Withdrawal/Redaction Sheet
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: political (2 pages)	n.d.	Personal Misfile
002. paper	re: political (2 pages)	n.d.	Personal Misfile
003. paper	re: political (2 pages)	ca. 2000	Personal Misfile
004. paper	Medicare paper re: political (2 pages)	n.d.	Personal Misfile
005. note	re: phone number (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

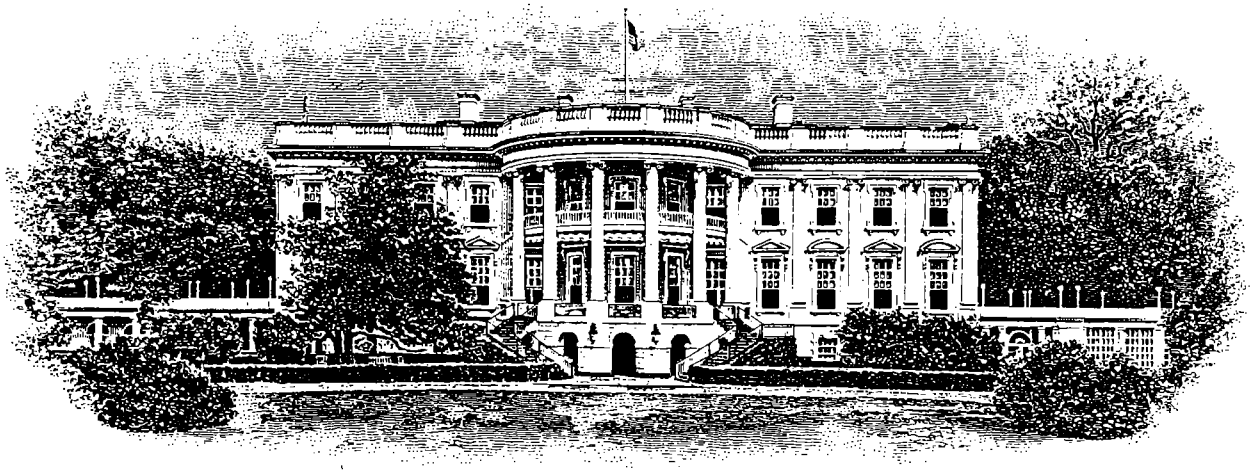
P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

The White House



PHOTOCOPY
PRESERVATION

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. paper	re: political (2 pages)	n.d.	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. paper	re: political (2 pages)	n.d.	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
003. paper	re: political (2 pages)	ca. 2000	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
004. paper	Medicare paper re: political (2 pages)	n.d.	Personal Misfile

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Withdrawal/Redaction Marker
Clinton Library

DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
005. note	re: phone number (1 page)	n.d.	P6/b(6)

COLLECTION:
Clinton Presidential Records
Domestic Policy Council
Devorah Adler
OA/Box Number: 20148

FOLDER TITLE:
Patients' Bill of Rights/Coverage/Other Event [1]

2012-0463-S
rc703

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

U S Senate
106th Congress
2nd Session

June 8, 2000
5:41 p.m.

Temp. CR S-4807

Related Votes
116-122

RECORD VOTE 121

DOD AUTHORIZATION, 2001
(PATIENTS' BILL OF RIGHTS)

S. 2549 **AMENDMENT NO. 3273**

"National Defense Authorization Act for Fiscal Year 2001"

Nickles motion to table the Daschle, et al., amendment which provides an independent external appeals process to help patients get care quickly and resolve disputes; provides for a fair and reasonable process for medical decision making which takes into account: (1) current medical evidence, (2) the patient's medical record, (3) the opinion of the treating physician, and (4) the recommendation of the health plan; makes health plans liable for negligent decisions that result in patient injury or death; and provides other essential patient protections including: (1) access to specialty care, (2) access to clinical trials, (3) access to needed drugs, (4) direct access to women's health care services, (5) access to emergency care, and (6) access to a point of service option for patients who need out-of-network care.

MOTION TO TABLE AGREED TO

PARTY COHESION

Democrats

100%

Republicans

93%

SYMBOLS

Absence
1 Official Business
2 Necessarily Absent
3 Illness
4 Other
Other Positions
AY Announced Yea
AN Announced Nay
PY Paired Yea
PN Paired Nay

YEAS (51)		NAYS (48)		NOT VOTING (1)	
Democrats (0 or 0%)	Republicans (51 or 93%)	Democrats (44 or 100%)	Republicans (4 or 7%)	Democrats (1)	Republicans (0)
	Abraham, Allard, Ashcroft, Bennett, Bond, Brownback, Bunning, Burns, Campbell, Cochran, Collins, Coverdell, Craig, Crapo, DeWine, Domenici, Enzi, Frist, Gorton, Gramm, Grams, Grassley, Gregg, Hagel, Hatch, Helms, Hutchinson, Hutchison, Inhofe, Jeffords, Kyl, Lott, Lugar, Mack, McConnell, Murkowski, Nickles, Roberts, Roth, Santorum, Sessions, Shelby, Smith, B., Smith, G., Snowe, Stevens, Thomas, Thompson, Thurmond, Voinovich, Warner	Akaka, Baucus, Bayh, Biden, Bingaman, Boxer, Breaux, Bryan, Byrd, Cleland, Daschle, Dodd, Dorgan, Durbin, Edwards, Feingold, Feinstein, Graham, Harkin, Hollings, Inouye, Johnson, Kennedy, Kerrey, Kerry, Kohl, Landrieu, Lautenberg, Leahy, Levin, Lieberman, Lincoln, Mikulski, Moynihan, Murray, Reed, Reid, Robb, Rockefeller, Sarbanes, Schumer, Torricelli, Wellstone, Wyden	Chafee, L., Fitzgerald, McCain, Specter	Conrad-2	

DPC Vote Information Office
ST-50, U.S. Capitol 4-5854

VOTE
Democratic Policy Committee
INFORMATION

U.S. Senate
106th Congress
2nd Session

June 29, 2000
7:26 p.m.
Temp. CR S-6092

RECORD VOTE 166

LABOR-HHS-EDUCATION APPROPRIATIONS, 2001
(REPUBLICAN PATIENTS' BILL OF RIGHTS)

H.R. 4577 **AMENDMENT NO. 3694**

"Departments of Labor, Health, and Human Services, and Education and Related Agencies Appropriations Act, 2001"

Nickles amendment which excludes 113 million Americans from most of its so called "protections," providing coverage for only those 48 million Americans in self-funded plans; establishes a non-independent appeals system; preserves legal immunity for HMOs and insurers, except in the narrowest of cases; preempts current State liability laws; does not guarantee access to specialists; does not guarantee choice of doctor for everyone; does not guarantee access to nurse midwives or nurse practitioners in its access to ob/gyn care provision; allows HMOs to deny patients access to promising experimental therapies for heart disease, Parkinson's disease, and many other diseases for which conventional therapy has failed; and converts a medical savings account pilot program into a full-scale program and expands this untested product in private market and Medicare before demonstration results are in.

AMENDMENT AGREED TO

Related Votes
142-159, 161-167

PARTY COMPOSITION

Democrats

100%

Republicans

93%

SYMBOLS

Absence
1 Official Business
2 Necessarily Absent
3 Illness
4 Other

Other Positions
AY Announced Yea
AN Announced Nay
PY Paired Yea
PN Paired Nay

YEAS (51)		NAYS (47)		NOT VOTING (2)	
Democrats (0 or 0%)	Republicans (51 or 93%)	Democrats (43 or 100%)	Republicans (4 or 7%)	Democrats (2)	Republicans (0)
	Abraham	Akaka	Chafee, L.	Inouye-2	
	Allard	Baucus	Fitzgerald	Leahy-2	
	Ashcroft	Bayh	McCain		
	Bennett	Biden	Specter		
	Bond	Bingaman			
	Brownback	Boxer			
	Bunning	Breaux			
	Burns	Bryan			
	Campbell	Byrd			
	Cochran	Cleland			
	Collins	Conrad			
	Coverdell	Daschle			
	Craig	Dodd			
	Crapo	Dorgan			
	DeWine	Durbin			
	Domenici	Edwards			
	Enzi	Feingold			
	Frist	Feinstein			
	Gorton	Graham			
	Gramm	Harkin			
	Grams	Hollings			
	Grassley	Johnson			
	Gregg	Kennedy			
	Hagel	Kerrey			
	Hatch	Kerry			
	Helms	Kohl			
	Hutchinson	Landrieu			
	Hutchison	Lautenberg			
	Inhofe	Levin			
	Jeffords	Lieberman			
	Kyl	Lincoln			
	Lott	Mikulski			
	Lugar	Moynihan			
	Mack	Murray			
	McConnell	Reed			
	Murkowski	Reid			
	Nickles	Robb			
	Roberts	Rockefeller			
	Roth	Sarbanes			
	Santorum	Schumer			
	Sessions	Torricelli			
	Shelby	Wellstone			
	Smith, B.	Wyden			
	Smith, G.				
	Snowe				
	Stevens				
	Thomas				
	Thompson				
	Thurmond				
	Voinovich				
	Warner				

DPC Vote Information Office
ST-50, U.S. Capitol 4-6864

VOTE INFORMATION
Democratic Policy Committee

U.S. Senate
106th Congress
2nd Session

June 29, 2000
7:54 p.m.
Temp. CR S-6093

RECORD VOTE 167

LABOR-HHS-EDUCATION APPROPRIATIONS, 2001
(DEMOCRATIC PATIENTS' BILL OF RIGHTS)

H.R. 4577 **AMENDMENT NO. 3693**

"Departments of Labor, Health, and Human Services, and Education and Related Agencies Appropriations Act, 2001"

Dorgan, et al., amendment which requires any Patients' Bill of Rights legislation enacted by the Congress to provide a basic level of Federal protection to all of the 161 million Americans with private health insurance.

AMENDMENT REJECTED

Related Votes
142-168, 181-187

YEAS

NAYS

NOT VOTING

YEAS (47)			NAYS (51)		NOT VOTING (2)	
Democrats (43 or 100%)		**Republicans (4 or 7%)**	**Democrats (0 or 0%)**	**Republicans (51 or 93%)**	**Democrats (2)**	**Republicans (0)**
Akaka	Kennedy	Chafee, L.		Abraham	Hutchinson	Inouye-2	
Baucus	Kerrey	Fitzgerald		Allard	Hutchison	Leahy-2	
Bayh	Kerry	McCain		Ashcroft	Inhofe		
Biden	Kohl	Specter		Bennett	Jeffords		
Bingaman	Landrieu			Bond	Kyl		
Boxer	Lautenberg			Brownback	Lott		
Breaux	Levin			Bunning	Lugar		
Bryan	Lieberman			Burns	Mack		
Byrd	Lincoln			Campbell	McConnell		
Cleland	Mikulski			Cochran	Murkowski		
Conrad	Moynihan			Collins	Nickles		
Daschle	Murray			Coverdell	Roberts		
Dodd	Reed			Craig	Roth		
Dorgan	Reid			Crapo	Santorum		
Durbin	Robb			DeWine	Sessions		
Edwards	Rockefeller			Domenici	Shelby		
Feingold	Sarbanes			Enzi	Smith, B.		
Feinstein	Schumer			Frist	Smith, G.		
Graham	Torricelli			Gorton	Snowe		
Harkin	Wellstone			Gramm	Stevens		
Hollings	Wyden			Grams	Thomas		
Johnson				Grassley	Thompson		
				Gregg	Thurmond		
				Hagel	Voinovich		
				Hatch	Warner		
				Helms			

PARTY COMPOSITION

Democrats

100%

Republicans

93%

SYMBOLS

Absence
1 Official Business
2 Necessarily Absent
3 Illness
4 Other

Other Positions
AY Announced Yea
AN Announced Nay
PY Paired Yea
PN Paired Nay

DPC Vote Information Office
ST-50, U.S. Capitol 4-5554

VOTE INFORMATION
Democratic Policy Committee

Straight Talk AMERICA

'Recovering' McCain Resumes Crusade

Washington Post

May 31, 2000

Print it! Click here to display printer-friendly page

E-mail Send this article to a friend or colleague

By Helen Dewar

The Washington Post

By Helen Dewar

Sen. John McCain is back, feistier than ever.

For most of the two months since he dropped out of the presidential race and returned to the Senate, the Arizona Republican kept a low profile, boning up on work he missed and readjusting to the less exciting pace of Senate business. At first, he seemed tired, perhaps a little dispirited.

But now he is plunging back into the thick of Senate combat, with renewed passion and an even larger agenda of causes than he had before he left Capitol Hill to campaign full time last fall. He's not only renewing his push for old causes such as campaign finance reform, but as chairman of the Senate Commerce Committee he even held a hearing on global warming--an issue that largely escaped his attention until campaign supporters convinced him he should make it one of his priorities.

"It's fun again," an ebullient McCain said last week, dismissing the pessimism that grips many of his colleagues over the chances of getting much of anything done in the partisan atmosphere of this pre-election session.

But it may not be as much fun for Senate GOP leaders, who were often peeved and sometimes enraged by McCain's crusades in the past and are not likely to relish bigger and bolder versions of these ventures in the future. He has already irritated them by threatening to bring up campaign finance reform on any bill that rolls through the Senate from now on, and their anxiety is bound to build as he follows through on his intentions.

As McCain sees it, however, the 5 million Americans who voted for him in the primaries expect him to continue his crusades, regardless of the obstacles, and he intends at least to try.

Even though he lost the GOP nomination to Texas Gov. George W. Bush, "I think there was a certain authentication of the things I believe in," McCain said in an interview. "Obviously, I feel I have something of a larger voice, but I feel the real obligation I have is to those many people who voted for me, many of them for the first time, because they wanted a better relationship with their government and their legislature."

Besides, he said, "the best cure for a recovering presidential candidate is other challenges, so I've tried to hurl myself into them."

In doing so, McCain has found himself in an alliance of convenience with Democrats in insisting on the right to get votes on specific issues--which includes campaign finance for McCain and an array of subjects for Democrats--by offering unrelated amendments to bills that are pending on the Senate floor.

This has prompted a new rift between McCain and Republicans such as Sen. Mitch McConnell (Ky.), with whom McCain has long fueded over campaign finance. It's "a little exasperating" when McCain "praises Democratic leaders for dilatory tactics that are delaying action on appropriations bills," McConnell said recently.

McCain said he agrees with Democrats on the amendment issue only so long as their purpose is to get a vote, not to impede action. "I've never tied up the United States Senate," McCain said. "All I've asked for is votes."

McCain's first tussle with Republican leaders came when he tried to bring up a proposal to bar Nevada from allowing betting on amateur sports as an amendment to a big education bill that was already targeted for amendments by Democrats. GOP leaders blocked him and he stomped off the floor in anger, vowing to continue pushing for the proposal in connection with other legislation.

More recently, McCain worked with Sen. Carl M. Levin (D-Mich.) in leading a successful bipartisan effort to scuttle a proposed deadline for withdrawal of U.S. military forces from Kosovo, which was favored by GOP leaders. Then he joined Democrats in trying unsuccessfully to defeat the GOP's choice of Bradley A. Smith, a critic of campaign finance laws, to serve on the Federal Election Commission; he was the only Republican senator to vote against Smith's appointment.

But his biggest shot across the bow of his party came when he served notice he was ready to bring up his long-stalled proposal to overhaul campaign fundraising laws as soon as possible, perhaps as an amendment to the defense authorization bill for next year.

This set off a scramble among GOP leaders, including a clearly perturbed Armed Services Committee Chairman John W. Warner (R-Va.). Warner argued that McCain, a senior member of Warner's committee and a strong military advocate, had a stake in military reform proposals in the bill. But McCain remained resolute in pushing for a campaign finance vote in any way he can, and it appears that action on the defense measure may be delayed.

McCain says he would agree to a debate of no more than 15 minutes so long as he gets an up-or-down vote. This may sound simple, but it is precisely what Majority Leader Trent Lott (R-Miss.) and other foes of his campaign finance bill don't want. The legislation has the support of more than 50 senators and would pass if its foes give up their right to a filibuster, which takes 60 votes to break.

The bill, which would shut off the flow of unregulated cash to political parties, has no greater chance of clearing the 60-vote hurdle than it had when McCain forced it to a vote on earlier occasions. But it was a mainstay of McCain's campaign, and he has pledged to keep pushing for its passage, no matter what.

Campaign finance and the whole array of information technology issues that he oversees as chairman of the Commerce Committee, including Internet access and privacy, industry consolidation and "smut" control, still rank as his top priorities.

But overhaul of Social Security, which he championed in the campaign, has also moved to the top, he said. He has joined with Democratic Sens. Daniel Patrick Moynihan (N.Y.) and Bob Kerrey (Neb.) in proposing a bipartisan commission to draft Social Security reforms, and he plans to outline a proposal of his own shortly.

Another big--and relatively new--priority for McCain is legislation to expand the rights of patients in managed health care plans. During last

year's Senate debate on the subject, he voted with other GOP senators in favor of a more limited patients' rights plan.

But McCain says he heard "enormous frustration and anger out there" in the country over treatment of patients in health maintenance organizations and now plans to take a more aggressive role in pushing for legislation to regulate the industry, which is stalled in a House-Senate conference.

Still another new cause for him is education reform, including an experiment to test vouchers for private as well as public schools, which he developed in response to voter interest during his campaign.

As for global warming, he said his appreciation of the problem has changed, although he has yet to decide what should be done. "I have a much greater level of concern, although I don't have enough information yet for an informed decision," he said.

Even gun control has risen as a priority for McCain as a result of the campaign, especially in California. While he did not support the Democratic proposal to require background checks for all firearms sales at gun shows last year, he now thinks Congress should approve the Senate version of the legislation, including the gun show provision.

Meanwhile, McCain is planning to return to the campaign trail on behalf of Republican candidates for the House and Senate, including most Senate Republican incumbents who are in serious reelection battles. They requested his help and he's happy to oblige.

"I think I'm at about step eight in the 12-step recovery process," he joked.

Privacy Statement
Straight Talk America PAC | 200 G Street NE | Suite 200 | Washington, DC 20002
(202) 547-1900 **info@stapac.com**

An Integrated Web Strategy / VirtualSprockets Production

Copyright 1999 Madison Newspapers, Inc.
Capital Times (Madison, WI.)

October 13, 1999, Wednesday, ALL EDITIONS

SECTION: Editorial, Pg. 10A

LENGTH: 373 words

HEADLINE: HMOS USING SCARE TACTICS

BODY:

Those who stand to gain if any meaningful health reform legislation is once again defeated by Congress are back at their old tricks.

Last time it was the insurance companies with their infamous "Harry and Louise" ads that succeeded in scuttling health care reform with falsehoods and innuendo.

This time it's the HMOs, many of them run by some of the country's biggest insurance companies, who are pulling out all stops now that the Republican-controlled House has seen fit to pass a patient's bill of rights, including the ability to sue an HMO for shoddy practices.

The HMOs are flooding the TV airwaves with ads depicting, among other things, sharks chomping at fish. The voice on the ad implies that's how the lawyers are going to use your health plan as bait if the bill of rights becomes law, smothering the HMOs in court costs and increasing the cost of health premiums.

Let's hope that this time neither the American public nor members of Congress fall for these outrageous scare tactics.

One state that has had experience with HMO lawsuits, **Texas,** has had about half a dozen suits filed in the two years since it allowed them. And HMO premiums there aren't any higher today than they were in 1995.

What the ability to sue is more likely to do, however, is make HMOs more responsive to their customers, perhaps being more careful before arbitrarily denying medical procedures or overturning doctors' recommendations all for the sake of the bottom line.

The HMOs have brought the necessity for a patient's bill of rights on themselves. They have mistreated patients, refused to negotiate with doctors and have arrogantly insisted that only they know best.

Meanwhile, health costs are again soaring, and yet millions more Americans are not even being insured.

We would still like to see a nationwide single-payer health insurance plan that would insure everyone in this, the world's richest country, much as Social Security and Medicare insure our elderly.

Short of that, though, let's get on with the House-passed bill of rights that is at least a small step in the right direction to protecting more of the people who need it most.

And let's tell the HMOs and their ad pitchmen to quit lying.

LOAD-DATE: October 14, 1999

FOCUS™
Search: General News;patients' bill of rights; Focus:texas

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Danielle
Wyndham
West Shore Hotel
1813 286 4400
4860
West Kennedy

Copyright 1999 The New York Times Company
The New York Times

View Related Topics

October 27, 1999, Wednesday, Late Edition - Final

SECTION: Section A; Page 1; Column 6; National Desk

LENGTH: 1394 words

HEADLINE: CLINTON TO UNVEIL RULES TO PROTECT **MEDICAL PRIVACY**

BYLINE: By ROBERT PEAR

DATELINE: WASHINGTON, Oct. 26

BODY:

President Clinton will soon announce sweeping new Federal rules to protect the privacy of billions of medical records and will assail Congress for failing to enact any safeguards, Administration officials said today.

The proposed regulations would be the first comprehensive Federal standards specifically intended to protect the confidentiality of medical records. The move comes at a time when doctors, hospitals, pharmacists and health maintenance organizations are sharing more and more data, often without the knowledge of patients, and insurance companies are demanding more information to justify the payment of claims.

Consumer advocates support most of the Administration's proposals. But the proposed rules have generated criticism from insurance companies and hospitals, which say the rules would be costly to carry out. Law-enforcement officials have also expressed concerns because they believe the rules could require them to obtain search warrants in cases where warrants are not now required. And psychiatrists have criticized the rules, saying they may unintentionally weaken a patient's control over medical records.

The proposed rules would cover any medical records that are kept or transmitted electronically, as well as paper printouts of electronic transactions. Patients would generally have a right to review and copy their medical records, and to supplement the records or correct mistakes, Administration officials said. Doctors, hospitals and insurers could not disclose personal health information except for certain specified purposes like medical treatment and the payment of claims.

Most medical records are still kept on paper, but a growing number of health plans require doctors to submit claims electronically. In practice, health care experts said, the proposed rules would set standards for all medical records because it is not practical for doctors and insurers to follow different policies for the use of personal medical information kept in different forms.

Congress has been trying to write such protections into law, but the effort has stalled because of profound disagreements between privacy advocates and the health care industry. In 1996, Congress imposed a deadline on itself, requiring the Secretary of Health and Human Services to issue privacy rules if lawmakers failed to pass health privacy legislation by Aug. 21, 1999. The Administration's new proposals carry out that requirement.

The public will have an opportunity to comment on the proposed rules. Under the 1996 law, the Secretary of Health and Human Services must issue final rules by Feb. 21 next year.

In offering the proposed rules, White House officials said, Mr. Clinton will try to achieve three political purposes. He will put pressure on Congress to pass legislation, to provide a solid statutory framework

for the new standards. He will present himself as a champion of privacy rights, a politically popular cause. And, by making aggressive use of his power, he will try to counter the perception of himself as a lame duck.

The President expressed impatience on Monday, when he criticized Republicans for blocking his proposal to provide prescription drug benefits under Medicare. In a fleeting reference to his next initiative, Mr. Clinton said: "Because they have not taken action to protect the privacy of medical records, I will use the power of my office to do that in the coming days."

Chris Jennings, the health policy coordinator at the White House, said: "We would have preferred that Congress pass bipartisan legislation. They gave themselves three years to do it. But in the absence of action on Capitol Hill, the President will act."

Federal officials are still analyzing the cost of their proposals. A recent study by the Blue Cross and Blue Shield Association said that compliance with such standards could cost tens of billions of dollars because health care providers, health plans and insurance companies would have to retrain employees, hire privacy experts, rewrite contracts and reprogram computers.

Administration officials are compiling data to try to undercut those cost estimates.

The rules appear stricter than the comparable provisions of a landmark bill hammered out last week to overhaul the nation's financial system. Under that bill, divisions of a big financial conglomerate -- for example, an insurance company and a consumer bank -- could share information about a customer under many circumstances, and they would have to inform customers at least once a year of their policies on privacy and disclosure.

Under the **medical privacy** rules, an insurer would also have to inform the subscriber of its privacy practices, but it would be more difficult for the insurer to share health information with an affiliated company. In most cases, the insurer would have to get the consumer's permission before allowing use of the data for purposes unrelated to medical treatment or the payment of claims.

The proposed rules will probably not go far enough to satisfy psychiatrists, but may go too far for some law-enforcement officials.

Dr. Paul S. Appelbaum, vice president of the American Psychiatric Association, said: "The Administration's proposal would protect notes taken by a therapist in the course of psychotherapy, and that's good. But it would take away some of the power that patients have traditionally had to decide when and if their records are released to third parties. Under these rules, much information could be disclosed without the patients' consent to anybody involved in their care."

In general, law-enforcement agencies would need a search warrant, a subpoena or some other legal authorization to get confidential medical records. Federal, state and local law-enforcement officials said they wanted to preserve their ability to get immediate access to medical information without a warrant in emergencies -- when they are investigating a bomb threat or trying to rescue hostages, for example.

John R. Justice, chairman of the National District Attorneys Association, said investigators often did not have enough time or specific information to get a warrant for medical records in "exigent circumstances." For example, he said, the police may want to know about the health problems of a person who is holding hostages or being held hostage.

Experts on health privacy in and out of the Government said the rules also included these provisions:

*Health care providers and H.M.O.'s would not have to get a patient's consent before disclosing information needed for medical treatment or the payment of claims. But they would have to get the patient's consent if the information was to be used for marketing and certain types of research.

*The Federal rules would establish minimum protections for patients' privacy and would not override

any contrary provisions of state law that were "more stringent" than the Federal requirements.

*Before disclosing data, doctors would have to take reasonable steps to make sure they did not disclose more information than was needed to accomplish the purpose of the request. The rules would forbid the wholesale release of entire records when a small part would suffice.

*Doctors, hospitals and health plans could charge a reasonable fee to cover the cost of copying records.

Under Federal law, doctors and hospitals can be fined up to $50,000 for the improper disclosure of confidential medical information, and they are subject to larger fines if they sell such data for "commercial advantage" or "malicious harm." Under the proposed rules, patients would not gain any new Federal right to sue a doctor or an H.M.O. for divulging medical records. Federal officials said only Congress could create a new right to sue.

The proposed rules would provide additional protection for some sensitive personal information in mental health records, but not as much protection as many psychiatrists want.

Under the proposal, a psychotherapist would not need a patient's consent to disclose information about the diagnosis of a condition, the patient's level of functioning or medications when such information was necessary for treatment or for the payment of claims. But the therapist would have to get the patient's consent before disclosing more detailed information about a patient's feelings or sexual relationships.

http://www.nytimes.com

LANGUAGE: ENGLISH

LOAD-DATE: October 27, 1999

FOCUS™
Search: General News;medical privacy

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

LANGUAGE: ENGLISH

LOAD-DATE: November 1, 1999

FOCUS™
Search: General News;medical privacy

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1999 The New York Times Company
The New York Times

View Related Topics

November 1, 1999, Monday, Late Edition - Final

SECTION: Section A; Page 22; Column 1; Editorial Desk

LENGTH: 538 words

HEADLINE: Protecting Patient Privacy

BODY:

With Congress deadlocked on how to protect **medical privacy,** the Clinton administration has taken an important but incomplete first step in addressing the problem by proposing new federal regulations. Under the 1996 Health Insurance Portability and Accountability Act, Congress was supposed to pass a **medical privacy** law by August 1999. Because Congress failed to meet that deadline, the administration is required to develop regulations. The issuing of administrative rules, however, does not diminish the need for Congress to pass comprehensive legislation.

Dramatic changes in the medical industry mean that the flow of medical information is no longer limited to private notes jotted into a patient's folder at the doctor's office. The rise of computerization and health care networks serving hundreds of thousands of patients have made it possible to compile detailed patient information in databanks that can be shared by doctors, insurers, researchers, employers, pharmacists and others. This offers useful ways to track medical outcomes, monitor patient care and assess physician competence. But it can also result in a loss of confidentiality, a prospect that is causing justified concern about an erosion of privacy between doctors and patients.

Currently there is no federal law prohibiting the disclosure of personal medical records to employers, marketing firms and other entities for reasons unrelated to medical care without a patient's knowledge or consent. Some states do have privacy laws, but the patchwork of state laws can lead to confidential information being passed on for inappropriate uses.

The new federal rules would prohibit all health plans, hospitals and doctors from releasing identifiable patient records for reasons unrelated to treatment, payment or health care operations without getting consent. The rules would give patients the right to know who has received their private information, and would give them access to their own files and the right to make corrections. They would also require that health plans and providers create internal systems to ensure that records are secure, and would impose civil and criminal penalties for disclosure violations.

That is all to the good. But some medical groups, like the American Psychiatric Association and the American Medical Association, say the regulations still allow too much disclosure of information without the patient's consent for treatment, payment and health operations purposes. The issue of whether the patient should be given more say needs further airing. The rules may need to be tightened before they become final.

These regulations can only be considered a partial solution. Because the administration is operating under limited statutory authority, the rules only apply to electronic records, not paper files. They do not directly govern how employers, life insurers or public health agencies handle medical information. Nor do they allow individuals harmed by a disclosure of confidential information to sue.

Those broader protections are only possible through Congressional legislation. The administration's proposed regulations offer a good baseline on which to build stronger privacy rights for patients.

http://www.nytimes.com

standpoint of the economy as a whole, it could mean not only a huge drop in purchasing power but a massive waste of resources. Today, Internet start-ups with no idea of how to make a profit are able to raise billions in financial markets. Meanwhile, many industrial firms with real products and customers are being starved for capital.

This sort of crowding out of productive investment is every bit as harmful when carried on through financial market euphoria as when it occurs via huge government deficits. As long as resources that could be invested productively are instead directed to wasteful ventures, the whole economy will pay a price. It took the New Deal and World War II before the economy recovered from the last great crash. Have we learned enough since then to avoid or mitigate another crash—or have we forgotten what we learned? ◆

DEAN BAKER is the co-director of the Center for Economic and Policy Research and the author of the *Economic Reporting Review* (www.fair.org), a weekly online commentary on the economic reporting in *The New York Times* and *The Washington Post*.

Bargaining Chip

BY JOSHUA GREEN

In his continuing effort to cater to swing voters, George W. Bush is venturing ever further onto Democratic turf. For example, his campaign touts the governor's support for the Children's Health Insurance Program (CHIP), intended to help working families who make too much for Medicaid but too little to afford private health insurance. "When the CHIP program was first implemented," a press release reads, "Governor Bush embraced it as an opportunity to help deliver health coverage to more than 423,000 children."

Those are impressive numbers. And the need is plain in Texas, where a quarter of the residents—1.4 million of them children—lack health insurance. But Bush's actual record on CHIP is anything but supportive. As previously reported, Bush fought doggedly, but unsuccessfully, to limit the number of Texas children the program would cover. One reason was Bush's desire to keep money free for a big tax cut. But another key reason has received less attention: Bush's desire to prevent more children from getting Medicaid.

CHIP and Medicaid are inextricably linked because eligibility for one program kicks in where the other ends. Many families applying for CHIP discover that while they don't qualify for that program, they are eligible for Medicaid. This is known as the "Medicaid spillover" effect. And it's particularly important in Texas, which offers little Medicaid outreach and thus has many eligible families who aren't in the program. Normally, one would consider insuring more kids to be a positive development—unless, of course, one happens to be a conservative Republican governor running for president. Not only does a Medicaid recipient cost Texas more than a CHIP recipient does, but Medicaid is an entitlement whose numbers in Texas have been falling for years—one of Bush's proudest accomplishments as governor.

