limited coverages of little value; eliminate deceptive selling

practices; add coverages in the public interest; promote efficient management of health service; and make qualified plans available to all persons regardless of age, sex, occupational status or medical condition. After the standards are issued, each carrier files a sample contract with the Department. The contract is available to the Rhode Island Consumer Council. If the Council requests a hearing, it will be held to review the contract provisions. The Department may approve, disapprove or modify a contract and, as necessary, all other carrier contracts will be modified to conform with the decision. Insurers must offer the same plan to all persons. Also, they must offer the same coverage to all employers regardless of the characteristics and the number of their employees. The carriers are required to promote efficient management and reimburse only those which are certified by the Department of Health. Insurers operating for profit and self-insured organizations may enter into arrangements to form a reinsurance pool. The pool will spread the losses among the insurers in proportion to the number of persons covered under qualified policies. These agreements must be approved by the State Department of Business Regulation and the Department which, after a hearing, may require all insurers to participate in the pool. In addition, carriers must submit to the State Department of Business Regulation their proposed rates or rating formulas for health insurance. The Department will provide hearings for the public and for representatives of the carrier and the Rhode Island Consumer Council. At the hearings the carriers will be required to prove that the

proposed rates are appropriate for the coverage provided, consistent with the proper conduct of the carrier's business and in the public interest. The Department is authorized to approve, disapprove, or modify proposed rates. Providers of health services must be certified by the Department of Health as a condition of participation in the program. They must meet existing laws and regulations and agree to provide services without regard to race, religion, sex, age or occupational status. Service providers must also offer services at costs, charges or rates that are equitable, non-discriminatory and in the public interest. The State Department of Business Regulation (after a hearing) will be able to disallow payments made by a carrier to a non-certified provider or one engaging in discriminatory practices against insurers. This, in summary, is the essence of the Rhode Island Catastrophic Health Insurance Plan.[21/]

In contrast to Rhode Island, the program in Hawaii only mandates coverage for almost all employed persons, as already noted, while not covering dependents. While deductibles, coinsurance and other cost-saving devices are permissible, the law requires thorough and near total coverage of basic and catastrophic health costs. The program is employment-based with costs to be paid by the employer or shared with the employee. The employee portion of the cost is limited to half the premium costs, not to exceed 1.5 percent of his wages. Provisions are made for state subsidization of those small employers who would be heavily burdened by the costs of this program. The state uses funds from general revenues and penalty

fines to subsidize the premiums of an employer with less than eight employees if the employer's share exceeds 1.5 percent of total wages payable to employees and the amount of the excess is greater than 5.0 percent of the employer's income before taxes that are directly attributable to the business. A formula in the law determines income for this purpose. A special premium supplementation fund is used to pay the subsidy for an employer's share of a premium that exceeds the limits specified above. Employer's penalty fines for failure to comply with the law are deposited in the special fund.[22/]

As already noted, Connecticut's state health insurance plan became effective on April 1, 1976. The program has incorporated several mechanisms in order to control its costs. One is three sets of deductible options--low, middle and high--that are available for individual choice and which already have been discussed. The amount of deductible that is chosen may not be greater when a service is rendered on an outpatient basis than when the service is offered on an inpatient basis. The plan also contains a coinsurance mechanism of 20 percent for charges for all kinds of health care in excess of the deductible chosen and 50 percent for specific kinds of health services listed in the act that creates the program. However, the sum of the deductible and co-payments required in any calendar year under any option may not exceed a maximum limit of $1,000 per covered individual, or $2,000 per covered family. Both the deductible thresholds and the $1,000 and $2,000 annual limits may be adjusted on an annual basis by the State Insurance Commissioner to correspond

with the change in the medical component of the Consumer Price Index. The law that creates the state health insurance program also authorizes the State Commission on Hospitals and Health Care, within one year of April 1, 1976, to adopt regulations designed to require state Professional Standards Review Organizations established under P.L. 92-403 to extend their review of certain inpatient services to services received by all patients. The State Insurance Commissioner also shall adopt regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies: basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident coverage. Specified disease policies, riders and benefits shall be prohibited whether they are issued on a group or individual basis. The state program also creates a Health Reinsurance Association for high risk insured. Any plan that is not insured by or through the Health Reinsurance Association or any other medical market association may not exceed the premium which would be applicable through participation in such associations. Finally, each self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan available under a conversion privilege to every person covered by the plan who is a resident of the state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of a layoff, death

or termination of employment. The individual has his choice of low, middle and high option deductibles under this situation as well.[23/]

THE FUTURE

The future of the state health insurance movement cannot be viewed with precise clarity for national health insurance is still a viable possibility for enactment in the 95th Session of the U. S. Congress. Although several states have enacted health insurance programs and several other jurisdictions are presently contemplating the introduction of health insurance bills in their 1977 legislative sessions, the experience that has been gained thus far from these plans is still too minimal to make any decisive statement as to whether or not they are achieving the goals for which they have been or are being enacted. But, the fact that state government has chosen to create such vehicles to assist its residents in paying for the costs of medical care only underlines how serious a problem the financing of such costs has become for many of our citizens. The enactment of state health insurance programs may now be considered an appropriate role and extension of state activity in the health care area but until recently the provision of health insurance protection has been the province of private industry--not the responsibility of state government. However, as already noted, the problem of individual state health insurance programs is that they are individual creations and not uniformly designed among the states in terms of benefit coverage and other areas of legislative intent.

Even though model health insurance bills have been adopted by the Congress of Insurance Legislators (COIL) and the National Association of Insurance Commissioners (NAIC), it is still the decision of state government as to whether or not it wishes to adopt a model bill for its own jurisdiction or enact a bill of its own formulation. The following is one problem that can result from these activities. Should states enact health insurance programs that are diverse in content as well as in intent, then it would be possible that without a national health insurance program this country could be faced with another type of Medicaid situation of having 50 diverse and separate state health insurance plans rather than a uniform 50-state plan with all the possible problems that have attended Medicaid's enactment and operation. If nothing else has been learned from the Medicaid experience after a decade of operation, it should be that the path and experiences incurred under Medicaid should be avoided under diverse state health insurance plans as well so that all involved in such programs--the purchasers, the providers and the payers--will be treated equitably at costs that are reasonable to all.

FOOTNOTES

1. "States Mandating Health Insurance Benefits," Perspective, Fall, 1976, p. 29.

2. Ibid.

3. Ibid.

4. Susanne A. Stoiber, "Catastrophic Health Insurance," Congressional Budget Office, Congress of the United States, Washington, D. C., January, 1977.

5. Casey Crawford, "CBO Releases Definitive Study on Catastrophic Health Insurance," Health Services Information, January 31, 1977, p. 6.

6. Ibid.

7. Susanne A. Stoiber, op. cit., p. xv.

8. Ibid., pp. xv and xvi.

9. Saul Waldman, "Rhode Island Catastrophic Health Insurance Plan," Social Security Bulletin, February, 1975, pp. 41-43.

10. American Medical Association, "Catastrophic Health Insurance," State Health Insurance Report, October 3, 1975, pp. 8 and 9.

11. "States Mandating Health Insurance Benefits," op. cit.

12. Alfred M. Skolnik, "Compulsory Health Insurance in Hawaii," Social Security Bulletin, December, 1975, pp. 23 and 24.

13. "States Mandating Health Insurance Benefits," op. cit.

14. Saul Waldman, op. cit., pp. 41-43.

15. "Benefit Payments Reported Up 16 Percent in Rhode Island's State Health Insurance Plan," National Health Insurance Reports, March 14, 1977, pp. 8 and 9.

16. "Catastrophic Illness Program," State of Maine Department of Human Resources, March, 1976.

17. Alfred M. Skolnik, op. cit., pp. 23-24.

FOOTNOTES (CONTINUED)

18. "Comprehensive Health Care Plans," State of Connecticut, Chapter 692, Hartford, Conn., April 1, 1976, p. 283.

19. "Comprehensive Health Insurance," State of Minnesota, Health Care (62E.02), 1976, pp. 1003-1005 and 1007.

