Employees' Health Insurance Program of New York State

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IN 1955, Governor Averell Harriman requested the president of the New York State Civil Service Commission to survey the status of fringe benefits for State employees. The survey was made by the department of civil service and submitted to the State budget director in October 1955. Chief among the recommendations resulting from the survey was that the State should provide some kind of health insurance coverage for its employees. This recommendation was based in part on findings that State employees were generally less favorably treated in this area than were employees of industrial and commercial enterprises. Also, it was felt that this particular type of employee benefit would meet a real employee need and would benefit the State as well.

During the 1956 session of the State legislature, several bills proposed some kind of health insurance coverage for State employees. One of these bills was introduced at the request of the State administration. Another bill was introduced by a State senator whose Joint Legislative Committee on Health Insurance Plans had been studying the general subject of health insurance coverage for some time. Still other bills were introduced under other sponsorship.

What finally emerged was a bill to add article VII to the New York State Civil Service Law. This bill was signed into law by Governor Harriman as chapter 461 of the New York State Laws of 1956. It provided for the creation of a Temporary Health Insurance Board and authorized the president of the New York State Civil Service Commission to "establish a health insurance plan for State officers and employees and their dependents" and "to purchase a contract or contracts to provide the benefits under the plan . . . ." The law stated the general character of the plan as follows:

The health insurance plan shall be designed by the president, with the approval of the board, (*a*) to provide a reasonable relationship between the hospital, surgical, and medical benefits to be included, and the expected distribution of expenses of each such type to be incurred by the covered employees and dependents, and (*b*) to include reasonable controls, which may include deductible and reinsurance provisions applicable to some or all of the benefits, to reduce unnecessary utilization of the various hospital, surgical, and medical services to be provided and to provide reasonable assurance of stability in future years of the plan, and (*c*) to provide benefits on a nondiscriminatory basis to the extent possible to active members throughout the State, wherever located.

The statute prohibited coverage of certain kinds of expenses and placed a limit on the State contribution toward the cost of the insurance. Among the kinds of expenses excluded are expenses for dental care and treatment, eye glasses and hearing aids, cosmetic surgery, treatment for illness or injury arising out of employment and covered under workmen's compensation, services received in a United States Government hospital for which no charge is made, and expenses to the extent of benefits provided under any other employer group plan.

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The law also provided that coverage could be continued after an employee retires from State service. And it provided that any contracts purchased by the president of the civil service commission were to be subject to approval by the Temporary Health Insurance Board.

The Temporary Board

The Temporary Health Insurance Board, appointed pursuant to the provisions of the statute, consisted of four members appointed by the Governor, two members appointed by the temporary president of the senate, and two members by the speaker of the assembly. The board first met in June 1956.

Since the responsibility for the development of the program rested with the president of the civil service commission, staff work for the board was assigned to the personnel services division of the department of civil service.

While chapter 461 provided that the plan should be designed by the president of the civil service commission, it was his opinion that the board should cooperate in its development in order to expedite approval. The board agreed that it should develop its own specifications rather than purchase an existing "package" plan from a carrier.

Members of the staff submitted to the board comparative information on benefits under several large plans. The staff also submitted a statement of a comprehensive plan for board discussion. Since the board could not agree on this type of program, it was decided to set forth in detail the kinds of benefits which could be agreed to as essential to any well-rounded health insurance program. The descriptions of these various benefits became the preliminary specifications which were ultimately submitted to several carriers.

At this time it became evident that it would be desirable to have the advice and assistance of technically qualified personnel from the various carriers. A Technical Advisory Committee consisting of representatives of the Blue Cross and Blue Shield plans in New York State and of the insurance industry was appointed. During the course of the early deliberations of the board and the Technical Advisory Committee, the opinions of several employee groups were obtained.

To aid the board in estimating the probable cost of the program, the members of the Technical Advisory Committee submitted estimates of costs on a unit basis for each of the benefits under consideration. (One set of estimates was submitted by representatives of Blue Cross-Blue Shield and a separate set by representatives of the commercial insurance companies.) With this information, the board was able to discuss more realistically the kind of program it could construct within the fiscal limitations established by law and by State fiscal authorities.