THOUGH GEORGE W. BUSH NOW CLAIMS CREDIT FOR INSURING TEXAN CHILDREN, HE WAS PRACTICALLY ALONE IN TRYING TO LIMIT COVERAGE.

The spillover from a broad-based CHIP program threatened to reverse that trend. "The mantra among Bush staffers during the legislative process was, 'Keep the lid on any program that will expand government,'" says Democratic state representative Glen Maxey of Austin. "That translated to, 'Keep children off Medicaid at all costs.'" Says another representative, "I was told that Medicaid costs were not to go up while Bush was considering a run for the presidency."

Bush also helped pare Medicaid rolls by refusing to simplify Medicaid applications, as health care advocates had urged. While parents can apply for CHIP by phone or mail, Texas requires Medicaid applicants to appear in person, fill out a stack of forms, and repeat the

EYEWIRE

process every six months. (Texas is also one of only a handful of states that still requires an asset test, which can disqualify otherwise eligible families for owning a second car or even a cemetery plot.) As a result of these multiple obstacles, roughly 600,000 children who qualify for Medicaid don't get it.

Bush dragged his feet on implementing CHIP for as long as he could, thereby putting off the uptick in Medicaid enrollment. Rather than formulate a CHIP program, Bush waited a year until the state legislature came back into session and lawmakers wrote their own. When they set to work, Bush fought to limit the program's size and cost. Though federal law allows states to extend CHIP benefits to families earning up to 200 percent of the federal poverty line, Bush initially wanted benefits held to only 133 percent. The legislature unanimously passed a bill to cover the full 200 percent, but only after heavy resistance from the governor. Though Bush now claims credit for insuring children, he was practically alone in trying to limit coverage. There was no organized legislative opposition to fully funding the program. "The only impediment was Bush's presidential campaign," says Maxey.

This record hardly squares with Bush's theme of compassionate conservatism. So it's no surprise that Bush never took a public stand to limit CHIP. In effect he wanted it both ways—no programs, but also no bad press for standing in their way. Bush's representatives made sure the message got through to legislators. "The governor didn't want any entitlements, period," says state representative Garnet Coleman, a Democrat from Houston. "To that effect, he employed a passive-aggressive style of mitigating the value of the health care legislation while he himself was removed from the process."

A bit of political horse trading finally convinced Bush to sign the bill, and the deal speaks volumes about where children's health care fell on Bush's list of priorities. According to state legislators and policy analysts with close knowledge of the negotiations, Bush finally agreed to the bill in exchange for a raft of tax breaks for Big Oil. "Bush wanted an emergency bailout of Exxon and Mobil that consisted of around $86 million in tax breaks to major oil companies," says one state representative. "Liberals went along with this in return for Bush's signature on a bill that covered kids up to 200 percent, covered state employees, and covered legal immigrants. It was the most progressive victory in the state legislature in the last 10 years. And Bush fought it all the way."

By stalling on CHIP, Bush succeeded in limiting the number of Medicaid recipients. The first child was not insured under CHIP until April 2000, long after children were being covered under the program in other states. By the end of June, only 28,312 Texas children were covered out of the 500,000 believed to be eligible. "Was a tax cut [for oil companies] more important than children's health?" wonders Coleman. "For Bush's political purposes, yes." The Bush campaign concedes that the oil company bailout was one of Bush's key legislative priorities, while denying there was any quid pro quo. The governor's representatives also claim that the delay in implementing CHIP was not a matter of foot dragging but rather a result of the fact that the Texas legislature meets only every other year. To implement the program any more quickly Bush would have had to submit an emergency measure. In fact, he did submit such a measure in February of 1999—not for CHIP, but for his prized oil company bailout. ◆

Candidate of the Century

BY CHRISTOPHER B. DALY

As the Republicans prepared for their national convention, the party's official Web site welcomed party members to Philadelphia and pointed out helpfully that the city has two airports. In a telling aside, the GOP planners also noted that one of the airports could "accommodate private and corporate planes."

Once they get off their jets, the Republicans will engage in ideological time travel and proceed to hash out a platform from the days of the horse and buggy. The official statement of party principles, full of platitudes and hedged with the rhetoric of compromise, is likely to be soon forgotten. But before that happens, it's worth imagining how the platform would read if it were put in plain English and boiled down to its essentials. The bumper-sticker version might be: REPEAL THE 20TH CENTURY! If you listen to the speeches and read the position papers of George W. Bush, it becomes clear that the Republican candidate and his supporters want an America that looks like this:

- Income taxes are dramatically lower—or, better yet, don't even exist. Consequently, the federal government is drastically smaller.
- Abortion is a crime and, thus, very rare. (Bush would make exceptions for rape and incest.)
- There are no restrictions on private gun ownership.
- American public schools do not teach biological evolution, and they require daily recitation of Christian prayer. (Actually, Bush has refined his position to accommodate the reality of court rulings. In a June 19 statement, he said: "I support the constitutionally guaranteed right of all students to express their faith freely and participate in voluntary, student-led prayer.")
- There is no such thing as affirmative action, quotas, or minority set-asides. Instead, everyone is free to use whatever connections they have to get ahead and need not worry about discrimination.
- Christian leaders confidently and successfully assert their values. A militant clergy does not hesitate to shape legislation or to censor unwelcome views.
- Homosexuality is shameful, sinful, and—on the whole—criminal.
- The government does not meddle with the free enterprise system, leaving businesses unencumbered by rules and regulations.

10 of 61 results Previous Story | Next Story | Back to Results List

10-21-1999

ACCESS/QUALITY/COST - CHIP & MEDICAID: TX LEADS NATION IN UNINSURED CHILDREN

A disheartening new study reveals that, in the twelve states with the largest number of uninsured residents, fewer children were covered in 1999 by Medicaid and CHIP than were covered in 1996 by Medicaid alone. The study, released Wednesday by "consumer watchdog group" Families USA, reported that although CHIP participation has increased significantly in recent months, coverage gains were more than offset by reductions in children's Medicaid coverage -- largely due to welfare reform (Families USA release, 10/20). The report, which studied Arizona, California, Florida, Georgia, Illinois, Louisiana, New Jersey, New York, North Carolina, Ohio, Pennsylvania and Texas, discovered that children's enrollment in federal-state health insurance programs declined by 219,910 from 1996 to 1999, with the ranks of uninsured children increasing by 14.2% in Texas alone. From December 1998 to June 1999, CHIP enrollment in these states, which accounts for nearly two-thirds of the nation's uninsured children, increased by more than 55%; but from 1996 to 1999, the 12-state Medicaid enrollment dropped from 11 million to 10 million. "We are taking an impressive step forward in covering children through the Children's Health Insurance Program," said Families USA Executive Director Ron Pollack, "But due to the state's shoddy implementation of welfare reform, we are taking an even larger step backwards in covering kids" (Families USA release, 10/20). The full report and state specific information can be obtained on the Families USA web site, www.familiesusa.org.

WELFARE TO BLAME

Families USA blames the coverage decline on the 1996 welfare reform law, which "delinked" welfare programs and Medicaid. Consequently, eligible children are either dropped from Medicaid coverage or never enrolled. Senate Health, Education, Labor and Pensions ranking member Edward Kennedy (D-MA), who spearheaded CHIP, noted, "At least half of the children who lose Medicaid when their family moves from welfare to work are likely to remain uninsured" (CongressDaily/A.M., 10/21). An unrelated study by the Center for Budget and Policy Priorities (CBPP), a "liberal research group," concurs with the Families USA findings. The CBPP report, which examined low-income children in 1996 and 1998, found that there were "7 million low-income uninsured children last year, a number that has not changed over two years, despite low unemployment and the creation of [CHIP]" the AP/Worcester Telegram & Gazette reports. Moreover, the study found "sharp declines" in the number of poor children on Medicaid -- as states enroll children in CHIP, they are simply replacing (at least numerically) those who lose Medicaid coverage. The CBPP study concludes, "The nation is losing a significant

opportunity to reduce the number of low-income children without health insurance" (10/21).

BAD NEWS FOR BUSH

With over 1.4 million Texas children uninsured, the study results quickly became political ammunition for opponents of state governor and GOP presidential hopeful George W. Bush. Vice president Al Gore's camp commented, "Today's report is further evidence that the governor's batting average, when it comes to children, is bush league -- last in environment, last in children's health care coverage and near last in the quality of life for our kids." Bush spokesperson Mindy Tucker responded that Gore was overlooking the 69% of Texans, "who just last year overwhelmingly approved of Gov. Bush's record of ... expanding health care coverage for children ..." (Lee, Dallas Morning News, 10/21).

PRIVATE SOLUTION? DELL STEPS IN

While the politicians duke it out, Texas computer tycoon Michael Dell will be forking it out -- Dell and his wife have pledged to help pay for insurance coverage for children in two Texas counties until the state's full CHIP implementation, scheduled for May 2000. The AP/Dallas Morning News reports that, with the Dells' donation, eligible families "can apply for medical and dental insurance that will cost between $15 per year and $18 per month per family, depending on income." In an effort to "jump-start" Texas CHIP enrollment, the Dells have also pledged an additional $1.9 million of their personal fortune to a sign-up campaign (10/21).

American Healthline

10 of **61** results Previous Story | Next Story | Back to Results List

American Health Line
A Daily Briefing on Health Care Politics and Policy

6 of 61 results Previous Story | Next Story | Back to Results List

04-11-2000

CAMPAIGN 2000 - TEXAS: HIGH UNINSURED RATE UNDERSCORES BUSH'S RECORD

The importance of health care in the election agenda may not bode well for GOP presidential candidate George W. Bush, who, as governor of Texas since 1995, "has not made health a priority," the New York Times reports. Currently more than one-quarter of Texans are uninsured and the state is home to some of the nation's highest rates of AIDS, diabetes, tuberculosis and teenage pregnancy. According to the Kaiser Commission on Medicaid and the Uninsured, 27.5% of Texans ages 19 to 65 lacked insurance in 1998, compared to the national uninsured rate of 19.7%. In 1994, one year before Bush became governor, 27.8% of Texans were uninsured compared to 18.6% nationally. Despite the opinions of most public health experts in the state, the Bush-appointed Texas Commissioner of Health, Dr. William Archer, downplayed the role of health insurance and indicated that the uninsured still were receiving care. He said, "I think insurance is important. But I don't think it's the most important thing." Archer also has accused Texas physicians of opposing preventive care because it will hurt their practices down the line. Archer also has stirred some controversy by attempting to shift away from traditional services offered by his office and focus on the cultural causes of unhealthy behavior. He indicated that part of the state's high teen pregnancy rate stems partly from the large Hispanic population that does not believe "that getting pregnant is a bad thing." Archer said, "If I were to go to a Hispanic community and say, 'Well, we need to get you into family planning,' they say 'No, I want to be pregnant,' it doesn't work very well." Archer also defended the state's unsuccessful effort to enroll the 598,000 children eligible for Medicaid into that program. He said, "The problem is that the Legislature knows that if we are successful, and we got all those kids registered, they would not balance their budgets any more. It's not one person saying, 'Don't do this.' It's not one agency saying,'Don't do this.' It's sort of 'Why would we all rock the boat at this point?'"

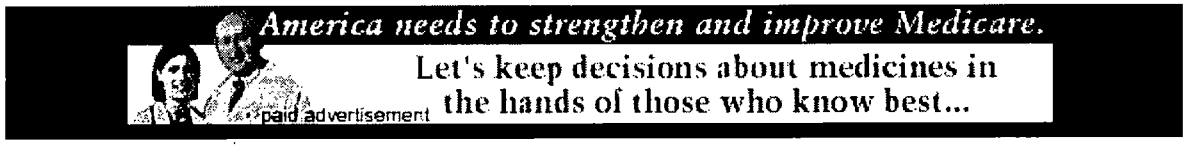
UNINSURED KIDS

Most health professionals disagree with Archer. Clair Jordan, executive director of the Texas Nurses Association said, "Uninsured children end up in the most costly place, the emergency room." State Rep. Elliot Naishtat (D) agreed: "The biggest health problem in Texas is the exorbitant number of people, primarily children, who have no health insurance." One of the biggest barriers to Medicaid enrollment, according to the Henry J. Kaiser Family Foundation's Executive Vice President Diane Rowland, is that the application process makes Texas "one of the most difficult states for someone to figure out how to get enrolled." However, the number of the state's uninsured children

may soon drop, as Texas officials will finally expand efforts to enroll children in the Children's Health Insurance Program (CHIP) enacted by President Clinton in 1997. Bush originally fought to limit coverage to children whose families' incomes were 150% of the federal poverty level, while the federal program allowed children up to 200% of the poverty level to enroll. At a recent press conference, Bush would not explain why he pushed for 150%, but said, "I signed the 200% bill." State officials estimate that nearly 420,000 children will be enrolled in CHIP over the next year (Clymer, 4/11).

American Healthline

6 of **61** results Previous Story | Next Story | Back to Results List



American Health Line
A Daily Briefing on Health Care Politics and Policy

3 of 61 results Previous Story | Next Story | Back to Results List

06-14-2000

STATELINES - TEXAS: HEALTHY KIDS PROGRAM FACES FINANCIAL WOES

Thousands of children enrolled in Texas Healthy Kids Corp., a joint public-private effort launched three years ago to provide coverage for the uninsured, will have to find a new insurer next month due to a shortfall in program funding, the Wall Street Journal reports. The Texas Legislature authorized state funding for Healthy Kids in 1997 with the expectation that private donations would subsidize the remaining costs, but the program managed to raise only about $400,000 in private contributions during its first two years -- "far below" its goal of $8 million. Also, enrollment turned out to be much lower than organizers of the privately run not-for-profit agency had anticipated. Consequently, Healthy Kids officials say they do not have enough private funds to pay for "sharp" rate increases set to take effect July 1 and thus, will have to drop many of the program's 11,233 enrollees who will not be able to afford higher premiums. To address the situation, Texas Insurance Commissioner Jose Montemayor plans to survey the state's insurance companies to determine "what coverage is available for children in the program." He will present his findings at a meeting on June 27. Most Healthy Kids enrollees should be able to secure coverage through the Children's Health Insurance Program, but about 550 do not qualify for the state-federal health coverage. Several insurers that offer child-oriented plans may be able to cover former Healthy Kids members. Still, the Wall Street Journal reports that those options do not "do anything for many of the children without insurance that Healthy Kids was supposed to help but never enrolled." About 350,000 families with children earn too much to qualify for CHIP.

HEALTHY COMPETITION?

Officials attribute the fundraising troubles and low enrollment to competition from the "larger and better-financed" CHIP, which was established in Texas shortly after the launch of Healthy Kids. While Healthy Kids has no income limit and charges $58 to $113 a month for coverage, low-income CHIP beneficiaries pay only $15 a year and higher income families pay only $18 a month plus co-payments. CHIP also offers "slightly more expansive benefits" than Healthy Kids (Elder, 6/14).

MORE CHIP?

Meanwhile, some health advocates want the state to expand eligibility for CHIP and to allow parents of eligible children to enroll as well. Currently, children in a family of four earning up to 200% of the federal poverty level, or $34,100 annually, qualify for coverage, but advocates are pushing lawmakers to raise income limits to 250% of poverty guidelines, or $42,624. The increase would render an additional 160,000 to 180,000 children eligible. Analyst Lisa McGiffert of the Consumer's

Union said, "This is a really smart way to cover more people without creating a new program." The proposal is just one of several under consideration by the state's Blue Ribbon Task Force on the Uninsured, which will make recommendations this summer on how to provide coverage to uninsured Texas, who make up 25% of the state's population. Other proposed plans include: expanding Medicaid coverage to more adults and providing access to prescription drugs for HIV/AIDS patients and the mentally ill; requiring proof of health insurance at the time of car registration; and mandating coverage for all college students. The uninsured are a "difficult problem in a state as big and diverse as Texas," state Sen. Chris Harris (R), chair of the task force, said, adding, "I hope to make some real headway in this problem" (Merle, Wall Street Journal, 6/14).

American Healthline

3 of **61** results Previous Story | Next Story | Back to Results List

For People in the Know

American Health Line
A Daily Briefing on Health Care Politics and Policy

1 of 61 results | Next Story | Back to Results List

07-13-2000

CAMPAIGN 2000 - TEXAS & CHIP: SALON QUESTIONS BUSH STATEMENTS

Attempting to tell the "whole story" of Texas Gov. George Bush's (R) record with the state's Child Health Insurance Program, Salon.com's "Lie of the Week" column -- which highlights inflated or misleading campaign messages by both Vice President Al Gore and Gov. Bush -- last week skewered Bush. Salon columnist Micah Marshall writes that Bush "loves to promise crowds that 'we'll love the babies.'" According to a Bush press release, "When the CHIPs program was first implemented, Gov. Bush embraced it as an opportunity to help deliver health coverage to thousands of uninsured children and signed legislation providing health insurance for more than 423,000 children." But Marshall asserts that this is not true, saying that Bush fought "tooth and nail" to limit the federal matching program's eligibility to 150% of the poverty level, "denying coverage to roughly 200,000 Texas children." Ultimately, the governor lost the battle and signed legislation with the "more generous" 200% eligibility level. The assertion that Bush "embraced" the program is, therefore, "a bit of a stretch," Marshall argues. According to Dan Bartlett, Bush's press spokesperson, Bush simply "followed the lead" of the state legislature's Interim Committee on Children's Health Insurance, which recommended a 150% eligibility cap. When the legislature approved a bill with a higher limit, Bartlett said, the governor "eagerly signed" it. But Democratic state Rep. Glen Maxey, an interim committee member, called Bartlett's explanation a "blatant, outright lie, a Texas tall tale," adding that the committee never recommended a 150% level. Rather than following the committee's lead, Maxey said, Bush "slow-rolled the process so that the program wouldn't get up and running until roughly a year after it could have gone into effect." Eager to avoid higher Medicaid rolls in an election year, Maxey said Bush wanted to prevent the "Medicaid spillover" that could occur with a less restrictive children's program. This would happen when parents, while enrolling their children in CHIPs, realized that they were eligible for Medicaid benefits, Maxey notes. "Bush worked pretty hard to cover as few kids as possible under the CHIPs program," Marshall concludes, calling Bush's press release on the matter not "just a stretch. It's a lie" (Marshall, Salon.com, 7/7).

American Healthline

1 of 61 results | Next Story | Back to Results List

[redacted]

Now, as Bush makes Latino outreach a cornerstone of his campaign, he continues to walk a tightrope in regards to benefits for immigrants. "I think it's very fair to say that the governor's office has been eager to never take a position that's overtly opposed to immigrants, but they've also not supported proactive initiatives to help the policy," said Anne Dunkelberg, senior policy analyst for the Center for Public Policy Priorities in Austin, Texas.

The center's nutrition-policy analyst, Celia Hagert, said that in 1999 there was a push to cover an additional 7,300 legal immigrants who were not picked up by the 1998 federal legislation. That bill would have covered children and seniors currently living in Texas who arrived after the August 1996 cutoff date, and to lower the senior eligibility age from 65 to 60. That measure never got out of the Legislature after clearing some preliminary votes.

"Had we gotten more support from the governor's office, it probably would have passed," said Hagert. "His office indicated to us that he would not support that bill."

Although Hagert says there is no way of knowing how many formerly eligible immigrants are now uncovered, there were approximately 168,000 receiving food stamps before the welfare act passed in 1996. Now, there are only 52,000 currently getting benefits in Texas, though a booming economy may have eliminated some of the demand.

▸ More news on Gun Control

Print story

E-mail story

Though Bush has not supported many of the center's initiatives, Dunkelberg did give the governor partial credit for instituting the state-funded program in 1997. "One of the first things to remember about Texas is that we're one of those states that doesn't have any state funded [welfare] programs," she said.

But now that the federal government has made welfare the charge of the states, Dunkelberg said next year's legislative session will be pivotal in determining the

Mothe Who Th Tuesd Spotli
CLICK HE

New York's party convention officially nominates the first lady for the U.S. Senate while a certain mayor goes unmentioned.
By Jesse Drucker
[05/17/00]

The blundering pundit
Dick Morris' predictions about the New York Senate race have all been off the mark.
By Eric Boehlert
[05/16/00]

Don Giuliani
A masterwork given new meaning.
By Jake Tapper
[05/16/00]

Campaign video:
George W. Bush talks about why John McCain's endorsement is important to him.

legislative session will be pivotal in determining the future of welfare in Texas. "One of the things the welfare reform act did was tell states that pre-August '96 and post-August '96 immigrants get treated completely differently. The question is what kind of benefits we are going to provide after the five-year time limit is up. Are you going to provide these benefits after that five-year bar is up. Nobody is up until 2001."

"We just got around to enacting a new children's health insurance program, and as part of that package, we included a provision to pick up any of those kids who arrived after August '96. We asked the governor's office to support the bill, but they politely declined."

salon.com | March 29, 2000

About the writer
Anthony York is an associate editor for Salon News.

Sound off
Send us a Letter to the Editor
Send e-mail to Anthony York

Get a printer-friendly version

E-mail a friend about this article

Backflip this article to find it again

Search Salon

Search
Advanced Search | Help

FREE
Step-By-Step
Stock Evaluation
www.quicken.com

Copyright © 2000 Salon.com All rights reserved.

CLICK HERE FOR CONVENTION COVERAGE
salon.com
< click now >
essay contest
POLITICS!
Search About Salon Table Talk Newsletters Advertise in Salon Investor Relations

Search
All of Salon.com
Only Politics
The Web with
Ask Jeeves
OK
Directory
Hot Topics
Religion
Pat Buchanan
George W. Bush
Campaign Finance
Hillary Rodham Clinton
Death Penalty
Ross Perot
Al Gore
Gun Control
Ralph Nader
Articles by date
All of Salon.com
SALON.COM SITES
Arts & Entertainment
Books
Business
Comics
Health
Mothers Who Think
News
People
▸ Politics
Sex
Technology
- Free Software Project
Letters
Columnists
Table Talk
Salon Plus
Salon Shop
Salon Radio
PARTICIPATE

Lie of the Week

Such a kidder!

George W. "We'll love the babies" Bush says he's a champion of children in Texas. Roughly 200,000 of them might disagree.

By Joshua Micah Marshall

July 7, 2000 | All I can say is I've tried. Since Lie of the Week first launched, we've had one column targeting Al Gore and four skewering George W. Bush. It wasn't supposed to be this way. The brief from the editors was to be a switch-hitter, to nail each side. The problem was supposed be balancing out the misstatements of Gore. Isn't Gore supposed to be the fibber?

The only problem is that George W. just doesn't seem to want to cooperate. This week's Lie is a perfect example.

The latest Bush-Gore dust-up is over their competing policies for providing health insurance for children in low-income families. In particular, they're arguing over a program called CHIPs, the State Child Health Insurance Program, a program that was passed with bipartisan support in 1997 and that aimed to provide coverage for children whose parents couldn't afford private insurance but made too much money to qualify for Medicaid.

Print story
E-mail story
Backflip this article to find it again

In Bush's press release it says: "When the CHIPs program was first implemented, **Governor Bush embraced it** as an opportunity to help deliver health coverage to thousands of uninsured children, and signed legislation providing health insurance for more than 423,000 children."

Well, not exactly. Bush, who while campaigning loves to promise crowds that "we'll love the babies," did eventually

SHOP → N g
Salon Shop for inspiration.
Check o live aud video c of the Republic convention.
Seeking child care or elder care? Use our convenient Car
Get Salo your hand devi AvantGo
More great o Salon P
Mothe Who Th Tuesd Spotli CLICK HE
Current Sto
GOP-looza S the convent protests res a rock show particularly security mo they do the Seattle.
By Anthony [07/30/00

Table Talk
[Freewheeling Salon forums]

Is it time to make amends? Reparations for slavery reconsidered

With liberty and justice for some Does the Libertarian Party believe in checkbook justice?

The Constitution promises a well-informed electorate How much responsibility does the media bear?

Posts of the week

The Well
[Pioneering members-only discussions]

Tyrannical toddlers Is there parental sex after childbirth?

Sound Off
E-mail Salon
Send us a Letter to the Editor
Today's letters

WAYS TO GET SALON

Newsletter
Sign up to receive free e-mail updates from Salon -- now in 12 different varieties!

Downloads
Get Salon.com on your PDA
Salon.com headlines from My Netscape
More ways to get Salon

"sign" a bill that provided health insurance to roughly that number of kids. That's not the whole story.

First, a few details: The CHIPs program involves a mixture of federal and state money. The federal government will pay for health coverage for children whose parents make up to double what is considered the poverty line as long as the state agrees to foot a portion of the bill (in Texas' case, 26 percent of the tab). A number of Republican governors have eagerly embraced the program, most notably John Engler in Michigan, John Rowland in Connecticut, Christie Todd Whitman in New Jersey and George Pataki in New York.

But in healthcare policy circles, Bush has actually been rather notorious for trying to make sure the program covers as few kids as possible. Though the program allowed states to insure kids at up to double the poverty line -- or 200 percent -- Bush first tried to limit coverage to kids whose parents made up to 133 percent of the poverty line, later agreeing to bump it up to 150 percent. Bush fought tooth and nail with the state legislature to keep coverage to 150 percent, rather than the more generous 200 percent. In human terms, this meant denying coverage to roughly 200,000 Texas children. The legislature eventually won, and Bush signed the bill. But Bush fought it every step of the way.

So, signed it? Yes. But "embraced" it? Well, that sounds like a bit of a stretch. Doesn't it?

To clarify matters I talked to Dan Bartlett, Bush's press spokesman who covers healthcare policy matters. According to Bartlett, the charge that Bush tried to lowball the CHIPs program and keep coverage at 150 percent is just a misleading "snapshot" of the legislative process. Bush followed the lead of the legislature's Interim Committee on Children's Health Insurance, which recommended starting with coverage at 150 percent, and then later eagerly signed the bill when the full legislature decided to go with 200 percent. The key point in Bartlett's version of events is that Bush was basically just following the lead of the interim committee.

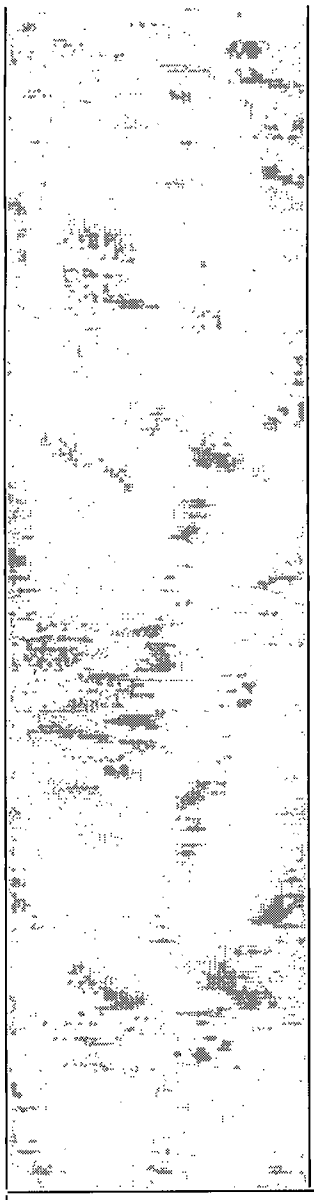
That's not how Texas state Rep. Glen Maxey sees it. Maxey, a Democrat, has worked closely on the CHIPs issue in Texas and was on that interim committee. Maxey calls Bartlett's version of events a "blatant outright lie, a Texas tall tale." The committee never recommended the 150 percent coverage level. Not only did Bush push hard for the lower coverage number, he also slow-rolled the process so that the program wouldn't get up and running until roughly a year after it could have gone into effect.

"Out of the roughly 500,000 who the program should cover, only 28,000 [have been enrolled]. Other states have been up and running for a long time. We're turning back money to the federal government," he says. (Maxey also notes that one

The long go
Sen. John M
gets booed
stumping fo
and takes a
lap on the S
Talk Express
By Alicia
Montgomery
[07/30/00

Inside the
Republican
pro-choice c
Meet the wo
who are vow
floor fight in
Philadelphia
abortion.
By Adele M.
[07/29/00

All in the fam
Dick Cheney
lesbian daug
Mary, is exp
to stump for
GOP ticket.
gay corpora
relations ma
for Coors, sh
knows all ab
the hard sel
By Dave Cu
[07/29/00



of the reasons Bush resisted the program so mightily was that the enrollment process could lead to something called "Medicaid spillover." That means that in the process of signing up for CHIPs, some parents might discover they were actually eligible for Medicaid. The last thing candidate Bush wants is rising Medicaid rolls in Texas while he's running for president.)

The bottom line seems to be that Bush worked pretty hard to cover as few kids as possible under the CHIPs program. To say that he "embraced [the program] as an opportunity to help deliver health coverage to thousands of uninsured children" isn't just a stretch. It's a lie.

Your tips

E-mail your suggestions for Lie of the Week to: lieoftheweek@hotmail.com.

salon.com | July 7, 2000

- - - - - - - - - - - -

About the writer
Joshua Micah Marshall is Washington editor of the American Prospect.

Sound Off
Send us a Letter to the Editor

GO TO: Salon.com >>

Salon News A Salon-eye view of the day's news, with investigative reports, analysis and interviews with newsmakers

Quicken.com **Everything about your portfolio in one place. FREE.** **Click here**

Salon Search About Salon Table Talk Newsletters Advertise in Salon Investor Relations

Arts & Entertainment | Books | Business | Comics | Health | Mothers Who Think | News
People | Politics | Sex | Technology and The Free Software Project
Letters | Columnists | Salon Plus | Salon Shop

Reproduction of material from any Salon pages without written permission is strictly prohibited
Copyright © 2000 Salon.com
Salon, 22 4th Street, 16th Floor, San Francisco, CA 94103
Telephone 415 645-9200 | Fax 415 645-9204
E-mail | Salon.com Privacy Policy

Copyright 2000 The Houston Chronicle Publishing Company
The Houston Chronicle

View Related Topics

August 01, 2000, Tuesday 3 STAR EDITION

SECTION: A; Pg. 23

LENGTH: 782 words

HEADLINE: Lies can't mask Bush's bad record on **Texas** kids

BYLINE: STATE REP. GLEN MAXEY; Maxey, a Democrat, represents District 51 in the state Legislature. The district covers the Austin area.