20. "Catastrophic Illness Program," State of Maine, op. cit.

21. Saul Waldman, op. cit., pp. 42 and 43.

22. Alfred M. Skolnik, op. cit., p. 24.

23. "Comprehensive Health Care Plans," State of Connecticut, op. cit., pp. 3, 280-294.

ELIGIBILITY AND BENEFITS UNDER MINNESOTA CATASTROPHIC HEALTH EXPENSE PROTECTION ACT OF 1976

By Larry R. Fredrickson

I. Historical Background:

The first significant Legislative interest in a state catastrophic health insurance plan was in 1973 when two state senators asked Legislative staff to start working on legislation for a state catastrophic health insurance program. They were prompted by complaints from constituents who had suffered maior economic reverses due to health care expenses.

In 1974 two bills were introduced in the State Senate. One bill emphasized catastrophic protection for middle-income people who exhausted their insurance coverage. The other bill emphasized protection for low-income working people who were not eligible for medical assistance (Minnesota's medicaid program). Several hearings were held in a Senate subcommittee, but no action was taken. There was serious concern as to who would benefit under a catastrophic health insurance program and how much it would cost. Little concrete information and data were available then (or later).

A special Senate subcommittee was appointed to study health care costs during the interim between the 1974 and 1975 Legislative sessions. Its membership included five senators and five public members including an insurance company executive, a registered nurse, a union official, a housewife and a Native American. The subcommittee recommended an alternative to a

state catastrophic health insurance program which would include establishing minimum benefits (including catastrophic protection) for health insurance policies and a mechanism to enable uninsured people to obtain health insurance. They recommended that the state:

> Encourage further work and study in mandating minimum benefits provided under health insurance policies sold in the State, including minimum benefits for catastrophic coverage, and development of a plan of health insurance providing catastrophic coverage to the handicapped, uninsurable and others not having health insurance available. Both of these acts should provide coverage for ambulatory services. Minimum benefits in group health insurance plans should cover services including but not limited to periodic screening, immunization and non-communicable disease control . . . .

At the start of the 1975 session, the Governor recommended a $17 million state catastrophic health insurance program patterned after the then newly-enacted Rhode Island program. A group of Minnesota Senators, Representatives and staff made a site visit to Rhode Island to study their program. During the same site visit, meetings were held in New York with representatives of the Health Insurance Association of America. The officials and insurers working on the Rhode Island program were very enthusiastic about their law. The national insurance industry representatives supported the alternative recommendation of the Senate subcommittee - an approach which was later enacted in Connecticut. During the 1975 session, the Senate supported the recommendation of their subcommittee, while the House supported the Governor's recommendation. There was some committee action, but because of the conflict between the House and the Senate, no final action was taken.

At the start of the 1976 session, a new bill was introduced in the House which combined the basic features of the House and the Senate bills from the year before into one omnibus bill. The new bill became the basis for the law which was enacted in 1976.

II. Basic Content of Law:

The 1976 law contained three articles and is codified in Chapter 62E of the Minnesota Statutes. The first article dealt with health insurance standards and availability. Minimum standards were established for qualified health insurance policies. Insurers could continue to sell unqualified insurance but were required to offer qualified policies to all applicants for health insurance. Employers were generally required to make health insurance available to their employees. A state-mandated risk pool was established, using a private insurer as the writing carrier, to allow uninsurable or under-insurable people to purchase health insurance.

Because of a fear of inflation in health costs due to increased third party coverage, a second article was included. It increased the powers of the state insurance commissioner to regulate health insurance rates and established a hospital rate review system.

The final article established a state-funded catastrophic health expense protection program (hereafter "state program") to pay health care expenses of people who exceeded the specified threshold level of out-of-pocket expenses. There was not a great deal of legislative discussion of eligibility and benefits

under the article. In order to enable the health insurance availability programs of Article I to begin to function first and potentially save the state money, the third article was given a delayed effective date of July 1, 1977. The state program was originally to be administered by the State Insurance Department to avoid the appearance of it being a welfare program. At the last minute it was changed to have the Department of Public Welfare do the administration primarily because of their prior experience with the medical assistance program.

III. Eligibility Standards:

A. Legislative Considerations:

Initially there were attempts to devise a statutory formula which utilized three factors in determining eligibility: income level, expense level, and insurance protection level. This was the approach used in Rhode Island and seemed to be working there. It was decided to focus on people who were not eligible for existing categorical programs. (In fact, there was some sentiment for excluding people who were already eligible for categorical programs since they already had some protection.)

There was little objection to including the income and expense level factors in the formula. It was generally agreed that expenses in excess of a specified percentage of income should be the major factor. The state Tax Study Commission prepared a computer analysis of a sampling of itemized state tax returns. With this information, it was possible to obtain a rough approximation of the number of people at various income levels who had medical expense deductions in excess of specified dollar amounts.

The computer data did not differentiate between tax deductions for expenses which would be covered under the state program and tax deductions for expenses which would not be covered. This required the use of "guess" factors to estimate the actual numbers of people who would qualify under various threshold factors and the cost to the state of paying the qualified expenses of those people. This was especially true, for example, with senior citizens where it was assumed that many of them with high expenses had been paying for nursing home care which was not expected to be fully covered under the state program. With the Tax Study Commission data, the Legislature was able to select income and expense level thresholds which matched their policy and fiscal concerns.

The question of utilizing levels of insurance coverage as a qualification factor quickly became the major focus of the debate over eligibility standards.

Some legislators strongly felt that insurance coverage should be a major factor. (It is a significant part of the Rhode Island formula.) They were concerned that a failure to do so would, in effect, penalize those people who took the initiative in obtaining their own health insurance and reward those people who neglected or refused to obtain their own insurance protection. They argued that people would simply "gamble" on remaining healthy and not buy insurance if they knew that the state back-up protection would save them from total economic devastation if they guessed wrong.

On the other hand, other legislators felt that using existing insurance

coverage as an eligibility factor would penalize those people who could not obtain health insurance because of economic or health problems. They also argued that:

(1) The state protection program would require a significant enough out-of-pocket expense level to deter any "gambling";

(2) The day-to-day expenses of health care (as opposed to catastrophic expenses) are high enough to create a stronger incentive to buy insurance than any incentives not to buy insurance;

(3) The person who makes the decision not to buy the insurance may not be the one to need the health services - it could be a spouse or dependent child who became sick;

(4) It would be harder to draft a tripartite formula; and

(5) It would be harder to administer a tripartite formula.

The opponents of an insurance-related eligibility formula ultimately prevailed.

Four other factors did receive some scrutiny during the Legislative deliberations:

First, there was a concern that nonresident people with serious health problems would move into Minnesota to avail themselves of the state program. Various residency tests were considered and eventually rejected. The main arguments against them were court decisions which have rejected most types of residency tests imposed on beneficiaries of public assistance programs and a

contention that the proposed benefits were not lucrative enough to entice any significant number of people into the state.

Second, there was discussion over whether the primary purpose of the program should be (i) protection from non-recurring high cost episodes of illness or injury, (ii) protection from high-cost chronic diseases, or (iii) both. It was decided that the emphasis should be on non-recurring expenses. This enabled the legislature to set an income and expense level threshold which was not particularly generous. The required out-of-pocket expenditures were set high enough so that most households could not afford to make them year after year and continue to qualify for the state program. Instead, they would eventually qualify for another assistance program such as medical assistance. In light of the decision on the thrust of the program, it was decided to not emulate the Rhode Island approach which established a lower threshold for the second year's eligibility. To provide more assistance to the victims of a single high-cost episode, it was decided to provide for a flexible year of eligibility. The potential recipient can, in effect, pick the twelve month period in which to receive the benefits in a way to maximize benefits. This differs from the usual approach of using a calendar year as the basis for benefits.

Third, it was decided to go with a very broad definition of household income. All income of all members of the household was to be included. There was some discussion of providing limited exceptions in some cases such as where a dependent child was working to earn money for college. None of the suggested exceptions were adopted. On the other hand, proposals to factor

in assets such as real property, savings, or investments were also rejected primarily to avoid complicating the administration of the state program.

