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.

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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.

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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.

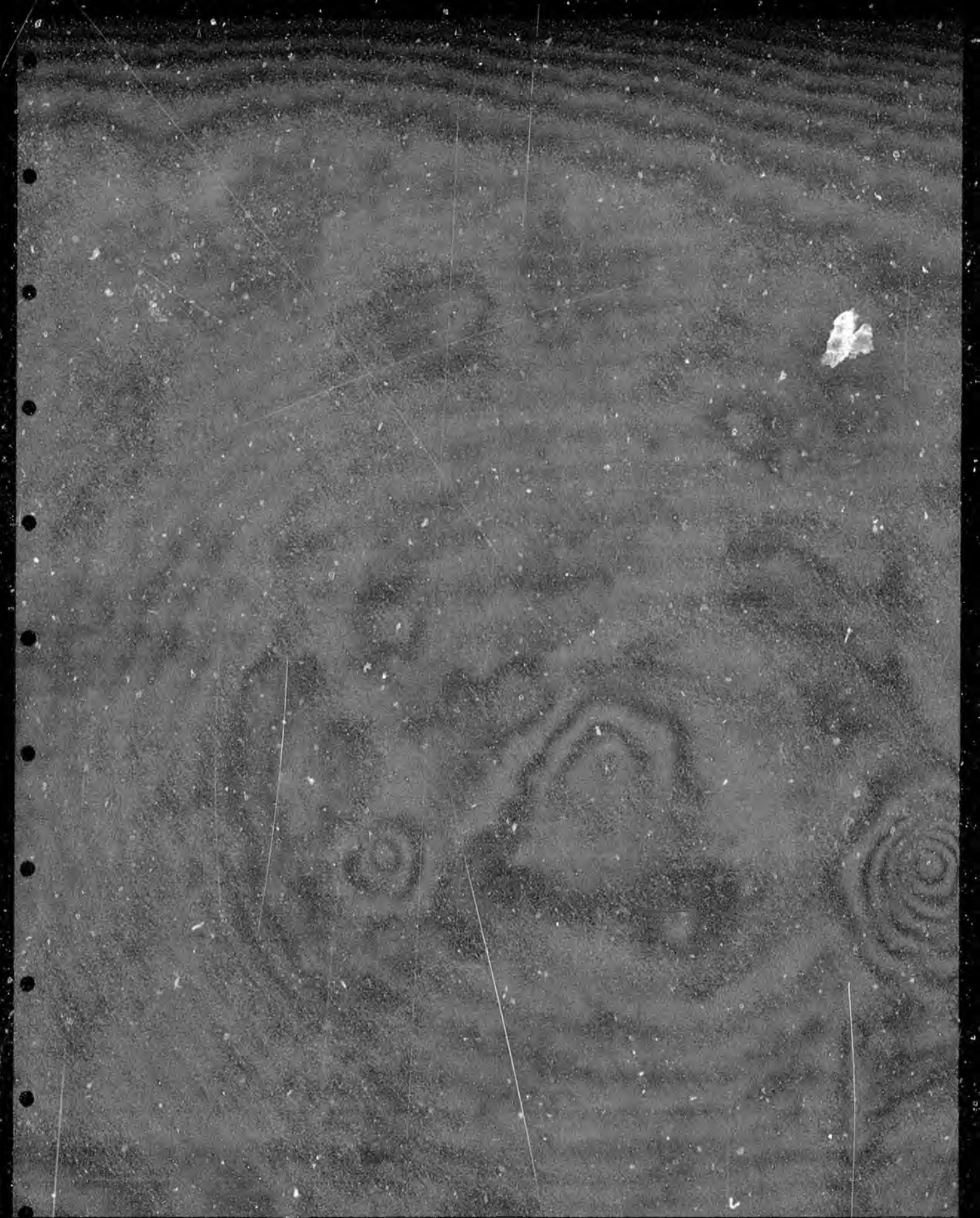
HEALTH POLICY CENTER CONSULTANTS

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

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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