BODY:

"LEAVE no child behind?" When I was a child, my mama taught me that you don't try to lie your way out of a bad situation because you only make it worse. So, Gov. Bush, let's tell the truth about kids in **Texas.** In selecting "Leave no child behind" as the theme of the first day of its national convention, the Republican Party selected a very "compassionate" slogan. I just wish the GOP wasn't fibbing and making up tall tales to cover up what it and its nominee have failed to do for children in **Texas.** As a member of the **Texas** Legislature, I know a little about Gov. George W. Bush's record in **Texas.** I represent about 120,000 very caring, "compassionate" constituents. One of those "compassionate" constituents is Gov. Bush. I also happen to serve on the Human Services and Public Health committees in the House and have watched the governor and his administration's policies regarding children. Leave no child behind? Let's talk about the kids Gov. Bush fought to leave behind, starting with the very public debate over covering some of the 1.4 million uninsured kids in **Texas.** Congress created a **Children's Health Insurance** Program, or CHIP, for the children of working Texans with low incomes. The tobacco settlement assured that **Texas** had adequate nontax generated dollars to pay our state's share. So, it was a no-brainer to create a program to cover the maximum number of children: almost a half million who live in families below **200 percent** of poverty. Although Bush could have started planning the program a year or so earlier and just waited for the Legislature to appropriate the funds for it in the 1999 legislative session, his administration sat idly by until the Legislature mandated the program. Consequently, we are just now enrolling thousands of children left behind for over a year when the program could have been up and running last September. Most amazingly, Bush took a position and steadfastly fought to limit coverage for kids up to only **150 percent** of poverty. That position would have left behind about a quarter of a million **Texas** children. Bush even said to me upon unanimous passage of the program covering the maximum number of children: "Glen, congratulations on the **Children's Health Insurance** Program. You crammed it down our throats." He surely left me with the impression that he didn't care that he was going to leave those families uninsured. What about the hundreds of thousands of **Texas** children who have no health coverage because they have not been informed that they qualify for Medicaid? What about the thousands of children in **Texas** with asthma because of our poor air quality? More than 1,000 polluters have been "grandfathered" without permits for almost 30 years in **Texas.** When I tried to bring them into compliance with clean air standards, Gov. Bush led the fight to let them "voluntarily" clean up. The governor's staff even let the lawyer for the **Texas** Chemical Council draft his version of the bill. Those kids are left behind under a cloud of smog and health-threatening situations. What about Gov. Bush's insistence on a property tax reduction for homeowners when the Legislature wanted to guarantee funding for kindergarten and pre-school programs? (**Texas** still doesn't fund kindergarten for all our children.) Where was Gov. Bush when legislators pushed for a $ 6,000 pay raise for teachers? Well, Gov. Bush was arguing for only $ 1,500. What about Gov. Bush's long and vociferous support for vouchers so that public education dollars could flow to private schools? It was clear to the majority of the Legislature that we'd see billions of dollars siphoned away from public education, leaving many children to remain in underfunded public schools. It was pretty clear that the poorest kids would be left behind. What about Gov. Bush's veto of a bill that I sponsored setting up parental involvement programs in the public schools of **Texas?** Gov. Bush said it wasn't necessary in his veto message. What about his veto of a bill to coordinate hunger programs in

Texas? When the press inquired about hunger in **Texas,** Bush asked, "Where?" Gov. Bush should be ashamed of himself for letting the Republican National Convention distort the true record in **Texas.** Don't be fooled by cute kids surrounding him in campaign photo ops. The real picture tells a different story. Governor, I like you as a person and as a human being. But your record does not live up to rhetoric - and I don't like the idea of it being distorted. Hopefully, you will still be governor of **Texas** in January 2001 so we can work together to take care of the problems facing all the children who are being left behind during your race for the White House.

GRAPHIC: Drawing

LANGUAGE: ENGLISH

TYPE: -LINKS-; Editorial Opinion

LOAD-DATE: August 2, 2000

FOCUS™
Search: General News;texas and children's health insurance and 150 percent and...

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 2000 The Austin American-Statesman
Austin American-Statesman

View Related Topics

June 28, 2000, Wednesday

SECTION: News; Pg. A1

LENGTH: 1774 words

HEADLINE: Caught without coverage; Advocates and **Texas** officials trying to

BYLINE: Mary Ann Roser

BODY:

The first time Carla Savannah applied for Medicaid, she was pregnant. She got a lecture but no health coverage.

"My son's now 1, and I'm still not covered," said Savannah, 18, of Austin. "I just have bills."

Despite three or four tries, Savannah has not successfully navigated the complex Medicaid system, dominated by poor women and children entitled by federal law to health care. Although Medicaid is intended as a safety net for the state's most vulnerable residents, the poorest children in **Texas** have the hardest time getting covered.

Texas maintains some of the nation's most stringent Medicaid rules. The restrictions are in sharp contrast to **Texas'** new **Children's Health Insurance** Program, which serves the working poor whose incomes generally are higher than Medicaid families.

"The very poor have to jump through the most hoops to get their kids insured," said Lisa McGiffert , a senior policy analyst at Consumers Union, a nonprofit product testing and consumer information organization. "It's not fair."

A fourth of the state's population -- 4.8 million, including 1.4 million children -- doesn't have health insurance, numbers attracting national attention as Gov. George W. Bush runs for president.

Texas' numbers are being driven by its large share of low-income families, its young population and its concentration of workers in businesses that don't provide health insurance. The state's Medicaid rules also are a problem, advocates of the uninsured said.

"It has come to a head. It is clear to us we have a draconian Medicaid system that puts artificial barriers up to people trying to access health care," said state Rep. Garnet Coleman, a Houston Democrat serving on a state panel examining health-care access, Medicaid rules and other insurance issues in **Texas.**

The Blue Ribbon Task Force on the Uninsured, made up of Coleman, other lawmakers and representatives of Bush, expects to make recommendations to the Legislature next year. It is looking into easing Medicaid restrictions.

Texas requires parents to appear in person at Medicaid offices to enroll and to return every six months to remain covered. They must provide detailed documentation of their assets, not counting their homes or personal property. In general, families are limited to $2,000 in resources. If their car is valued above $4,650, the excess counts toward the resource limit.

By contrast, parents or guardians can apply for CHIP, launched May 1, over the phone or by mail. No

assets test or face-to-face interviews are required. Plus, children are guaranteed coverage for a year, even if their parents' finances improve.

State officials at the Health and Human Services Commission say they have launched an aggressive campaign, known as the TexCare Partnership, to sign up more uninsured children. The commission oversees Medicaid, CHIP and **Texas** Healthy Kids Corp., a nonprofit corporation that targets children not eligible for Medicaid or CHIP.

Texas Healthy Kids expects about 95 percent of the 11,000 children it's been serving to transfer to CHIP. That will leave the corporation with about 550 children. The corporation's board voted Tuesday to continue providing coverage at least until June 30, 2001, and to match children with private carriers.

Since the corporation was created in 1997, 19 insurance carriers have created specific programs to serve children. But cost is an issue, and some parents could have trouble covering their children, advocates of the uninsured said.

CHIP enrollments, meanwhile, continue to grow.

By Saturday, the state expects to have 28,312 children covered by **Children's Health Insurance** Program, said Jason Cooke, state CHIP director. **Texas** hopes to have 320,000 children enrolled by Aug. 31, 2001. In all, 500,000 children are believed to be eligible. The program is expected to cost about $400 million in the current two-year budget cycle.

Mike Jones, a spokesman for Bush, said the state has taken steps to improve outreach to families with uninsured children. For example, Bush signed legislation last year requiring social-service agencies to notify families, formerly on welfare, that their children still might qualify for Medicaid, Jones said. He was unaware of other actions Bush might be planning.

Savannah, who is unemployed and has several thousand dollars in medical bills, has applied for Medicaid and CHIP. She's already been told she doesn't qualify for the latter program because she has no income, she said.

Now she's waiting to hear from Medicaid.

"I'm just 18, and there's some stuff I don't understand," she said. "If I don't get it this time, I guess I'll just give up."

Roseanna Szilak , executive director of People's Community Clinic in Austin, said too many families do just that.

"It takes all sorts of legwork, and if one small thing is missing, it's back to square one," Szilak said. "It's no wonder parents are discouraged."

Like Savannah, uninsured patients in Travis and Williamson counties seek treatment at health centers such as the People's Community Clinic. Or, they use a hospital emergency room where the care is expensive and, ultimately, passed on to others in the form of higher insurance premiums and medical fees.

A recent report by the state comptroller's office said providing health care to uninsured patients costs $4.7 billion a year in **Texas.** The money comes from taxpayers, medical providers and charities.

It would be cheaper and more efficient to cover people with Medicaid and CHIP, Coleman said.

The U.S. Department of Health and Human Services' Office of Civil Rights is looking into how **Texas** operates its Medicaid program because of a steep drop in recipients, he added.

Texas' Medicaid program, estimated to cost $3.6 billion over the current two-year budget period, covers

fewer children today than it did five years ago -- 1 million compared with 1.2 million in 1995. An estimated 600,000 children, now uninsured, are eligible for Medicaid, said Charles Stuart, a spokesman for the **Texas** Health and Human Services Commission.

Medicaid used to be provided automatically to families on welfare. But many families that went off public assistance also lost Medicaid, including some who are still eligible.

Easing Medicaid rules would be one way to get more uninsured children signed up, advocates said. **Texas,** Montana and Arkansas are the only states that have not taken steps to simplify Medicaid eligibility, said Anne Dunkelberg, senior policy analyst at the Center for Public Policy Priorities.

Bush administration officials could change the rules. So could the Legislature.

But **Texas** has resisted. Medicaid carries a stigma left from the days when it was tied to welfare, advocates for the uninsured said. "Policy-makers have shamed people who need help, and it's horrible that it's tied to access for health care," McGiffert said.

State officials also fear being inundated by people seeking coverage, Dunkelberg said.

Budget officials estimated the cost of scrapping the face-to-face interviews and assets test at $1.4 billion, because of anticipated new enrollments. **Texas** would be on the line for about $600 million of that, with the rest coming from the federal government.

Coleman said he is optimistic the state will ease its Medicaid rules. He is talking with the governor's office, but he has found the staff more cautious because of the presidential race, he said.

"We are working diligently to do this without a change in legislation," Coleman said. "Why wait? Those kids are not going away, and their health problems are not going away."

You may contact Mary Ann Roser at maroser@statesman.com or 445-3619.

From Box:

Texas programs for uninsured children

Medicaid

What: A state and federal government-financed program that provides health care at no cost to children from families with certain income levels.

Requirements: Parents must enroll in person and report their financial situation to the state Medicaid office every six months for face-to-face interviews to continue coverage. Parents also must provide extensive documentation on their assets, which cannot exceed certain limits. Children must be younger than 19.

Income limits: They are based on federal poverty level -- incomes below $17,050 a year for a family of four -- and vary according to the child's age. The family's income must not exceed 185 percent of the federal poverty level for infants up to age 1; 133 percent of the level for children ages 1 through 5; and 100 percent of the level for children ages 6 through 18.

Contact: (800) 252-8263

Children's Health Insurance Program

What: A state-administered program operated by private contractors to provide broad health coverage to children in low- and moderate-income families. Launched in **Texas** on May 1, CHIP is financed by the federal government and the state, with **Texas** using settlement money from a tobacco industry lawsuit.

Requirements: Application can be made over the phone or by mail. There is no limit on assets, and coverage is guaranteed for a year even if the income situation changes. Children must be younger than 19.

Income limits: Income is limited to **200 percent** of the federal poverty level. Families at or below **150 percent** of the level pay an annual $15 enrollment fee and very low co-payments for medical services. Families between **150 percent and 200 percent** of the level pay either $15 or $18 per month, and co-payments are similar to commercial health plans.

Contact: (800) 647-6558

Texas Healthy Kids Corp.

What: A nonprofit corporation created by the Legislature to provide affordable health insurance to uninsured children. The corporation contracts with private health plans for coverage. It is planning to phase out such coverage, possibly as early as June 30, 2001. The corporation intends to match children with private insurers.

Requirements: The corporation will accept new applications through the TexCare Partnership for 60 days starting July 15. Children must be between the ages of 2 and 17. They also must be **Texas** residents for the past six months and uninsured for at least 90 days. They must be in school if of school age.

Income limits: None. However, with the start of CHIP, the program targets families making more than **200 percent** of the federal poverty level. As of July 1, premiums will range from $53.53 to $113 a month per child.

Contact: (800) 943-5437

GRAPHIC: According to the state comptroller's office, the cost of providing health care the uninsured, including Carla Savannah and her 1-year-old son, Malachi, is $4.7 billion a year. Advocates say changes in **Texas'** Medicaid system would get more people covered and ease the burden on taxpayers and providers. // Carla Savannah, with her son, Malachi, and their pets, has been frustrated by **Texas'** Medicaid system. She has applied for the program three or four times, but they remain uninsured.

LOAD-DATE: June 28, 2000

FOCUS™
Search: General News;texas and children's health insurance and 150 percent and...

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 2000 The Austin American-Statesman
Austin American-Statesman

View Related Topics

June 28, 2000, Wednesday

SECTION: News; Pg. A1

LENGTH: 1774 words

HEADLINE: Caught without coverage; Advocates and **Texas** officials trying to

BYLINE: Mary Ann Roser

BODY:

The first time Carla Savannah applied for Medicaid, she was pregnant. She got a lecture but no health coverage.

"My son's now 1, and I'm still not covered," said Savannah, 18, of Austin. "I just have bills."

Despite three or four tries, Savannah has not successfully navigated the complex Medicaid system, dominated by poor women and children entitled by federal law to health care. Although Medicaid is intended as a safety net for the state's most vulnerable residents, the poorest children in **Texas** have the hardest time getting covered.

Texas maintains some of the nation's most stringent Medicaid rules. The restrictions are in sharp contrast to **Texas'** new **Children's Health Insurance** Program, which serves the working poor whose incomes generally are higher than Medicaid families.

"The very poor have to jump through the most hoops to get their kids insured," said Lisa McGiffert , a senior policy analyst at Consumers Union, a nonprofit product testing and consumer information organization. "It's not fair."

A fourth of the state's population -- 4.8 million, including 1.4 million children -- doesn't have health insurance, numbers attracting national attention as Gov. George W. Bush runs for president.

Texas' numbers are being driven by its large share of low-income families, its young population and its concentration of workers in businesses that don't provide health insurance. The state's Medicaid rules also are a problem, advocates of the uninsured said.

"It has come to a head. It is clear to us we have a draconian Medicaid system that puts artificial barriers up to people trying to access health care," said state Rep. Garnet Coleman, a Houston Democrat serving on a state panel examining health-care access, Medicaid rules and other insurance issues in **Texas.**

The Blue Ribbon Task Force on the Uninsured, made up of Coleman, other lawmakers and representatives of Bush, expects to make recommendations to the Legislature next year. It is looking into easing Medicaid restrictions.

Texas requires parents to appear in person at Medicaid offices to enroll and to return every six months to remain covered. They must provide detailed documentation of their assets, not counting their homes or personal property. In general, families are limited to $2,000 in resources. If their car is valued above $4,650, the excess counts toward the resource limit.

By contrast, parents or guardians can apply for CHIP, launched May 1, over the phone or by mail. No

assets test or face-to-face interviews are required. Plus, children are guaranteed coverage for a year, even if their parents' finances improve.

State officials at the Health and Human Services Commission say they have launched an aggressive campaign, known as the TexCare Partnership, to sign up more uninsured children. The commission oversees Medicaid, CHIP and **Texas** Healthy Kids Corp., a nonprofit corporation that targets children not eligible for Medicaid or CHIP.

Texas Healthy Kids expects about 95 percent of the 11,000 children it's been serving to transfer to CHIP. That will leave the corporation with about 550 children. The corporation's board voted Tuesday to continue providing coverage at least until June 30, 2001, and to match children with private carriers.

Since the corporation was created in 1997, 19 insurance carriers have created specific programs to serve children. But cost is an issue, and some parents could have trouble covering their children, advocates of the uninsured said.

CHIP enrollments, meanwhile, continue to grow.

By Saturday, the state expects to have 28,312 children covered by **Children's Health Insurance** Program, said Jason Cooke, state CHIP director. **Texas** hopes to have 320,000 children enrolled by Aug. 31, 2001. In all, 500,000 children are believed to be eligible. The program is expected to cost about $400 million in the current two-year budget cycle.

Mike Jones, a spokesman for Bush, said the state has taken steps to improve outreach to families with uninsured children. For example, Bush signed legislation last year requiring social-service agencies to notify families, formerly on welfare, that their children still might qualify for Medicaid, Jones said. He was unaware of other actions Bush might be planning.

Savannah, who is unemployed and has several thousand dollars in medical bills, has applied for Medicaid and CHIP. She's already been told she doesn't qualify for the latter program because she has no income, she said.

Now she's waiting to hear from Medicaid.

"I'm just 18, and there's some stuff I don't understand," she said. "If I don't get it this time, I guess I'll just give up."

Roseanna Szilak , executive director of People's Community Clinic in Austin, said too many families do just that.

"It takes all sorts of legwork, and if one small thing is missing, it's back to square one," Szilak said. "It's no wonder parents are discouraged."

Like Savannah, uninsured patients in Travis and Williamson counties seek treatment at health centers such as the People's Community Clinic. Or, they use a hospital emergency room where the care is expensive and, ultimately, passed on to others in the form of higher insurance premiums and medical fees.

A recent report by the state comptroller's office said providing health care to uninsured patients costs $4.7 billion a year in **Texas.** The money comes from taxpayers, medical providers and charities.

It would be cheaper and more efficient to cover people with Medicaid and CHIP, Coleman said.

The U.S. Department of Health and Human Services' Office of Civil Rights is looking into how **Texas** operates its Medicaid program because of a steep drop in recipients, he added.

Texas' Medicaid program, estimated to cost $3.6 billion over the current two-year budget period, covers

fewer children today than it did five years ago -- 1 million compared with 1.2 million in 1995. An estimated 600,000 children, now uninsured, are eligible for Medicaid, said Charles Stuart, a spokesman for the **Texas** Health and Human Services Commission.

Medicaid used to be provided automatically to families on welfare. But many families that went off public assistance also lost Medicaid, including some who are still eligible.

Easing Medicaid rules would be one way to get more uninsured children signed up, advocates said. **Texas,** Montana and Arkansas are the only states that have not taken steps to simplify Medicaid eligibility, said Anne Dunkelberg, senior policy analyst at the Center for Public Policy Priorities.

Bush administration officials could change the rules. So could the Legislature.

But **Texas** has resisted. Medicaid carries a stigma left from the days when it was tied to welfare, advocates for the uninsured said. "Policy-makers have shamed people who need help, and it's horrible that it's tied to access for health care," McGiffert said.

State officials also fear being inundated by people seeking coverage, Dunkelberg said.

Budget officials estimated the cost of scrapping the face-to-face interviews and assets test at $1.4 billion, because of anticipated new enrollments. **Texas** would be on the line for about $600 million of that, with the rest coming from the federal government.

Coleman said he is optimistic the state will ease its Medicaid rules. He is talking with the governor's office, but he has found the staff more cautious because of the presidential race, he said.

"We are working diligently to do this without a change in legislation," Coleman said. "Why wait? Those kids are not going away, and their health problems are not going away."

You may contact Mary Ann Roser at maroser@statesman.com or 445-3619.

From Box:

Texas programs for uninsured children

Medicaid

What: A state and federal government-financed program that provides health care at no cost to children from families with certain income levels.

Requirements: Parents must enroll in person and report their financial situation to the state Medicaid office every six months for face-to-face interviews to continue coverage. Parents also must provide extensive documentation on their assets, which cannot exceed certain limits. Children must be younger than 19.

Income limits: They are based on federal poverty level -- incomes below $17,050 a year for a family of four -- and vary according to the child's age. The family's income must not exceed 185 percent of the federal poverty level for infants up to age 1; 133 percent of the level for children ages 1 through 5; and 100 percent of the level for children ages 6 through 18.

Contact: (800) 252-8263

Children's Health Insurance Program

What: A state-administered program operated by private contractors to provide broad health coverage to children in low- and moderate-income families. Launched in **Texas** on May 1, CHIP is financed by the federal government and the state, with **Texas** using settlement money from a tobacco industry lawsuit.

Requirements: Application can be made over the phone or by mail. There is no limit on assets, and coverage is guaranteed for a year even if the income situation changes. Children must be younger than 19.

Income limits: Income is limited to **200 percent** of the federal poverty level. Families at or below **150 percent** of the level pay an annual $15 enrollment fee and very low co-payments for medical services. Families between **150 percent and 200 percent** of the level pay either $15 or $18 per month, and co-payments are similar to commercial health plans.

Contact: (800) 647-6558

Texas Healthy Kids Corp.

What: A nonprofit corporation created by the Legislature to provide affordable health insurance to uninsured children. The corporation contracts with private health plans for coverage. It is planning to phase out such coverage, possibly as early as June 30, 2001. The corporation intends to match children with private insurers.

Requirements: The corporation will accept new applications through the TexCare Partnership for 60 days starting July 15. Children must be between the ages of 2 and 17. They also must be **Texas** residents for the past six months and uninsured for at least 90 days. They must be in school if of school age.

Income limits: None. However, with the start of CHIP, the program targets families making more than **200 percent** of the federal poverty level. As of July 1, premiums will range from $53.53 to $113 a month per child.

Contact: (800) 943-5437

GRAPHIC: According to the state comptroller's office, the cost of providing health care the uninsured, including Carla Savannah and her 1-year-old son, Malachi, is $4.7 billion a year. Advocates say changes in **Texas'** Medicaid system would get more people covered and ease the burden on taxpayers and providers. // Carla Savannah, with her son, Malachi, and their pets, has been frustrated by **Texas'** Medicaid system. She has applied for the program three or four times, but they remain uninsured.

LOAD-DATE: June 28, 2000

FOCUS™
Search: General News;texas and children's health insurance and 150 percent and...

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1999 Star-Telegram Newspaper, Inc.
THE FORT WORTH STAR-TELEGRAM

October 5, 1999, Tuesday FINAL AM EDITION

SECTION: EDITORIAL/OPINIONS; Pg. 9, Editorial

LENGTH: 1031 words

HEADLINE: Health insurance:**Texas** being **Texas** once again

BYLINE: Molly Ivins, Star-Telegram Writer

BODY:

AUSTIN - So here's **Texas** yet again at the bottom of the barrel, worst in the nation, No. 50 in health insurance. This is not a consequence of accident or socioeconomic conditions in the state - it's the result of deliberate policy and lack of policy both.

According to the Census Bureau, 24.5 percent of Texans have no health insurance, the highest rate of any state - compared to, say, Hawaii, with a respectable 8.8 percent uninsured.

When the information comes in numbers like that, it doesn't mean much. But we are talking about (among others) 200,000 children in this state who have just fallen off Medicaid in the last two years, since welfare reform started.

Ninety-nine percent of those who leave AFDC (now called TANF, for Temporary Assistance for Needy Families) should still have their children enrolled in Medicaid - but no one has bothered to tell them that.

It's difficult to get hard data on what has happened to these kids, but the Center for Public Policy Priorities has collected some information, and others who work in the field have anecdotal information.

"The main thing we hear is that DHS Department of Human Services workers go out of their way not to inform families of their right to stay on Medicaid," said one consultant.

Here's the real issue: If you want welfare reform to work and families to become self-sufficient, government has to do something at least about health care - and probably child care, transportation and job training as well.

Tommy Thompson, the Republican governor of Wisconsin who really started welfare reform, would be the first to tell you that the only way to make it work is to spend more money than we were spending on the old system, at least for the first several years.

But in **Texas,** practically no one in government saw it that way - they only saw a chance to save themselves money. When they say, "We reduced the welfare rolls," all they're talking about is cutting the welfare budget.

With a few honorable exceptions, including state Rep. Elliott Naishtat, chair of the House Human Services Committee, no one here is interested in getting these families on their feet. They just want them off welfare.

Not that **Texas** ever shelled out much for welfare in the first place. Just this last session, while sitting on top of a whopping budget surplus, we finally oonched the welfare payment for a woman with two children over $ 200 - to $ 201 a month starting Oct. 1. At least this puts us ahead of Mississippi and Louisiana. For the longest time the payment was stuck at $ 188 a month, leading to the much-noted shortage of welfare Cadillacs in our fair state.

We've always known we could get people off welfare fairly easily.

The trouble is, we can only get them into low-paying, no-benefit jobs, so they have to come back when their kids get sick.

The feds have been fooling around with this problem and finally came up with CHIP - the **Children's Health Insurance** Program, a mostly federally funded program for the children of the working poor.

The big fight in the Lege last session was to get CHIP to cover families up to **200 percent** of poverty, over the governor's objections - he wanted the cheaper **150 percent** option. Then they had to figure out how to let folks know about the new program. The dirty little secret of **Texas** government, as I have written before, is that our famously low-tax, low-service system gets along by cheating the poor.

Thanks to Naishtat and a few others, one can now apply for CHIP insurance for the kids by mailing in an application and proving income; insurance is good for 12 months. But to get Medicaid in **Texas,** you still have to "prove assets," which means you have to prove that your total assets come to less than $ 2,000.

If you have to have a car to work, you have to prove it's worth only so much, and all this other bureaucratic bushwa. And even if you get all your paperwork done, you can't just mail it in. You have to go to a DHS office for a interview that takes at least a couple of hours; and, naturally, the offices are open only 8 to 5, Monday through Friday. To put it mildly, it is not a friendly system, and the insurance is only good for four to six months, and then you have to go through the whole process again.

What's happening, of course, is that when a parent applies for CHIP, it frequently turns out that the whole family is poor enough to be eligible for Medicaid, which costs the state more because the matching funds aren't as good.

Sitting in Washington is a pool of $ 27 million earmarked for **Texas** to use for outreach programs to get the folks who qualify signed up for the new insurance. We haven't touched a penny of it, and the option to use it runs out on the last day of this year.

This is what they call enhanced matching money, meaning that the feds put up 75 to 90 percent of it, depending on how it's used, so in the thinking of state budgeters, this is practically free money. But

we're so afraid of seeing the more costly Medicaid rolls swell that we haven't even asked for it.

Forty-one other states have dropped the awkward process of "proving assets," and **Texas** may actually be the only state left doing it. (Information on the others could not be obtained by deadline.)

Obviously, lack of health insurance is not a problem that affects only poor people in this country. The Census Bureau says that more employers are cutting health insurance. In households with incomes of more than $ 50,000 a year, the number of people without health insurance increased last year by 1.7 million to more than 12 million.

"This is a troubling trend," said Chris Jennings, the health policy coordinator for President Clinton, in happy understatement.

But of course the biggest increase was among children under 6, to 23.6 percent nationally last year from 20.1 percent in 1997. Ever been around a 3-year-old with a bad earache?

Molly Ivins is a columnist for the Star-Telegram. You contact her at 1005 Congress Ave., Suite 920, Austin, TX 78701; (512) 476-8908; or mollyivins@star-telegram.com.

LANGUAGE: ENGLISH

LOAD-DATE: October 6, 1999

FOCUS™
Search: General News;texas and children's health insurance and 150 percent and...

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1999 The Houston Chronicle Publishing Company
The Houston Chronicle

View Related Topics

May 02, 1999, Sunday 2 STAR EDITION

SECTION: OUTLOOK; Pg. 1

LENGTH: 678 words

HEADLINE: **Texas** is too rich to leave its poor children behind

BYLINE: SEN. LLOYD BENTSEN, LAN BENTSEN; Former U.S. Sen. Lloyd Bentsen chaired the Senate Finance Committee responsible for the maternal and child health block grant, Medicaid and the new state **Children's Health Insurance** Program. Lan Bentsen is a former national trustee of the March of Dimes Birth Defects Foundation and chaired the **Texas** Coalition on Maternal and Child Health

BODY:

SIX-year-old Marie turns the sound up so loud on the television at home that her siblings leave the room. She is late learning to read because she has trouble hearing herself or her teachers say the words. A simple outpatient operation to install tubes in her ears would make all her troubles go away. But her working parents have no health insurance at the office and aren't eligible for Medicaid. They simply can't afford the cost of the surgery. Without it, she likely will go deaf.

Marie isn't alone. **Texas,** one of this country's economic leaders, sadly can claim another first - the highest percentage of uninsured children in the country. Twenty-five percent of little Texans have no health insurance compared to the national average of 13 percent. That's a total of 1.4 million uninsured children in the Lone Star State.

So Marie's parents are waiting and hoping that the **Texas** Legislature will authorize the new **Children's Health Insurance** Program, or CHIP. Legislation has already passed unanimously in both the House and Senate.

But there is a critical difference between the state Senate and House plans. The Senate proposal would offer health insurance only to children ages 0 to 10 in families with incomes up to **200 percent** of the poverty level or $ 33,400 for a family of four. Children ages 11-19 would be covered at **150 percent** of the poverty level or $ 25,200 for a family of four. The more inclusive House bill covers all children up to **200 percent** of the poverty level.

What's the difference? Approximately 198,000 more eligible children statewide under the version in the House. Of those, 32,000 are in Houston. **Texas** has the resources to cover all children whose family income is below **200 percent** of the poverty level.

Money to fund CHIP comes primarily from the federal government in the form of a block grant to **Texas** of more than $ 500 million a year. The federal government will spend $ 3 for every $ 1 **Texas** puts up. **Texas** has funds available from the tobacco settlement and a budget surplus generated by its strong economy. And, under CHIP, working families will contribute to the cost of their children's insurance.

So **Texas** can afford to go to **200 percent** of the poverty level for all kids. Indeed, it really can't afford not to. The reasons:

In 1998, the Harris County Hospital District served nearly 31,000 uninsured children. Of those, 1,900 were between **150 percent and 200 percent** of poverty. The district spent $ 20 million doing so. If the House version becomes law, the district could spend those monies instead on other community health-care priorities.

The health insurance free market is failing to cover **Texas'** families. An estimated 100,000 more children became uninsured last year. In addition, 14,000 **Texas** businesses dropped health insurance in 1997, according to the **Texas** Department of Insurance.

In 1994, working Texans with uninsured children missed 550,000 more days of work than working parents with insured children. And, more than eight out of 10 children eligible for CHIP live in a home with working parents.

The **Texas** Department of Health estimates that in 1997, local school districts lost a total of $ 4 million per day in funding due to absenteeism. Uninsured children are 25 percent more likely to miss school than those with insurance.

The statewide drive to insure our children began last fall when the March of Dimes organized a series of public forums to alert the public to this critical problem. Since then, a groundswell of popular support has pushed the issue to the forefront of the Legislature's agenda.

Today, 30 other states have covered their children at **200 percent** or more. Gov. George W. Bush and **Texas** legislators ought to do the same so that **Texas** children won't be left behind.

Meanwhile, what of Marie? She has trouble hearing her parents call her name at home. She's been transferred to a reading class for children with learning disabilities. She likely will have to repeat first grade next year. And all she needs is the fluid drained out of her ears.

GRAPHIC: Drawing (p. 5)

LANGUAGE: ENGLISH

TYPE: Editorial Opinion

LOAD-DATE: May 3, 1999

FOCUS™
Search: General News;texas and children's health insurance and 150 percent and...