Finally, there was consideration of making special provisions for unemployed people and low income people without health insurance. Amendments were drafted to establish a mechanism for purchasing health insurance for these groups in the state risk pool for uninsurables. It was eventually decided to delay a decision on these provisions until the state program had been in operation for two or three years.

B. Standards in the Law:

The law has a graduated schedule for determining eligibility. As originally passed, it read:

> 62E.53. [APPLICATION FOR ASSISTANCE.] Subdivision 1. Any person who believes that they are or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.
>
> Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay 90 percent of all qualified expenses of the eligible person and his dependents in excess of:
>
> (a) 40 percent of his household income under $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or
>
> (b) $2,500;
>
> whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his

payment to the usual and customary charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

The bill which originally passed the House did not contain a graduated formula or the copayment requirement. The Senate, whose bill did not contain the state program, suggested in conference committee that some changes be made to control costs and make eligibility standards high at higher income levels. The conferees then developed the graduated income formula and the copayment feature primarily as cost and utilization control features.

Under the income and expense formula as adopted, the following out-of-pocket expenses would have to be incurred by a household to qualify:

Household Income	Out-of-pocket Expenses Incurred	Incurred Expenses as a Percentage of Income
$ 5,000	$ 2,500	50%
10,000	4,000	40
15,000	6,000	40
20,000	8,500	42.5
25,000	11,000	44
40,000	20,000	50
75,000	41,000	54.7
100,000	56,000	56

By and large, higher income households must pay a higher percentage of household income as out-of-pocket expenses before qualifying. The exception comes for households with very low incomes. It was assumed that these households would easily qualify for other assistance programs - hopefully ones where the Federal Government would participate in the costs of the program. Once it qualifies a household must still pay 10 percent of the costs of services provided. A second cost control mechanism was the provision in the law allowing the Commissioner of Public Welfare to establish mechanisms to review provider charges and prohibiting providers from attempting to collect excess charges from consumers.

IV. Benefits Schedule:

A. Legislative Considerations:

The question of benefits under the state program was not a major part of the deliberations in the Legislature once the bills were introduced. This was surprising - especially since the benefits were identical to those required to be covered by qualified health insurance policies sold by insurers and made available to employees by employers. This triple purpose for the schedule of benefits resulted in most of the little discussion that occurred focusing on the health insurance standards aspect rather than on the state program aspect. (In fact, the part of the law which created the state-funded catastrophic program does not list the benefits. It merely cross-references the benefits in the Insurance Standards Act.)

The triple purpose of the benefits schedule provided some consistency in achieving the three purposes of the schedule. However, it also meant that some of the standards were different from those that would have been established if each had been done separately.

The initial schedule of benefits was drafted by an insurance company's head actuary. It was then revised by the authors and Legislative staff after comparing it with similar laws and bills in other states, the National Association of Insurance Commissioner's Model Act, and the Conference of Insurance Legislators' Model Act.

Since the same benefits were being used for the state program, the minimum standards for qualified health insurance and the required offering by employers, the proposed benefits schedule was then reexamined in light of its effects on the health insurance industry and on employer-sponsored benefit plans.

Legislative staff obtained access to an insurance industry sponsored study of employee benefit plans. This study found that about 70 percent of the existing employer plans did not provide the required medical coverage, 40 percent did not provide the required hospital coverage, 25 percent did not provide the diagnostic x-ray and laboratory coverage, 85 percent did not provide the required major medical coverage, and 85 percent did not provide the required maternity coverage. Generally, larger employers were more likely to be in compliance. The relatively low level of coverages was something of a

surprise to legislators and a cause of some concern. However, it was felt that a dramatic rise in health insurance coverage would impose a serious burden on some employers and could cause serious inflation in health care costs. At this point there was consideration of having separate benefit standards for health insurance and for the state program. In the end, the decision was made to keep the benefits consistent and lower them somewhat to lessen the disruption in existing programs. The benefits schedule was therefore re-written again. Also, insurers and employers were allowed to substitute actuarially equivalent benefits for those set forth in the act. The state program would not make substitutions.

Once it was revised the second time and the bills were introduced, there were few changes.

There were five areas where conflicts did arise:

1. Coverage of Blood and Blood Derivatives:

The bill originally covered blood and blood derivatives. There was objection from some insurers and blood donor groups that this coverage under insurance policies would diminish the public incentives for voluntary blood donations. Because of this, the provision was deleted. This was done despite the counter-argument that the deletion would, in effect, disqualify most hemophiliacs from the state program.

2. Coverage of Preventive Services:

There was little input into the benefits schedule by consumer groups. Efforts were made to get comments from various consumer groups, but they

generally lacked the time and the expertise to participate. A consumer task force which was working with the Foundation for Health Care Evaluation (a joint insurer-physician peer review organization) did do some lobbying for the inclusion of more preventive services. As a result of efforts, and despite some mild opposition from insurers, the law was amended so that benefits will be expanded to cover well baby care, check-ups, annual physicals and diagnostic testing beginning in 1980.

3. Nursing Home Coverage:

The authors of the bills wanted to limit nursing home coverage in the benefits provisions of these bills. There was a concern about mandating it as a health insurance benefit and about the estimated cost of including it under the state program. It was predicted that coverage of nursing home expenses would lead to a state takeover of most of the nursing home expenses not already paid by the state under the medical assistance program - an additional $56 to $64 million per year. (Minnesota's medical assistance program already pays about two-thirds of the costs of nursing home care in the state.) As a result, the bills limited nursing home coverage in the same way that it is limited under Medicare - a maximum of 120 days per year with the stay commencing within 14 days after a hospital stay of at least three days. There was also an exclusion of domiciliary and custodial care. Objections raised by representatives of senior citizens organizations led to the removal of the exclusion. However, they were unsuccessful in their efforts to increase the coverage for nursing home care.

4. Coordination of Benefits:

There was a major disagreement between insurers and the Minnesota Department of Public Welfare as to coordination of benefits between insurance coverage and various governmental programs. It was not really resolved. Medicare was made primary to insurance. Medical assistance was left as an open question subject to some unclear existing statutory language. There was also some concern that the state might end up paying 100 percent of the cost of treatment for people who would have eventually received medical assistance (56 percent Federal share in Minnesota). Vice-President (then Senator) Mondale was able to obtain an indication from HEW that a Federal contribution to the cost could still be received for people who benefitted under the state program if they would also have eventually been eligible for medical assistance.

5. Specialized Coverages:

Minnesota, like most other states, had already mandated various other coverages under existing group health insurance plans. In fact, Minnesota already mandated nine specified coverages - far more than any other state. These coverages included:

* alcoholism treatment
* conversion privileges
* chiropractic treatment
* optometric services
* maternity benefits
* outpatient surgical treatment
* newborn child coverage
* handicapped and retarded coverage
* mental illness coverage

It was felt that not all of these services were appropriate benefits for the state program. However, they were all passed earlier due to well-organized lobbying efforts. Exclusion of any or all of them might have resulted in major disputes as to their appropriateness. It was decided that another front in the fight over passage of the bill should not be opened. Numerous other conflicts had already arisen. The existing mandated services were consequently included by cross-reference.

B. Benefits Provided:

The new law passed in 1976 provided the following benefits:

> 62E.06 [MINIMUM BENEFITS OF QUALIFIED PLAN.] Subdivision 1. Number three plan. A plan of health coverage shall be certified. . . if it otherwise meets the requirements established by chapters 62A and 62C*. . . and meets or exceeds the following minimum standards:
>
> (a) The minimum benefits. . . shall be the usual and customary charges for the following services and articles when prescribed by a physician:
>
> (1) Hospital services;
>
> (2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;
>
> (3) Drugs requiring a physician's prescription;
>
> (4) Services of a nursing home for not more than 120 days in a year if the services commence within 14 days following confinement of at least three days in a hospital for the same condition;
>
> (5) Service of a home health agency up to a maximum of 180 visits per year;

*This language has the effect of incorporating existing mandated benefits by reference.