Characteristics and Specifications

While information on the benefit program was being developed, the staff compiled data on group characteristics which would be essential if the proposals of the carriers were to be realistic. Information was included on the age distribution of State employees, the number of male and female employees, the salary distribution for these employees, the age, number, and sex of retired employees, the number of employees living in the various geographic areas of the State, and other related information.

In connection with this phase of the program, the State health department, in cooperation with the staff of the department of civil service, surveyed by questionnaire some 3,000 State employees to determine the extent of their present health insurance coverage and to learn their desires as to the kind of program they felt the State should adopt. The department of audit and control, through the New York State Employees' Retirement System, also made available a considerable amount of information with respect to the coverage group.

To maintain flexibility with respect to adoption of the final plan, the board agreed that the specifications should include eight alternatives in addition to the basic specification. These alternatives had to do with immediate coverage of maternity care, physicians' attendance in the hospital, use of an initial amount of payment (deductible) in connection with basic hospital, basic surgical, and inhospital coverage, private duty nursing service, amount of obstetrical indemnity, and conversion privilege.

These specifications were approved by the board early in 1957, and the following few weeks were spent in developing forms and other materials to be sent to carriers with invitations to submit proposals. Although the board was not required, under chapter 461 of the New York State Laws of 1956, to get competitive bids, nevertheless it was deemed desirable to obtain proposals from as many different carriers as cared to submit them. Invitations were sent to approximately 50 insurance companies and nonprofit medical or hospital service corporations. The materials included with the invitation were:

1. The description of benefits.
2. A statewide fee schedule for surgery, radiation therapy, and physicians' attendance in the hospital for medical care. (The statewide schedule was essentially the same as that used in the Medicare program in New York State.)
3. An area fee schedule for surgery, radiation therapy, and inhospital medical care. (The area fee schedules used were those of the Blue Shield plans operating in New York State.)
4. A schedule for obstetrical services.
5. State employee population characteristics.
6. Distribution of State employees by age and sex.
7. Distribution of State employees by salary levels.
8. Distribution of State employees by county of residence.
9. Distribution of retired State employees by age.
10. Instructions for submitting premium or subscription charges.
11. A list of eight questions relating to conditions applicable to providing services and benefits.
12. Forms to be used in submitting proposals and in estimating costs and retentions for a 10-year period.

The carriers were asked in submitting their proposals to show separate figures for active employees and for "future retired" employees. In each case, they were asked to show separate figures for part I, hospitalization benefits, part II, basic surgical, radiation therapy, and inhospital benefits, and part III, major medical expense benefits. They were also asked to show a composite cost per employee based on a distribution of 35 percent individual coverage and 65 percent individual and dependent (family) coverage. The carriers were requested to show the total first-year premium cost for 70,000 active employees and 450 retired employees. They were requested also to show a separate figure for maternity costs if no waiting period was imposed for the charter group. Finally, the carriers were requested to show a 10th-year premium, again based on 70,000 active employees, but with 7,200 retired employees to be covered during the 10th year. (It was recognized that the figure, 70,000 actives, for the 10th year was not realistic since it did not anticipate any increase in the size of the employee group. It did illustrate the effect of expected higher costs as more employees reached retirement age.)

In estimating retentions, the carriers were requested to show for each of the first 10 years the premium or subscription charge, rate credits, dividend or retroactive credits, net costs, incurred claims, and total returns and retentions, including taxes, expenses, and reserves. Retentions were to be based on an assumption of incurred claims of 85 percent under part I, 85 percent under part II, and 75 percent under part III, and also for incurred claims of 75 percent on part I, 75 percent on part II, and 70 percent on part III.

Proposals of Carriers

The specifications were mailed on February 28, 1957, and the carriers were asked to return their proposals to the department of civil service not later than March 29. Representatives of the carriers were invited to be present when the proposals were opened.

