Our public assistance program is so liberal it is causing us severe financial strains -- but that's another story, and I won't digress into it, except to note that we eagerly look forward to federal reform initiatives promised by the Carter Administration.

The political foundation for eventual enactment of our prepaid health care law was further set during the mid-sixties in a program popularly labeled "The New Hawaii," adopted jointly by the legislative majorities and the Administration.

During this period, dramatic changes were advanced in terms of Hawaii's social, economic, and political conditions. Basically, the stated objective was to enact laws and programs to insure equal treatment and equal opportunities for all citizens. If this sounds simplistic, it should be borne in mind that Hawaii was pretty much the political domain of the sugar and pineapple plantation interests up until the end of World War II and that when, for the first time in our history, we elected a Democratic Governor and Democratic majorities in both houses of the State Legislature in 1962, there were not a few who thought the revolution was at hand.

But the changes we sought were achieved in orderly, not revolutionary, fashion. And there was early ferment for novel and innovative legislation to extend equal opportunity in basic human concerns to all segments of our society.

It appeared logical to move toward some form of mandatory prepaid health care law. The question then was how best to extend coverage to the uninsured working men and women

of Hawaii and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the State, bearing in mind that our centralized system imposes unusually heavy financial burdens on the State?

To determine cost factors and the numbers and classes of employees in the uncovered "gap group," a study was commissioned through the Legislative Reference Bureau, the Legislature's principal research arm. Dr. Stefan A. Riesenfeld, former University of California law professor and a widely recognized authority on social legislation, now counsel to the U.S. State Department, was selected to do the research. Professor Riesenfeld had prepared an earlier report for the Legislature on temporary disability insurance, which study was extremely valuable to us in enacting our TDI law in 1969.

The Riesenfeld report, published in 1971, was a thorough and comprehensive study. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the State's employed, 11.7 per cent did not have hospital coverage, 13.5 per cent lacked surgical coverage, and 17.2 per cent did not have regular medical insurance.

The existence of a significant number of otherwise uncovered potential beneficiaries of the proposed legislation formed the primary policy consideration of the program. Other factors considered included the rising costs of health care and the need to assue the most practical method of ensuring the financial availability of health care for Hawaii's working men and women. Thus, the overall health of our population was the over-riding concern; without ensuring the

ready accessibility of health care, how could optimum health care be maintained?

Data compiled and analyzed in the report were very thorough. Sources outside the State included the Health Insurance Association of America, the Health Insurance Institute, the Bureau of Labor Statistics, the Social Security Administration, and the Bureau of the Census. Information from State agencies included data from the State Statistician and the Departments of Taxation, Planning and Economic Development, Social Services and Housing, and Labor and Industrial Relations. Data was also gathered from labor unions, the Hawaii Employers Council, the HMSA, Kaiser Foundation, and through questionnaires mailed to all employers covered by the Hawaii Employment Security Law.

Data used included statistics relative to the following:

-- Population by age levels, civilian and military. The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entited to Medicare.

-- Extent of prepaid health plan coverage for hospital, surgical, and medical benefits, both for subscribers and dependents.

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

As indicated by the sources of data, the full range of interest groups became involved in the process, whether employer or employee oriented.

During our legislative committee hearings, testimony was presented by representatives of the insurance industry, the health professions, the University of Hawaii Schools of Public Health and Social Work, the Comprehensive Health Planning Council, and a wide range of individual citizens.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Riesenfeld report recommended the comprehensive coverage plan and specifically recommended the adoption of prevailing coverages in the State, which then became the legal minimum. This reflected the health care habits and patterns of the State and set a floor without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation proposed. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the State.

As to the question of affordability, the only new cost factors imposed upon the State weere founded upon the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, as it was smoothly meshed in as a responsibility of the Disability Compensation Division of the State's Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law; the TDI law passed in 1969; and the 1974 Prepaid Health Care Act. (Incidentally,

you may have noticed that what used to be known as Workmen's Compensation is now referred to as Workers' Compensation in our State, reflecting the many similar amendments we have adopted consonant to our accepted policy on equal rights.)