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses;

(10) Rental or purchase, as appropriate, of durable medical equipment;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and

(13) Services of a physical therapist.

(b) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for any care for any injury or disease either (i) arising out of an injury in the course of employment and subject to a worker's compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance or medicare;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(c) Effective January 1, 1980, the minimum benefits. . . shall include, in addition to those benefits specified in clause (a), benefits for the following services. . .:

(1) Well baby care;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician; and

(3) Multiphasic screening and other diagnostic testing. . .

* * *

V. Estimated Program Costs and Beneficiaries:

Using the data obtained from the Tax Study Commission's computer study of tax returns, actuarial studies provided by an insurer, and from Rhode Island's actual experience with their program which was already in operation, several estimates of costs and the number of beneficiaries by income level were made.

Based on the Tax Study Commission figures, the following estimates were made:

Program Cost

	Calendar Years			
	1976	1977	1978	1979
Cost of Care*	$11.3	$12.1	$12.9	$13.8
Less 10% Copayment	1.1	1.2	1 3	1.4
Gross State Cost	10.2	10.9	11.6	12.4
Less Savings in Other Programs**	1.7	1.8	1.9	2.1
Net State Cost***	$ 8.5	$ 9.1	$ 9.7	$10.3

All figures in millions of dollars

*1975 figures inflated 15% for inflation in health care costs and deflated 8% for inflation in income each year.

**It was assumed that there would be offsetting cost savings in other state health care payment programs.

***It was assumed that the Tax Study Commission figures were too high because of the inclusion of non-covered benefits which are tax deductible.

Beneficiaries by Income Level

Household Income Level	Senior Citizens (1,250 Households)	Others (500 Households)	Total (1,750 Households)
0-$5,000	40%	33%	38%
$5,000-$10,000	40%	50%	43%
$10,000-$15,000	20%	17%	19%
Over $15,000	0%	0%	0%

Based on Rhode Island's actual experience, the following estimates were made:

Time Period	Rhode Island (Actual)		Minnesota (Estimated)	
	Cost	Recipients	Cost	Recipients
First Six Months	$200,000	58	$ 800,000	230
Second Six Months	300,000	104	1,200,000	415
Third Six Months	400,000	261	1,600,000	1,045
Fourth Six Months	540,000	N.A.	2,160,000	N.A.

It was concluded that the Rhode Island figures indicated that there would be a lower level of participation in the early phases of the state program, probably because people would not be fully aware of the program, and that the Rhode Island figures would probably be more indicative of what Minnesota's actual experience might be.

The Legislature eventually approved a biennial budget of $17 million for the program. It is expected to be more money than needed, but health expense payment programs have historically cost more than anticipated.

VI. 1977 Amendments:

Even before the law took effect, pressures to make changes in the eligibility and benefit standards started to build. Insurers, consumer groups and the state Department of Public Welfare all requested changes in the law. Bills and amendments were introduced which would:

1. Provide specific coverage for blood and blood derivatives under the state program. (This was designed to bring hemophiliacs back under the provisions of the law.)

2. Provide specific coverage for renal dialysis and related costs under the state program.

3. Provide specific coverage for nursing home care under the state program.

4. Require coverage for a second opinion on surgery under both the health insurance mandatory coverage provisions and the state program.

5. Provide an earlier effective date for the coverage of the preventive services.

6. Make minor adjustments in the overall benefit schedule.

7. Exclude the income of certain dependents from the determination of household income.

8. Delay the effective date of the state program for another year.

Bills which actually passed did the following:

1. Provided state payment of 90 percent of the household expenses for nursing home care in excess of 20 percent of household income. The coverage would only apply to the expenses of people under age 65 and only after three years of treatment in a nursing home. (1977 Session Laws, Chapter 448)

2. Excluded the income of dependents under age 23 in determining household income. (1977 Session Laws, Chapter 448)

3. Excluded custodial and domiciliary care. (1977 Session Laws, Chapter 409)

4. Included coverage of a second opinion on surgery effective in 1979. (1977 Session Laws, Chapter 409)

5. Made health insurance and tort recovery primary to any state payments. (1977 Session Laws, Chapter 409)

6. Provided that health care providers be reimbursed on the same schedule as providers under medical assistance. (1977 Session Laws, Chapter 409)

VII. Summary:

The Minnesota state program is primarily designed to provide protection to households which face major health care expenses of a non-recurring nature. Since the program has only been operative since July 1, 1977, the efficacy of its benefits and eligibility standards are not yet known.

BENEFIT COVERAGE AND ELIGIBILITY STANDARDS OF STATE HEALTH INSURANCE PLANS RHODE ISLAND CATASTROPHIC HEALTH INSURANCE PLAN (CHIP)

Prepared by
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One issue of great importance in the design of a health insurance program--be it a publicly sponsored or privately sponsored plan--is the determination of its benefit structure and eligibility standards. Questions relating to eligibility qualifications, the kind, extent and priority of benefit coverage, projected utilization rates, for example, are all issues of great importance. In this section of the seminar program, we present two papers that discuss both sides of the same issue. Larry Fredrickson of Minnesota analyzes how a state determines the benefit and eligibility standards that it wishes to incorporate into its plan design while this paper discusses the actual experiences of such determinations once the plan has become operational and has incurred several years of utilization experience.

I. ELIGIBILITY

Eligibility standards are delineated primarily through the guidelines of the Catastrophic Health Insurance Plan (CHIP) itself. Program eligibility is contingent upon essentially two elements: residency and a deductible. An applicant would normally be the head of a household and must be a permanent resident of the state for at least three months and must not have moved here

primarily to become eligible for CHIP. In addition, an applicant's out-of-pocket family medical expenses must exceed a CHIP deductible specified in the law, after all payments are made by his or her private health insurance plan. This deductible will either be a flat dollar amount or a percentage of the family's income, whichever is greater. Income is defined by Regulation as "the adjusted gross income of the taxable family unit, minus dependents allowances, as set forth by the Internal Revenue Service." Those persons who are Medicare subscribers only have to meet a dollar deductible since they are generally living as a group on fixed incomes. When found eligible, all members of a household are covered for CHIP benefits.

There are six levels of CHIP deductibles. They are applied to a particular applicant based upon the type and quality of the person's private health insurance plan. As the quality of a person's coverage goes up, the CHIP deductible goes down. The lowest deductible category is utilized when a person has what the law defines as a "qualified plan." This would be a combination of plans, provided by either Blue Cross or a commercial insurer, which includes the following:

- Semi-private hospital coverage for at least 120 days
- A medical/surgical plan providing coverage for usual and customary physician charges
- A major medical program providing at least $10,000 in supplemental coverage

CHIP DEDUCTIBLES

Health Insurance Status	Amount	% of Income
Qualified plan	$ 500	10
Semi-qualified plan (no major medical coverage)	1,250	25
Non-qualified plan		*
No health insurance plan	5,000	50
Qualified Medicare plan	500	N/A
Non-qualified Medicare plan	1,000	N/A

*The difference between a qualified and a non-qualified plan plus the deductible of a qualified plan.

Since CHIP has been designed as a "last payor" program, all other resources available to the applicant must be utilized first before CHIP would consider payment. For example, if a person was injured in an automobile accident and also has private health insurance, CHIP would not only be secondary to the health insurance plan but also to any automobile medical payments available as a result of the accident. CHIP would also be secondary to other programs such as Workmen's Compensation, Vocational Rehabilitation, Medicare and Medicaid.

The Division of Health Insurance of the Rhode Island Department of Health is responsible for the overall administraiton of the CHIP program. These duties also include eligibility services. Most applications are handled by mail but occasionally personal interviews are requested by either party. The Division also

directly refers CHIP applicants to other available programs. Outreach services of CHIP are considered to be an integral part of the program.