Eleven carriers submitted proposals on one or more parts of the program. At this point, it was determined that the department of civil service should have the assistance of consultants in the insurance field to help analyze the proposals. The chief actuary of the Insurance Department of New York State prepared an analysis and report, including recommendations, on the proposals. The department also obtained the services of an insurance consultant who also analyzed the proposals and submitted a report to the president of the civil service commission.

Representatives of the staff, together with the consultants, then met informally with representatives of six of the carriers whose proposals were deemed best. At these conferences, the carriers' representatives were asked to explain in greater detail various aspects of their proposals and were questioned by the consultants and by staff members. Subsequently, the reports were turned over to the Temporary Health Insurance Board. The six carriers were given the opportunity to appear before the board to describe and support further their respective proposals. Members of the board were given the opportunity to question each of the carriers' representatives.

Following the presentations by the carriers' representatives, the board, with the two consultants present, discussed the proposals. After lengthy deliberation, the board decided to negotiate with the Blue Cross corporations of New York State for the part I hospitalization benefits, with the Blue Shield corporations of New York State for the part II surgical, radiation therapy, and inhospital benefits, and with the Metropolitan Life Insurance Company for the part III major medical expense insurance benefits.

The contracts with these carriers were to constitute what subsequently became the "statewide plan" for which all State employees were eligible. The board also approved two optional plans, both of which carried the basic hospitalization coverage provided through the Blue Cross plans of New York State, but which in other respects differed from the statewide plan. One of these options was the Group Health Insurance, Inc., and the other, the Health Insurance Plan of Greater New York.

The board approved the program in June 1957, and the contracts providing for coverage were completed in August.

Enrollment

At this point, so as to inform prospective enrollees, it became necessary to fix a date on which coverage was to begin. This date had to be fixed sufficiently far in advance to permit the preparation of literature and the organization and the carrying out of an adequate educational and enrollment campaign.

The development of the necessary descriptive literature was a difficult task. In any program in which there is more than one carrier, care must be exercised to insure that the plan is described accurately and fairly, especially if employees are to have options. Two different booklets and two different enrollment forms were issued to prevent confusing the employees unnecessarily. One booklet described the statewide plan and the two options; the other described only the statewide plan, since this booklet was to be used in those areas where only the statewide plan would be available.

Enrollment of not less than 75 percent of the eligible employees was required under the terms of the contracts. It was estimated that, to achieve this percentage, 3 to 4 weeks of intensive enrollment would be required. Basically, the educational program was decentralized to the various departments and agencies of the State government. In order to do this, it was necessary to hold intensive training sessions for those who would conduct the employee meetings. The first session was of 3 days' duration and was limited to training personnel who were well acquainted with the techniques of presenting material to groups of employees. This group needed only to be instructed in the details of the health insurance program. The other sessions lasted 5 days and included not only details of the program but also techniques of presentation. Each department or agency sent one or more representatives to a training session; these trained individuals then returned to the agency to conduct employee meetings.

In the department of mental hygiene, with its 25 institutions and some 30,000 employees, the presentations were made by staff members of the health insurance unit in the department of civil service. Booklets and enrollment forms were distributed by the agencies, and educational material was made available through the employees' press and through the *State Personnel News*, a publication of the department of civil service which reaches all employees.

The fact that a number of employees working in State hospitals receive a considerable amount of medical care without charge tended to affect enrollment adversely. Also many State employees already had coverage through a spouse who worked in an industrial or commercial

establishment. The effectiveness of the enrollment program, however, was attested to by an original enrollment of more than 73,000 employees, which was in excess of the 75 percent required.

The plan went into effect on December 5, 1957. During the first 6 months, more than 25,000 claims were presented. It has not been possible as yet to analyze these claims in detail to determine incidence of various types of illnesses, number of hospital admissions, average length of hospital stay, and other similar information. The claim figures cited above do not include claims under the GHI option nor do they cover services under the HIP option.

Summary of Benefits

While it is not appropriate here to describe in detail the plans, a summary of the benefits will provide a general understanding of the program.