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1998 Cheyenne Newspapers, Inc.
Wyoming Tribune-Eagle

May 16, 1998, Saturday

SECTION: local; Pg. A1

LENGTH: 472 words

HEADLINE: WYOMING RANKS LAST IN CHILD INSURANCE POLL

BYLINE: Steve Bahmer

BODY:

CHEYENNE -- **Wyoming** ranks at the bottom of a recently released Children's Defense Fund survey of state health insurance programs for children.That's because **Wyoming** did not submit a proposal to use about $7.7 million in federal money to insure children whose families earn incomes too high to qualify for Medicaid but too low to pay for private insurance.To get the federal money, the state would have had to provide about $2.7 million in matching funds.In February, however, the state Senate voted down a bill that would have provided insurance for about 10,000 uninsured **Wyoming** children.The state Department of Health estimates that there are 21,384 uninsured children in **Wyoming.**"As long as the state doesn't use the (federal) money, there are children who could benefit from it who are going without necessary health care," said Gregg Haifley, CDF health director.The **Children's Health Insurance** Program, which President Clinton signed into law late last year, provides the states with about $4 billion in annual federal grants. The program allows states flexibility to design their own insurance programs.Haifley said states could expand Medicaid to cover children, establish a separate state program or, as some states have done, combine the two.Some state legislators argued during the recent legislative session against expanding Medicaid coverage. That would have been movement toward "a national health care system by increments," Sen. Charles Scott, R-30/Casper, told the **Wyoming** Tribune-Eagle in February.He could not be reached for comment Friday.Gov. Jim Geringer and several legislators supported hiring an insurance company to do the job, but some wondered whether U.S. Health and Human Services Secretary Donna Shalala would approve the plan." The feds clearly prefer the Medicaid option," Scott told the WTE.Haifley said Scott's assertion is simply not true."There is no evidence that there is a preferred way to cover children," he said. "They scrutinize the plans to be sure they meet all CHIP requi

rements."California, for example, did not expand Medicaid. Instead, it developed a separate state insurance program, he said.As of April 30, 43 states had either submitted plans to the Health Care Financing Administration for approval or completed state legislative action on CHIP.Connecticut, Georgia and Maryland received the highest ratings in the CDF survey for eligibility, cost, available service and ease of enrollment in their insurance programs. Alabama, Mississippi, Texas and **Wyoming** scored lowest.Scott said in February that a "good chance" exists a child insurance bill will resurface in **Wyoming** next year.Because the application deadline was extended, **Wyoming** can still receive the $7.7 million set aside for this year if the Legislature approves a plan by September 1999, Haifley said.

LANGUAGE: English English

LOAD-DATE: May 28, 1998

FOCUS™
Search: General News;wyoming and children's health insurance

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1999 Cheyenne Newspapers, Inc.
Wyoming Tribune-Eagle

December 17, 1999, Friday

SECTION: Front; Pg. A1

LENGTH: 806 words

HEADLINE: INSURANCE PROGRAM FOR KIDS STARTS

BYLINE: Paula Glover

BODY:

CHEYENNE -- A few of **Wyoming's** 38,920 uninsured children are a step closer to having health insurance with the launch of a new program this week.

Wyoming Covering Kids is the umbrella name of a health care expansion that offers five programs for children whose families are over the federal poverty level.

One local mother, who asked that her name not be used, knows what it like to have a job and still face lack of health insurance.

She has coverage under Title 19 now for her daughter, but a pending raise at her job will put her over the income limit.

"I hate to just cross my fingers and hope my daughter doesn't get sick," she said. "And my raise will go to cover my student loans, which are due, so I can't afford to buy health insurance for my family in addition to my coverage through my job."

She was glad to hear there is a program available so she can continue insurance after her raise.

Having Medicaid was "a real blessing" she added, and it allowed her to have good prenatal medical care and care for her daughter -- care that she would have to lose if the new programs weren't in place.

Under the new programs, families are allowed to have income between 133 and 185 percent of the federal poverty level, depending on the program.

Roughly, that means a family of four that makes $1,850 a month or more would probably qualify for the programs. Families could make more and still qualify for the programs with higher allowances. The federal poverty income level for a family of four is $1,200 a month.

The process to apply is easy and can be done through the mail, said Karen Green, a supervisor for the **Wyoming** Department of Family Services. People can apply by calling 777-6800 and receive an application by mail or set an appointment.

She said people should apply even if they are uncertain if they qualify, as there are several qualifying factors and allowances that are taken into consideration. Qualification is not based on resources, but rather on need, so people can own a car or home and still qualify.

Green said several families have already qualified for the expanded care programs.

In her experience as a social worker, she said she saw many families who could afford a doctor appointment, but then couldn't purchase the prescription. This program is designed to help working poor families with situations such as these.

Wyoming Covering Kids is a project of the Robert Wood Johnson Foundation health care initiative. It is being promoted in the state with a central office in Cheyenne and pilot sites in seven counties -- Albany, Fremont, Laramie, Natrona, Uinta, Washakie and Weston.

Mary Lynn Nacey is the Laramie County coordinator of the program, and she is going around to schools and social service agencies to get the word out. She's also visiting with the general public, with booths at local discount stores.

"Applying for this program is really easy," Nacey said. "There are only nine questions and all the information is self-reporter."

Nationwide, around 15 percent of children don't have health insurance. Working families with incomes up to 200 percent of the federal poverty level make up 85 percent of those who have uninsured children.

The federal government has addressed the lack of health care for children by allocating $24 billion to states for five years to expand health insurance coverage for children. **Wyoming** has received a grant that is just under $1 million from the Robert Wood Johnson Foundation to administer the **Wyoming** Covering Kids project.

"There are a large untapped number of clients who could benefit from these programs," Green said. "These are people who would not qualify before who would qualify now."

Wyoming Covering Kids Projects:

Wyoming Kid Care -- Health insurance for uninsured children who meet income requirements of up to 150 percent of federal poverty level. Contact Jeanne Scheneman, 777-7371.

Medicaid for **Children -- Health insurance** for uninsured or underinsured children who meet income requirements of between 100 and 133 percent of federal poverty level. Call (888) 966-8786 for local representative.

Blue Cross and Blue Shield Caring Program for Children -- Option for primary preventative care, emergency health care and outpatient dental care for children not eligible for **Wyoming** Kid Care or Medicaid for Children and who meet income requirements of up to 165 percent of federal poverty level. Administered by **Wyoming** Department of Health, call (888) 566-8074 or (307) 432-2821.

Children's Health Services -- Health care option for children with special needs that meet income requirements of up to 185 percent of federal poverty level. Call 777-7941.

Dental Program -- A dental care program for children not enrolled in the **Wyoming** Kid Care or Medicaid for Children. Call 777-7945.

LANGUAGE: English

LOAD-DATE: December 17, 1999

FOCUSTM
Search: General News;wyoming and children's health insurance

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

The Associated Press State & Local Wire

View Related Topics

The materials in the AP file were compiled by The Associated Press. These materials may not be republished without the express written consent of The Associated Press.

November 19, 1999, Friday, BC cycle

SECTION: State and Regional

LENGTH: 368 words

HEADLINE: Health department has high hopes for kidcare

DATELINE: CHEYENNE, **Wyo.**

BODY:

State health officials expect the number of children enrolled in the new "kidcare" health insurance program to climb from 11 to 747 by the end of June.

When the program was created during the 1999 Legislature, they had hoped to enroll about 1,400 children the first year.

Projections now anticipate 3,352 by the end of June, 2002, although state health department administrator John Harper conceded that is an educated guess.

What is certain: 11,000 **Wyoming** children are underinsured or uninsured and live below 150 percent of the poverty level, he told the Joint Interim Committee on Labor, Health and Social Services Committee on Wednesday.

Some qualified families "in the **Wyoming** way" will never apply for the program, while others may enroll but never use it, he said.

While the application was cut from 38 pages to one, Rock Springs Democratic Sen. Tex Boggs and Rep. Kenilynn Zanetti, said it is still too complicated.

Zanetti said the form includes applications for welfare programs and the kidcare program. She said she was worried that applicants would shy away because of the "stigma of welfare."

"This is a welfare program," interjected Sen. Charles Scott, R-Casper, the committee chairman. "Any time you have income testing you have a welfare program."

Wyoming's program, also called the **children's health insurance** program, has two parts.

One is a "Medicaid look-alike" for families with incomes between 100 percent and 133 percent of the federal poverty level, or between $16,655 and $22,151 for a family of four.

Part two is a voucher plan for families with incomes between 133 percent and 150 percent of the federal poverty level, or $22,151 to $24,982.

Beginning in the spring, eligible families will be able to use the vouchers to stay with their employer-sponsored plan or to buy their own health insurance plan.

"We still have no idea what the voucher program will look like," Harper told the committee.

The program cost $485,000 from the state and $1.4 million in matching federal money the first year.

For 2001-2002, the health department is asking for $1.4 million, to be matched by $4.2 million in federal funds.

LANGUAGE: ENGLISH

LOAD-DATE: November 20, 1999

FOCUS™
Search: General News;wyoming and children's health insurance

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

Copyright 1999 Cheyenne Newspapers, Inc.
Wyoming Tribune-Eagle

August 12, 1999, Thursday

SECTION: Local; Pg. A3

LENGTH: 695 words

HEADLINE: GERINGER ASKS FOR CLINTON'S HELP

BYLINE: Chris George

BODY:

CHEYENNE -- Gov. Jim Geringer has asked President Bill Clinton for help in obtaining a waiver for **Wyoming's** Child Support Enforcement program.

Geringer attended the National Governor's Association meeting in St. Louis over the weekend and spoke with the president about the waiver.

The governors also discussed assessment testing for teachers, the Census 2000 effort and **children's health insurance,** according to Geringer. The Geringers also had a chance to get to know the Venturas of Minnesota.

Currently, **Wyoming** clerks of court collect and disburse child support payments. State law also provides for a single address for employers to send payments, although a legislative subcommittee is proposing to delete that provision.

Federal regulations require that all support payments be sent to a single source and the state risks losing federal welfare funding by not complying. The state has asked the U.S. Department of Health and Human Services for a waiver once before and been denied.

The waiver **Wyoming** is seeking would lift the single address requirement. The Cowboy State system has been very successful, boasting one of the highest collection rates in the country.

How did the president react?

"He was perplexed," Geringer said. "He seemed as puzzled as I was as to why his own department would say '**Wyoming** cannot get a waiver.' It does not matter how good **Wyoming** is, it cannot get a waiver because the federal government wants **Wyoming** to follow this process."

Geringer said he came out of the conference more impressed than ever about the importance of installing some kind of assessment program for students. And he wants to hear what the business community has to say about education reform.

Geringer warned that without some kind of assessment system, The Cowboy State's education system could get left in the dust.

"They (other states) are so focused on improving student achievement that **Wyoming** will be left behind if we're not out there competing to see what we can do to enable teachers to teach, administrators to provide resources for students to learn. That can be enabled by an assessment test," Geringer said.

And without the participation of the businesses of the state, **Wyoming's** efforts will be set back.

"If the business community believes that education reform is necessary, they need to step forward and

say so," Geringer said. "Gov. (James) Hunt from North Carolina was very emphatic on that: he said you've got to have the business community involved or the public won't believe in it. I'd say that's amen in **Wyoming.**"

Geringer was also told that because the Census Bureau was expecting to use statistical sampling right up until a recent U.S. Supreme Court ruling saying that every person must be counted, the bureau is a little behind.

"For **Wyoming's** purposes, we could be under-counted in areas where we don't want to be under-counted," Geringer said, such as high poverty areas.

Geringer also reported that a states-initiated, federally-funded child health care program has picked up half the 2.6 million eligible children in the first six months of operation. **Wyoming,** which is a year behind in implementing the program, has only had statutory authority to do so since July 1.

And Gov. Geringer and First Lady Sherri Geringer met Gov. Jesse Ventura and First Lady Terry Ventura. Geringer described the man as having a piercing, almost intimidating look. "The Body's" staff never really know what he's going to say at press conferences, though Geringer said the man's ability with a sound bite was very good.

Ventura is an active, vested member of the Screen Actors Guild, according to the governor's association.

Geringer said the former pro-wrestler was naive about what he could accomplish as a governor, annoyed at some of the things the press have and have not said about him and very concerned about children's issues. Mrs. Ventura is publicity-shy and simply interested in working on her projects, Geringer said.

Geringer and Ventura sat together at Gateway School in St. Louis. As part of a creative writing exercise, they each drew a monster based on student descriptions.

LANGUAGE: English

LOAD-DATE: August 12, 1999

FOCUS™
Search: General News;wyoming and children's health insurance

To narrow this search, please enter a word or phrase:

FOCUS

Example: **House of Representatives**

About LEXIS-NEXIS | Terms and Conditions | What's New
Copyright © 2000 LEXIS-NEXIS Group. All rights reserved.

7 of 9 results Previous Story | Next Story | Back to Results List

03-02-1998

STATELINES - WYOMING: STATE SENATE KILLS KIDDIECARE PROPOSAL

The Wyoming Senate last week voted 20-10 against a bill that would have allowed the state to participate in the federal Children's Health Insurance Program (Kiddiecare). The AP/Casper Star Tribune reports that "[h]igh costs and burdensome federal regulations outweighed" the senators' desire to provide health insurance coverage for children of the working poor. If Wyoming had entered the Kiddiecare program, the federal government would have matched the state's $2.7 million contribution with $7.7 million a year for five years. State Sen. Tom Kinnison (R) opposed the measure because he believed "it would force the state to tap its already-tight coffers at the expense of other pressing needs." He said, "We hear so often that we can never cut a program, and here we are adding another program. I appreciate the work done on this bill, but we have got a lot of other problems in the state." The AP/Star Tribune reports that the measure would have allowed the state "to reduce its expenses if federal funding declined" and permitted "state officials to choose not to participate if the federal agency rejected the state plan" (Sarche, 2/28).

American Healthline

7 of 9 results Previous Story | Next Story | Back to Results List

8 of 9 results Previous Story | Next Story | Back to Results List

02-25-1998

STATELINES - WYOMING: KIDDIECARE BILL CLEARED BY SENATE COMMITTEE

The state Senate Labor, Health and Social Services Committee approved a bill yesterday to give low-income families assistance in "obtaining health insurance for their children," the AP/Casper Star-Tribune reports. The bill (SB 50) would set aside about $2.6 million dollars in funds for children's health programs, to be matched by about $7.7 million in federal funds. According to Labor, Health and Social Services Committee Chair Charles Scott (R), the measure "would allow the state to contract with private insurers," so as not to foster competition between private insurers and "a government insurance program." Under the bill, the state would "contract with private insurers" to provide coverage and families with incomes under 150% of the federal poverty level would qualify for full subsidization of health costs. From there, "families' premium payments would increase on a sliding scale up to 75% of the full premium for families with income ranging" up to 175% of the poverty level (Sarche, 2/24).

American Healthline

8 of 9 results Previous Story | Next Story | Back to Results List

American Health Line
A Daily Briefing on Health Care Politics and Policy

6 of 9 results Previous Story | Next Story | Back to Results List

04-08-1998

STATELINES - WYOMING: LOOKING BACK ON THE KIDDIECARE REJECTION

American Medical News looks at Wyoming legislators' decision to not participate in the federal Children's Health Insurance Program (Kiddiecare). In February, the Wyoming Legislature voted against creating a CHIP plan, with lawmakers contending that "a severe budget crunch made it impossible to come up with the state's $2.7 million share of the program's generous 25% state, 75% federal match." State Sen. Charlie Scott (R), the chair of the Senate Health Committee, explained, "There is considerable mistrust of the federal government here." But Dr. Larry Meuli, a Republican and head of the Cheyenne health department, said lawmakers "ignored problems about health care coverage for poor children that are rarely discussed." For example, he noted that many children treated at Cheyenne health clinics lack a regular doctor, meaning they only get "episodic care, crisis-oriented treatment." In addition, the Henry J. Kaiser Family Foundation found that Wyoming "has a greater proportion of uninsured children than the rest of the nation" -- with 25% or more of children in families below 200% of the federal poverty level lacking coverage. Amnews notes that Washington, the "only other state to refuse" Kiddiecare dollars, rejected the program in part because lawmakers "argued that they already have a generous program for uninsured children." However, Wyoming "cannot make the same claim" since its Medicaid program covers children from birth through age 6 up to 133% of the federal poverty level and children 7-14 up to 100%, according to the Kaiser Foundation.

THE BUDGET PROBLEM

Dr. Bob Prentice, president of the Wyoming chapter of the American Academy of Pediatrics, said "legislators cannot point to the state's fiscal problems for their lack of action." He noted that "federal guidelines permit states to spend as little as several thousand dollars on the program this year and still retain the full 1998 allotment." Prentice, along with state health department officials, "presented such a funding strategy" to lawmakers, but to no avail. State Sen. Tom Kinnison (R) said Wyoming's economy "is in the toilet," and some lawmakers noted that the Legislature "also failed to fill a $5.1 million Medicaid shortfall, meaning that reimbursements could dry up as early as May." Kinnison "argued on the Senate floor" that the existing Medicaid shortfall precluded adding another health program to the state's budget.

A BAD PLAN ANYWAY

Wyoming Health Department Deputy Administrator John Harper said the Kiddiecare plan debated by lawmakers "might well have led to a federal rejection." The plan, written by Sen. Scott contained two options for providing coverage through private carriers, but Harper said "none of the state's major insurers

indicated any interest in those ideas." A third option would have offered medical savings accounts to eligible children, but Harper "said he warned that" federal officials would reject the MSA plan. Amnews notes that Scott's bill required that all three private options be accepted by the federal government, so "denial of the MSA option would have meant that the state's entire children's insurance program would then have been killed."

FIGHTING ON

Prentice "vows to fight next year for" a less controversial Kiddiecare plan, but he "concedes that it will be an uphill battle." Amnews reports that "[s]ome key legislators vowed they would vote against the program next year" (Page, 4/6 issue).

American Healthline

6 of **9** results Previous Story | Next Story | Back to Results List

DEPARTMENT of HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY for PLANNING and EVALUATION

Office of Health Policy

TO: Deborah Adler

PHONE: 456-5707

FAX: 456-5557

DATE: 8/3/00

Number of pages including cover: 49

FROM: Sarah Goodell
(202) 401-0882 phone
(202) 690-6167 fax
sgoodell@osaspe.dhhs.gov

MESSAGE: HIAA document

HIAA

Health Insurance Association of America

STATE HEALTH INSURANCE MID-YEAR REPORT

A STATE-BY-STATE ANALYSIS

HIAA Press Briefing
June 22, 2000

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

ALABAMA

Alabama convened its 2000 regular session on February 1 and adjourned *sine die* on May 15. Democrats control both houses of the legislature and the governor's mansion, where Governor Don Siegelman is in the middle of a four-year term. Since the legislature was mired down with non-health insurance issues for most of the session, health insurance received only minimal consideration. The legislature was expected to consider omnibus patient protection legislation but the potential sponsor postponed introduction.

Mental health parity: The legislature passed and Governor Siegelman signed H.B. 677, a mental health parity mandated offer. The bill excludes alcohol and drug abuse and exempts small groups from the provisions of the bill.

Privacy/Confidentiality: S.J.R. 80 was enacted by the legislature creating an interim consumer information privacy study committee which will report back to the legislature with suggested legislation by the end of 2000.

Long-term care/Medicare supplement: The legislature passed and sent to the governor H.B. 170, implementing the NAIC Long-term Care Insurance Policy Minimum Standards Act and amending the state Medicare Supplement Minimum Standards Act to conform to the NAIC model.

Other: Legislation concerning domestic violence risk classification was enacted this session as well (S.B. 348). The legislation, entitled the "Domestic Abuse Insurance Protection Act," prohibits an insurer from engaging in unfair discriminatory acts against victims of abuse. The legislature also enacted H.B. 275, requiring health benefit plans to provide specified information on identification cards concerning pharmaceutical benefits. The specified information shall conform to the standards of the National Council for Prescription Drug Programs.

ALASKA

The legislature convened on January 10 and adjourned *sine die* on May 3. Governor Tony Knowles (D) was elected in 1998 to a four-year term. Republicans maintain strong control of both houses of the legislature. The House will be up for re-election in 2000 and the Senate in 2002.

Physician antitrust waivers: S.B. 256 moved through various Senate committees this session before moving to the House where it died in the first committee is was assigned. This was a tough fought issue that is expected to be reintroduced for the 2001 session.

Health plan liability/External review: Patients' bill of rights legislation (H.B. 211) carried over from the 1999 session. This bill, which was redrafted numerous times, originally contained health plan liability and medical necessity. The final version that the governor has signed does not contain a liability or medical necessity provision, only a moderate external appeals section.

Mental health parity was expected to be the primary issue for 1999. HIAA filed comprehensive comments on mental health parity with a task force commissioned by the legislature to examine this issue. In February 1999, the task force recommended legislation that would require employers who offer health benefits and who have 20 or more employees to provide benefits for the treatment of biologically based mental illnesses, including substance abuse, in full parity with benefits for physical illnesses. Legislation to implement that recommendation (H.B. 149) was introduced shortly thereafter by the task force co-chair, Representative Gary Davis. HIAA shared its comments on mental health parity with the NFIB and the Alaska Chamber of Commerce, both of which joined HIAA in opposition to the bill. H.B. 149 stalled in 1999 and carried over for this session, but never gained much momentum. This bill died in committee.

Mandated benefits: H.B. 298/S.B. 276, a diabetes mandate, was signed by the governor. Among the provisions of the bill, it includes a $1,500 cap on outpatient self-management training, which sunsets in 2003.

ARIZONA

The Arizona Legislature convened its 2000 session on January 10, and adjourned *sine die* on April 18. Both houses of the legislature are controlled by the Republicans, who hold a slim margin in the Senate and a substantial one in the House. Governor Jane Dee Hull (R) was elected to a four-year term in 1998.

In late 1999, the industry and key legislators began meeting to try to hammer out a reform package that both sides could endorse. Representative Barbara Leff (R) and Senator Edward Cirillo (R) introduced omnibus bills that reflected many of the compromises that had been worked out. The compromise was also expected to focus the activity on the issues in the omnibus bills. However, a liability amendment was tacked on in the House and the bill passed with few dissenting votes. After negotiations forced by Senate President Burns between the trial lawyers and the industry, new liability language was crafted, and was immediately passed by both bodies and allowed to pass into law by Governor Hull who, while expressing opposition to health plan liability, felt unable to veto the legislation given the large majorities. The liability provisions in the legislation are unique to Arizona and may be the subject of litigation once the legislation takes effect in January 2001.

In addition to health plan liability, a bill was enacted that requires carriers to cover all four phases of clinical trials for cancer. A number of new *mandate bills* were run, but only PKU coverage (H.B. 2043) and an off label cancer drug requirement (H.B. 2600) were enacted. On a positive note, UETA was passed as well as some reforms to the state's onerous advertising filing requirements. The legislature also made some relatively minor changes to the health care external appeals law. Going forward, external review results are admissible in court and both long-term care policies as well as Medicare supplement policies were categorically excluded from the reach of the external review law. Of special note, a bill to remove the requirement of a finding of a "business practice" to allow for an adverse finding under the Unfair Claims Settlement Practices Act was defeated as were bills requiring a health care ombudsman, health marts, a contraceptive mandate and *physician antitrust waivers*.

ARKANSAS

The General Assembly is not scheduled to convene for a regular legislative session in 2000. At press time, a primary election was being held to determine the candidates for all 100 seats in the House of Representatives and the 17 Senate seats that will be contested in November. With term limits prohibiting 24 members of the House and 13 members of the Senate from seeking re-election, this will be an active election cycle. Governor Mike Huckabee (R) will face re-election in 2002.

The legislature is studying health insurance purchasing groups, the cost of medical care and pharmaceutical products (Proposal 99-83), and competition in the health insurance market (Proposal 99-84). In connection with these studies, Insurance Commissioner Mike Pickens recently told the House Insurance Subcommittee that Arkansas faces a health care crisis if lawmakers do not take steps to make insurance more affordable for consumers, including making Arkansas a more "managed-care friendly" state. The commissioner noted that 39 insurance companies have left the state in the past two years, leaving only a handful of health insurers writing business in Arkansas. He recommended the following remedies: (1) reduce state interference in health care; (2) place a moratorium on mandated benefits; (3) authorize small group purchasing arrangements; (4) make medical savings accounts more attractive; (5) provide a tax credit for the purchase of health insurance; (6) require external reviews for HMO complaints; (7) expand the availability of a premium tax salary credit to attract health insurers to the state; (8) enact measures to spread risk in the small employer market; and (9) do not allow the business of insurance to be "politicized" by insurers and health care providers, but listen first to "health insurance consumers."

Commissioner Pickens, somewhat inconsistently with the concerns expressed above and over strenuous objections from HIAA, had adopted a bad prompt payment regulation applicable to health insurance. After hearing further objections from Arkansas employers, and even some concerns about the regulation from physicians who had urged its adoption, Commissioner Pickens finally delayed its implementation. Efforts are proceeding to revamp the rule to be more acceptable to all concerned. If a revised rule is not sufficiently to the liking of physicians, however, it is expected that they will push for prompt pay legislation in 2001.

Governor Huckabee recently pledged $10,000 from his campaign funds to help put a plan on the November ballot for spending tobacco settlement proceeds. The plan, which the legislature rejected earlier this year during a special session, would provide for health insurance for the working poor, create a school of public health, and finance medical research at Arkansas state universities. The funds available to Arkansas from the settlement are expected to total $1.6 billion over 25 years. The plan was drafted by a group of health care interests known as the Coalition for a Healthy Arkansas Today.

CALIFORNIA

The State Legislature convened January 3 and is scheduled to adjourn *sine die* on August 31. Substantial carryover legislation remains on the table despite an extremely active year in 1999.

Democrats continue to flex their muscle, holding the governor's mansion for the first time since the days of Jerry Brown, as well as clear majorities in both houses of the legislature. Insurance Commissioner Chuck Quackenbush, one of only two Republicans that hold statewide office, is embroiled in an ugly political battle regarding his handling of Northridge earthquake settlements.

Last year, California became the third state to pass health plan liability, doing so easily and with little public debate. The legislature also enacted a comprehensive external review process and a mental health parity law. As the 2000 session moves into high gear, Democrats continue to push for other reforms that did not wind their way through the process before the September 1999 adjournment.

Physician antitrust waivers: Senator Jackie Speier (D) introduced S.B. 2007, which in its original form would have created the "Quality in Health Care Contracts Act," establishing an antitrust waiver that would allow physicians to bargain collectively. When it was clear that the sponsor did not have the votes to move the bill out of the Senate Insurance Committee, she gutted the bill and replaced it with an alternative mechanism. On May 3, the Senate Insurance Committee approved the bill, which now requires the Director of the Department of Managed Care (DMC) to establish and maintain a system of receiving, reviewing, and acting on provider complaints regarding current or proposed contracts with plans. However, on several occasions, the Senate Appropriations Committee has refused to take a vote on the bill.

Health plan liability: On May 9, the Assembly Judiciary Committee defeated legislation (A.B. 2039), which would have amended the 1999 health plan liability law to remove "significant financial harm" as grounds for filing suit with a health plan and bypassing the external review process. The bill died in committee, even though the bill was sponsored by committee chair Sheila Kuehl (D), who also co-authored the 1999 law. Assemblywoman Kuehl introduced it to carry out a promise made in the closing moments of the 1999 session as the liability bill went through. The health plan liability law, S.B. 21 (1999), does not go into effect until January 1, 2001. It is possible that this issue will be addressed through other vehicles as the session moves on, but the viability of such an amendment is unclear at this time.

In a related initiative, legislation (A.B. 1751) was introduced to ban health insurance contracts from including a clause that requires members to submit to binding arbitration for disputes. The binding arbitration clauses have been characterized as a strategy for insurers to avoid lawsuits – and the new health plan liability law. On March 28, A.B. 1751 was approved by the Assembly Judiciary Committee and moved to the Assembly floor, where it stalled, failing to be approved before the crossover deadline. Alternative legislation to A.B. 1751 has also been under consideration. S.B. 1934, which would establish that an individual under arbitration is eligible for the same damages as could be awarded in court, passed the Senate on May 31.

Privacy/Confidentiality: Despite passing a comprehensive bill last year, both the Assembly and the Senate are continuing debate on the privacy issue. In the Senate, conference committee hearings on S.B. 129 have been a forum for general policy discussions on privacy issues, including the state implications for the federal Gramm-Leach-Bliley Act (GLB). On April 12, the conference committee met for the third time. During the meeting, there was spirited discussion between Republican and Democratic members. Republicans argued that democracy is

best served by the widest possible dissemination of information and where you draw the line depends on the type and quality of the information and where and how it will be used. They argued that you could not fashion a one-size-fits-all solution for all situations at all times. Some Democrats argued that individual privacy rights should be paramount and therefore protected by an opt-in provision. The committee struggled with the question of how best to balance the right to privacy against the need to accommodate commerce. Some questioned whether there really is a harm that results to business from an opt-in provision while others argued that the burden of proof of need for an opt-in provision should be borne by those who are asking for it. The chair, Senator Steve Peace (D) concluded the hearing by stating that he believes that privacy is the civil rights issue of the turn of the century, that the business community is behind the curve in realizing that, and that they should start thinking outside of the box in proposing solutions or the danger is that they will have badly conceived legislation forced upon them. At press time, there was still no work product or draft proposal from the committee, other than the bill itself, and no decisions have been made by committee members. Senator Peace has submitted three proposals for drafting by legislative counsel: (1) an ombudsman proposal; (2) an opt-in proposal; and (3) adding some defining language to the provision in the State constitution relating to privacy. At press time, none of these concepts are yet in print. It should be noted that there are no barriers to the conference committee continuing its work until the closing days of session in late August.

In other Senate action, the Senate Finance, Investment and International Trade committee heard two opt-in bills (S.B. 1372, S.B. 1337) on April 12. After a lengthy hearing, Senator Tim Leslie (D) amended his bill, S.B. 1372, to be an opt-out bill, but the bill was defeated on a 3-1 vote. S.B. 1337 died on a 2-1 vote (and also failed reconsideration April 24). Upon reconsideration, S.B. 1372 was reported out of committee because the Democrats on that committee did not want to be left without any vehicle for privacy legislation. However, on May 9, S.B. 1372 was defeated in the Senate Judiciary Committee. When this bill was up for reconsideration the following week, both the chair of the committee and Senator Peace (who sits on this committee and chairs the S.B. 129 conference committee on privacy) made a plea to the author to join the privacy conference committee process. Senator Peace argued that Senator Leslie would be a valuable addition to his committee and that his presence would help in getting a final product negotiated. The vote for reconsideration was not taken, effectively keeping S.B. 1372 alive. It is possible that it could be revived as a vehicle for the legislation developed by the conference committee if that process stalls, or to allow Senator Leslie to carry a piece of the privacy package developed by the conference committee.

In the Assembly, several privacy bills (A.B. 1707, A.B. 2797) have been active this Spring. A.B. 1707 and A.B. 2797 were heard April 24 in the Assembly Banking and Finance Committee. A.B. 1707, an "opt-in" bill, died on a 3-3 vote with 8 votes needed for passage. There was substantial opposition to the bill from the financial services industries, banks, insurers, and some businesses. As an alternative, the committee on a 13-0 vote passed A.B. 2797. This bill is substantially narrower. It prohibits insurers from disclosing personally identifiable information concerning the health or medical or genetic history of a customer to any affiliate or nonaffiliated third party for use with regard to the granting of credit. The Association of California Life and Health Insurance Companies (ACLHIC), the Bankers Association, and the Financial Services Association supported this bill as an alternative to the other opt-in bills. They argued that A.B. 2797

addresses the most sensitive privacy area, and that the legislature should allow Gramm-Leach-Bliley to govern in the other areas affecting financial institutions.