The major gaps in CHIP, as can be readily seen by reviewing the deductible structure, concerns those persons who do not have any health insurance coverage and in particular those who are earning just above the Medicaid upper income limits. Since CHIP was developed to assist the average working person, and only incidentally other income groups, no research has been initiated to ascertain the nature and extent of the financial implications resulting from any expansion of coverage to those groups falling through the gaps in the program as it is presently designed.

II. BENEFITS

The benefits provided to those persons found eligible for CHIP are essentially the same as described in the law under a "qualified plan," previously outlined. Additionally, the Department of Health has promulgated rules and regulations for the CHIP program which also carefully describe benefits and exclusions. The benefit structure of a qualified plan was extracted mainly from the best existing Blue Cross plans in the state. Blue Cross of Rhode Island covers approximately 85 percent of the state's population. If the Division of Health Insurance cannot readily determine if an applicant's plan is qualified, the policy will be referred to the Health Insurance Section of the Department of Business Regulation for review and comment according to an existing

cooperative agreement. The Department of Business Regulation may have the policy reviewed by its actuary, especially if the applicant has multiple health insurance plans, which taken singularly are not qualified, but as a composite may be an actuarial equivalent to a qualified plan.

Coverage in several specialty areas were added by regulation to those benefits provided directly by the law. For example, a qualified plan would pay for the deductibles and co-insurance for those persons on Medicare. However, neither Medicare nor a qualified plan provides coverage for prescription drugs. Since this was one of the most costly items to the consumer and largely unreimbursed by third parties, the CHIP regulations allowed for coverage of this type of expense. On the other hand, mental health benefits are currently under review since a full 20 percent of CHIP benefits in 1975 went for these services. Currently, CHIP allows for full coverage and 50 percent reimbursement for outpatient psychiatric care.

CHIP pays for 100 percent of the usual and customary costs of those eligible health expenses not otherwise payable by an insurer, state or federal agency. CHIP was designed to "top off" any existing health insurance plan a resident may have. Therefore, with only one exception (outpatient psychiatric), payment is at the rate of 100 percent. As mentioned previously, CHIP covers most of the benefits provided under a qualified health insurance plan. The only notable exception, in addition to the drug benefits

for Medicare persons, as compared with other plans offered or provided by insurers or agencies, is in the area of mental health. The Medicaid program does not provide any psychiatric benefits. Therefore, although a family may otherwise qualify for Medicaid, psychiatric benefits when required would be covered by CHIP.

Claim cost control is exercised over virtually all areas of benefit coverages, including prescription drugs and medical/ surgical supplies and equipment through the use of usual and customary fee profiles. Historically, psychiatric benefits have proven to be the most difficult to control. Selected cases, especially for out-of-state private facilities, have been referred to the Psychiatric Peer Review Committee for examination. Committee results have been a disappointment as a method for substantially reducing utilization and related costs.

The expansion of CHIP coverage to those persons who may fall through the gaps in the program would have to be extended first to those who have semi-qualified plans prior to making the coverage available to others who have no coverage. Here again, this concept would be in keeping with the intent of the law which is structured to help the average working person. However, the average working person is becoming increasingly difficult to define. There are many average working persons who for various reasons are unable to afford qualified health insurance plans. These persons rather than the uninsured should perhaps be the target group of any eligibility restructuring. With the proliferation of state

catastrophic health insurance plans, several key issues must be addressed. First, with more and more states considering the adoption of health insurance plans, is this a clear signal to Washington that the states do not want national health insurance with the inherent loss of local control over the health care/financing system? We believe this to be the case in Rhode Island and suspect the same to be true in other states. Secondly, has there been any noticeable migration of individuals to states which have the CHIP coverage? There is always the potential for this problem with any public program, most noticeably involving Unemployment Compensation and Medicaid. The Rhode Island CHIP program has only a three month residency requirement. However, CHIP is patterned in such a way as to "reward" persons with better coverage by affording them a lower deductible as a threshold to eligibility. Also, the program is meant to function as a "super" major medical plan with a good base of private health insurance as a prerequisite for total catastrophic health insurance protection. With this goal in mind and considering the structure of the plan, it would not seem to be worthwhile for a family to move to Rhode Island from another state just to be able to attain coverage under CHIP. If this does occur, and we are able to confirm that this is why a family moved to the state, we would be able to deny coverage on the basis of a relevant section in the law. Specifically, it excludes persons from CHIP who were found to have moved to Rhode Island for the primary purpose of receiving CHIP benefits. The Department has found that this is not a viable issue at this time.

Finally, it is probably appropriate here to end the discussion of benefits with a few comments concerning future changes to the program. Obviously, the program is still in its developmental stage and vast coverage changes cannot be recommended at this time. However, the Department believes that the General Assembly should be the proper vehicle for amending the list of covered services provided by the CHIP program. The Department of Health has tried unsuccessfully in the past to change benefits through regulation. Since the benefits are essentially similar to the benefits which are defined by the law as constituting a qualified plan, perhaps the safer course for the Department to take would be to seek amendment to the law. It should be noted that the General Assembly has been hesitant in the past to approve any new spending programs or amend existing ones in such a way as to substantially increase the cost burden to the state. It appears that any proposed amendments liberalizing the CHIP benefit structure would encounter great opposition in the immediate future.

III. UTILIZATION

In calendar year 1976, 189 persons actually received CHIP benefits as compared to 114 in 1975. Other statistics include:

	1975	1976
Total applications	234	258
Total family units	162	150

Original projections estimated that about 200-300 persons would become eligible for the CHIP program on an annual basis. Therefore,

the program's results appears to be somewhat lower than anticipated. However, original projections by the Task Force which helped shape the legislation were only rough estimates.

Of the 150 eligible family units in 1976, 57 had Blue Cross, 65 Medicare, 14 commercial insurance and 14 were without health insurance. Those persons eligible for Medicare appear to be benefiting substantially from the CHIP program since 43 percent of the eligible family units involved this group. Another breakdown of utilization was to group the persons actually receiving benefits by age group--32 were dependent children, 97 adults under age 65 and 60 were over age 65. The Department believes that the program must mature longer before definitive conclusions are delivered.

IV. CATASTROPHIC ILLNESSES

Although "catastrophic" is defined in terms of the financial loss to the family rather than by diagnosis, a diagnosis very often signals an impending catastrophic loss. The Task Force which developed the CHIP legislation originally suggested a dread disease type of plan which eventually was replaced by the present program which focuses on the finances of a family as it is affected by the patient's illness.

Catastrophe, in a medical sense, is both an absolute and a relative concept. Any serious health problem is a catastrophe to the individual and family experiencing the affliction. Physically and psychologically, any substantive illness is, almost by definition, an extremely stressful occurrence.

The financial implications of any period of illness beyond the most minor are equally distressing and only serve to increase the seriousness of other problems. The degree of financial catastrophe is determined by such factors as the total cost of diagnosis and treatment (which relate to the duration of the illness and the sophistication of available medical modes, etc.); the adequacy of basic health insurance coverage in force; the availability of various supplemental program (both public and private); independent financial resources available to cover medical expenses (taking into account other critical needs, such as maintenance of the family unit); and the encumbrance of basic earning capacity. Clearly, the interrelationship of these factors becomes most serious when a spell of illness becomes "catastrophic." Although little formal research work has been done to define "catastrophic," it is clear that the threshold can be reached very rapidly as nonreimbursable costs are incurred. The accelerating spiral of medical costs and the related expansion of technological alternatives merely intensify the problem, both for the present and the future. The combination of medical and financial "catastrophes" must have an extraordinarily heavy social impact, particularly on the dynamics of a family structure, and the resulting effects of both the fiscal and psychological stress represent a real and significant cost to society.

Major disability statistics for 1976 experience indicates again, as in 1975, that emotional disorders lead the list of reported conditions. Although there were 189 persons receiving benefits, in

many cases more than one person in a family received payment and such persons on an average did not have catastrophic type conditions. Therefore, these relatively minor diagnoses have not been reported here.