Much to our pleasant surprise, the administrative expenses of Act 210 have been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of $250,000 in General Funds to cover salaries and other expenses. Much to the division's credit, Act 210 was implemented with substantially the existing staff. The first appropriation thus lapsed, and it was renewed this year at the same annual level on the expectation that additional personnel will be recruited during the next biennium.

A feature of Act 210 is a provision for premium supplementation financed by the State to cover employer premium requirements caused by limits imposed on employee contributions. This feature subsidizing employer contributions was included to provide a cost protection for marginal small businesses. Initially, $375,000 was set aside in a trust fund for premium supplementation. Again, to our pleasant surprise, there has been little need to supplement premiums. It's estimated that, to date, only some $20,000 to $30,000 has been tapped from the trust fund in subsidies. Meanwhile, the fund is held in an interest-earning status.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that about 18,500 employers have thus far been registered. However, the extent

of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld has estamated some 40,000 employees were not covered at the time he conducted his study. The Disability Compensation Division is of the opinion that actually more than 40,000 received new benefits because of the requirement that employers cover at least half of the premium costs.

Of the 18,500 employers, all but some 1,000 have elected plans offered by the State's two major insurers -- HMSA and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council.

The advisory council provision serves another purpose. During the course of legislative hearings on the act, public health advocates had expressed concern that the required benefits might be too rigid and unresponsive to changes in health care over the years. The Prepaid Health Care Advisory Council provisions were thus added to establish an appropriate agent to review medical equivalency of benefits.

To conclude, in light of Hawaii's experience, I believe any national health insurance plan should take into consideration the course that we have opted for. I am confident the standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true state plan such as Rhode Island's,

I suggest federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1 -- A political climate sympathetic to social needs.

2 -- Timeliness in terms of progressive improvements to the general body of social legislation already on the books.

3 -- A comprehensive study of a state's needs, to arm proponents with the information necessary to justify the proposed legislation.

4 -- Open discussion involving all interested elements within the public.

5 -- The last may be an element not very common to other jurisdictions, but I believe it was an important consideration in our own deliberations. This is the fact, well established in our study, that the majority of employees insured under voluntary plans or through government-employee programs were covered under plans offered by two major insurers in the State. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all the State's working men and women.

I hope our experience and the foregoing thoughts presented for your discussion prove helpful to you in your own endeavors to develop plans for extending health care benefits to all others who need such coverage in our Nation.

Mahalo.

# # #

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3870

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM May 27, 1977

SUBJECT: State Health Insurance (W.O. #4206)

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley SH
Research Analyst

Carter's National Health Insurance Proposal

The Carter Administration has not developed a comprehensive health insurance proposal. An advisory committee was recently established to evaluate the alternative approaches to national health insurance, and they are currently taking testimony in several cities across the country.

During the campaign, Carter promised national health insurance with the following provisions:

1. universal and mandatory coverage, implemented in stages based on priorities of need and financial feasibility;
2. comprehensive and uniform benefits with emphasis on preventive medicine;
3. financing by payroll taxes and general tax revenues;
4. cost and quality controls, uniform standards and set rates;
5. maximum personal interrelationship between patient and physician, consumer choice of provider, and basic concern for the dignity of the person, unrelated to wealth or income;
6. incentives for improved delivery of services, for increased productivity, for redistribution of health personnel, and

resources for the development of alternative delivery systems;

7. consumer representation in development and administration.

Carter estimated the cost of implementing this program at $10 billion of new federal expenditures. It is not clear what his reasoning was to arrive at such a low figure, since he has not proposed a plan that can be costed out. One comprehensive mandatory plan that has been cost estimated is the Health Security Act, and the estimate of new federal expenditures for that plan is $80 billion.

There were 23 different national health insurance proposals before Congress last year, but none are moving now.

State Approaches

Two national organizations have developed model state health insurance legislation. The Conference of Insurance Legislators proposes a comprehensive health care program with universal voluntary coverage, regulated by the state, but administered by private carriers and financed by consumers. The National Association of Insurance Commissioners proposes a catastrophic health care program financed by the state. We have requested copies of these two models.