The statewide plan consists of the three parts mentioned previously. Hospitalization benefits are provided under part I. Benefits for surgery, radiation therapy, anesthesiology, obstetrics, and inhospital medical care are provided under part II. Part III covers major medical expense benefits, including a wide range of medical care expenses divided generally into (*a*) extensions of the benefits provided under parts I and II and (*b*) benefits for certain services not covered under parts I and II.

The statewide plan and the two options provide the same basic hospitalization benefits, which include:

1. A total of 120 days' room and board charges at the semiprivate accommodation rate. (If a private room is occupied, the benefit allowed equals the charge most common for a semiprivate room.)
2. All hospital diagnostic and therapeutic services.
3. Maternity benefits of flat amounts.
4. Emergency outpatient services for treatment of injuries arising from accidents or for emergency surgery if given not later than the day following the accident.

The contract provides for hospitalization benefits for pulmonary tuberculosis and for mental or nervous disorders, but the benefit in such cases is limited to 30 days in a general or public hospital rather than 120 days.

Maternity care under part I and obstetrical benefits under part II total $150 for normal delivery, $175 for cesarian section or ectopic pregnancy, and $50 for a miscarriage. In the $150 indemnity for a normal delivery, $75 is paid through Blue Cross under part I, and $75 through Blue Shield under part II (or $87.50 each for cesarian section and ectopic pregnancy, and $25 each for a miscarriage). If, in a normal delivery, the amount under part I should be only $60, then Blue Shield could pay the difference between this amount and $150, or $90. The same relationship exists between benefits under part I and part II in the payments for cesarian section and miscarriage.

The part II benefits, as well as the benefits under part I, may be extended by the major medical expense portion of the program, part III. If, for example, the benefits for surgery under part II fail to meet the entire cost, the excess cost is subject to reimbursement under part III. An illustration of how part III extends the benefits of part I is the case of the person who stays in the hospital for more than 120 days. Under the major medical expense program, benefits are provided for these additional days. In addition, part III of the program covers such services as private duty nursing, drugs and pharmaceuticals, rental of durable equipment, prosthetic appliances, and local professional ambulance services. These latter services are generally not covered under part I or part II of the statewide plan.

Benefits under part III are subject to an initial charge, or "deductible," of $50 for each covered individual in each calendar year. Total benefits under parts I, II, and III of the statewide plan are limited to $7,500 in any one year and $15,000 in a lifetime, with reinstatement permitted under certain conditions after benefits of $1,000 have been paid.

The GHI option covers general medical care, care of allergies, surgery, consultations, inhospital medical care, maternity care, diagnostic laboratory procedures and diagnostic X-rays, and visiting nurse service.

The HIP option provides for general, medical, surgical, and obstetrical care, laboratory and diagnostic procedures, periodic health ex-

aminations and immunizations, physical therapy, visiting nurse service, and ambulance service.

The statewide plan is available to all State employees regardless of where they work or live. The GHI option is available in the counties of Albany, Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Queens, Rensselaer, Richmond, Rockland, Suffolk, Ulster, and Westchester. The HIP option is available only to those in the Bronx, Columbia, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. (In Columbia, Nassau, Suffolk, and Westchester, the program is not available to all residents of the counties but only to those in areas served by the medical groups.)

Other Features of the Plan

Some other general features of the plan deserve mention. The employee may continue his coverage after he retires provided he has at least 5 years of State service and has participated in the plan the required length of time during his years of active service. The employee continues to pay his share of the cost of coverage after his retirement. Another feature is that benefits can be made available for services given either within or outside New York State.

We should also note the "service" feature of the plan which, under certain conditions, assures enrollees that the benefit will not be less than the charge made for the service. Under part II of the statewide plan, eligibility for "service benefits" depends on the employee's income status and his use of a participating physician. Under the GHI option, the employee must use a participating physician and, for covered services given in a hospital, must not apply for or use a private room if he is to be eligible for "service benefits." Under the HIP option, "service benefits" are available if the services are obtained from the medical group in which the employee participates.