MAJOR DISABILITIES BY FAMILY UNIT:

Emotional	25	Birth Defects	2
CVA	19	Epilepsy	1
Cancer	16	Paget's Syndrome	1
Cardiac	13	Cerebral Palsy	1
Kidney	12	Myasthenia Gravis	1
Orthopedic	7	G.I.	1
GYN	6	Brain Damage	1
Leukemia/blood	5	Pancreatitis	1
Respiratory	5	Scleraderma	1
Arthritis	4	Syringamyelia	1
Quadraplegia	4	Appendix	1
Neurological	4	Circulatory	1
Multiple Sclerosis	4	Muscular Dystrophy	1
Amputation	3	Myeloma	1
Colitis	3	Brain Stem injury	1
Aneurysm	3	Anorexia Nervosa	1

TOTAL 150

V. SUMMARY AND EVALUATION

The CHIP program provides for mandatory yearly evaluation and health system reporting through the Annual Report on the Health

Condition of the State and Health Expenditures by the Director of the Department of Health by each January 30th to the Governor and General Assembly. In addition, the Department of Health, Division of Health Insurance implements the following monitoring programs:

1. Annual audit of fiscal intermediaries and those state agencies with whom the Department of Health has cooperative agreements
2. Preparation of a CHIP benefits annual report with statistics and demographics.
3. Contracting with private health research corporations, when required, to acquire data necessary to evaluate the program

The success of CHIP depends upon many factors: chiefly, the absolute necessity for cooperation between state government, insurers, and providers. The Law was initially conceived as a "working person's program," stressing the purchase of good private insurance as a step toward total catastrophic illness prevention. It was designed to provide an incentive for persons to purchase good basic health insurance coverage as an initial step and as an integral part of total catastrophic health insurance protection for all of the residents of Rhode Island. The State was the first nationally to implement this new approach to health insurance coverage and thereby ensure that no citizen would be forced to "spend down" or "abandon" his family to receive the kind of help which would reasonably be given to any neighbor or friend who has been struck by tragedy. The jury is still out as to a final verdict in regard to our endeavor.

ADMINISTRATIVE ORGANIZATION OF A STATE HEALTH INSURANCE PLAN
RHODE ISLAND CATASTROPHIC HEALTH INSURANCE PLAN (CHIP)

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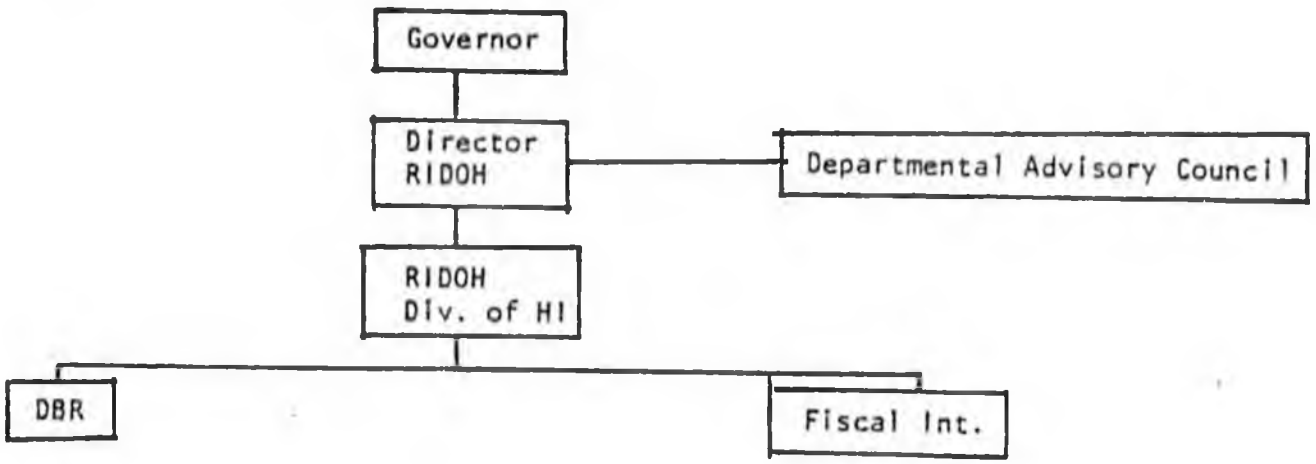
As of July, 1977, only five jurisdictions had enacted into law state health insurance plans whose purpose is to provide protection against the incidence of ill health above and beyond whatever other health insurance coverage may be provided to their residents either from public or private sources. Very few states have established their own health insurance department within their governmental structure to administer such a program with all the implications that ramify from such an organization. One state which has, however, is Rhode Island. This state offers a clear profile of the character of a state administered health insurance plan and the following is a discussion of this jurisdiction's program.

I. ADMINISTRATIVE ORGANIZATION AND RELATIONSHIP

Organizational Structure



The Director of the Rhode Island Department of Health is assigned the overall responsibility for the CHIP Program according to the enabling CHIP legislation and reports directly to the Governor. The Director has delegated all administrative duties to the Chief of the Division of Health Insurance. The Division of Health Insurance (DHI) has access to various Departmental advisory groups in matters relating to appeals, claims and other specific program areas, such as certification of Health Maintenance Organizations.

The DHI administers all aspects of the CHIP Program from one central location. There are no local Health Departments in Rhode Island. Duties include the following: monitors those program components assigned to other agencies (Department of Business Regulation); provides assistance and information to all applicants and general public; determines eligibility; develops and implements program policy, rules and regulations; develops, monitors and audits programs for CHIP claim administration with insurers; provides for appeal procedures and hearings; organizes program promotion and publicity; certifies and monitors Health Maintenance Organizations.

The Department of Business Regulation (DBR) is responsible to the Director of the Department of Health (DOH) for expenditures and program performance relating to the various duties assigned to it within the CHIP legislation. These include the development and

enforcement of minimum standards for health insurers, certification of qualified health insurance plans, review and approval of rates and management of a Facility Reinsurance Pool. The Director of DBR is ultimately responsible to the Governor directly on all matters relating to actual program performance. Joint decisions are made between directors on program areas which require the concurrence of both by law. The DOH reimburses the DBR for all salaries and expenses related to the performance of CHIP duties. A special Health Insurance Section has been established within the DBR to perform the tasks created by the passage of CHIP.

Prior to CHIP, health insurance regulation in the state was minimal. The primary source for contact between Departments is for requests to DBR for review of potentially qualified plans. When an applicant applies for CHIP benefits to the DOH, a review of the person's private health insurance is mandatory since eligibility is contingent upon the type of insurance plan a person may have. The law outlines what is described as a "qualified plan." The closer a person's policy comes to this qualified plan, the lower the deductible will be for them and subsequently eligible for CHIP. Therefore, the DOH utilizes the DBR to review selected policies of the applicants to determine if they are "qualified." The DOH is able to make such determinations in many cases involving only one or two basic policies held by an applicant. However, many applicants have multiple insurance poliies or complicated policies which are not readily identifiable as qualified. In several cases,

the DBR has had to utilize the services of their consulting actuary since the law allows them to qualify some of the more involved policies on the basis of actuarial equivalencies. The law indicates that "any plan or combination of plans which provide qualified plan benefits, or their actuarial equivalent, may be deemed to be a qualified program."

Fiscal intermediaries are utilized for claim administration purposes. They are appointed by the Director of the DOH and are responsible to the DHI on matters relating to claims paid, administrative costs and expenses. They are also subject to audit by the Division. Blue Cross of Rhode Island pays CHIP claims for those applicants who are Blue Cross subscribers, have no health insurance, are members of an HMO or who are on Medidare (Title XVIII). Metropolitan Life is the intermediary for those persons who have commercial health insurance. Both intermediaries have assigned one person to work on CHIP claims exclusively. In the case of Blue Cross, the person works on CHIP full time; with Metropolitan, it is a part-time function. The intermediaries both bill the DOH monthly for the costs of claims plus administrative costs, which is a percentage of the month's total paid claims. The rate is subject to review and adjustment on an annual basis. An Administrative Servcies Agreement with the DOH governs the performance of the intermediaries' duties under CHIP. The original appointment of the fiscal intermediaries was developed and concluded with the cooperative assistance of Blue Cross and the Health Insurance Association of America.