There are five states that have passed and implemented state health insurance. In Rhode Island, Maine, and Minnesota, the state provides financial assistance for catastrophic health expenses. In Hawaii, Connecticut and Minnesota, again, the state regulates private comprehensive health coverage to insure quality and availability and to control costs. No state directly subsidizes comprehensive health insurance for its residents, because it appears to be prohibitively expensive.

Hawaii: Every employer in Hawaii is required to offer a qualified health care plan to his/her employees and to pay at least half the premium. Qualified plans must meet state minimum standards. Small employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, when that excess is greater than 5% of the employer's income from the business are entitled to a state subsidy for the remainder of the premium. This statute took effect in 1975, and though several employers applied for state assistance, none were found to be eligible.

Connecticut: The Connecticut comprehensive health care plans statute insures the universal availability of comprehensive health care insurance contracts meeting state minimum standards, at standardized premiums. The Health Reinsurance Association is created with mandatory membership of all carriers in the state to pool risk for the mandated coverage. The premium rates vary by sex and age, and for group contracts by geographical area, as well. Sample quarterly premium rates are in Table I.

Table I - Sample Quarterly Premium Rates for Connecticut Comprehensive Health Care Plans

Individual/ /Group*	30-year old Female	60-year old Male
Deductible $200	$114.57/ /$103.11	$243.15/ /$218.82
$500	$ 85.92/ /$ 77.34	$182.37/ /$164.13
$750	$ 74.46/ /$ 67.02	$158.04/ /$142.23

* Rate for Hartford, New Haven and Fairfield region.

Minnesota: The Minnesota statute requires all health insurance carriers to offer health coverage which meets minimum state standards, and requires employee health benefits to meet minimum standards. It also establishes a state comprehensive health plan available to any resident who is rejected, restricted, or limited in their health coverage from the private sector. This state plan is offered by all carriers and reinsured by an association of carriers, in which membership is mandatory, to pool the profits and losses of high risk coverage.

This comprehensive health insurance statute in Minnesota took effect in January of this year. There are now 12 law suits pending challenging the law. Interstate employers complain that when Minnesota law requires a high standard of health benefits for employees, the employer must offer the same high benefits to its employees in other states. Thus, the law has impact beyond the borders of the state and may be unconstitutional.

Minnesota also has a Catastrophic Health Expense Protection Act under which the state pays 90 percent of a resident's health care expenses after the resident's out-of-pocket expenses exceed (a) 40 percent of his/her household income under $15,000, 50 percent of his/her household income between $15,000 and $25,000, plus 60 percent of his/her household income in excess of $25,000; or (b) $2,500; whichever is greater. This statute does not take effect until July 1 this year, so its fiscal impact is not known. On the basis of very crude estimates, it was budgeted for $18 million over the two year budget period, plus $50,000 for administration.

Rhode Island: Rhode Island's catastrophic health insurance statute has been in effect for three years. For the 85 percent of Rhode Island's residents who have private health coverage which meets minimum standards,

the state will pay costs of health care beyond the limits or coverage of the private insurance and above $500 or 10 percent of the resident's income. For the other 15 percent who do not have private insurance, the state will pay costs over $5,000 or 50 percent of the resident's income. The program is not well known yet. Of the 300 to 400 applications to the state for payment of health bills received each year, only half are found to be eligible. The annual state expenditure for the coverage is running $1,500,000 per year.

A health resources development fund is established not only to pay catastrophic costs but to make grants, loans, or contracts for the improvement of health facilities, services or education.

The statute also authorizes state regulation regarding consumer protection, quality of health coverage, universal availability, and rates.

Maine: The Maine catastrophic illness statute provides that the state will pay all remaining eligible health care expenses when the resident's out-of-pocket expenses reach 20 percent of the resident's net income, plus $1,000. For residents whose net worth exceeds $20,000 and such net worth includes cashable assets, 10 percent of such cashable assets are added to the out-of-pocket expenses threshold.

Considerations for Alaska

Although Alaska has a Catastrophic Illness Committee, it has not been given clear guidelines nor adequate funding.