Mandated benefits: It appears that legislators are hesitant to move too quickly on mandates this year, after last year's plethora of legislation. Among the bills that have been amended to remove mandates: (1) A.B. 536, which would have mandated human leukocyte antigen testing, but was amended to delete the mandate and replace it with a General Fund appropriation to cover the cost; (2) S.B. 1630, which would have required plans to provide infertility treatment, was amended to delete this requirement; (3) A.B. 2265 would have mandated that plans and long term care insurers that cover hospice care reimburse physicians and others for the costs of specified end-of-life care services, but was amended to delete the mandate; and (4) S.B. 1764 was a broadly drafted bill that would have required specified plans and health insurers to provide coverage for the treatment of alcohol and other drug abuse or dependency, but the mandate was deleted.

There are still several mandates pending, but most have a limited scope. There are several clinical trials bills pending. A.B. 591 and A.B. 610 were introduced in 1999 and provide clinical trials coverage for cancer. Similarly, S.B. 1839 requires plans and health insurers to provide coverage for routine patient care costs relating to the treatment of life-threatening prostate cancer in specified Phase II or Phase III clinical trials.

Long-term care: HIAA continues to work with ACLHIC and member companies in opposing Senator Joseph Dunn's bill (S.B. 898), which would impose market-killing reforms on the way long-term care insurance is sold. After he easily passed the bill in the Senate last year, Senator Dunn (D) still has several months to round up support for his bill, which failed to attract sufficient votes to be reported out of a House committee last year.

Medicare supplement: Legislation (S.B. 1814) that would make Medicare supplement insurance available on a guarantee issue basis to individuals who are disabled but not 65 years old, has passed the Senate. Earlier this session, this bill passed the Senate Insurance Committee with support from several seniors groups. HIAA argued that the bill would raise rates on seniors, an argument that did not prevail given the support from these groups.

Tax incentives: Several bills granting tax credits or deductions for health insurance expenditures have been introduced. Most of the bills remain in their respective appropriations committee and prospects for passage are unclear. With a large budget surplus, there are a seemingly infinite number of interests vying to reap the benefits of the windfall. The long-term care insurance tax credit (A.B. 2281) was held in the Assembly Revenue and Taxation Committee, as was a tax credit for prescription drugs (A.B. 2533), and other medicine (A.B. 2713). Bills still pending include tax credits for small employers that provide health insurance (A.B. 1734, A.B. 2765), and a sales tax exemption for blood glucose monitors, lancets, and blood glucose test strips (A.B. 2587).

Other: Several onerous bills have been defeated this session. For example, as introduced by Senator Jackie Speier (D), S.B. 2020 would have required health plans either to offer a plan for children's services for families above 250 percent of the federal poverty level or to pay an

investment fee at not less than 1.12 percent of the plan's total annual gross revenue. It was opposed by a broad range of plans, insurers and business, and the author took amendments to delete the entire section of the bill that created the mandate and the alternative tax. Senator Speier had another bill, S.B. 2022, which sought to prohibit health plans and insurers from imposing a preexisting condition exclusion on individual health plan coverage for pregnancy or maternity care. Strong opposition from HIAA and its allies, including ACLHIC, the California Chamber of Commerce, a number of health plans, and the California Association of Health Underwriters, helped defeat the bill in Senator Speier's own Senate Insurance Committee.

COLORADO

The General Assembly convened on January 5 and adjourned *sine die* on May 3. Republicans enjoy majorities in the Colorado House (25 D, 40 R) and Senate (15 D, 20 R). Governor Bill Owens (R) was elected to his first term in 1998.

Practice of medicine/Medical necessity: Legislation (S.B. 148) was introduced that defined the term "medically necessary" and prohibited health plans from creating financial disincentives for a provider who refers a patient for "medically necessary" treatment. Negotiations with the sponsor of S.B. 148 resulted in an amendment that limited the bill to prohibiting financial disincentives based on the number of referrals made by a provider so long as the provider adheres to the carrier's utilization review policies and procedures. This version of the bill was enacted, effective August 2, 2000.

Privacy/Confidentiality: Comprehensive privacy protection legislation (H.B. 1110) was introduced this year, but did not pass. A bill (H.B. 1395) creating a legislative task force to study privacy issues was enacted.

Mandated benefits: Legislation mandating coverage for prosthetic devises (H.B. 1478) was enacted, effective August 2, 2000.

Small group market reforms: HIAA and a coalition of interested health plans and other parties are working to gather support for an initiative to ease small group rating restrictions. Legislative action did not materialize this year, but the coalition will continue its work toward a solution in future sessions.

Long-term care: The Division of Insurance is preparing to propose a number of changes to the basic and standard long-term care insurance policies that all carriers offering long-term care benefits in Colorado are required to market. HIAA has met with the Division on several occasions to urge it to support a legislative repeal of the basic and standard requirement. The Division's response has not been favorable. We expect it to go forward with the proposed changes to the plans.

Tax incentives: Legislation (H.B. 1060) that provides a state tax credit of up to $500 for the cost of purchasing individual health insurance did not pass. Legislation (H.B. 1295) creating a state income tax credit for up to 25 percent of the amount an employer contributes annually to

employee medical savings accounts, not to exceed $50,000, was also introduced, but stalled in the Senate.

Other: Legislation (S.B. 95) mandating direct access to optometrists and ophthalmologists was signed by Governor Owens on March 27, effective January 1, 2001.

CONNECTICUT

The 2000 session convened February 9 and adjourned *sine die* on May 3. A special session is scheduled to convene on June 19, with a veto session that same day. The purpose of the special session is to vote on the budget implementer bill for the Department of Social Services (DSS). Due to protests by the pharmacy associations and the pharmaceutical manufacturers' association, this bill was not voted on by the Senate on the last day of the regular session.

Governor John Rowland (R), who was reelected to a four-year term in 1998, faced a legislature solidly controlled by Democrats. A primary will be held in September to determine the candidates for the 151 House of Representative and 36 Senate seats up for grabs in November.

Physician antitrust waivers: Two bills (S.B. 282 and S.B. 581) were introduced, but died in committee.

Health plan liability: The legislature passed a comprehensive managed care reform act in 1999, but the issue of HMO liability was not addressed in the legislation. This year, liability (S.B. 511) was introduced early in the session, but failed to meet the joint favorable deadline.

Mandated benefits: On May 16, the governor signed H.B. 5120, requiring individual and group health insurance policies that provide coverage for ostomy surgery to provide coverage for up to $1000 in related appliances and supplies. The governor also signed H.B. 5126, prohibiting insurers from limiting assignment of benefits to dentists and oral surgeons. The legislature enacted H.B. 5792, which amends the 1999 dental anesthesia mandate to apply to in-patient, outpatient or one-day dental services. In addition, a provision mandating benefits for pain management is included in the DSS implementer bill, which is pending consideration in the special session. Three other mandated benefits bills (H.B. 5696, H.B. 5824 and SB 547) died in committee.

Small group market reform. Legislation (H.B. 5694) was enacted that, among other things, amended the definition of small employer to include self-employed individuals.

Tax incentives: H.B. 5632, which would exempt high-deductible health insurance plans used to establish MSAs from the $50 maximum home health care deductible required in certain individual and group health insurance policies, passed the House at the end of the session, but the Senate took no action on the bill before adjourning.

DELAWARE

The General Assembly convened the second year of its two-year session on January 11, and adjournment is scheduled for June 30. Governor Thomas Carper (D) is term-limited beyond 2000 and has already informally announced his candidacy to challenge U.S. Senator William Roth (R). Democrats control the Senate, while Republicans control the House. Several onerous measures from 1999 have carried over.

Physician antitrust waivers: H.B. 366 was introduced at the end of the 1999 session to allow physicians to bargain collectively with health plans regarding non-reimbursement matters (unless the plan has significant market share, in which case fee-related matters can be discussed).

Health plan liability: H.B. 53 was carried over from 1999. Support for the measure tapered off at the end of the session last year, but with the recent federal and state focus on the issue, it is very possible that supporters of liability will be rejuvenated in 2000.

External review: The Department of Health and Social Services attempted in 1999 to implement external review via regulations without any specific legislative authorization to do so. Senator Patricia Blevins (D), chair of the Senate Health and Social Services Committee, has introduced S.B. 299 and held hearings. Movement is possible.

Mandated benefits: Several mandated benefit bills are under consideration, including congenital deformity coverage (H.B. 110); addiction, ADHD and autism treatment (H.B. 294); contraceptive coverage (S.B. 87); prenatal vitamin coverage (S.B. 156); and diabetic equipment and supplies (S.B. 190). The contraceptive and diabetes mandates appear to have the most momentum at this stage.

Mental health parity: This issue has garnered a great deal of attention as the Mental Health Parity Panel (created by 1998 legislation) has met. Additionally, the House Insurance Committee has held hearings on H.B. 294, which mandates mental health parity and substance abuse treatment.

Small group market reforms: H.B. 166, which carried over from 1999, incorporates HIPAA requirements on waiting periods and preexisting conditions into the state small group law. Additionally, the Insurance Department has indicated the possibility of proposing small group rating regulations.

DISTRICT OF COLUMBIA

The District of Columbia Council continues to pose interesting and unique challenges to the health insurance industry. The Council will continue its two-year session through December 2000. Physician antitrust waivers, health plan liability, and mandated benefits will likely receive significant consideration throughout the year. HIAA will continue to work with the D.C. Insurance Federation and the D.C. HMO Association to minimize the onerous legislation.

Physician antitrust waivers: Bill 13-333 continues to generate significant interest as D.C. attempts to grant physicians an antitrust waiver to provide the ability to bargain collectively with insurers. The bill passed first reading of the D.C. Council on May 3, and second reading on June 6. The industry and business community have been aggressively lobbying the councilmembers for the bill's defeat. Recently, the *Washington Post* issued an editorial on the District legislation calling for the Council to defeat the legislation since adequate managed care dispute resolution mechanisms are in place.

Health plan liability: Bill 13-92 was introduced in Fall 1999 but has yet to receive a hearing from the Committee on Consumer and Regulatory Affairs. However, health plan liability would be enacted through the physician antitrust legislation (Bill 13-333) with the provision which permits providers to negotiate over "respective physician and health plan liability for the treatment or lack of treatment of health plan enrollees."

Mandated benefits: The Committee on Consumer and Regulatory Affairs conducted a public hearing on Bill 13-45, Cancer Prevention Amendment Act (requiring breast reconstruction following mastectomy); Bill 13-399, Contraceptive Coverage Act; Bill 13-403, Diabetes Health Insurance Expansion Act (covers diabetic equipment, supplies, and education); and Bill 13-534, Drug Abuse and Mental Illness Parity. The committee is likely to favorably report all four of these bills, but the hearing generated positive discussions about the relationship between the cost of insurance and mandated benefits.

Long-term care: The Council has enacted Bill 13-246, the Long-Term Care Insurance Act of 2000.

FLORIDA

The legislature convened on March 7 and adjourned *sine die* May 5, 2000. Most of the focus on health insurance issues in the 2000 session revolved around prompt pay issues, patients' rights, and mandated benefits. Several pieces of compromise legislation regarding these issues passed, but most health insurance legislation never saw significant action. Governor Jeb Bush (R) is currently serving his second year of a four-year term and Republicans enjoy sizeable majorities in both legislative chambers. Term limits will bar more than a third of the legislature's 160 members from seeking re-election in November 2000 and will also apply to elected cabinet positions.

Physician antitrust waivers: Legislation was filed in the House but was never heard in committee (H.B. 1589). There was no Senate companion measure. The House bill was ultimately withdrawn.

Health plan liability: While several proposals saw action in the Senate, the final patients' bill of rights package (H.B. 2339) did not include liability, but did include language that merely codified existing statutory rights.

Practice of medicine/Medical necessity: Several bills were introduced attempting to define utilization review as the practice of medicine. A provision included in H.B. 2339 requires

adverse determinations to be made by a licensed physician, as opposed to a Florida-licensed physician. The bill also included language preventing health plans from requiring use of hospitalists.

Mandated benefits: A large variety of mandated benefits were introduced. However, the only mandate to pass was H.B. 399, a newborn hearing screening mandate. Defeated mandates included: infertility, contraceptives, clinical trials, organ transplant costs, mental health parity, and therapeutic services related to "autism spectrum disorder." H.B. 591 includes funding for a cost impact study of all proposed mandates. A proposal to permit the sale of a "mandate free" plan was never heard.

Small group market reforms: Legislation passed that would limit enrollment to one-life groups and add rating flexibility to the small group market (S.B. 1300). S.B. 2086 contains a rewrite of the Community Health Purchasing Alliances (CHPAs) program.

Individual market reforms: S.B. 1226 contains individual portability restrictions to narrow conversion eligibility coverage under Florida's version of HIPAA requirements. Guarantee issue of individual coverage will occur only if the 18 months of previous individual coverage was issued in Florida as opposed to another state. Industry groups drafted a bill that would have used tobacco settlement funds to create a mechanism similar to a high-risk pool, but the proposal died when the funding failed to materialize.

Long-term care: H.B. 1993 establishes a study commission to look at availability of long-term care and affordability of long-term care insurance. Includes industry representation.

Department of Insurance discretion over rate filings: A bill (H.B. 397) that would have removed much of the department's authority to regulate health insurance rates died in the Senate due to opposition from the Senate President's office.

Prompt pay: S.B. 1508 enacts the recommendations of an Agency for Health Care Administration study on claims payment issues between providers and health plans. The study recommended some state involvement in arbitrating payment disputes. It also recommended adopting the National Uniform Billing Committee's standards for clean claims. The legislation provides that automatic upcoding by providers is fraud and automatic downcoding by health plans is an unfair trade practice.

Solvency: H.B. 591 places regulation of HMOs under certain sections of the insurance code. HMOs are subjected to the insurance holding company act. HMOs may enter into contracts only with entities in good standing and impaired HMOs are prohibited from entering into new contracts. Federal solvency requirements are imposed on PSOs. The bill also specifies fees for HMO exams by the DOI.

Cabinet reorganization: A constitutional amendment passed in 1998 requires a reduction in Cabinet level positions and a merger of the departments of banking and Insurance to occur by January 1, 2003. However, the House and Senate were unable to agree on an approach to insurance regulation during the 2000 session. The proposals differed in how rates should be

regulated and whether the Commissioner should be elected or appointed. The Legislature will have to try again in 2001.

Other: Legislation was also enacted that: (1) reorganizes the Agency for Health Care Administration (H.B. 2037); (2) establishes state prescription drug program based on financial need to provide coverage to Medicare participants who do not otherwise have access to such coverage (S.B. 940); and (3) implements UETA (S.B. 1334). The UETA legislation also establishes a Technology and Privacy commission to look at financial services information. The Florida Insurance Council has a seat on the commission.

Legislation becomes effective on July 1, 2000, unless otherwise noted in the legislation. At press time, most of the passed legislation is on the Governor's desk awaiting action.

GEORGIA

The 2000 legislative session convened on January 10 and adjourned *sine die on* March 22. Democrats remain in control of both the House and the Senate, and Governor Roy Barnes (D) is in his second year of his four-year term. The enactment of health plan liability, consumer advocate legislation, and the Consumer Choice Option highlighted a tumultuous 1999 session. In contrast, the 2000 session did not present such contentious issues, with Governor Barnes focusing on education issues.

Mandated benefits: S.B. 361 and H.B. 1640, concerning clinical trials, as well as H.B. 1484 and H.B. 1538, regarding craniofacial surgery were considered, but not enacted.

Tax incentives: H.B. 1243, sponsored by Representative Charles Bannister (R), establishes that taxable net income of an individual taxpayer shall not include an amount equal to the amount expended by such taxpayer for premiums for long-term care insurance for a qualifying family member. Although this bill died when the General Assembly adjourned, momentum for this type of credit may be building as individual legislators have sought HIAA information regarding its benefit.

Other: The Department of Insurance has adopted the Consumer Choice Option. In addition, the General Assembly passed H.B. 670, requiring insurers to provide enrollees with a health insurance identification card, containing specified information.

HAWAII

The legislature convened on January 19 and adjourned *sine die* on May 3, 2000. Democrats control both legislative houses and the governor's mansion. A primary election will be held in September to determine the candidates for the House and Senate races in November. All 51 seats in the House of Representatives, and half of the 25 seats in the Senate, will be up for grabs in the fall. Governor Ben Cayetano will not seek re-election in 2002, and Lieutenant Governor Mazie Hirono (D) is expected to seek the Democratic nomination.

Physician antitrust waivers: S.B. 3039, which would have established requirements for joint contract negotiations between physicians and insurance companies, mutual benefit societies and HMOs, was introduced early in the session but was held in the Senate Commerce and Consumer Protection Committee and died.

Health plan liability: S.B. 787 expands rights of enrollees in managed care plans including right to sue for denial of care. S.B. 998 makes HMOs, managed care entities, health insurers, and mutual benefit societies liable for harm to an insured or enrollee caused by failure to exercise ordinary care when making health care treatment decisions. Both bills were carryover legislation from the 1999 session, and both died in committee.

External review: Two bills were introduced in the 2000 session addressing external review (H.B. 2811, S.B. 2655), establishing an expedited process for an appeal of a managed care plan's decision, extending the time period to request an external review of a managed care plan's final determination, and establishing standards for determining whether a health intervention is a medical necessity. H.B. 2811 died in the Finance Committee, while S.B. 2655 was sent to Governor Cayetano for his signature on May 3.

Privacy/Confidentiality: As in the 1999 session, health information privacy continues to engage the attention of legislators. When the Privacy of Health Care Information Act was passed during the 1999 legislature (Act 87), finalization of HIPAA privacy regulations was expected before the adjournment of the Regular Session of 2000. With the delay in the finalization of the federal HIPAA privacy regulations, the legislature decided that that it would be a waste of resources to comply with one set of regulations pursuant to the state Privacy of Health Care Information Act, only to amend those procedures a short time later to comply with HIPAA regulations. To remedy the situation, the House Consumer Protection and Commerce Committee amended S.B. 2254, which addresses health information privacy, to push back the implementation date of the Privacy of Health Care Information Act to July 1, 2001, in order to allow state regulations to be coordinated with HIPAA regulations, as was the original intent of the 1999 law. S.B. 2254 was sent to the Governor for his signature on May 3.

One other health information-specific privacy bill (H.B. 2004) languished in committee. The bill authorizes the Director of Office of Information Practices to bring an action against any person engaging in activities that would make the person subject to a civil monetary penalty due to a violation of the medical records confidentiality law.

Mental health parity: Several mental health parity bills were introduced, with S.B. 2819 becoming the vehicle. The bill clarifies that the definition of mental illness means any mental health condition or disorder of adults and children, as listed in the Diagnostic and Statistical Manual of the American Psychiatric Association, excluding alcohol or substance abuse, or in the Mental Disorders Section of the International Classification of Diseases. The bill prohibits deductible and co-payment amounts applied to alcohol or drug dependence or substance abuse services from being greater than those applied to other illnesses or diseases. The bill also allows an insurance policy to limit the number of treatment episodes, but prohibits limiting the number to less than two treatment episodes per lifetime. S.B. 2819 was sent to Governor Cayetano for his signature on May 3.

Mandated benefits: Various mandated benefit bills were introduced in the 2000 session, but only one was sent to the Governor for his approval. H.B. 2392 requires coverage for diabetes outpatient self-management training and education, and equipment and supplies. Other mandated benefit bills were introduced, including mandates for medical foods, aeromedical services, contraception, and social anxiety disorder.

Long-term care: The legislature continues to show interest in long-term care, with 25 bills introduced on the subject since 1999. The bills address varying areas, including tax incentives, study commissions, and the establishment of a state plan. While there was no legislative action on these bills in 2000, this will continue to be an important issue.

Tax incentives: While several initiatives were pending this session, none passed.

IDAHO

The Idaho Legislature convened its 2000 session on January 10 and adjourned *sine die* on April 5. Governor Dirk Kempthorne (R) enjoys friendly majorities in both chambers of the legislature. This year the legislature took significant action with respect to the *individual health insurance market*. Legislation (H.B. 750) was enacted that creates an individual high risk pool and, over the next two years, eliminates the rate band requirements enacted in 1994. Also, the legislature enacted S.B. 1473, which removes the state's prohibition on use of age rating in individual policies. In other action, the industry was able to defeat H.B. 595, a financial *privacy* bill, brought forward by the state's attorney general.

ILLINOIS

The General Assembly convened for its regular session on January 12 and adjourned on April 15. The legislature will return in the fall for a brief veto session. While any legislation is technically eligible for consideration, no health issues are expected to be considered this fall. The legislature is split with Republicans holding a four-seat margin in the Senate and Democrats maintaining a two-seat majority in the House. All 118 members of the House of Representatives, and 19 members of the Senate face reelection in November. Governor George Ryan (R) was elected to his term in 1998, and will not face reelection until 2002.

Physician antitrust waivers: Legislation (H.B. 3321) was introduced in late January, but meaningful discussion and movement is not expected until the 2001 session, at the earliest.

Health plan liability: H.B. 4304 was introduced in early February but remained in the Rules Committee. The bill amends the 1999 Managed Care Reform and Patient Rights Act and provides that managed care entities have the duty to exercise ordinary care when making health care treatment decisions and are liable for damages approximately caused by failure to exercise ordinary care. Authorizes a private right of action.

External review: Legislation was enacted in 1999.

Mental health parity: Legislation was introduced that would have provided for mental health parity (H.B. 111, S.B. 1724) and coverage for court-ordered substance abuse treatment (S.B. 195). Neither bill made it out of the Senate Rules Committee.

Mandated benefits: Although two bills were introduced mandating coverage for Lyme disease, Senator Parker introduced legislation (S.B. 1510) that initiates a study of the issue rather than a mandate. This compromise passed both chambers and awaits Governor Ryan's signature. Many other mandated benefit bills were introduced, but did not pass: contraceptives (H.B. 61, H.B. 597); PKU (H.B. 140); emergency services (H.B. 2187); social anxiety disorder (H.B. 3399); investigational treatments and clinical trials for cancer (S.B. 388); and childhood immunizations (S.B. 196).

Small group reform: The legislature was expected to introduce legislation addressing small group reform, which most likely would have leaned in the direction of a HIPAA-CHIP type pool. However, action was averted.

Tax incentives: Two bills were introduced (H.B. 3241, H.B. 3948) that would have provided tax incentives for the purchase of prescription drugs and long-term care respectively. However, both bills died in the House Rules Committee.

The legislature has spent a great deal of time addressing uniform prescription drug legislation (H.B. 4176). The bill passed both chambers, and awaits Governor Ryan's signature.

INDIANA

The General Assembly convened on January 11 and adjourned into informal session on March 3. All of the 100 House seats are up for election in November. Currently, Republicans control the Senate (31 R, 19 D) and the Democrats control the House (53 D, 47 R). Governor Frank O'Bannon is expected to face a strong Republican challenge in the November 2000 elections from either U.S. Representative David McIntosh or David Price, an Indianapolis attorney.

External review: Legislation was enacted during the 1999 session (H.B. 1309) requiring HMOs to develop and implement external review procedures. Because the law was limited to HMOs, S.B. 156 was introduced in 2000 to expand current external review procedures to include non-HMO managed care organizations, including PPOs. Another bill, H.B. 1189, contained managed care reform legislation, including external review provisions and onerous disclosure requirements was also introduced. Neither bill passed the Senate floor even though H.B. 1189 gained momentum as the session came to a close.

Medical necessity: S.B. 225 was introduced that would have established criteria for determination of the medical necessity of covered health care services. The determination would have to be provided to the insured and the treating health care provider in writing. That bill died in committee.

Mandated benefits: Several mandated benefits were introduced, but most died in committee. Governor O'Bannon signed two mandated benefits bills: colorectal screening (H.B.1293) and

treatment of morbid obesity (S.B. 212). S.B. 395 was introduced that would have exempted health insurance and HMO policies issued to individuals or businesses that employ fewer than 25 employees from mandated benefits statutes. That bill died in committee. S.B. 461 was introduced to provide coverage for social anxiety disorders, but the bill died in committee.

Tax incentives: Legislation died (S.B. 226) that provided a tax deduction to taxpayers for insurance for medical care for the taxpayers, taxpayers' spouses, and dependents. The bill also would have amended provisions that provide a tax deduction for premiums for qualified long-term care policies.

Other: Governor O'Bannon signed H.B. 1050, which reduces the insurance premium tax rate from 2 percent to 1.3 percent over a five-year period. He vetoed a similar bill (H.B. 1150) that would have also established criteria for insurance companies approved to be domiciled in the state after June 30, 2000.

IOWA

The legislature convened January 10 and adjourned *sine die* April 26. Republicans maintain control of the House by a 12-seat margin and the Senate by a 10-seat margin. The entire House will be up for re-election in November 2000 and Governor Tom Vilsack (D) will face re-election in 2002. Most of the health insurance-related legislation, including mandated benefits, was defeated this year in committee prior to the crossover date.

Health plan liability: Legislation was defeated in committee. There was little momentum on this issue due to passage of an external review law in 1999.

External review: External review legislation was enacted in 1999. No further activity was expected.

Privacy/Confidentiality: Confidentiality provisions consistent with federal law (Gramm-Leach-Bliley) were part of the Insurance Commissioner's omnibus legislation (S.B. 2409), which was signed by the Governor at the end of March.

Mental health parity: All bills were killed in committee that carried over from 1999, except for H.B. 2080, which made it all the way to the Senate calendar of unfinished business before dying while legislators fought over the scope of the bill. The issue is expected to return in 2001.

Mandated benefits: Most of mandated benefit bills that carried over from 1999 were defeated, except for two mandates: prescription contraceptives (S.B. 2126) and dental anesthesia (H.B. 754), which were both signed by Governor Vilsack.

Small group and individual market reforms: The Insurance Commissioner's omnibus bill (S.B. 2409) includes modifications to the small group law. The use of similar case characteristics for small employers is eliminated as part of the definition for base premium rate, index rate, and new business premium rate. The bill provides that rates for basic and standard health care coverages are to be determined as a product of a basic and standard factors and the lowest rate available for

issuance by an insurance carrier or organized delivery system. Basic and standard factors are specified.

Tax incentives: Several long-term care tax incentive bills died in committee.

Solvency/Insolvency: Insolvency provisions were adopted in S.B. 2409 that establish an assessment mechanism in the event that HMOs or organized delivery systems are found to be insolvent. H.B. 2316 was also enacted, which regulates HMOs for purposes of solvency and establishes a measure for the risk-based capital of HMOs.

KANSAS

The legislature convened on January 10 and adjourned *sine die* May 24, 2000. A primary election will be held in August to determine the candidates for the House and Senate elections in November. All 125 members of the House of Representatives and 40 members of the Senate face reelection. Republicans currently control both houses of the legislature by solid margins. Governor Bill Graves (R) is term-limited and cannot serve beyond 2002.

Health plan liability: Legislation (H.B. 2963) died in committee that would have implemented health plan liability similar to legislation enacted in Texas.

Mental health parity: Two mental health parity bills were introduced, but none survived.

Mandated benefits: A number of mandated benefits bills were killed in committee, including durable medical equipment (H.B. 2097); treatment for osteoporosis (H.B. 2770); contraceptives (H.B. 2777); secondary consultations for cancer (H.B. 2778); and social anxiety disorder (H.B. 2869).

Small group market reforms: Provisions in S.B. 668 that create a "business health partnership," were incorporated into H.B. 2005, which was signed by Governor Graves. Also, S.B. 441 was enacted, striking the sunset language from the Kansas Uninsurable Health Insurance Plan Act.

Long-term care: Legislation was enacted (H.B. 2870), creating a task force on long-term care services. The task force is required to submit a report and recommendations to the Governor and the legislature each year through 2005.

Tax incentives: Three bills were killed in committee. H.B. 2835 would have provided a tax deduction of no more than $2000 for individuals who purchase long-term care insurance, while H.B. 2134 and H.B. 2472 would have provided an income tax deduction for long-term care insurance premiums costs.

Other: The Senate Substitute for H.B. 2005, which was signed by Governor Graves, is a wide-ranging bill that: (1) requires insurance companies filing financial reports with the Insurance Department to use the risk based capital instructions and formulas developed by the NAIC; establishes *solvency* requirements for HMOs; (2) authorizes the Insurance Commissioner to

adopt regulations to implement the *privacy* provisions of Gramm-Leach-Bliley; and (3) establishes the Kansas Health Care *Prompt Payment* Act. Governor Graves also signed H.B. 2879, a bill enacting the Uniform Electronic Transactions Act, which establishes basic rules for electronic transactions.

KENTUCKY

The General Assembly convened January 5 and adjourned *sine die* on April 14. The Kentucky legislature meets for regular session only in even numbered years. The 1999 defection to the GOP of two formerly Democratic state senators—Senators Dan Seum and Bob Leeper—made the 2000 legislative session the first time in Kentucky's history that Republicans have held a majority in either chamber of the legislature.

Individual market reform: Legislation (H.B. 517) effecting significant "re-reforms" of Kentucky's individual market was enacted. Among other things, H.B. 517 replaces Kentucky's existing risk-spreading mechanism for individual coverage—the Guaranteed Access Program (GAP)—with a risk pool and permits greater flexibility in the rating of individual coverage. In addition, the bill exempts health insurance premiums for individual health plans from county and municipal premium taxes. The risk pool established by H.B. 517 is to be funded from two sources: (1) a one-time appropriation of $39 million in tobacco settlement monies and (2) funds from an existing annual assessment on major medical health insurance premiums, which is now financing GAP. The assessment is capped at one percent of annual premium. Reinsurers providing stop-loss coverage to self-funded employer plans are assessed at a rate of $2 for every $100 of premium. This bill is generally effective January 1, 2001.

External review: External review legislation (H.B. 390) was passed by the House and Senate and signed by Governor Patton on March 31, effective July 14, 2000 (pending promulgation of regulations).

Practice of medicine/Medical necessity: Legislation (H.B. 525) requiring same-state licensure of medical directors was enacted this year, effective July 14, 2000.

Mental health parity: Legislation (H.B. 268) mandating full mental health parity was enacted, effective July 14, 2000.

Mandated benefits: Legislation (H.B. 9) mandating coverage of mammograms was enacted this year, effective July 14, 2000. A bill (H.B. 450) mandating coverage of contraceptives was defeated.

Other: Legislation (S.B. 279) requiring *prompt payment* of claims was enacted.

HMO solvency legislation (S.B. 331) was enacted this year. Major provisions of the legislation include an enrollee "hold harmless" requirement; priority of payment for out-of-network claims in the case of insolvency; required approval of certain HMO provider contracts by the insurance commissioner and new authority for the commissioner to require greater reserves if an HMO transfers an unapproved amount of risk to a provider; a provision stating that HMOs must take

"reasonable steps" to ensure that providers who assume insurance risk are able to accept and manage that risk; risk-based capital requirements for HMOs; and an increase in initial capital requirements for HMOs applying for a COA after July 15, 2000. Under the authority established by S.B. 331, the commissioner has begun the process for promulgating regulations implementing the NAIC risk-based capital model.

Legislation prohibiting health plans from requiring providers to accept *all products* was attached to H.B. 517. Legislation prohibiting health plans from requiring the use of a *hospitalist* also was attached to H.B. 517.

Legislation (S.B. 195) restructuring the regulation and licensing of *prepaid dental plans* has been enacted. Under S.B. 195, a prepaid dental plan now licensed under subtitle 43 of the Kentucky insurance code will be reclassified as either a "single service organization" (SSO) or a "health discount plan." An SSO is defined generally as a health organization that accepts insurance risk but provides only one type of service (e.g., dental, podiatry, vision, or mental health services). Prepaid dental plans that take on no insurance risk will be classified as "health discount plans" (HDPs) and will be subject to minimal regulation by the department. The proposal provides that SSOs will be regulated as HMOs subject to subtitle 38 of the insurance code.