II. RELATIONSHIP TO OTHER PROGRAMS

The CHIP law was designed to be the last payer and secondary to any other health benefits available to an individual. For example, if a person has a private health insurance plan, this plan would always assume the primary position even after a person qualifies for CHIP. As long as the plan remains in force, CHIP would assume the balance of covered expenses not payable by the insurance program. In addition, if a person is or may be potentially eligible for Workman's Compensation, Medicaid (Title XIX), Maternal and Child Health Programs, medical payments on an automobile policy and so on, CHIP would be secondary to any payments made by these sources or may be totally out of the picture, particularly in the case of a person's eligibility for Medicaid.

The DHI will assist any applicant who may be unaware of the availability of such other programs. Contacts have been established with these agencies and placement is normally made by telephone with a written communication following to the agency and/or applicant.

Blue Cross and the commercial insurers have been asked to "case find" for CHIP, particularly when an insured person may be approaching their major medical maximum. Blue Cross has even gone so far as to print a computer produced note in such cases on the explanation of benefits worksheet which is sent to the subscriber detailing a particular major medical payment.

The DHI has a special relationship with Health Maintenance Organizations (HMOs) in the state. According to CHIP, they are

considered both a provider and an insurer. In the case of the latter, the DHI would consider a qualified HMO in a similar manner to an insurer if a person requests assistance from CHIP and is enrolled in an HMO. Very few CHIP applicants are in this category since HMOs normally provide a comprehensive range of prepaid services.

CHIP also requires all employers of one or more employees in the state to provide a "dual choice" to their employees if they currently participate in a group insurance program. The law now requires them to offer the choice of the insured plan or the HMO membership if a qualified HMO exists which includes the employees' place of resident in their service areas. The DHI is responsible for determining whether or not an applicant HMO is qualified. Criteria have been established within the CHIP Rules and Regulations. There are presently three HMOs in the state--all are qualified. Re-application must be made each year to the DHI. Review of applications is made by the DOH HMO Advisory Council. Qualification as a provider is different from qualification as an insurer. The DHI regulations speak to the quality of care and related administrative functions of operating an HMO and only incidentally address the issue of the specifics in the scope of benefits.

The DBR is responsible for enforcement of the dual choice option itself with employees in the state and all complaints and infractions are referred to them. Regulations have also been issued by them to cover their duties under this section of the law.

The HMO dual choice provisions of CHIP are looked upon as meeting one of the law's primary goals--that each person in the state have access to available diagnostic, curative and rehabilitative health services. Prior to CHIP, employers outwardly rejected approaches from HMOs to solicit their employees and as a result, the entire HMO movement in the state was faced with dissolution. The law has produced significant and immediate results and another HMO is being planned for organization shortly.

III. COST AND QUALITY CONTROL

Due to the projected limited scope of the CHIP program, a rate setting formula or separate reasonable fee system was not developed. It was thought that this would add another unnecessary layer of control over the existing overburdened system (e.g., Medicare, Medicaid, Blue Cross, Workmen's Compensation). Instead, the fiscal intermediaries utilize, according to the CHIP regulations, their respective reasonable fee profile systems for reimbursement of provider charges. However, they must follow the regulations completely to ascertain whether or not a particular service is covered by the program. Moreover, the intermediaries must employ their medical advisors in reaching any decisions in judgment areas such as overutilization, custodial care and medical necessity.

Applicants may appeal to the Director of the DOH any adverse decision made by an intermediary regarding all aspects of claim administration. They may also appeal any adverse decision made by the DHI concerning eligibility. A formal appeal system is

provided for by the state's Administrative Procedure Act. When an appeal is received by the Director, it is referred to the DHI. The DHI then schedules a meeting of the CHIP Appeals Review Committee, composed of a registered nurse, social worker, physician, medical advisor and CHIP coordinator of the intermediary involved and the Chief of the DHI as Chairman. Medical records and case records are carefully reviewed and the Committee has the power to overturn the decision of the DHI eligibility section and/or intermediary. If the decision sustains that of the DHI or intermediary, then the applicant may request an adjudicative hearing within the DOH before an impartial hearing officer. The officer also has the power to overturn any previously adverse decision. If the appeal is denied at this level, the applicant may file an action in the Superior Court System of Rhode Island and no further appeal is available within the DOH.

Intermediaries are required to accumulate specific demographic data from claims processed which are provided to the DHI as requested in order to monitor program performance, recommend changes to the law and regulations and to provide a base for preparation of annual reports. Application data are also used by the DHI for these purposes. Additionally, Rhode Island Health Services Research, a private non-profit locally based health research firm, is employed by the DHI to analyze such data, conduct household surveys and to provide input for the required annual CHIP report.

Medical Society Review Committees are used by the intermediary on selected cases involving custodial care, overutilization and reasonable fees. The DHI has contracted with Equifax, Inc., a private investigative firm, to conduct checks into possible duplicate coverage not reported by an applicant, residency and financial data, when none is available from the Rhode Island Division of Taxation. Since there is a percent of income requirement on certain cases in order to determine the CHIP deductible, the DHI has established a program for requesting such information from the Division of Taxation. When a return has not been filed recently, an Equifax referral may be necessary.

IV. PROGRAM COSTS

The following financial statistics reflect program experience during 1976:

Total claim expenditures	$858,865
Average monthly	$ 71,572
Average per applicant	$ 4,544
Difference over 1975	+$351,206
Percent change over 1975	+ 69%
Total Claims (Metropolitan)	$ 68,001
Total Claims (Blue Cross)	$790,864
Total administration (Metropolitan)	$ 13,874
Total administration (Blue Cross)	$ 55,951

Program costs are projected annually during the budget preparation time period for the following two fiscal years. Projections have

not matched costs for 1976 but are expected to do so for 1977. Program promotion efforts are now beginning to demonstrate some positive results. Slow progress was made during the first full year of operation. A contact program has been established throughout the state with various providers, special interest groups and other involved state agencies. Also, the DHI has made over two hundred appearances during the last one and one half years before different groups and organizations in the state promoting the CHIP program.

Although the total administrative costs appear to be high, many of the CHIP related duties do not pertain to claims, as was previously discussed. The actual administrative costs relating to claims, including a percentage of time from the DOH and DBR, is approximately 10%.

Officials of the State Medicaid program do not believe that the existence of CHIP has, to any measurable extent, impacted upon the administrative costs of their program. In fact, due to the nature of CHIP as a "bottomline" program, the DHI has been case finding for Medicaid. It is very difficult for the reverse to occur. As previously mentioned, Blue Cross and commercial insurers case-find for CHIP where practical when a person approaches the major medical maximum. Here again, we believe that the costs associated with these efforts are barely measurable.

Many of the CHIP cost control devices could be utilized by other states contemplating health insurance programs. For example,

most states have a variety of medical society peer review committees. Accumulation of only the specific data needed to perform an objective analysis of the program is extremely important in order to implement an effective cost control plan. If the administrative agency does not have the expertise to initiate such a program, outside professional resources should be employed. A uniform reporting system should be developed as soon as possible during the implementation phase of a new program in order to capture the required data from the outset.

V. NATIONAL HEALTH INSURANCE

CHIP has been designed to coordinate with any future National Health Insurance Program (NHI). In fact, such wording is part of the Exclusions listed in the CHIP Act--"...medical services which may be financed in the future on behalf of all citizens by the United States." This would not necessarily close down the CHIP Program but it would be altered according to the nature and extent of the NHI plan. Of course, a complete evaluation of the CHIP goals and priorities should occur immediately if and when NHI is enacted.

INFORMATION ABOUT MINNESOTA'S CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM

(PP
Minnesota Department
of Public Welfare
Box 30176
St. Paul, Minn. 5517[illegible]

What Is the Catastrophic Health Expense Protection Program?

The Catastrophic Health Expense Protection Program ("CHEPP") is a state program to help people who have had very high expenses for health care which no insurance company or other plan of health coverage will pay.