The state approaches which have been tested elsewhere which you may want to consider for Alaska include:

1. state minimum standards for comprehensive health plans offered by private carriers;
2. mandatory availability of such plans to all state residents regardless of age or physical condition;
3. mandatory membership of all health insurance carriers in a reinsurance association to pool risk;
4. regulation of premium rates and provider reimbursements;
5. comprehensive health benefits mandated for all employees, with at least 50 percent of the premiums paid by employers;

All of the above provisions combined would still leave some people without comprehensive coverage. Self-employed, part-time or non-working people with adequate incomes would have a choice whether or not to purchase coverage, and some would choose not to. Self-employed, part-time, unemployed and non-working people with low incomes, however, could not afford to purchase private health insurance. People in this category might include farmers, homesteaders, miners, independent truckers, fishermen, small family business people, widows, retired people not eligible for Medicare, lots of low paid part-time workers (mostly women) and, of course, all their dependents. In addition, there are large numbers of seasonally employed people in Alaska who would only have coverage part of the year, such as loggers, cannery workers, and tourist industry employees. Public Health Services, Medicaid, and Medicare provide coverage for large sectors of low income Alaskans, plus General Relief-Medical and other state programs provide piecemeal health services for eligibles, but we are still far from comprehensive coverage for all.

The only way for the state to insure universal coverage is to subsidize it to the tune of millions of dollars.

Before we can proceed to draft a state comprehensive health insurance plan for Alaska, some policy decisions must be made:

1. Coverage - is enrollment voluntary or mandatory, and for whom is the coverage targeted?
2. Benefits - which expenses will be covered?
3. Financing - what portion will the state or employers pay? How much in premiums, deductibles, or co-payments must the consumer pay?
4. Cost and Quality Control - how will rates or standards of care be set?
5. Administration - what is the role of private carriers? What is the role of the state?

There will be a seminar on state health insurance plans on Friday, July 29, in Washington, D. C., sponsored by the Georgetown University Health Policy Center. There will be four forums: (1) political planning for enactment of state health insurance; (2) administrative aspects; (3) benefit coverage and eligibility; and (4) the cost of state health insurance, and looking ahead to national health insurance. Reservations or inquiries should be directed to: Jordan Braveman, Director of Policy Analysis, Georgetown University Health Policy Center, 3520 Prospect Street, N.W., Washington, D. C. 20057. He can also be reached by phone at (202) 625-3092.

We will be happy to meet with you at your earliest convenience to discuss these questions.

SH:jm

ONE HUNDRED AND SEVENTH LEGISLATURE

Legislative Document **No. 1161**

H. P. 1162 House of Representatives, March 25, 1975

On Motion of Mr. Drigotas of Auburn, referred to Committee on Taxation. Sent up for concurrence and ordered printed.

EDWIN H. PERT, Clerk

Presented by Mr. Silverman of Calais.
Cosponsor: Mr. Connolly of Portland.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FIVE

AN ACT to Amend the Taxing Provisions under the Catastrophic Illness and Medically Indigent Program.

Be it enacted by the People of the State of Maine, as follows:

36 MRSA § 4365, 2nd and 3rd sentences, as enacted by PL 1973, c. 768, § 2, are repealed and the following enacted in place thereof:

Any increase in tax authorized by the public laws of 1973, chapter 768, section 2, to fund catastrophic medical expenses shall terminate when the catastrophic medical expense for the medically indigent program is terminated or suspended by legislative action or when any similar federal program becomes effective. In no event shall the funds that are raised by said tax increase, to the amount appropriated by the Legislature for said program, be made unavailable for the program except by the Legislature.

STATEMENT OF FACT

The 106th session of the Legislature enacted the catastrophic illness program to provide financial assistance to individuals and families faced with medical expenses beyond their ability to pay. The Legislature provided a 2¢ per pack increase in the cigarette tax to finance the legislation.

The taxing provisions of the catastrophic illness law allow for the tax to continue should the Legislature, the Governor or the Department of Health and Welfare see fit to discontinue the program. This legislation would provide for an immediate end to the 2¢ increased tax when the catastrophic illness program ends.

ONE HUNDRED AND SEVENTH LEGISLATURE

Legislative Document No. 1601

H. P. 1287 House of Representatives, April 2, 1975

Referred to Committee on Appropriations and Financial Affairs. Sent up for concurrence and ordered printed.