Costs and Coverage

A word about costs. Under the statewide plan, the employee who buys coverage only for himself pays one-half of the cost and the State pays one-half. If he purchases coverage for himself and his dependents, the State again pays one-half of the cost for the employee's coverage and also pays 35 percent of the cost of covering his dependents. For the current contract year, the employee who covers only himself pays $1.42 each biweekly payroll period and the State pays $1.42. If the employee has family coverage, he pays $4.38 each biweekly pay period and the State pays $3.01. (Coverage costs more under the GHI and HIP options than under the statewide plan, and since the State contribution is the same as under the statewide plan, the employee's cost is necessarily higher under the two options. For example, the cost of individual coverage under the GHI option is $2.07 for the employee and $1.42 for the State, and under the HIP option, $1.94 for the employee and $1.42 for the State.)

Chapter 461 states that the health insurance contracts should provide health insurance "for retired State employees and their spouses and dependent children . . . on such terms as the Board may deem appropriate. . . ." As indicated previously, the coverage of active employees who meet the required conditions can be continued after their retirement. To provide coverage for former employees who retired prior to December 5, 1957, the date when the program for the active employees began, the contracts were amended in March 1958. The plan for retired employees embodied in the amendment included only the benefits of parts I and II of the plan for active employees. It did not include the major medical benefits which constitute part III, nor did it make available the GHI and HIP options.

This plan went into effect on July 1, 1958, with approximately 5,600 retired employees enrolled. The retired employee's share of the cost is deducted from his retirement allowance. In order to be eligible to participate, the retired employee must belong to one of six retirement systems maintained and operated by New York State.

A Change in the Law

At the 1958 session of the legislature, a change was made in the original health insurance law to permit local government units in New York State, except New York City, to

participate in the program. Under this change (chapter 950 of the Laws of 1958) there are several specific requirements for participation. The local subdivision must elect to participate, and its participation must be approved by the Temporary Health Insurance Board. It must pay the same rate of contribution as is paid by the State. The local subdivision is also required to pay its proportionate share of expenses of administering the plan as determined by the board. Finally, the local subdivision must agree to make its employment and payroll records available for inspection by the board.

In the present program approximately 88,000 employees are covered. With their dependents, the number covered is in excess of 200,000. If the total potential of the local subdivisions is realized, there would be an employee group of approximately 300,000 and a total coverage group of 850,000 to 900,000 persons. In addition, the present 12 employer participants would increase to more than 5,000. It is not anticipated, however, that all local subdivisions will participate, or that all of the employees in those subdivisions which do participate will enroll in the plan. Nevertheless, the coverage group will be one of the largest covered by a single set of contracts.

Before concluding, a word about administration is appropriate. The central administration of the health insurance program is the responsibility of the department of civil service. The health insurance unit of this department generally performs the following functions: maintains records of enrollment and status, certifies eligibility for benefits, interprets contracts when carrier disagrees, receives money and pays premiums to the carriers, and evaluates the program. The State's departments and agencies enroll employees in the plan and aid employees in filing claims. They also make the necessary employer certification with respect to workmen's compensation cases.

Benefits provided through the Blue Cross plans and through the Blue Shield plans do not require submission by the employee of a claim form. This is true also of benefits provided under the HIP option. Claims for benefits under the major medical expense portion of the statewide plan are prepared by the employee and submitted to the Metropolitan Life Insurance Company through the personnel office in his agency. The claim form is accompanied by a worksheet also prepared by the employee. This worksheet itemizes expenses and includes space for the employee to indicate the total amount of benefits claimed. The employee may obtain assistance from his personnel office in preparing the worksheet if he wishes to do so. The claim form and worksheet are reviewed by the carrier and a check in the proper amount is sent to the employee through his agency's personnel office.

Under the GHI option, the employee has the doctor complete the appropriate section of the form. Then the employee completes the subscriber's portion and forwards it directly to Group Health Insurance, Inc.

Although there have been many administrative and other problems in connection with the program during the early months of its operation, there is widespread agreement that the plan is doing a good job for the employees at a reasonable cost to them and to the State.