LOUISIANA

The Louisiana Legislature convened on April 24 for a session limited to fiscal matters, and adjourned *sine die* June 7. Party control of the legislature remains relatively unchanged following the November 20, 1999, election, with the Republicans gaining a seat in the House (77 D, 28 R) and the Democrats gaining a seat in the Senate (27 D, 12 R). The House elected a new Democratic speaker in January with the governor's backing. Meanwhile, Republican Governor Mike Foster's term does not expire until 2003. On the regulatory front, Insurance Commissioner Jim Brown was reelected in 1999, but will face trial in federal court on racketeering charges in June.

Three working groups of the Louisiana Health Care Commission (LHCC) have been meeting to develop draft regulations for statutes enacted in 1999. HIAA's retained counsel is a member of LHCC and is providing extensive input into the rulemaking process: (1) The first working group is currently looking at how to implement the Medical Necessity Review Organizations Act, which will govern external review procedures. (2) A second working group will begin meeting shortly on the issue of medical records confidentiality. (3) The third working group has recently completed a working draft of prompt pay regulation, which has entered the formal rulemaking process of the Department of Insurance. The rule was published in the May 26 issue of the register, with a hearing scheduled for July 26.

Individual Market: A first draft of the state budget did not contain the normal $2 million appropriation for the high-risk pool. A bill (H.B. 223) that would have imposed a premium tax on bail bond policies to fund the high-risk pool, was defeated in committee by a 14-1 vote as a result of heavy lobbying by the bail bond industry.

MAINE

The Maine Legislature convened January 5 and adjourned *sine die* on May 12. Democrats control both houses of the legislature. Many of the bills under consideration this year were carried over from 1999, including health plan liability, external review, and mental health parity.

Health plan liability/External review: After previously opposing liability, Governor Angus King (I) offered his own version of liability in the patients' bill of rights legislation (L.D. 750/ H.P. 543) near the end of the legislative session, which prohibited punitive damages, capped non-economic damages at $150,000, required exhaustion of remedies, and provided that the cause of action created by the bill shall be the exclusive private remedy available under state law for an individual suing a carrier for its health care treatment decisions. Following this proposal, Democrats and Governor King deadlocked for several weeks, with Democrats pushing a higher cap on non-economic damages and against the exclusive remedy provision. In the end, L.D. 750 was enacted at the end of the session, with Governor King signing the bill with no fanfare – no bill signing ceremony, no press involved. As passed, the bill prohibits punitive damages, capped non-economic damages at $400,000, requires exhaustion of remedies, and includes the provision the makes the new law the exclusive private remedy available under state law. The patients' bill of rights also includes the establishment of an external review mechanism, effective August 11, 2000.

Mental health parity: At a January 31 work session, the Joint Banking and Insurance Committee voted to recommend that the following bills relating to mental health and substance abuse parity "ought not to pass": L.D. 1000/S.P. 346, requiring parity for substance abuse treatment; L.D. 1158/ H.P. 835, expanding Maine's existing mental health parity requirements; and L.D. 1493/H.P. 1062, requiring parity of coverage for serious mental illnesses under long-term disability insurance policies.

Mandated benefits: The patients' bill of rights (L.D. 750/H.P 543) also included a clinical trials mandate for enrollees with life-threatening illnesses. Several other mandated benefit bills were considered this session and rejected by the Joint Banking and Insurance Committee, including mandated coverage of school-based health services (L.D. 2424/H.P. 1718).

Downstream risk: In March, Governor King signed legislation (L.D. 2029/H.P. 1422) regulating health plan contracts creating "downstream risk." The new law, among other things, requires carriers to submit certain contracts involving downstream risk to the Superintendent of Insurance for review and approval. The bill also mandates access to out-of-network providers and limits the benefit differential level between network and out-of-network providers to 20 percent. In regulatory activity, the Maine Department of Human Services (DHS) has issued a proposed rule on HMO oversight. Many provisions of the proposed rule regulate areas already subject to regulation by the Bureau of Insurance. DHS has indicated that it will eliminate provisions of the rule that would subject health plans to dual regulation and will deem nationally accredited health plans to be in compliance with many other provisions of the rule.

Prescription drug price controls: On May 11, the legislature passed compromise legislation, which Governor King immediately signed (L.D. 2599/ S.P. 1026). The new law creates a "Maine

Rx" program through which an estimated 325,000 residents who lack insurance coverage for their prescriptions will get membership cards good for discounts at participating pharmacies, effective January 1, 2001. The original bill would have imposed price controls on prescriptions by Oct. 1, 2001, unless manufacturers agreed to substantial price cuts before then. The price controls would have lowered Maine's prices to those charged in Canada, where some state residents have gone to fill prescriptions. Instead, under this bill, the state will determine by January 5, 2003, whether retail prices in Maine have dropped enough to comply with the law. If not, the state will order mandatory price cuts, effective July 1, 2003.

MARYLAND

The General Assembly convened January 12 and adjourned *sine die* on April 10. The state government is heavily Democratically controlled, with Governor Parris Glendening term-limited beyond 2002, a sizeable Democratic majority in the Senate, and a three-to-one Democratic advantage in the House.

Privacy/Confidentiality: S.B. 371 was introduced, but died when the legislature adjourned. This bill would have prohibited the disclosure of medical records by sale, rental, or barter. The bill exempted personal notes (mental health professionals) from the definition of medical records. The bill also imposed punitive damages if a person knowingly and willfully requests and obtains medical records under false pretenses with the intent to sell, transfer or use individually identifiable health information for commercial advantage or knowingly and willfully discloses a medical record in violation of the law with intent to sell, transfer or use individually identifiable health information for commercial advantage.

Mandated benefits: Several mandates were introduced this year. H.B. 6 was passed, prohibiting health insurers, nonprofit health service plans, and HMOs that provide coverage for rehabilitation for children from denying coverage because the rehabilitation was necessary as a result of condition present at birth. Others included wig/hair prosthesis (H.B. 22) – which has been signed by the Governor; hearing aids (H.B. 26, H.B. 66) – both received unfavorable reports and have died; Thin Prep pap test (H.B. 200) – received an unfavorable report from the House and has died, and colorectal screening (S.B. 174) passed the Senate, but did not pass the House as the session closed.

Small group market reforms: H.B. 91 has passed both chambers and has been signed by the Governor. This new law is intended to adopt the latest NAIC changes to the Small Group Model and bring Maryland into compliance with HIPAA. H.B. 297, which would have changed the size of small groups up to 100 and would have changed the rating bands and eliminated one-life groups, received an unfavorable report from the House and has died.

Tax incentives: S.B. 170 was introduced and received an unfavorable report and therefore has died. S.B. 171 passed the Senate and House and has been signed by Governor Glendening. This bill allows an individual a credit against the state income tax for 100 percent of long-term care insurance premiums paid by the individual up to $500 for each insured for one taxable year.

Other: Maryland became the second state (Virginia) to enact legislation (H.B. 19/S.B. 142) implementing the Uniform Computer Information Transactions Act (UCITA).

MASSACHUSETTS

The General Court began the second year of its two-year session on January 5 and is scheduled to adjourn into informal session on July 31, 2000. Legislation from the 1999 session carried over to 2000. Governor Paul Cellucci (R) began serving the second year of his first full term as governor and faces a legislature dominated by Democrats. An ad hoc coalition has launched efforts to place a single-payer initiative on the 2000 ballot, with related legislation pending in the General Court. HIAA is participating in a committee formed to oppose the initiative.

Health plan liability/External review: The Senate re-passed its 1998 version of the managed care package while the House has passed a slightly different version. The Senate external review bill (S.B. 1746) includes a liability piece, but the House bill (H.B. 4525) does not. Senate leadership held a press conference and indicated that the Senate will not pursue health plan liability in this vehicle. However, leadership did indicate that the chamber would pursue health plan liability in other legislation. The bills are currently in conference committee. HIAA submitted comments to the conferees on key issues such as medical necessity.

Privacy/Confidentiality: An onerous privacy of medical records bill (H.B. 4494) passed the Joint Committee on Health Care and was referred to the House Ways and Means Committee in July 1999, where the bill has been ever since. Industry has submitted extensive technical concerns on the bill, and the committee has indicated receptiveness to some of our changes. Governor Cellucci has a proposal of his own (H.B. 4483), and yet another bill (H.B. 4994) was introduced this year and heard on February 8 which attempts to change the federal privacy provisions contained in the Gramm-Leach-Bliley Act of 1999 (GLB) from an "opt-out" to an "opt-in." Insurance Commissioner Linda Ruthardt recently met with HIAA and companies to seek their input on what measures the DOI needs to take to comply with GLB. The Commissioner is leaning toward passage of a state law that permits the Banking Commissioner to conform state regulations to federal law.

Mental health parity: Legislation was enacted (S.B. 2172) and signed into law in May 2000. The conference committee report contains the following provisions (1) permits health plans to adhere to policy terms and conditions not inconsistent with the provisions of the act; (2) delays the implementation of the bill until April 2001; and (3) delays application of the mandate to small groups for one year so that a cost study can be completed.

Mandated benefits: A Senate mandate (S.B. 2109) for diabetes treatment, education, and supplies was enacted in the spring of 2000. Various mandated benefit bills have been filed, including: reconstructive surgery following a mastectomy, occupational therapy, Lyme disease, educational psychologists, and continuous-wave laser treatment for port-wine stain. The Lyme disease and port-wine stain mandates were referred to study committee. Many other mandates were released and could see further action. A mandate requiring coverage of dental anesthesia for certain children passed out of committee. The Joint Committee on Insurance released a mandate for

pediatric care. A Senate mandate for gynecological and contraceptive services recently passed the Senate and went to the House for referral.

Individual and small group market reforms: HIAA's proposal to freeze the small group and nongroup rate bands in place was signed into law on August 18, 1999. The statutory rate bands were scheduled to ratchet down to 1.5-1 from 2-1, but will now remain as is.

HIPAA compliance: Massachusetts continues to be out of compliance with HIPAA. Representative Flavin's solution (H.B. 4993), which contains a reinsurance mechanism for losses in the nongroup market, was redrafted by the Ways and Means Committee and passed by the House. The bill would have prohibited the cancellation of nongroup closed blocks, which had been slated to be terminated in 2000. The Senate amended the bill (S.B. 2159), but the House objected because the requirement to renew closed blocks was made optional and the reinsurance mechanism was limited to nongroup guarantee issue plans. As a consequence, the bills have gone to conference committee. At press time, the conferees had not yet met.

Tax incentives: A long-term care insurance tax credit bill filed by HIAA (S.B. 1502) was heard in the Joint Insurance Committee and was granted an extension until October 1999. There has been no further action on the bill.

Solvency: Legislation (H.B. 5070) was introduced by the Governor and passed by the Joint Insurance Committee to place minimum solvency standards on HMOs in the wake of the Harvard Pilgrim crisis. The bill is being supported by the Department of Insurance, Department of Consumer Affairs and Business Regulation which oversees the Department of Insurance, and the Massachusetts Hospital Association. HIAA has submitted written comments to the House Ways and Means Committee, which is expected to make changes to the bill.

Risk classification: Governor Cellucci filed a domestic abuse bill (H.B. 4164), which was referred to study by the Joint Insurance Committee. HIAA submitted a long list of technical concerns. The Senate passed a bill (S.B. 1948) that would prohibit gender rating in life and health policies. The House is unlikely to take up the measure. Genetic testing legislation was released from the Senate Science and Technology Committee and passed the full Senate. The bill currently contains a broad definition of genetic information. Currently, there is no House sponsor for the legislation. There are six genetic testing bills in the House Science and Technology Committee (S.B. 1948, H.B. 2461, H.B. 2463, H.B. 2648, H.B. 3955), which recently held a hearing on the measures. It is not clear whether any of the bills will pass.

MICHIGAN

The 2000 legislative session convened on January 11 and will last throughout the year. Governor John Engler (R) faces term limits and thus cannot seek re-election when his term expires in 2002. In addition to controlling the governor's mansion, Republicans enjoy majorities in both houses of the legislature.

Physician antitrust waivers: H.B. 5151 permits physicians to bargain collectively with health plans. The bill has yet to be considered by any legislative committee, but since Michigan meets throughout the year, this legislation may possibly gain momentum as the session progresses.

Health plan liability: Several bills have been introduced to provide health plan enrollees the ability to seek legal damages from their health plans. None of these bills were considered during 1999, and action on such legislation this year is uncertain.

Privacy/Confidentiality: Several bills have carried over from 1999 that would limit disclosures of private health information without prior authorization. Legislation was expected to move last session but failed to receive serious consideration before adjournment.

Mandated benefits: H.B. 4903 establishes a mandated benefit review panel to consider all mandated benefit legislation. Several mandated benefits are under consideration including mandated cancer screenings, contraceptive coverage, infertility treatment, and diabetes treatment.

Tax incentives: S.B. 241 was introduced in 1999 to allow individual tax deductions for the purchase of long-term care insurance. The bill has not received serious consideration to date.

MINNESOTA

The Minnesota Legislature convened February 1 and adjourned *sine die* May 17, 2000. Minnesota's state government is truly "tripartisan," with the Republicans controlling the House, Democrats in the majority in the Senate, and the governor's mansion occupied by Reform Party Governor Jesse Ventura. Governor Ventura has begun an effort to reform the state's bicameral legislature into a unicameral body, which is supported by some in power and disdained by others. The effort would require approval by the legislators to place the proposal on a future ballot; however, citizens do not seem to share the governor's strong desire to make the change.

Health plan liability: This issue was considered in 1999 but legislators opted to enact external review instead of health plan liability. Despite the fact that external review has yet to be implemented, health plan liability received play throughout the session, including being attached to several unrelated measures. State Attorney General Mike Hatch successfully convinced the Senate to take his bill (S.F. 953) up on the floor even though it had not been heard in any committee and had failed to pass committee deadlines. When referred to the House, however, the bill was sent to the Health Committee, where it remained for the rest of the session.

Mandated benefits: Minnesota insurers already face among the most mandated benefits in the nation; however, several additional mandates were considered including cochlear implant coverage, eyeglasses and hearing aids, laser eye surgery as well as clinical trials. Of these, mandated coverage of clinical trials for cancer patients received the most attention this year, but did not pass in the final hours of the session.

Tax incentives: The legislature considered legislation to increase the state's tax credit for individuals purchasing long-term care insurance, as well as legislation to create a tax incentive for individual purchase of health insurance. Neither measure received serious consideration.

MISSISSIPPI

The Mississippi Legislature convened on January 4 and adjourned *sine die* on May 7. A tight November gubernatorial election between former congressman Mike Parker (R) and Lieutenant Governor Ronnie Musgrove (D) left no clear winner, thus requiring the House to select a winner. In a historic event January 5, the House of Representatives voted 86-36 in favor of Ronnie Musgrove (D) to become the state's next governor. House Speaker Tim Ford (D) was overwhelmingly reelected, as was Speaker Pro Tempore Robert Clark (D). Commissioner George Dale (D) easily won re-election with his defeat of Charles Ravencraft (I) by receiving 74 percent of the votes cast to remain the longest-serving elected insurance commissioner in the nation. In the legislature, Democrats retained a solid majority in both the Senate and House.

The only health insurance related bill signed by Governor Musgrove was H.B. 1330, which deletes the repealer for same-state licensure for utilization review. Various mandated benefits, including mental health parity (H.B. 194, H.B. 655) and infertility (H.B. 702), died in committee. Prompt payment (H.B. 243, S.B. 2997), and uniform prescription drug card (S.B. 2853) legislation also died in committee. Despite the governor's promise of a patients' bill of rights package, there was not enough support in the legislature to have a preliminary draft.

Health plan liability: Liability did not become a serious issue last year and did not gain any momentum this year.

External review: Earlier this session, it was indicated by key legislators that an external review bill would be introduced and likely engrossed, if not enacted. Governor Musgrove initially indicated that he wanted a patients' bill of rights (PBOR), but never had a bill introduced. HIAA lobbied on the different PBOR elements, which proved successful since not one of the issues came to fruition.

Mental health parity: All mental health parity mandates died in committee last year, but the issue quickly reemerged this year. H.B. 194 was introduced, but a hearing was never scheduled. This issue died in committee.

Mandated benefits: Legislation (H.B. 50) was filed, which requires carriers to provide coverage for inherited metabolic diseases and the treatment of such diseases. The bill, assigned to the House Committee on Insurance was never voted on in committee and died.

Genetic testing: Legislation prohibiting the consideration of genetic information in determining coverage or other policy provisions was introduced last year, but did not move through the legislative process.

MISSOURI

The General Assembly convened on January 5 and adjourned *sine die* on May 12. While there were several bills active related to health insurance, no such legislation was enacted during the 2000 session. Governor Mel Carnahan (D), who is term-limited beyond 2000, faced a friendly legislature comprised of majorities in both the House (86 D, 76 R) and Senate (18 D, 16 R). Governor Carnahan is running for U.S. Senate against incumbent John Ashcroft (R) in what may be one of the closest Senate races in 2000. In addition, term limits will force out approximately half of the House and Senate between 2000 and 2002. Many House members will be running for Senate seats in 2000 and will be looking for visibility on key issues. The speakership will also be up for grabs after the 2000 elections.

Physician antitrust waivers: The Senate Insurance and Housing Committee heard testimony, but took no action regarding antitrust waiver legislation (S.B. 829) being supported by the Missouri Medical Association. The bill would have permitted physicians to jointly negotiate contract terms, including fee-related items. The bill assigned regulatory oversight to the Department of Insurance; however, the bill's sponsor offered a substitute to shift oversight to the Attorney General's office, securing support of the bill by the Attorney General's office. Due to the limited slots available for bills to reach the Senate floor, the bill was not taken up again.

Health plan liability: Several proposals were filed but were not given further committee action. HMOs in Missouri are already subject to liability under the medical malpractice statutes.

Mandated benefits: A variety of mandates were filed and all were defeated. The House floor substitute for H.B. 1362 (see below) contained a mandated benefit review commission. However, the commission would not have included industry representation. H.B. 1362 also contained an amendment that would require all mandates to first be applied to the state employees' plan for one year before they could be applied to other health plans. Other mandated benefits that were defeated include requiring coverage for prescription contraceptives (H.B. 1090 and H.B. 1150), devices for needlestick safety (H.B. 1747), scalp hair prosthesis treatment (H.B. 1201), and hearing aids (H.B. 1874).

Individual and small group market reforms: The House floor substitute for H.B. 1362 contained a version of HIPAA compliance; changed the size of the small group market to 2–50; and proposed guaranteed issue of the two most popular plans to HIPAA eligibles under restrictive rating, combined with a reinsurance mechanism. The bill also contained a proposal to set up HIPCs. Missouri remains one of the four states that have not passed legislation to comply with the federal law. The bill died on the House informal calendar. The bill's sponsor was never able to resurrect it or amend it to other legislation.

Long-term care: Legislation implementing a long-term care shopper's guide bill (H.B. 1737), including a ban on LTC polices providing abortion coverage, died in the Senate Insurance Committee.

Tax incentives: Several bills were introduced to increase the 50 percent deduction for long-term care insurance to 100 percent (H.B. 1158, H.B. 1466, H.B. 1830, H.B. 2076). All died in the committee of origin except for a Senate bill (S.B. 807) that died on the Senate floor.

Genetic testing: H.B. 1200 would have amended the narrow definitions of "genetic test" and "genetic information" contained in current law. The bill was heard in committee but no action was taken and as a result, the bill died in committee.

Omnibus insurance legislation: In the waning hours of the session on May 12, a Republican-led filibuster in the Senate resulted in the death of the two major health insurance initiatives pending in the 2000 session. S.B. 856 would have imposed a civil remedy for any violation of the Missouri prompt pay laws and H.B. 1292 would have provided a "fix" to the coordination of benefits statute.

MONTANA

The Legislature is not scheduled to meet for a regular legislative session in 2000. However, Governor Marc Racicot (R) called a special legislative session in May to find funding for state economic development programs. Although the special session was intended to address only the economic development issue, legislators also considered two competing proposals for spending tobacco settlement proceeds, with the legislature enacting S.B. 13. The bill places a constitutional amendment on the November ballot to create a permanent trust fund for 40 percent of the tobacco settlement cash, with income to be spent on smoking cessation and other health-related projects. There is still considerable legislative sentiment for the defeated proposal, which would have used a portion of the tobacco funds to leverage federal matching funds for Medicaid. This issue is likely to be reconsidered during the 2001 session.

A primary election will be held in June to determine the candidates for all 100 seats in the House and 26 Senate seats. Also to be determined are candidates for Governor, Lieutenant Governor, Attorney General, and State Auditor (Insurance Commissioner). The current Insurance Commissioner, Mark O'Keefe, is term-limited, but is a Democratic candidate for Governor.

NEBRASKA

The legislature, the nation's only unicameral, nonpartisan state legislative body, convened on January 5 and adjourned *sine die* April 17. Governor Mike Johanns (R) will not face re-election until 2002.

Health plan liability: Legislation (L.B. 1142) died in committee that would have provided liability for damages caused by not exercising ordinary care in making health care treatment decisions applicable to insurers, HMOs, and other managed care entities. The bill also contained a prohibition on hold-harmless clauses.

Mandated benefits: Governor Johanns signed L.B. 930, requiring coverage of reconstructive surgery following mastectomies. Additionally, the bill requires HMOs to annually file financial

statements with the director of insurance on forms prescribed by the director, which conform to standards of the NAIC. The Governor also signed L.B. 950 that requires coverage for infant hearing screenings. The Governor also signed a comprehensive bill (L.B. 1253) that: (1) mandates coverage for dental anesthesia; (2) changes the system for how the net loss in the state's Comprehensive Health Insurance Pool (CHIP) is paid; (3) changes the statutory definition of "pre-existing condition"; and (4) equalizes such benefits for adopted and biological children effective upon the date of placement of the adopted child or the date of the adoption order, whichever came first. Other mandated benefits legislation died in committee including contraceptive drugs (L.B. 845) and colorectal screening (L.B. 1250).

Medicare supplement: L.B. 1248 was introduced, requiring the sale of Medicare supplement policies to individuals under the age of 65 who are eligible for Medicare due to disability. The bill stalled in committee.

Tax incentives: L.B. 325 and L.B. 943, which would have provided for a tax credit for premiums paid on long-term care insurance policies, died in committee.

NEVADA

The Nevada legislature will not meet in regular session in 2000 and is not expected to conduct any significant interim activities of interest to the health insurance industry. Republican Governor Kenny Guinn will serve the second year of his four-year term in 2000.

NEW HAMPSHIRE

The New Hampshire legislature convened on January 5 and is adjourned *sine die* on June 1. Democrats hold a slim majority in the Senate (13D, 11R), but Republicans control the House by a considerable margin (154 D, 244 R, 1 I). Democratic Governor Jeanne Shaheen's second term in office expires in 2001. Shaheen has not announced whether she will seek a third term, but the word in Concord is that she will run.

Physician antitrust waivers: In February, the House Commerce Committee considered a bill (H.B. 1496) that would permit physicians to form collective bargaining units for the purpose of negotiating with health plans. After receiving testimony expressing strong concerns about the bill from Attorney General Philip McLaughlin, Insurance Commissioner Paula Rogers, and HIAA, the committee declined to approve H.B 1496 and instead sent the bill for interim legislative study.

Health plan liability: "Patient protection" legislation containing health plan liability was carried over this year from the 1999 session. Although other aspects of the patient protection legislation were enacted (see below), the liability provisions were rejected by the legislature.

Practice of medicine/Medical necessity: In March, Governor Shaheen signed an omnibus "patient protection" bill (H.B. 640) that, among other things, requires medical directors responsible for utilization review decisions affecting New Hampshire residents to be licensed in

New Hampshire, gives the New Hampshire Board of Medicine jurisdiction to hear complaints lodged against medical directors, and permits the board to take disciplinary action against a medical director found to have engaged in misconduct.

External review: External review provisions are included in the "patient protection" bill (H.B. 640) signed by Governor Shaheen.

Privacy/Confidentiality: Legislation was introduced (H.B. 1623), which limits disclosure of personal information by financial institutions, including insurance companies. On April 6, the House Commerce Committee voted 12-1 against the bill, with all but one member of the Committee voting the bill "inexpedient to legislate." The issue will be studied during the interim.

Mental health parity legislation was carried over from 1999 but did not receive serious consideration this year.

Mandated benefits: Legislation mandating the coverage of infertility treatment carried over from 1999 but did not pass this year. S.B. 409, a clinical trials bill mandating phases I through IV of clinical trials for life-threatening diseases was enacted.

Genetic testing: H.B. 1589, which would apply the current genetic testing law to long term care policies has passed the House. However, the Senate refused to accept the bill and a conference committee approved amendments ordering a study of genetic testing for life, long-term care, and disability income insurance.

Prompt pay: H.B. 1240, which requires, among other things, clean claims to be paid in 45 days, has passed and is awaiting action from Governor Shaheen.

NEW JERSEY

The New Jersey State Legislature began the first year of a two-year session on January 11. The session is scheduled to last throughout 2000, and bills introduced but not receiving final action will carry over to 2001. Governor Christine Whitman (R) will be forced out of office by term limits in 2001. The Assembly was up for election in the fall of 1999. The Republicans maintained control, but lost a few seats. Republicans also control the Senate.

Governor Whitman has signed A.B. 1890, which provides for payment of certain individual and provider claims against HIP Health Plan of New Jersey, Inc. and American Preferred Provider Plan, Inc. The bailout is funded by a $52 million assessment of HMOs and the bill appropriates $50,000,000 from the tobacco settlement proceeds.

Physician antitrust waivers: A.B. 464, A.B. 2169, and S.B. 1033 have been introduced, permitting joint negotiations by physicians with health benefits plans over terms and conditions of their contracts. The bills also provide for physicians to negotiate on specified non-fee related issues. Although the Senate Health Committee conducted a meeting with the physicians on the antitrust waiver issue, legislators have not further considered this legislation.

Health plan liability: Five bills have been introduced to create health plan liability. The bills are A.B. 724, A.B. 1636, A.B. 1805, A.B. 2055 and S.B. 722. All of these bills create the right of covered persons to sue their health insurance carrier for medical malpractice arising from health care treatment decisions made by the carrier.

External review: A.B. 322 has been introduced and establishes that decisions rendered by independent utilization review organizations under the Independent Health Care Appeals Program are binding on insurance carriers. A.B. 845 has been introduced and creates the Carrier Appeals Program to provide an independent review of any appeal by a carrier contending the service is not medically necessary. The bill is not intended to require coverage of a benefit that is not covered by an insured's health benefits plan, and would terminate the Independent Health Care Appeals Program.

Privacy/Confidentiality: A.B. 453 establishes that an individual's health care information is confidential and may not be disclosed by a health care practitioner or health care facility except as otherwise provided.

Mandated benefits: Over 20 mandated benefit proposals have been introduced in the legislature, including bills for epilepsy (A.B. 133), contraceptives (A.B. 180), Lyme disease (A.B. 690, A.B. 994), and sickle cell anemia (A.B. 1120, A.B. 1122). These bills will likely receive consideration during the year.

Tax incentives: A.B. 788 and A.B. 1187 would create employer tax credits for long-term care.

NEW MEXICO

The State Legislature convened January 18 and adjourned into informal session on February 17. Governor Gary Johnson (R) is term-limited beyond his current term, which expires in 2002. The legislature is controlled by Democrats in the House (40 D, 30 R) and in the Senate (25 D, 17 R).

Mandated benefits: S.B. 430, mandating payment for all stages of clinical trials, was introduced this session, but died in committee.

Mental health parity: S.B. 345 and H.B. 452 were introduced, requiring parity for mental health benefits. H.B. 452 was signed by Governor Johnson, who had indicated before the start of the 2000 legislative session that he would sign a bill that passed the legislature. The bill applies to group health plans and employer-provided group health plans providing coverage beginning on or after October 1, 2000. Mental health benefits coverage as indicated in the bill does not include coverage for treatment for substance abuse, chemical dependency, or gambling addiction.

Prompt pay: S.B. 164, prompt payment of "clean claims" legislation, was signed by Governor Johnson, applicable to HMOs, PPOs, and third party payers or their agents. S.B. 194, stop-loss legislation, was signed by the governor that expands the definition of the term "health insurance"

to include insurance that reimburses or pays on behalf of an employer or health care plan sponsor all or part of the employer's or sponsor's expenses or obligations arising pursuant to a health care plan.

NEW YORK

The 2000 New York legislative session convened on January 5 and is scheduled to recess in June. Having passed the state budget, lawmakers will now turn their attention to more substantive issues such as privacy and prompt pay. Senate Majority Leader Joseph Bruno is adamant that the legislature adjourn on June 14, so there will be likely be a rush of bills to be voted on in the coming weeks. Governor George Pataki (R), elected to a four-year term in 1998, faces a split-controlled legislature, with a Republican Senate and Democratic Assembly. A primary election will be held in September to determine the candidates for the House and Senate races in November, when all 150 Assembly seats and 61 Senate seats will be up for grabs.

Physician antitrust waivers: The Senate passed an antitrust exemption bill out of the Senate Health Committee, but it was referred to the Finance Committee, where there doesn't appear to be a concerted effort to pass such legislation.

Health plan liability: Four health plan liability bills (A.B. 140, S.B. 38, S.B. 545, S.B. 801) have been introduced, but all have stalled in the Senate. The Senate has not shown much interest in the liability issue, though the Greater New York Hospital Association has launched an extensive television ad campaign in support of managed care reform and liability.

Privacy/Confidentiality: Nine confidentiality bills have been introduced, most recently the following: S.B. 6928, which bans insurers and fraternal benefit societies from using an insured's social security number as such insured's identification, policy, contract, rider or endorsement number or for any insured identification purpose; S.B. 7089, which prohibits health insurance plans governed by the Civil Service Law from using a patient's social security number as his or her identification number; and A.B. 10324, which regulates the disclosure, protection and access to protected medical records by commercial and clinical users of such medical records. These confidentiality bills are still in their committee of jurisdiction, and had not been voted on at press time. However, both the Assembly and Senate are working on health information privacy bills to be introduced.

Mandated benefits: Over 30 mandated benefits bills have been introduced, including infertility treatments, dental anesthesia, contraceptive coverage, social anxiety disorder, smoking cessation, podiatry care, bone density testing and osteoporosis, gamete storage, infant formula, and coverage for cleft lip and palate. An infertility mandate will pass; however, the language has not been finalized. Health care activists and the cancer treatment centers continue to push for expanded coverage of experimental and investigational treatments. There is also pressure to pass "women's health" legislation, addressing mammograms, cervical cancer screening and pap tests.

Small group reform: A.B. 10208 alters requirements applicable to standardized health insurance contracts for qualifying small employers and individuals. The bill was introduced in March, and referred to the Committee on Insurance. There has been no further action at this time.