The program will pay 90 percent of the reasonable cost of covered services over and above an annual deductible that each eligible family must be responsible for itself.

When Am I Eligible?

You and your family are eligible for help from CHEPP when the sum of what you owe and what you have paid for health services received after June 30, 1977 equals your deductible. This is called satisfying the deductible. The charges used to satisfy the deductible must be for services covered by CHEPP, and they must be charges for which no one else is or has been liable. This means that anything paid or owed by an insurance company, Medicare, Worker's Compensation, or some other third party doesn't count.

How Much Would My Deductible Be?

Your "out-of-pocket" deductible is figured for your family--you and your tax dependents. It is always at least $ 2,500 per year. Often it is more.

To figure your deductible, take 40 percent of your gross family income up to $ 15,000 for the calendar year before the year in which you apply for CHEPP. To that figure, add 50 percent of your gross family income between $ 15,000 and $ 25,000 for that year. Then add in 60 percent of your gross family income in excess of $ 25,000 for that year. The sum is your deductible unless it is less than $ 2,500. In that case, your deductible is $ 2,500.

Some Examples:

A family applying for CHEPP in 1977 had gross family income in 1976 of $ 6,000. 40 percent of $ 6,000 is $ 2,400. This is less than $ 2,500, so the minimum deductible of $ 2,500 applies.

A family applying for CHEPP in 1978 had gross family income in 1977 of $ 26,000. 40 percent of $ 15,000 is $ 6,000. 50 percent of $ 10,000 (that is, $ 25,000 minus $ 15,000) is $ 5,000. 60 percent of $ 1,000 is $ 600. So the deductible is $ 6,000 plus $ 5,000 plus $ 600, which adds up to $ 11,600.

What Is Gross Household Income?

Gross household income is the sum of all the money income of all the members of a family except the children during a calendar year. It includes salaries, Social Security, pensions, welfare cash assistance, and tax-exempt interest income. It includes disability income payments, but food stamps, payments by Medicare, and payments by health insurance companies are not included. Gross household income is roughly what a family would report on its application for the Minnesota Homeowner and Renter Income-adjusted Homestead Credit or for the Senior Citizen's Special Property Tax Freeze Credit. (These applications are the goldenrod color forms that come with the Minnesota Individual Income Tax forms and instruction booklets.)

How Long Could I Be Eligible for Chepp?

CHEPP eligibility runs for 12 calendar months, beginning on the date of the first service offered in satisfaction of the CHEPP deductible. After the 12 months, you must requalify for CHEPP by incurring a new deductible. The new deductible is based on your gross family income in the calendar year before your new application.

What Health Services Are Covered?

The following health services are covered by CHEPP (if they were prescribed by a physician) but only to the extent that nobody other than yourself and your family is or has been liable for paying for the charges. These are also the services whose costs can count towards the CHEPP deductible, to the extent that nobody else is or has been liable for them.

1. Hospital services, both inpatient and outpatient;
2. Services of a medical doctor or osteopath (but not outpatient care for mental illness);
3. Drugs which require a physician's prescription;
4. Up to 120 days of care in a skilled nursing facility which meets Medicare standards, but only if the care is for serious illness or for rehabilitation, and only if the care begins within 14 days of a hospital stay of at least 3 days and is for a condition which was treated during the hospital stay; custodial care is not covered;
5. Home health agency services from an agency which meets Medicare standards, if the services are reimbursable under the Medicare program.
6. Use of radium, deep X-rays, and other radioisotopes;
7. Oxygen;
8. Anesthetics;
9. Prostheses such as artificial legs (but not false teeth or dental bridges);
10. Rental or purchase (whichever is most appropriate) of durable medical equipment (but not eyeglasses and hearing aids);
11. Laboratory tests and diagnostic X-rays;
12. Oral surgery for partly or completely unerupted impacted teeth, tooth roots, or for the gums or mouth tissues if the surgery is not related to the simple repair or extraction of teeth;
13. Services of a qualified physical therapist;
14. Medically necessary transportation in a licensed ambulance to the nearest facility qualified to treat the patient's condition; and
15. Nursing home care for patients under age 65 who have been in a nursing home continuously for at least 36 months. [*Note: payments for this group of nursing home residents are made on the basis of a special formula, and then only at the end of each state fiscal year (June 30).*]

When Can I Apply for CHEPP?

You can apply for CHEPP when you think you owe (or have paid) enough money for covered health services to satisfy the deductible that applies to you and your family. The money you owe or that you have paid must be for services received after June 30, 1977.

Where Do I Apply for CHEPP Help?

Apply for CHEPP benefits at your county welfare or social service office.

What Should I Bring if I Apply?

1. Bills for health services you want to apply to the CHEPP deductible. Also bring bills in excess of your deductible which you would like CHEPP to pay. If you have paid some of these bills, bring proof that you paid them.
2. All of your family's health insurance and automobile insurance identification cards (or copies of the policies or certificates).
3. Tax returns from the previous year to show what your gross family income was. If you filed for the Renter's Credit, Income-adjusted Homestead Tax Credit, or Senior Citizen's Special Property Tax Freeze Credit, bring a copy of your application.
4. Medicare, Veterans' Administration, and CHAMPUS identification cards.
5. Other information about people who may be liable for health care or for buying insurance for members of your family (such as a divorced husband).

Must I List All My Property and Assets?

Owning property and having savings will not make you ineligible for CHEPP. But your county welfare department will ask you about your assets to see if you might qualify for Medical Assistance ("Medicaid") or for General Assistance Medical Care. If you are eligible for one of those programs, you are probably not eligible for CHEPP. Those programs cover more kinds of care than CHEPP. They pay 100 percent of the cost of care. Often they have a lower deductible than CHEPP. But they have restrictions on property and other assets.

What Happens if I Am Eligible for CHEPP?

When you become eligible for CHEPP, your county welfare department will give you instructions and a handbook.

You will get a family CHEPP identification card. This card must be shown to all providers of health services which you want billed to CHEPP. It tells the provider what your CHEPP claim number is and alerts him to the fact that he will have to bill CHEPP instead of you. (In most cases CHEPP will not accept bills from you personally once you have become eligible.)

If you have already paid for services in excess of your deductible at the time you apply for CHEPP, copies of those bills and evidence of what part of them you paid will be collected. Then the state will pay you 90 percent of the reasonable cost of those services, minus any third party payments made to you or on your behalf.

Once a month you will get a listing from the state's computer of all the bills the state has paid for members of your family. This is called an Explanation of Medical Benefits ("EOMB"). It tells you how much copayment (the 10 percent which the state doesn't pay) you owe to the provider of each service. If the state has decided that part of a charge was too high, that part is forgiven by state law. You owe only the listed copayment amount.

Can I Substitute CHEPP for Health Insurance?

The Catastrophic Health Expense Protection Program is not intended to take the place of your own health insurance. This is why the minimum deductible is so high. (Your family's deductible may be considerably higher than the $ 2,500 minimum.) CHEPP is intended to help people whose medical bills have run way beyond what their insurance will pay or who haven't been able to buy health insurance. You don't have to have health insurance in order to qualify for CHEPP, but having some form of health insurance or prepaid health coverage is to your advantage.

How Does CHEPP Relate to the MCHA "Bad-risk" Insurance Program?

The law which set up CHEPP also set up a program of health insurance for people whose health problems have made them practically uninsurable. This other program, sometimes called "catastrophic health insurance," is run by the Minnesota Comprehensive Health Association (the "MCHA") under the supervision of the Insurance Division of the Minnesota Commerce Department. Information in this pamphlet does not apply to the programs of insurance offered by the Minnesota Comprehensive Health Association. *Information about these programs is available from:*

The Minnesota Comprehensive Health Association
Box 9309
Minneapolis, Minnesota 55440

Where Can I Get More Information about CHEPP?

To get more information about CHEPP, write to the address on the cover of this pamphlet or, after July 1, 1977, call your county welfare or social service office.

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