EDWIN H. PERT, Clerk

Presented by Mrs. Berry of Madison.

Cosponsor: Mrs. Morin of Old Orchard Beach.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FIVE

AN ACT to Amend the Catastrophic Illness Program by Exempting Senior Citizens from Certain Requirements and Assuring Reimbursement under Certain Circumstances.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 22 MRSA § 3454, 2nd ¶, as enacted by PL 1973, c. 768, § 1, is amended by adding after the 7th sentence a new sentense to read:

Provided, that in the case of an applicant 62 years of age or older, 2 of the above requirements shall not apply, namely: The requirement that 20% of net income before taxes be applicable to liabilities for care and the requirement that the "residual liability" be greater than $1,000 for a payment to be made from this fund.

Sec. 2. 22 MRSA § 3454, 2nd ¶, as enacted by PL 1973, c. 768, § 1, is amended by adding at the end a new sentence to read:

When a person has been declared eligible in the previous 12-month period, no reimbursement shall be denied in the next subsequent 12-month period solely because an administrative redetermination of eligibility has not been made or is in the process of being made.

STATEMENT OF FACT

The purpose of this bill is to exempt persons 62 years of age or older from 2 deductible provisions of the catastrophic illness program, and to assure that applicants who have been in the program in one year are not denied participation solely because an administrative redetermination of eligibility has not been made in the next.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-FOUR

H. P. 1991 — L. D. 2535

AN ACT to Increase the Cigarette Tax and Provide Funds for Catastrophic Medical Expense.

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. R. S., T. 22, § 3454, additional. Title 22 of the Revised Statutes is amended by adding a new section, 3454, to read as follows:

§ 3454. Medical expenses for catastrophic illness

The Department of Health and Welfare is authorized to provide financial assistance to, or in behalf of, families or individuals whose costs for hospital in-patient or out-patient care, physicians' services, drugs, appliances and other related services, including skilled nursing home care as defined by the department and as determined by the department to be necessary, cannot be met from their own or other sources, when said costs are of such magnitude as to constitute a financial catastrophe for the said families or individuals, or when it can be determined that medical indigency exists. Skilled nursing home care shall be an eligible service only when the patient is admitted to a skilled nursing facility within 7 days of discharge from a general hospital, following a minimum in-patient stay of at least 5 days. Furthermore, eligibility for payment for skilled nursing home care shall be for a maximum of 60 days in any one year, or in association with any one illness episode.

Application for assistance through the catastrophic medical expense fund shall be made by the individual who is, or has been, receiving the care for which financial assistance is being sought, or by a person who is legally responsible for such costs, or by a legal representative of said individual. Assistance shall be available through this fund only in behalf of specific individuals, and only for those who are not eligible for aid through federally matched medical care programs as administered in Maine, and, furthermore, it shall terminate when any similar federal program becomes effective. The Governor shall determine by proclamation when said federal program has become effective. Eligibility for, and aid through, this fund shall be on a year to year basis, and eligibility and amount of aid shall be determined only after the full application to the costs of medical care in any one year of all applicable health care insurance benefits, other 3rd-party payor benefits legally provided for, or liability benefits identified as being for medical or rehabilitative care. Furthermore, from all net income before taxes received by the applicant or those legally responsible for the costs of the applicant's care, 20% will be assumed to be applicable to the liabilities for the care for which assistance is being sought. If the applicant has, or those legally responsible for the applicant's care have, or they jointly have, a net worth in excess of $20,000, and the excess net worth includes cash or readily cashable assets, then 10% of such cash or cashable assets shall be assumed to be applicable to the liabilities for care. If after the application of all of the above resources, the residual liability, in any one year, for which assistance is being sought is less than $1,000, no payment shall be made from this fund, and only that amount in excess of

$1,000 shall be paid. No reimbursements shall be made for bills already paid. Payments from this fund shall only be made directly to the vendors or providers of care. However, this section shall not be deemed to create any rights or causes of action against the State in such a vendor or provider of care, his heirs or assigns. When eligibility has been established, the Department of Health and Welfare may make payments from this fund, during the remainder of the year of eligibility, for those goods and services provided for in this section.