Prompt pay: S.B. 6745, introduced by Senator Seward, requires that claims submitted electronically be paid within 30 days rather than 45 days. S.B. 6745 also requires insurers to notify the policyholder of a determination not to pay a claim in whole or in part and to state the specific reasons within thirty days, and establishes a compliance standard of 95 percent for payment of claims within 45 days. The bill also defines "clean claim" as a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment. S.B. 6745 has passed the Senate and been referred to the Assembly Committee on Insurance for consideration.

NORTH CAROLINA

The General Assembly reconvened on May 8 for its short session, which traditionally considers only fiscal legislation and bills that passed their chambers of origin the previous year. The legislature, which is solidly controlled by Democrats, is expected to adjourn for the year by early July. Governor James Hunt (D) is term-limited and thus will not serve beyond 2000. Since it is a fiscal session and concerns have been raised about shortfalls in the state health plan, it is unclear the extent of consideration the legislators will give to health insurance issues in 2000.

Health plan liability (H.B. 1133) passed third reading in the House and was sent to the Senate for committee referral shortly before the General Assembly adjourned its 1999 session. House Insurance Committee Chairman Bill Hurley (D) was successful in amending the bill on the floor to place a cap on punitive damages and to require the plaintiffs to exhaust administrative remedies before they can pursue litigation. The North Carolina Medical Society made a plea for the passage of the liability legislation during the February 3, 2000 meeting of the Managed Care Study Committee.

Prompt pay legislation is another priority of the Medical Society. H.B. 1537/S.B. 1327 have been introduced which require completed claims be paid within 30 days of receipt. If payment has not been made in accordance with the Act, the claim payments will bear 18 percent interest per year, beginning on the date on which the claim should have been paid. Further, H.B. 1529/S.B. 1325 were introduced concerning HMO *solvency/insolvency*. The bills authorize the commissioner to levy a 2 percent assessment on solvent carriers when an HMO is declared insolvent. Lastly, *external review* legislation was introduced. H.B. 1538/S.B. 1324 provides for the establishment of an independent external review following the exhaustion of the internal appeals process.

Mental health parity: The General Assembly appears poised to reexamine the issue of mental health parity with the introduction of H.B. 1567/S.B. 1254. Similar legislation was considered in 1998 which undertook a very public and contentious fight before it ultimately died.

NORTH DAKOTA

The legislature is not scheduled to convene for regular legislative session in 2000. The November 2000 elections will determine the successor to Republican Governor Edward Schafer, whose term expires this year. Candidates are also vying for the posts of Lieutenant Governor,

Attorney General and Insurance Commissioner. A primary will be held in June. Insurance Commissioner Glenn Pomeroy is not running for reelection, but instead is a candidate for Attorney General. The Republican candidate to succeed Commissioner Pomeroy is a state legislator; the Democratic candidate is a plaintiff's attorney.

Interim: The Budget Committee on Health Care is studying, among other things, changes in the delivery of health care in the state as a result of managed care and trends in health insurance premium rates.

OHIO

The General Assembly reconvened on January 4 and is slated to meet throughout the year. Republicans control both chambers. Governor Robert Taft (R) won election in 1998 campaigning on health insurance reform and health plan liability, but the industry was successful in 1999 in staving off the liability attack in deference to industry-backed external review (which also included tax incentives for individual insurance and long-term care insurance). Because comprehensive managed care reform passed in 1999, 2000 is not expected to be as brutal.

Mental health parity: H.B. 53, which mandates mental health coverage, including substance abuse and addiction treatment, received a great deal of attention in committee in 1999, and momentum for the bill is expected to be even stronger this year.

Mandated benefits: Several mandates are under consideration in 2000 including contraceptives (H.B. 42), dental anesthesia (H.B. 173), prescription infant formula (H.B. 218), osteoporosis screening and treatment (H.B. 272), and diabetes treatment (S.B. 147). Additionally, the legislature is considering a bill requiring all mandated benefit bills to undergo study before being considered (H.B. 221). This legislation appears to have momentum as well.

Small group market reforms: H.B. 210 was introduced last year to require small employers to provide medical savings accounts to employees. The bill has seen no significant action to date.

Tax incentives: H.B. 33 and H.B. 88 call for tax incentives for long-term care and are technically alive; however, long-term care tax incentives were enacted as part of Governor Taft's health insurance reform legislation (H.B. 4) in 1999. HCR 37, a resolution calling for the federal government to remove barriers to state/private long-term care partnerships, was introduced but did not receive much attention during the 1999 session.

OKLAHOMA

The Oklahoma Legislature convened February 7 and adjourned *sine die* on May 26, 2000. Democrats control both legislative chambers, but Republicans control the governor's mansion until at least 2002, when Governor Frank Keating (R) will be forced out by term limits. A primary election will be held in August to determine the candidates for the House and Senate races in November. All 101 seats in the House of Representatives and 24 of 48 Senate seats will be up for grabs this fall.

Physician antitrust waivers: The Oklahoma State Medical Society (OSMA) intended to introduce antitrust exemption legislation during the 2000 session, but retreated from that position until further study of the issue could be completed. Legislation is expected during the 2001 session.

Health plan liability: On April 28, Governor Keating signed S.B. 1206, the "Health Care Liability Act" into law. The bill holds all health insurance carriers, health maintenance organizations, and other managed care entities liable for failure to exercise ordinary care, but specifies that carriers are not subject to new liability for negligence or medical mistakes on the part of providers. The law also requires that enrollees exhaust all available appeals processes prior to bringing action under the new law and stipulates that no class action lawsuits may arise under the provisions of the act. The law becomes effective on July 1, 2000.

Privacy/Confidentiality: H.B. 2673, the Financial Services Act, was requested by the Insurance Commissioner and authored by Representative Bob Weaver, Chairman of the House Banking Committee, to address issues raised by the passage of the Gramm-Leach-Bliley Act. Representative Weaver has been meeting with the State Banking Commissioner and the Director of the State Department of Securities to work on language for the bill. However, the independent agents expressed some concerns and requested that the Insurance Sales Consumer Protection Act be added to H.B. 2673. The bill passed out of the House, and received a "Do pass as amended" recommendation from the Senate Finance Committee. The bill was not taken up by the Senate before the legislature adjourned.

Mental health parity: Several mental health parity bills carried over from the 1999, however none saw action in 2000.

Mandated benefits: The legislature introduced several mandated benefit bills for the 2000 session, and many carried over from 1999. One mandated benefit bill (H.B. 2725) was enacted, mandating coverage for wigs and scalp prosthesis for individuals undergoing treatment of cancer and other conditions treated by chemotherapy or radiation therapy. The benefit is capped at $150 and excludes individual and small group policies.

Prompt pay: Two bills (H.B. 2582, S.B. 1472) have been sent to Governor Keating for his signature. The bills reduce the time period for payment of a claim from 60 days to 30 days and increase the interest rate applied to claims that are not paid in a timely fashion. The bill applies to all claims, including property and casualty claims.

OREGON

The Oregon Legislative Assembly is not scheduled to convene for a regular legislative session in 2000. Democratic Governor John Kitzhaber, M.D., faces term limits and completes his term in 2002. Kitzhaber set a record for most vetoes following the 1999 session, mostly due to budgetary disagreements with the Republican-led legislature.

Mental health parity: A study commission on mental health parity was formed last session and will continue to meet periodically throughout 2000, but no action is expected.

Other: Despite the lack of legislative activity, 2000 was particularly threatening to the industry, as several "patient protection" initiatives have been submitted for the 2000 ballot. For example, there is an initiative that would create a single payor system that has been submitted to the Secretary of State for approval. All of these measures must garner sufficient signatures to be placed upon the ballot.

PENNSYLVANIA

The General Assembly convened its 2000 legislative session on January 4 and is expected to adjourn on November 30. Governor Thomas Ridge (R) faces friendly majorities in both chambers of the legislature; however, the House is controlled by a tentative three-seat Republican majority. Scandals, retirements, and criminal investigations threaten the fragile House Republican majority as it heads toward the fall elections.

Physician antitrust waivers: Legislation has been introduced to grant providers antitrust waivers, but there appears to be little momentum to move a bill at this time.

Health plan liability: Several bills are under consideration, including H.B. 710, which was heard by a Judiciary subcommittee in January. The subcommittee chair and the sponsor of the bill both expressed interest in taking a deliberative approach to the measure, but the state attorney general and several provider groups testified in strong favor of the bill's passage. It is expected that health plan liability will be considered in several hearings this year, but the potential for enactment is not clear at this point.

External review: S.B. 585 was introduced last session to allow the state Supreme Court to establish local panels to review HMO coverage and claims payment decisions. The bill has not generated a great deal of interest to date.

Medical necessity: H.B. 384, which provides a definition for medical necessity, was introduced in 1999 but has received no action to date.

Privacy/Confidentiality: Several medical records confidentiality bills have carried over from last year, but no action has yet been taken on any. The legislative leadership has not indicated that such legislation is a priority in 2000.

Mandated benefits: Several mandates are under consideration by the legislature including contraceptives, medical/low protein foods, TMJ, dental anesthesia, cancer screenings, artificial insemination, chiropractic services, newborn hearing screening, osteoporosis, home health coverage for medically necessary reasons, hearing aids, and handcycles. All mandated benefits must undergo the scrutiny of the Health Care Cost Containment Council (HCCCC) before being approved by the legislature. Currently, the TMJ, medical foods, and contraceptive bills are being considered by the HCCCC.

Small group market reforms: H.B. 1165 requires all health insurers to offer small group plans that are free from mandated benefit requirements. In addition, S.B. 1068 allows insurers to offer

five standard small group plans on a community-rated basis. Neither bill has received much attention to date.

Individual market reforms: S.B. 1067 was introduced in August 1999 to require open enrollment and community rating in the individual market, but this bill has not seen any action to date. HIAA continues to monitor the legislation, but enactment of such a measure is not expected at this point.

Long-term care: Long-term care partnership legislation has been introduced and heard in committee, but no significant action has been taken.

Tax incentives: Several long-term care tax incentive bills have been introduced, but none have received action at this time. A quirk in Pennsylvania law would require a constitutional change to allow individual tax incentives for long-term care insurance; however, HIAA continues to pursue individual and employer tax incentives for long-term care insurance.

RHODE ISLAND

The Rhode Island 2000 legislative session convened on January 4 and is expected to adjourn *sine die* in mid-July. Governor Lincoln Almond (R), term-limited beyond 2002, faces large Democratic majorities in both chambers of the legislature. Two of the state's largest insurers, Harvard Pilgrim Health Care and Tufts Health Plan of New England, recently announced the insolvency of their Rhode Island units and exited the market. The insolvencies have left the Departments of Health and Business Regulation scrambling to find coverage for the thousands of lives dropped by the two plans. Despite these insolvencies and the fact that Rhode Island is already one of the most regulated insurance markets in the country, more regulation is expected to be sought in 2000. A slew of mandates and other onerous bills have carried over from 1999.

Physician antitrust waivers: Several bills have been filed to grant physicians antitrust waivers. With the very tentative managed care market in Rhode Island at present, it is uncertain whether any of these bills will receive action this session.

Health plan liability: Several bills were introduced in 1999 to implement health plan liability, and several more are expected in 2000. A joint study committee was commissioned and met throughout the interim to consider testimony and provide recommendations to the legislature on health plan liability. The co-chairs of the committee (Representative Suzanne Henseler and Senator Bill Irons) have introduced health plan liability legislation in both chambers (H.B. 8057, S.B. 2847) based upon the study committee recommendations. HIAA has testified against health plan liability during interim hearings and continues to stringently oppose this legislation throughout the session.

External review: Several measures have been introduced to amend the state's external review statutes, but none are expected to generate a great deal of interest this session.

Privacy/Confidentiality: The legislature is considering a few bills aimed at increasing protections for consumer medical records, but with the recent focus on health plan liability and HMO solvency, action on such legislation is unclear.

Mandated benefits: The legislature is considering virtually every type of mandated benefit bill imaginable, including hearing aid coverage, pharmacy mandates, prosthetic devices, fertility, contraceptive coverage, cancer screenings, diabetes, ambulance services, any willing chiropractor, osteoporosis, and continuity of care. Most of these bills carried over from 1999 and may not receive serious consideration.

Tax incentives: Long-term care tax incentive legislation is under consideration, but action is unclear at this point. HIAA activated grassroots efforts last year to encourage enactment of long-term care tax incentives, but anticipation of high fiscal impact caused legislators to postpone consideration.

SOUTH CAROLINA

The South Carolina Legislature convened its 2000 regular session on January 11, and adjourned *sine die* June 1. Republicans control the House (68 R, 56 D), while Democrats hold a six-seat majority in the Senate. Governor James Hodges (D) is up for re-election in 2002. Health insurance issues were a source of much debate in the legislature due to interim work on external review and mental health parity.

Health plan liability and external review: An alternative to potential health plan liability legislation was developed under the direction of the Department (S.B. 1163) which establishes external review without any new causes of action. In the waning days of the session, the South Carolina Trial Lawyers Association put on a full court press to defeat this bill, either to have the provision relating to subsequent use of an external review panel's findings deleted from the legislation or to kill the bill. They failed to do either thanks in large part to support from Senators McConnell and Saleeby, the bill's sponsors.

Mental health parity: The General Assembly passed S.B. 1041, requiring the state health insurance plan and group health insurance to provide coverage for treatment of mental health conditions and alcohol or substance abuse. Although the original version of the legislation would have rolled the mandate over to the private sector if certain thresholds are met, the passed version removed the automatic rollover and sunsets the legislation on December 31, 2005.

Medicare supplement: H.B. 3561 died, which would have required carriers to offer Medicare supplement insurance to persons under 65 years of age who qualify for coverage due to Social Security Disability or any other reason.

Tax incentives: The General Assembly introduced three bills related to tax credits or deductions for long-term care insurance. Unfortunately, minimal consideration was provided to these bills.

SOUTH DAKOTA

The South Dakota Legislature convened January 11 and adjourned *sine die* March 14. During the interim, the legislature is expected to study insurance privacy issues. Also, industry representatives are working with the Insurance Division on draft legislation concerning disability income insurance.

A primary election will be held in June to determine the candidates for the House and Senate races in November. All 70 seats in the House and all 35 seats in the Senate will be contested this fall. Term limits will force Governor William Janklow to step down in 2002.

Privacy/Confidentiality: H.B. 1175 was enacted to authorize the Division of Insurance to promulgate rules regarding the privacy of medical records.

Mandated benefits: H.B. 1133 was enacted to prohibit a health insurer that issues a policy providing coverage for prescription drugs from excluding coverage of off-label uses of FDI-approved drugs. Coverage is required for the treatment of cancer or life threatening conditions if the drug is recognized for treatment of that indication in one of the standard reference compendia or in medical literature. H.B. 1085 was also enacted, which extends the application of the mental health mandate to certificateholders solicited within the state, even if their group health plan is outside of the state. H.B. 1085 also includes a new mandate for diabetes coverage.

Individual market reforms: H.B. 1035 was enacted to clarify the law relating to health insurance issued on a franchise basis. The bill, introduced at the request of the Insurance Division, was originally intended to repeal the franchise law. S.B. 5 was enacted to apply individual insurance rating restrictions to policies in-force as of July 1, 1996, the effective date of the original rating law, which had been prospective only. S.B. 5 phases in the retroactive effect, providing that the premium rates charged during a rating period to individuals with similar case characteristics for the same or similar coverage, or the rates that could be charged to such individuals under the rating system for that class of business, may not exceed three times the base premium rate after July 1, 2001, two and one-half times the base premium rate after July 1, 2003 and two times the base premium rate after July 1, 2005.

Other: S.B. 73 was enacted to require insurers offering health insurance that limits coverage to usual, customary, or reasonable charges to disclose the limitation on the contract of insurance and to disclose that the limitation may cause the insured to incur additional out-of-pocket expenses. Insurers may comply by including the required disclosure in an outline of coverage. The law applies to all individual and group health policies solicited or sold in the state, but does not apply to policies subject to the Medicare supplement requirements.

TENNESSEE

The General Assembly convened its 2000 regular session on January 11 and was scheduled to adjourn *sine die* late-April. Although it is has not been formally announced when the legislature will adjourn, it is expected that they will remain in session through June 2000. Governor Don

Sundquist (R), term-limited beyond 2002, faces Democratic majorities in both houses of the legislature. All House seats and even-numbered Senate districts are up for election in 2000.

Physician antitrust waivers: S.B. 2672 was introduced earlier this session and had two hearings. The Attorney General testified at both hearings, where he characterized the proposal as "price-fixing." S.B. 2672 has been tabled for the session and is expected to be a focus of the legislature next session.

Health plan liability: H.B. 2002 was introduced and assigned to the Judiciary Committee where it was voted out unanimously. The bill went to the House floor where it passed by a vote of 87-11. On May 16, the Senate Commerce Committee declined to vote on this issue. Although it was indicated earlier that passage of a liability bill seemed imminent, the bill was tabled for the 2000 session without a vote. The committee is not scheduled to meet again before the 2001 session.

While the Senate has declined to act on health plan liability, the House seems hard-driven to get this issue passed. The House has amended the body of H.B. 2002 on to a non-related health insurance bill, S.B. 2804, which relates to civil procedure. At this writing, it does not appear that the House will have the Senate's support on this bill, but that may be decided in a conference committee. It should be noted that H.B. 2002 also contained a same state licensure provision for medical directors. That provision is also in S.B. 2804.

Mandated benefits: Several bills were introduced in the 1999 session, including childhood immunizations (H.B. 170), chlamydia screening (H.B. 227), and infant hearing screening (S.B. 31). In addition, legislation creating a mandated benefit review panel (S.B. 3) was introduced, as well as an infertility mandate (H.B. 1871). The carryover bills have not had hearings this year and, at this writing are expected to die in committee. Thus far only infant hearing screening (H.B. 2134) has been introduced in 2000.

Individual and small group market reform: TennCare, the state's Medicaid program, high risk pool, and HMO for the working poor, has come to a financial impasse. The $4.3 billion program is bankrupting the state budget. In efforts to secure the program's future, Governor Sundquist authored "play or pay" legislation in last year's special session. The legislation, if enacted, would have required insurers to participate in TennCare, sponsor one of TennCare's HMOs or pay an additional assessment. The bill was never voted out of committee. Although it was initially thought that the Administration would push a similar proposal during the 2000 session, they have backed off considerably and have not indicated what legislation they might support, if any.

At this writing, the prospects for the future of the TennCare program are unclear at best, as well as what legislation may be considered, if any at all, to cure TennCare's problems. Thus far, all proposals to reform TennCare have been tabled until next session. Recently, Governor Sundquist held a press conference where he pledged over $30 million to TennCare. The governor has decided that the state will begin to assume more risk of the program since two of the program's MCOs are under state receivership and the Blues continue to lose money. However, presently, it does not appear that there will be any significant TennCare reforms enacted this session.

Prompt pay: S.B. 1573/H.B. 1192 will be up for a floor vote by next week. It is expected that the governor will sign whichever bill gets to him first. The HIAA and domestic industry, along with providers, worked on this bill. Originally, this bill would have subjected companies to $100,000 fines after a single violation of the prompt pay law (which is 30 days). The proposals have been significantly altered from the original form and now: (1) contain a less onerous definition of "clean claim"; (2) require providers to file claims more promptly and; (3) impose lesser fines after multiple violations of the statute.

TEXAS

The Texas Legislature does not convene a regular session in 2000, but committees are expected to meet in the interim. Republican Governor George W. Bush, the 2000 GOP presidential nominee, is expected to spend a great deal of his time campaigning. During the interim, studies of the uninsured, health benefit mandates, the Children's Health Insurance Program, Medicaid managed care, and Medicaid/long-term care will be undertaken. Additionally, the attorney general finalized rules on the 1999 provider collective bargaining law (see HIAA State Bulletin Texas No. 15-00, dated May 17, 2000). HIAA continues to work with retained counsel, the Texas Association of Health Plans, the Texas Association of Life and Health Insurers, the Texas Association of Businesses and Chambers of Commerce, and its Health Partners Task Force to monitor interim committee activities.

UTAH

The Utah Legislature convened its 2000 regular session on January 17 and adjourned *sine die* on March 1, 2000. As has been the case for most of the past 20 years in Utah, Republicans control both houses. Republican Governor Mike Leavitt is in the last year of his second four-year term.

External review: The legislature enacted S.B. 50, which creates a new internal review procedure and directs the Insurance Department to promulgate rules establishing an external review for claims payment of coverage denials. HIAA is on the task force to develop the rules.

Mental health parity: After lengthy debate, legislation (H.B. 35) was enacted with a third substitute on the final day of session. The law requires insurers to offer small and large employers "catastrophic mental health coverage" and also to offer "50/50 mental health coverage" to small employers. The "catastrophic" plan does not allow insurers to apply limits on mental health coverage that impose a greater financial burden than coverage for physical conditions. "50/50" coverage pays for at least 50 percent of covered services for the diagnosis and treatment of mental health conditions (as defined). Parity provisions similar to federal requirements are included in S.B. 190, which was also enacted.

Mandated benefits: The legislature enacted S.B. 108, which directs the Insurance Department to develop, by rule, standards for a mandate of benefits for diabetes. S.B. 190 also included maternity stay and breast reconstruction mandate provisions. The legislature also passed S.B. 164, which allows an insurer selling individual health insurance to offer a health benefit plan that excludes a specific physical condition when the insurer and insured mutually agree in writing to

a condition-specific exclusion rider. S.B. 9 was defeated, which would have mandated coverage for contraceptives.

Genetic testing: HIAA successfully defeated H.B. 278, which would have set up certain privacy protections for individually identifiable genetic information. The legislative momentum for this issue appears to be waning. It hit its high point in 1999 when a bill (H.B. 177) was defeated on the House floor, which followed intense interim study of the issue.

VERMONT

The General Assembly convened its 2000 session on January 4 and adjourned *sine die* on May 17. Democrats maintain majorities in both chambers. Governor Howard Dean (D) will be up for re-election in 2000, as will all 30 members of the Senate and 150 House members.

Health plan liability: Legislation was introduced (S.B. 105) and passed the Senate last year. Although it seemed as if the bill was going to pass the House in the session's waning hours, it remained in House Judiciary Committee for an interim study. Late last year, several legislators indicated that liability had a better than average chance of passing the House and going to the governor. However, this year in his State of the State address, Governor Dean requested the legislature not to pass liability, as it would only lead to increased health insurance premiums. All liability proposals died without any extensive action this session. This issue will most certainly emerge again next year.

Practice of medicine/Medical necessity: S.B. 738, a professional regulation bill, has been signed by the governor. An amendment requiring same state licensure for utilization review decisions was added to this bill on the floor before a vote and was accepted. The Banking, Insurance and Health Care Administration is concerned about this law, as the Department was not contacted about this issue prior to enactment.

Mandated benefits: In Governor Dean's State of the State address, he also requested the legislature not to enact any more mandated benefits. Again, Governor Dean said that such requirements would only lead to more expensive health insurance policies. Five mandated benefit bills were carried over from last year, but none received any significant attention.

Individual and small group market reform: H.B. 684 would create a basic and standard plan and permit insurers to deviate from the community rate. Although a move in the right direction, this bill did not make it out of committee.

VIRGINIA

The General Assembly convened for the first year of its two-year session on January 12 and adjourned on March 10. Legislation not considered during the 2000 session will carry over to 2001. Governor James S. Gilmore III (R) faces term limits and will complete his term in 2001. Republicans earned a historic victory in the legislature in November by retaining control of the Senate (21 R, 19 D) and gaining outright control of the House (52 R, 47 D, 1 I). This marks the first time since Reconstruction that Republicans have been the majority party.

Health plan liability: Early in the session, Republicans held firm in committee, defeating health plan liability in the House Courts of Justice Committee (H.B. 92). However, two Republicans voted with the Democrats to approve a liability amendment to H.B. 726 on the House floor and then passed the bill in the House. However, a motion to reconsider this action was granted, and after intense lobbying, the version with liability was defeated and the bill reverted to its original form. Republicans continued to offer this issue at every opportunity in the House and Senate, but were unsuccessful at each attempt.

External review: The bill that briefly became the vehicle for liability provisions (H.B. 726) originally provided amendments to the 1999 external review law. When the liability provisions were removed from that bill, it reverted to these amendments only, and was approved. Among other things, the amendments make clear that the 1999 law created an Office of Managed Care Ombudsman, rather than a single position, and define "utilization review entity."

Practice of medicine/Medical necessity: Legislation (S.B. 529) was introduced that would have required individuals making final adverse decisions for utilization review to be licensed or otherwise credentialed by a Virginia health regulatory board. This bill was substituted to add a definition of "medical director" that provides for Virginia licensure of the medical director. However, the amendments to the utilization review and private review agent law, where this definition was added, did not include any language beyond the creation of a definition. This bill was enacted.

Privacy/Confidentiality: Legislation was introduced to protect an insured's personal information relating to abuse (H.B. 1283) and financial information (S.B. 602). Neither bill passed and both will be carried over to the 2001 legislative session.

Mental health parity: Several bills were introduced to amend the 1999 mental health parity law. The legislature has enacted legislation (S.B. 358) that clarifies that the 1999 law is not retroactively applicable to policies, contracts, and plans in effect on the legislation's effective date. Senator Steve Martin (R), chair of the Advisory Commission on Mandated Health Insurance Benefits, introduced legislation (S.B. 729) that would increase the small group carve-out for the law to groups of 2-50. Currently, the exemption is only for groups of 2-25, which has been effectively ruled void by the Bureau of Insurance because it is inconsistent with HIPAA. However, this bill was not seriously considered because legislators balked at the idea of revoking coverage for small groups that have been covered under the act since July 1999.

Mandated benefits: Various proposals for new mandated benefits have been introduced this year, but passage was limited primarily to only those mandates that were approved by the Special Advisory Commission on Mandated Health Insurance Benefits: dental anesthesia (H.B. 165), childhood immunizations (H.B. 914/S.B. 221), colorectal cancer screening (S.B. 26), and an offer for morbid obesity (S.B. 541). The legislature also approved amendments to the 1999 diabetes mandate (H.B. 1376/S.B. 274). Bills mandating EEG biofeedback (H.B. 653) and hearing aids (H.B. 554/S.B. 272) have been referred to the Commission for consideration in the interim. The infertility mandate (H.B. 1151), which had been a contentious topic in the 1999

legislature and rejected by the Commission during the interim, was not seriously considered this session.

Long-term care: Two long-term care bills (H.B. 923, H.B. 1511) were enacted. H.B. 923 requires insurers to refund any unearned premium upon termination of a long-term care insurance policy by the insured or insurer. H.B. 1511 implements NAIC model language regarding incontestability and contingent nonforfeiture.

Solvency: The legislature has enacted legislation applying the Risk Based Capital Act to health organizations (S.B. 54) and legislation requiring applicants for an HMO license to provide a financial feasibility plan and financial statement, and an initial deposit of $300,000.

UCITA: On March 14, Governor Gilmore took great pleasure in becoming the first governor to sign UCITA into law (S.B. 372). However, the bill was given a delayed effective date to July 1, 2001, and HIAA expects to be involved in interim discussion of this issue.

Other: The General Assembly enacted legislation (H.B. 1176) that establishes standardized prescription drug cards, in compliance with NCPDP standards. This bill includes a reenactment clause, which requires the 2001 General Assembly to enact the bill again before the bill can become law. HIAA has joined the task force that will study this bill in the interim. The legislature also enacted a bill (H.B. 1366) that prohibits carriers from requiring its providers to participating in all plans. It requires that such contracts contain a provision that allows the provider to refuse participation in other provider panels at the time of the contract.

WASHINGTON

The Washington Legislature convened the second year of its two-year session January 10 and adjourned *sine die* on March 9. Governor Gary Locke (D) will face reelection in 2000 and confronts a split House (49 D, 49 R) and Democratically controlled Senate. Insurance Commissioner Deborah Senn has announced her candidacy to challenge U.S. Senator Slade Gorton (R) for his seat in 2000. The recent collapse of the individual health insurance market in the state left Commissioner Senn scrambling to find ways to justify the state's highly regulated market and find coverage for uninsured individuals. Additionally, a ballot initiative to repeal the state's car tax and require public approval of all tax and fee increases (Initiative-695) passed the muster of the electorate. As a result, localities have been left clamoring to offset the lost car tax revenue, and the business community faces the threat tax increases.

As part of a larger patients' bill of rights (S.B. 6199) *health plan liability* was signed into law by Governor Locke. Legislative leadership on both sides of the aisle, as well as the governor, attorney general, and insurance commissioner, all expressed support for health plan liability legislation prior to the start of the session. This legislation also contained: (1) requirements for health plan decisions undergoing *external review*; (2) language pertaining to the *practice of medicine*, as well as same-state licensure of medical directors and other utilization review requirements; and (3) provisions requiring health insurers to develop plans to protect the *confidentiality* of insureds.

Privacy/Confidentiality: Beyond S.B. 6199 (see above), Attorney General Christine Gregoire's proposal to enact financial privacy (S.B. 6513) passed the Senate but failed to pass the House.

Mental health parity: Legislation to require health insurers to provide coverage for mental health services at the same benefit levels as other medical services was defeated.

Mandated benefits: Several mandated benefits that were under consideration including infertility treatment, clinical trial coverage, contraceptives, cranial prosthesis, mastectomy, and coverage for treatment of eating disorders were defeated.

Individual market reforms: S.B. 6067, signed by Governor Locke on March 24, repeals many of the individual market reforms adopted in 1993 that contributed to the complete collapse of the individual market in Washington.

Other: Health Care 2000, a health consumer activist group, has launched an effort to include a single payer initiative on the November ballot. Backers filed the measure in January, and now must gather 180,000 signatures by July to place the measure on the ballot. The proposal would implement a state-run health insurance plan funded by premiums paid by individuals and subsidized by a 7 percent to 9 percent payroll tax assessed against employers.

WEST VIRGINIA

The West Virginia State Legislature convened January 12 and adjourned *sine die* in March. Governor Cecil Underwood (R) will face re-election in 2000. Democrats control both chambers of the legislature by sizable margins. Despite the strong push nationally for managed care reform, West Virginia Insurance Commissioner Hanley Clark has repeatedly testified in opposition to such initiatives, indicating that his department has very few complaints from managed care enrollees, and that many complaints are decided in favor of insurers. Clark has extolled West Virginia's existing patient protection statutes as sufficient regulation of the insurance industry.

The industry confronted and defeated a strong push for *mental health parity*, *HMO reform*, *health plan liability*, and several *mandates*. By the end of the session, no major onerous legislation was approved. Legislation that was approved includes a long-term care tax deduction (HB 4354), as was legislation requiring vision plans to allow for provider choice (SB 167) and a mandate for colorectal cancer screening (SB 513). The vision bill was a compromise between industry and vision care providers.

WISCONSIN

The Wisconsin Legislature convened its 2000 session January 25 and was to have officially adjourned in early April. However, unresolved issues surrounding funding for the renovation of Lambeau Field has kept the legislature in session at press time. The legislature is split, with Republicans holding a nine-seat majority in the House and Democrats holding a slim one-seat margin in the Senate. Governor Tommy Thompson's (R) term expires in 2002. A primary election will be held in September to determine the candidates for the House and Senate races in

November. All 99 seats in the House of Representatives and 16 of 33 Senate seats will be up for election this fall.

Health plan liability: A.B. 520, which codifies McEvoy v. Group Health Cooperative, 213 Wis. 2d (1997), allowing a person to sue a managed care plan in tort for bad faith denial of coverage, has remained in the Assembly Health Committee. This bill also included external review language that was incorporated into another bill, S.B. 350 (see below), without the health plan liability language.

External review: The legislature passed S.B. 350 in March and Governor Thompson signed the bill in May. The bill requires every insurer issuing a health benefit plan to establish an internal grievance procedure and to have an independent review procedure for decisions that are adverse to insureds. The bill includes specified disease and hospital indemnity plans in the definition of "health benefit plan." A requirement that clinical peer reviewers be health care providers satisfying specified criteria is also included.

Privacy/Confidentiality: A.B. 427, signed by Governor Thompson, defines "record" for purposes of patient health care and mental health confidentiality statutes. A.B. 428, which was also signed into law in April, relates to penalties and damages for violations of confidentiality laws for patient health care records, mental health court and treatment records, HIV test results, and insurer personal medical information. The bill establishes that any person who knowingly and willfully obtains information about an individual from an insurer or insurance support organization under false pretenses may be fined a maximum of $10,000, imprisoned for not more than one year in the county jail, or both. In addition, the bill modifies the penalty to provide that such a person may not be fined more than $25,000, imprisoned for not more than nine months, or both. Further, the bill creates a provision that states that such a person is liable to the individual for actual damages, exemplary damages of not more than $25,000 and costs and reasonable actual attorney fees.

Mental health parity: Citing the mental health report released by the U.S. surgeon general, Senator Mary Panzer (R) introduced S.B. 308, which requires health insurance coverage of nervous and mental disorders, alcoholism, and other drug abuse problems. A fiscal note was attached to the bill in March that estimated an additional cost of $27-$54 million if the mandate was applied to the state plan. The bill failed to pass.

Mandated benefits: A variety of mandated benefit bills carried over from the 1999 legislative session. In addition, legislation introduced during the 2000 session included: smoking cessation, child immunization, contraceptives, infertility, hearing testing and hearing aides, clinical trials for children's cancer, child hearing screening and acupuncture. None of these mandated benefit bills have passed.

Regulatory: The Chiropractic Examining Board is considering a regulation that defines utilization review as an activity within the scope of chiropractic practice and ensures that utilization review of chiropractic is performed by qualified persons familiar with Wisconsin law. The rule seeks to clarify that utilization review of a chiropractor's records of analysis, diagnosis,

and treatment constitutes the practice of chiropractic and requires that the review be performed by a licensed chiropractor.

WYOMING

The Wyoming Legislature convened for its 20-day session on February 21, 2000 and adjourned *sine die* on March 10. Republicans control both the governor's office and the legislature. Governor Jim Geringer's term expires in 2002.

As expected, the legislative session was fairly quiet. Only two health insurance-related bills passed: H.B. 54, increasing the fee schedule for various filings, licenses, and related department requirements (fees had not been raised since 1968); and H.B. 56, eliminating Wyoming's countersignature requirement, among other provisons. While the past two years have been fairly quiet for health insurance issues, several items have been deferred for interim study by the Joint Labor, Health and Social Services Interim Committee. The Committee will be studying Medicaid Reform, substance abuse (primarily from a community health perspective), and the topic of "rising health care costs." The final category includes the following: (1) review health insurance affordability; (2) follow up on 2000 H.B. 168, "Health insurer's conditions for reimbursement;" (3) update the sunset date for the high risk pool (which is currently 6/30/2001); (4) monitor the end stage renal disease program status, cancer screenings and statistics; (5) provide oversight to Wyoming's participation in the WWAMI program; and (6) transfer the assumption of mental health issues previously considered by the Select Committee on the State Hospital and Mental Health to the Joint Labor, Health and Social Services Interim Committee.

THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM: PRELIMINARY HIGHLIGHTS OF IMPLEMENTATION AND EXPANSION

President Clinton, with overwhelming bipartisan support from the Congress, created the State Children's Health Insurance Program (S-CHIP) in 1997, allocating $48 billion over the next 10 years to expand health care coverage to uninsured children. This new program, together with Medicaid, provides meaningful health care coverage to millions of previously uninsured children – including coverage for prescription drugs, vision, hearing, and mental health services. Today, every state has implemented S-CHIP, providing health insurance coverage to over 2 million children nationwide since the beginning of the program. The success of this Federal-State partnership is one of the most significant achievements of the Clinton-Gore Administration. This summary includes highlights from state-submitted evaluations of their S-CHIP programs.

BACKGROUND

The State Children's Health Insurance Program (S-CHIP) enables states to insure children from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance through separate state programs, Medicaid expansions, or a combination of both. Each state with an approved plan receives enhanced Federal matching payments for its S-CHIP expenditures up to a fixed state "allotment". As of July 1, 2000, 50 States, the District of Columbia and five U.S. Territories have implemented S-CHIP, covering over 2 million children. In addition, the number of children enrolled in Medicaid has increased because of state-wide outreach and eligibility simplification efforts.

Of these approved plans, 15 States have created a separate child health program, 23 States have expanded Medicaid, and 18 States have developed a combination of a separate state program and a Medicaid expansion program. In addition, many states have already amended their programs to expand eligibility beyond their original proposal. Prior to S-CHIP's creation, only 4 states covered children with family incomes up to at least 200 percent of the Federal poverty level (about $33,000 for a family of 4). Today, 30 states have plans approved to cover children with incomes up to at least this level.

However, millions of eligible children remain uninsured. One study found that two-thirds of eligible uninsured children are in two-parent families. Over seventy-five percent of the parents of these children work, and only 5 percent receive welfare. Nearly all low-income parents believe having health insurance coverage for their child is very important, and two-thirds of them have tried to enroll their children in Medicaid. However, over 57 percent of these attempts were unsuccessful. Studies indicate that lack of coverage negatively affects access to care among low-income children – 41 percent of parents of eligible uninsured children postponed seeking medical care for their child because they could not afford it.

States have made strong progress in implementing their S-CHIP programs, seeking and implementing new and innovative ways to identify and enroll uninsured children in both Medicaid and S-CHIP. The steady growth of the S-CHIP program is evidence of the success of this Federal-State partnership and the nation's commitment to ensuring that all children have health insurance coverage.

STATE EVALUATIONS

The S-CHIP statute requires States to regularly report on their progress toward covering low-income children under S-CHIP, and required that each State or Territory with an approved child health plan must submit to the Secretary of Health and Human Services an evaluation of its S-CHIP Program by March 31, 2000. These evaluations provide States with an opportunity to document program achievements, assess the effectiveness of their programs, and identify ways in which the State or the Federal government might improve program performance.

Working with the states, the Department of Health and Human Services (HHS), and other interested parties, the National Academy of State Health Policy facilitated the evaluation process and created an "evaluation framework" for the States that enabled them to report their findings in a standardized manner. The states' evaluations provided HHS with valuable information on best practices as well as challenges facing states in the implementation of their programs. This information, which is available to the public, will be used to provide continuing technical assistance to facilitate future program innovations. The States' evaluations will be posted on the HCFA web site at www.hcfa.gov.

The forty-seven state evaluations submitted as of July 1, 2000 offer important insights into the experiences and future direction of S-CHIP. The information that follows is a short description of preliminary findings from the States' reports, quarterly enrollment data currently available, and regional office reviews of Medicaid enrollment and eligibility processes.

STRONG ENROLLMENT TRENDS CONTINUE

Nearly 2 million children were covered by S-CHIP between October 1, 1998 and September 30, 1999, a doubling in enrollment from December 1998, and initial reports indicate that these strong enrollment trends are continuing through the first quarter of 2000 (although data from all states is has not yet been submitted). For example, from the second quarter of fiscal year 1999 (April 1 – June 30, 1999) to the second quarter of 2000 (April 1 – June 30, 2000), enrollment increased by more than 80 percent in the 43 states for which there are data. During that time period, 19 states reported that their enrollment had more than doubled, and nine of those states reported that their program enrollment had tripled.

ELIMINATING BARRIERS TO INITIAL AND CONTINUED ENROLLMENT

States reported having worked aggressively to simplify their application, enrollment, and re-enrollment processes to ensure that eligible families can easily apply, enroll, and remain enrolled. Steps such as using a joint and mail-in applications, offering presumptive eligibility, allowing retroactive eligibility, and providing continuous eligibility are all important strategies for simplifying the enrollment process and providing opportunities for families to apply and remain enrolled in Medicaid and S-CHIP.

Coordinating Enrollment and Eligibility Requirements for Medicaid and S-CHIP

In order to ensure that children receive the most generous benefit package for which they are eligible, 29 states – over 85 percent of those with separate state programs or combination programs – report using a joint application to enroll families in their Medicaid or separate child health program. These states confirmed that using one application for both Medicaid and their separate child health program reduces paperwork, minimizes processing errors, and offers a less intrusive, more family-friendly approach to the application process.

In addition, 39 states have eliminated face-to-face interviews in Medicaid for children or in both Medicaid and the State's separate S-CHIP program.

In addition, only seven states currently require an assets test for children enrolling in Medicaid or the S-CHIP program. Out of the 17 states with combination programs, 16 have dropped the assets test in both their Medicaid expansion and their separate state program, while one has dropped it for the S-CHIP program but not Medicaid. Thirteen of the 17 states with Medicaid expansions have dropped their assets test. Over the past several years, states have dropped this requirement in the face of mounting evidence and state experience that it serves as a barrier to enrollment.

North Carolina's Health Choice For Children Program. North Carolina has successfully implemented strategies to simplify the application and enrollment procedures for families for both Medicaid and S-CHIP. The state:

- Uses a joint application for Medicaid and S-CHIP;
- Guarantees eligibility for 12 months in S-CHIP and Medicaid;
- Provides a simplified two-page application in English and Spanish;
- Allows mail-in applications;
- Cross-trained eligibility workers so they would have the expertise to determine Medicaid or S-CHIP eligibility from the application in one review, shortening the time involved in processing applications and minimizing potential errors; and
- Automatically notifies families when it is time for them to re-enroll their children in Medicaid or S-CHIP.

Ohio's Healthy Start. Ohio recently eliminated burdensome eligibility verification requirements, such as proof of residency and birth date, for children applying for Medicaid (which includes their S-CHIP Medicaid expansion). In addition, the state:

- Uses a two page simplified application;
- Allows applications to be mailed-in; and
- Eliminated requirement for a face-to-face interview before determining eligibility.

As of July 1, 2000, Ohio also expanded coverage for parents through Medicaid up to 100 percent of the poverty level.

Oklahoma's SoonerCare. Oklahoma, which has also implemented important simplification measures in its Medicaid expansion program, has been consistently successful in its outreach and enrollment efforts. The state has:

- Simplified their application from 16 pages to 1 page;
- Over 40 outstationed eligibility workers that travel the state and conduct on-site enrollment at community based sites; and
- Eliminated the assets tests and accepts self-declaration of income.

Providing Children With Immediate Access to Health Care Services

The Balanced Budget Act of 1997 provided states with new authority to make children "presumptively eligible" for Medicaid in order to provide them with immediate access to health care services. This new authority allows designated providers/individuals to enroll children in the programs on a temporary basis, relying on information supplied by the family, until the final eligibility determination is made by the appropriate State agency. Ten states have taken advantage of this new authority in either Medicaid or S-CHIP. In the states with separate programs, five states have taken advantage of this new authority in both programs, despite evidence that this option allows children to receive health care services promptly, ensures providers are paid for services delivered, and enhances opportunities for families to apply for coverage in community based settings.

Nebraska's Kids Connection. Nebraska allows providers eligible to receive Medicaid payments and agencies authorized to determine eligibility for programs such as Head Start, child care services, or WIC to determine presumptive eligibility for Medicaid. Nebraska has found that presumptive eligibility provides an opportunity for continuity of care and implementation of treatment upon evaluation by the provider.

Providing Consistent Access to Health Care Services

The Balanced Budget Act of 1997 gave states the option to enroll children in S-CHIP and Medicaid for up to 12 months, regardless of changes in income or family circumstances. Thirty-two states –over 60 percent – have taken advantage of this new authority to ensure that children enrolled in S-CHIP do not lose their coverage unnecessarily as a result of temporary changes in income or fluctuation in monthly paychecks. All but four States have taken advantage of this new option in Medicaid as well as S-CHIP. These states provide continuous eligibility for either 6 or 12 months after a child has been determined eligible for S-CHIP, even if there is a change in the family's income, assets, or size.

Maine's CubCare. Families have a simple renewal process in which the family is sent a letter containing their income information and is asked simply to respond to the letter to continue their eligibility for the program.

- Single application for CubCare and Medicaid;
- Mail-in applications; and
- Eliminated the assets test.

Redetermination processes also affect continuity of care, since unnecessary disenrollment disrupts access to care, and hinders state efforts to increase enrollment. States reported that disenrollment rates from separate child health programs were, on average, lower than Medicaid expansion disenrollment rates; and attributed this to the more stringent requirements in Medicaid that require families to report changes in age or income. It is important to note that income and other eligibility reporting requirements are state options and not mandatory.

This information can yield important insights for States regarding processes that may need to be simplified or barriers to enrollment or retention that merit further examination.

Ensuring that Families Moving From Welfare to Work Retain their Health Insurance

Welfare reform created a unique challenge to ensuring that eligible families enroll in Medicaid and now S-CHIP. Prior to reform, Medicaid eligibility was linked to welfare. The President insisted in signing the welfare reform law that all families who would have been eligible for Medicaid prior to the law remain eligible. However, HCFA received a number of reports indicating that states had not made the necessary adjustments to state and/or local policies, systems and procedures in order to ensure that individuals in families transitioning to work were enrolled Medicaid and S-CHIP when eligible. To address this issue, last August, HCFA initiated comprehensive, on-site reviews of state Medicaid enrollment and eligibility processes. These reviews included interviews with state officials and case file checks to assess compliance with current law and to develop recommendations for improvements. After completion of the reviews in all 50 states, we are aware of serious problems in a number of states.

In some situations, state policies have been out of compliance with Federal regulations. For example, in some states, families and children are disenrolled from Medicaid without the state reviewing whether the parent or child continues to be eligible under another eligibility category. More frequently, State practices and procedures, often due to delays in reprogramming computer systems to account for the delinking of cash assistance and Medicaid, have led to problems. For example, in some states, when cash assistance ended, Medicaid was automatically terminated even though in almost all cases the children and the parent would have been eligible for continued coverage.

While states have made great strides in reducing the barriers to enrollment for children, many of these same barriers continue to operate to keep low-income families from receiving the Medicaid coverage they need as they move from welfare to the workplace. These barriers undermine State welfare reform goals and limit our ability reach our enrollment targets for children. For example, most states still retain a face to face interview requirement for low-income families needing Medicaid, and do not allow families to apply or to retain eligibility through a mail-in systems.

However, despite these problems, a number of states have taken strong action to ensure that families are not unnecessarily or erroneously terminated from health insurance coverage. They include:

Delaware. The state of Delaware has developed a computerized eligibility system that automatically evaluates an individual's eligibility across programs, ensuring that families retain their eligibility for Medicaid and food assistance as they move in and out of the welfare systems. The system evaluates the eligibility of everyone in the family, because even if a parent is determined to be ineligible, the children in the family could still retain their eligibility.

Washington. Upon identifying that the state's computerized eligibility and enrollment system was automatically disenrolling individuals leaving welfare who were still eligible for Medicaid, the state has attempted to reinstate close to 100,000 individuals to coverage. In addition, the state streamlined its Medicaid eligibility reviews by relying on available information in Food Stamp files to recertify Medicaid eligibility. This eliminates unnecessary requests for information from low-income working families and reduces burdens for State and local Medicaid agencies

IMPLEMENTING INNOVATIVE OUTREACH STRATEGIES

The success of S-CHIP programs nationwide is dependant on aggressive, broad-based outreach efforts to identify and enroll eligible children. Low-income working families who have never been eligible for traditional public assistance programs – but who are now eligible for S-CHIP and Medicaid – may not realize that they can receive benefits. In some states, the application process can be long, arduous, and beyond the ability of many families to complete. Cultural barriers, like difficulties in language comprehension, also pose a barrier for some families. States have taken strong action to reach out to families to educate them about this new program and encourage them to apply.

School-based Outreach Strategies

Because schools are accepted by parents as a conduit for important information, school systems are an ideal place to identify and enroll uninsured children in Medicaid or CHIP. In addition, health insurance promotes access to needed health care, which experts confirm contributes to academic success. Children without health insurance suffer more from asthma, ear infections, vision problems - treatable conditions that dramatically interfere with classroom participation. And children without health insurance are absent more frequently than their peers. States with particularly innovative and aggressive school-based outreach strategies include:

New Jersey's KidCare. At the beginning of the school year, Governor Whitman sent a letter to school principals about KidCare and provided each school with 500 brochures on S-CHIP and Medicaid to distribute to parents. Schools, together with local parent-teacher organizations, are also using report card days and direct mailings as opportunities to share information about S-CHIP. Parents completing the application for the Free and Reduced Cost Lunch program can request to receive information about NJ KidCare. School nurses and child study team members have been trained to assist families in completing applications. As a result, New Jersey has signed over 19,000 children to Kid Care, the state's S-CHIP and Medicaid program through strong school-based strategies.

Illinois KidCare. Applications for the free and reduced price lunch program in Illinois have a check-off box on the application form for parents interested in receiving further information about KidCare. The Chicago Public Schools distributed information on KidCare as part of their Report Card Pick-up Days in November 1998 and April 1999 at over 600 public schools. KidCare staff have presentations statewide to school administrators, principals, nurses, social workers, and teachers interested in learning more about KidCare to get eligible students enrolled.

Community-Based Efforts

Many states collaborate with community based organizations to ensure that outreach and enrollment strategies are precisely targeted to the needs of local communities. States with particularly innovative and aggressive community-based outreach strategies include:

Indiana's Hoosier Healthwise. In an attempt to reduce the stigma associated with local welfare offices, a key barrier to Medicaid enrollment, the State successfully identified 500 independent enrollment centers throughout Indiana. These enrollment centers include community action centers, child care centers, health centers and hospitals, schools, and various service providers. They have processed over 20,000 applications through the enrollment centers.

Targeted Populations

Outreach efforts geared towards the mainstream population may not be effective for many children eligible for Medicaid and S-CHIP. Vulnerable populations often face socioeconomic or linguistic issues, low literacy levels, geographic isolation, or other barriers that make it difficult for them to enroll in health insurance. States with particularly innovative and aggressive community-based outreach strategies include:

Arizona's KidsCare has launched a concerted effort to reach children in Hispanic families. Activities include:

- Developing Spanish-language applications;
- Creating mass media messages that appealed to the Hispanic population;
- Airing announcements about the program on Spanish language radio and television stations;
- Producing special editions of the Arizona Farmworkers Coalition on KidsCare; and
- Placing the KidsCare logo on the side of traditionally Hispanic businesses, such as "Paletas," ice cream pushcarts used during the summer.

Georgia's PeachCare. Georgia has implemented a concerted effort to reach children in rural areas. The state has:

- Sponsored public service announcements by well-known community members, participated in local parades, and made presentations at local churches;
- Working with local businesses to provide table mats in restaurants, print flyers on grocery bags, and insert "stuffers" in local phone bills; and
- Distributing information on PeachCare to fast food restaurants and small businesses to pass on to their employees.

unikid-state:March 99 **Tabulation of the March 99 CPS: Persons < 18 & Uninsured by Poverty**
########

	Total Persons < 18					
	Under 100%	**00%-150%**	**50%-200%**	**00%-250%**	**>=250%**	**Total**
TOTAL	14,149,930	7,574,029	7,582,321	7,046,731	35,668,734	72,021,745
AK	28,299	15,740	24,208	23,854	122,832	214,933
AL	241,719	67,222	93,806	112,155	456,665	971,567
AR	115,323	108,196	90,871	81,684	274,544	670,618
AZ	384,482	151,059	197,332	131,056	540,490	1,404,419
CA	2,266,408	1,210,520	947,043	883,074	4,027,268	9,334,313
CO	142,116	81,620	82,483	78,923	619,911	1,005,053
CT	108,194	73,682	38,867	71,349	543,100	835,192
DC	46,877	14,501	6,197	3,156	30,884	101,615
DE	36,102	20,028	26,483	22,153	109,986	214,752
FL	763,645	324,941	364,603	347,074	1,455,499	3,255,762
GA	511,380	265,974	173,827	201,517	929,766	2,082,464
HI	47,368	33,412	43,084	15,009	173,910	312,783
IA	116,641	73,842	91,763	101,105	350,986	734,337
ID	79,141	53,901	43,953	44,385	169,771	391,151
IL	527,227	400,478	302,115	325,593	2,005,232	3,560,645
IN	190,970	133,153	163,679	215,652	819,163	1,522,617
KS	92,808	85,053	66,715	59,397	403,078	707,051
KY	180,122	108,946	109,047	123,543	425,145	946,803
LA	339,700	112,711	141,451	110,453	446,216	1,150,531
MA	220,064	137,097	159,660	126,573	847,508	1,490,902
MD	120,724	80,641	78,273	44,911	884,610	1,209,159
ME	47,984	31,349	22,035	44,351	169,800	315,519
MI	479,706	311,488	227,272	284,572	1,605,659	2,908,697
MN	233,735	48,604	96,160	74,839	961,182	1,414,520
MO	221,727	155,194	105,964	142,339	761,670	1,386,894
MS	170,419	117,903	101,704	98,378	280,632	769,036
MT	61,776	34,863	31,232	35,587	102,767	266,225
NC	406,014	170,276	217,076	165,898	871,120	1,830,384
ND	39,513	32,229	17,216	16,610	78,584	184,152
NE	84,506	40,610	65,582	72,449	242,881	506,028
NH	58,898	29,103	24,763	30,882	205,989	349,635
NJ	266,428	183,080	230,471	166,048	1,192,807	2,038,834
NM	154,567	73,571	77,172	58,874	205,360	569,544
NV	90,569	46,247	66,018	58,212	290,098	551,144
NY	1,225,435	428,324	462,599	463,865	2,252,644	4,832,867
OH	550,815	218,752	334,627	289,927	1,560,582	2,954,703
OK	175,589	69,986	99,037	100,957	380,286	825,855
OR	191,984	117,924	117,713	64,673	383,666	875,960
PA	555,229	263,533	297,308	252,388	1,586,043	2,954,501
RI	47,869	20,426	16,357	20,669	130,621	235,942
SC	179,966	76,749	165,719	92,891	480,786	996,111
SD	23,227	19,051	19,900	28,284	99,742	190,204
TN	264,708	175,646	173,958	185,297	652,422	1,452,031
TX	1,305,256	788,101	749,619	517,020	2,369,562	5,729,558

	Total Persons < 18					
	Under 100%	00%-150%	50%-200%	00%-250%	>=250%	Total
UT	93,902	60,612	98,223	85,069	333,644	671,450
VA	157,587	168,861	169,931	175,281	988,020	1,659,680
VT	22,680	13,495	12,881	16,453	83,941	149,450
WA	187,090	125,508	175,587	190,422	844,738	1,523,345
WI	174,776	127,217	109,217	137,016	734,012	1,282,238
WV	97,286	53,995	33,907	39,419	124,499	349,106
WY	21,379	18,615	17,613	15,445	58,413	131,465

by State

	Uninsured Persons <18					
	Under 100%	00%-150%	50%-200%	00%-250%	>=250%	Total
TOTAL	3,736,281	1,949,052	1,613,640	1,180,770	2,593,021	11,072,764
AK	9,878	4,822	4,313	4,113	6,217	29,343
AL	57,352	25,743	19,320	27,666	43,743	173,824
AR	41,346	36,017	14,863	9,783	25,132	127,141
AZ	160,977	60,953	76,474	16,571	54,619	369,594
CA	642,541	352,795	268,166	266,014	375,627	1,905,143
CO	50,032	3,944	15,324	0	56,403	125,703
CT	38,695	9,552	7,443	8,331	20,718	84,739
DC	9,942	5,050	745	541	1,908	18,186
DE	13,316	5,454	8,317	2,170	8,604	37,861
FL	206,403	100,662	66,768	56,982	153,916	584,731
GA	153,335	71,286	32,337	50,914	89,379	397,251
HI	2,350	13,120	4,812	938	8,631	29,851
IA	11,844	21,684	15,559	3,701	11,008	63,796
ID	22,855	13,408	10,211	3,640	18,743	68,857
IL	120,368	116,236	98,321	67,918	117,255	520,098
IN	58,646	46,315	38,252	16,937	71,947	232,097
KS	4,908	15,517	10,607	13,712	11,794	56,538
KY	68,982	19,783	15,714	4,476	23,821	132,776
LA	83,140	23,702	30,340	15,704	59,095	211,981
MA	37,898	4,606	17,382	11,275	47,812	118,973
MD	74,826	36,217	21,234	7,923	70,850	211,050
ME	3,670	11,610	6,153	5,082	6,379	32,894
MI	67,681	63,284	70,027	27,989	81,990	310,971
MN	69,840	2,335	23,660	2,497	42,479	140,811
MO	31,316	27,806	18,082	4,122	42,083	123,409
MS	63,077	53,673	20,321	8,438	17,809	163,318
MT	18,581	6,633	7,304	7,210	13,053	52,781
NC	98,045	35,661	36,746	22,789	48,367	241,608
ND	10,978	9,967	4,719	1,226	3,316	30,206
NE	7,653	2,194	5,531	5,461	6,898	27,737
NH	14,566	846	1,989	6,609	9,489	33,499
NJ	56,926	30,720	33,395	43,427	108,304	272,772
NM	31,915	13,889	13,029	11,941	26,508	97,282
NV	42,384	16,598	13,777	11,088	43,438	127,285
NY	271,605	98,526	79,033	49,331	169,433	667,928
OH	83,354	49,330	33,493	33,168	68,410	267,755
OK	63,291	23,579	23,555	21,284	54,246	185,955
OR	35,562	22,473	13,385	6,011	26,191	103,622
PA	94,258	33,542	48,731	28,175	62,779	267,485
RI	7,207	2,299	1,315	379	6,714	17,914
SC	68,441	26,989	17,674	2,265	31,908	147,277
SD	6,119	7,065	4,026	5,678	6,229	29,117
TN	42,257	8,794	40,189	25,269	39,335	155,844
TX	491,631	318,346	268,450	173,196	201,459	1,453,082

1078427

7860000

	Uninsured Persons <18					
	Under 100%	00%-150%	50%-200%	00%-250%	>=250%	Total
UT	22,036	15,127	6,649	15,801	17,292	76,905
VA	70,299	48,736	11,391	27,614	55,851	213,891
VT	3,703	453	472	1,288	3,499	9,415
WA	46,564	2,328	3,637	23,638	66,960	143,127
WI	23,719	19,678	20,669	17,038	43,368	124,472
WV	13,105	6,720	5,946	1,156	6,414	33,341
WY	6,864	2,985	3,790	2,291	5,598	21,528

	Percentage of Uninsured Persons <18					
	Under 100%	0%-150%	0%-200%	0%-250%	>=250%	Total
TOTAL	26.4%	25.7%	21.3%	16.8%	7.3%	15.4%
AK	34.9%	30.6%	17.8%	17.2%	5.1%	13.7%
AL	23.7%	38.3%	20.6%	24.7%	9.6%	17.9%
AR	35.9%	33.3%	16.4%	12.0%	9.2%	19.0%
AZ	41.9%	40.4%	38.8%	12.6%	10.1%	26.3%
CA	28.4%	29.1%	28.3%	30.1%	9.3%	20.4%
CO	35.2%	4.8%	18.6%	0.0%	9.1%	12.5%
CT	35.8%	13.0%	19.1%	11.7%	3.8%	10.1%
DC	21.2%	34.8%	12.0%	17.1%	6.2%	17.9%
DE	36.9%	27.2%	31.4%	9.8%	7.8%	17.6%
FL	27.0%	31.0%	18.3%	16.4%	10.6%	18.0%
GA	30.0%	26.8%	18.6%	25.3%	9.6%	19.1%
HI	5.0%	39.3%	11.2%	6.2%	5.0%	9.5%
IA	10.2%	29.4%	17.0%	3.7%	3.1%	8.7%
ID	28.9%	24.9%	23.2%	8.2%	11.0%	17.6%
IL	22.8%	29.0%	32.5%	20.9%	5.8%	14.6%
IN	30.7%	34.8%	23.4%	7.9%	8.8%	15.2%
KS	5.3%	18.2%	15.9%	23.1%	2.9%	8.0%
KY	38.3%	18.2%	14.4%	3.6%	5.6%	14.0%
LA	24.5%	21.0%	21.4%	14.2%	13.2%	18.4%
MA	17.2%	3.4%	10.9%	8.9%	5.6%	8.0%
MD	62.0%	44.9%	27.1%	17.6%	8.0%	17.5%
ME	7.6%	37.0%	27.9%	11.5%	3.8%	10.4%
MI	14.1%	20.3%	30.8%	9.8%	5.1%	10.7%
MN	29.9%	4.8%	24.6%	3.3%	4.4%	10.0%
MO	14.1%	17.9%	17.1%	2.9%	5.5%	8.9%
MS	37.0%	45.5%	20.0%	8.6%	6.3%	21.2%
MT	30.1%	19.0%	23.4%	20.3%	12.7%	19.8%
NC	24.1%	20.9%	16.9%	13.7%	5.6%	13.2%
ND	27.8%	30.9%	27.4%	7.4%	4.2%	16.4%
NE	9.1%	5.4%	8.4%	7.5%	2.8%	5.5%
NH	24.7%	2.9%	8.0%	21.4%	4.6%	9.6%
NJ	21.4%	16.8%	14.5%	26.2%	9.1%	13.4%
NM	20.6%	18.9%	16.9%	20.3%	12.9%	17.1%
NV	46.8%	35.9%	20.9%	19.0%	15.0%	23.1%
NY	22.2%	23.0%	17.1%	10.6%	7.5%	13.8%
OH	15.1%	22.6%	10.0%	11.4%	4.4%	9.1%
OK	36.0%	33.7%	23.8%	21.1%	14.3%	22.5%
OR	18.5%	19.1%	11.4%	9.3%	6.8%	11.8%
PA	17.0%	12.7%	16.4%	11.2%	4.0%	9.1%
RI	15.1%	11.3%	8.0%	1.8%	5.1%	7.6%
SC	38.0%	35.2%	10.7%	2.4%	6.6%	14.8%
SD	26.3%	37.1%	20.2%	20.1%	6.2%	15.3%
TN	16.0%	5.0%	23.1%	13.6%	6.0%	10.7%
TX	37.7%	40.4%	35.8%	33.5%	8.5%	25.4%

	Percentage of Uninsured Persons <18					
	Under 100%	0%-150%	0%-200%	0%-250%	>=250%	Total
UT	23.5%	25.0%	6.8%	18.6%	5.2%	11.5%
VA	44.6%	28.9%	6.7%	15.8%	5.7%	12.9%
VT	16.3%	3.4%	3.7%	7.8%	4.2%	6.3%
WA	24.9%	1.9%	2.1%	12.4%	7.9%	9.4%
WI	13.6%	15.5%	18.9%	12.4%	5.9%	9.7%
WV	13.5%	12.4%	17.5%	2.9%	5.2%	9.6%
WY	32.1%	16.0%	21.5%	14.8%	9.6%	16.4%