The Department of Health and Welfare is authorized to promulgate and adopt the additional rules and regulations necessary for administration of this section.

Medical indigency and eligibility for assistance under this section are to be defined and determined in manners consistent with the requirements for the receipt of federal matching funds under Title XIX, or its successors, of the Social Security Act.

An applicant shall be an adult who requires care and assistance, an adult legally responsible for such care of another or an adult who is legally responsible for the care of, and is applying in behalf of, one or more dependent minor children. Applications may be made in behalf of said applicants by their legal representatives.

The income factor of eligibility will be met if, after reducing all income received by or available to the applicant by the liabilities for the kinds of goods and services provided for in this section, the residual income does not exceed 133% of an amount equal to the public welfare standards applicable to the applicant.

The application of any available insurance, other 3rd-party liabilities or other benefits to which the applicant may be entitled or the determination of other eligibility factors shall be in accordance with federal matching requirements.

The Department of Health and Welfare shall adopt and promulgate the additional rules and regulations which may be necessary for proper, equitable, and effective administration of this section.

Any balances of funds appropriated for medical expenses under this section shall not lapse but shall be carried forward from year to year to be expended for the same purpose.

Sec. 2. R. S., T. 36, § 4365, amended. The first sentence of section 4365 of Title 36 of the Revised Statutes, as amended, is further amended to read as follows:

A tax is imposed on all cigarettes held in this State by any person for sale, said tax to be at the rate of 8 mills for each cigarette and the payment thereof to be evidenced by the affixing of stamps to the packages containing the cigarettes. Any increase in tax authorized under this section shall terminate when a federal program similar to that provided in section 3454 becomes effective. The Governor shall determine by proclamation when said federal program has become effective.

Sec. 3. R. S., T. 36, § 4365, amended. The next to the last sentence of section 4365 of Title 36 of the Revised Statutes, as amended, is further amended to read as follows:

The Tax Assessor thereupon shall notify the unclassified importer of the amount of the tax due thereon, which shall be at the rate of 8 mills per cigarette.

Sec. 4. Cigarettes on hand; stamping or account; waiver provisions. The State Tax Assessor may by regulation waive for a period of not over 7 days following the effective date of sections 2 and 3 payment of additional tax by retail dealers with respect to stocks of cigarettes properly stamped at the rate of 7 mills per cigarette sold during such period, provided such stocks were on hand as of the effective date of sections 2 and 3 and pursuant thereto, the State Tax Assessor may also waive for the same period the application to retail dealers of Title 36, sections 4369, 4370 and 4372 as ~~pects~~ such cigarettes.

Nothing herein shall be construed to authorize any distributor or subjobber to distribute to any retail outlet cigarettes not properly stamped at the rate of 8 mills per cigarette.

Cigarettes in the hand of retail dealers subsequent to the period of waiver provided for above, not properly stamped at the rate of 8 mills per cigarette, shall be subject to confiscation under the provision of Title 36, section 4372; and such retailer shall be subject to any other penalties by law provided.

Sec. 5. R. S., T. 36, § 4366, amended. The 2nd sentence of section 4366 of Title 36 of the Revised Statutes, as amended by section 3 of Section E of chapter 191 of the private and special laws of 1967 and as last repealed and replaced by section 50 of chapter 504 of the public laws of 1969, is amended to read as follows:

To licensed distributors he shall sell such cigarette stamps at a discount of ~~2¼%~~ 2½% of their face value.

Sec. 6. Appropriation. There is appropriated from the General Fund the sum of $2,840,000 to carry out the purposes of this Act. The breakdown shall be as follows:

		1974-75
HEALTH AND WELFARE, DEPARTMENT OF		
Personal Services	(8)	$ 62,245
All Other		2,770,255
Capital Expenditures		1,600
		$2,834,100
FINANCE AND ADMINISTRATION, DEPARTMENT OF		
Bureau of Taxation		
All Other		5,900
		$2,840,000

Sec. 7. Effective date. This Act shall take effect July 1, 1974.