Nuclear Medicine

A unit to study long-range effects of nuclear energy on public health has been established at the University of Chicago School of Medicine, supported in part by the Rockefeller Foundation.

The section on nuclear medicine will explore such matters as the increase in sources of public exposure to radiation, the consequences of increased exposure, control of factors responsible, medicolegal aspects of injury and compensation, and psychological reactions of society to threatening aspects of nuclear energy.

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publications

Highlights of the National Conference on Air Pollution, 1958. *PHS Publication No. 648; 1958; 42 pages; 35 cents.*

A summary of the National Air Pollution Conference held in Washington, D.C., in November 1958, this booklet contains a digest of the six discussion sessions and a full report of the recommendations resulting from those sessions.

The topics covered were extent and sources of air pollution; its health, economic, and social effects; and methods, procedures, and administrative aspects of air pollution control.

Included also are excerpts of statements by Secretary of Health, Education, and Welfare Arthur S. Flemming, Surgeon General Leroy E. Burney, and Senator Thomas H. Kuchel, who introduced the first Federal air pollution control legislation in 1955.

Homemaker Services in the United States, 1958.

A nationwide study. *PHS Publication No. 644; 1958; by William H. Stewart, Maryland Y. Pennell, and Lucille M. Smith; 106 pages; 55 cents.*

Twelve descriptive statements. *PHS Publication No. 645; 99 pages; 55 cents.*

Homemaker services provided by about 150 agencies in continental United States are reported in the first of these publications. The nationwide study analyzes personnel policies and practices, administration, and policies governing service.

For the approximately 1,700 homemakers employed in these agencies, data on geographic distribution, training and experience, and work schedules are presented. Characteristics of families served as well as sources of referral and services performed by homemakers are also described.

Summary statistics for the study week and for the previous year show the volume of service and sources of funds for public and for voluntary agencies.

The programs described in the second publication illustrate major variations in organization, administration, and practices among the agencies providing homemaker services. Information on historical background, administration, policies and practices, advisory committees, financing, and evaluation is included in these statements, prepared by the individual agencies.

These publications should be helpful to persons interested in establishing new programs or improving existing ones.

Selected Materials on Environmental Aspects of Staphylococcal Disease. *PHS Publication No. 646; 1959; 289 pages; $1.50.*

Papers dealing with specific problems of hospital environment and lists of additional readings, audiovisual training aids, and sources of assistance are compiled for use as a reference and guide in developing training programs.

Major topics covered are building construction, water supply and liquid waste disposal, air contamination control and dust suppression, housekeeping and maintenance, and disinfection and sterilization.

Health Statistics From the U.S. National Health Survey. Acute conditions, incidence and associated disability, United States, July 1957–June 1958. *PHS Publication No. 584–B6; 1958; 47 pages; 35 cents.*

Incidence rates are estimated for infectious and parasitic diseases; respiratory and digestive disorders; fractures, dislocations, sprains, and strains; contusions, superficial injuries, open wounds, and lacerations; other current injuries; and all other acute conditions.

Data are given by age, sex, various severity criteria, and calendar quarter. Disability is shown in bed-days, work-loss days, and school-loss days.

Thirty-seven detailed tables and nine graphs are included. Two appendexes present technical notes on methods and definitions of terms.

Protecting Crops and Consumers. The Food and Drug Administration's pesticide control program. *FDA Leaflet No. 6; 1958; 11 pages.* Directed to farmers, agricultural leaders, and shippers of fresh fruits and vegetables. Designed to promote compliance with Federal law restricting amounts of pesticide residues which may remain on food crops. Defines "tolerance," presents rules for grower and packer-shipper, and outlines consequences of noncompliance with the law.

The Scientist in the Food and Drug Administration. *FDA Publication (unnumbered); 1958; by Robert S. Roe; 24 pages.*

Directed to college seniors and graduates, this illustrated recruiting brochure describes opportunities to use scientific training in positions offered in Washington, D.C., and 17 other major cities.

Work in the fields of food and nutrition, pharmaceutical chemistry, pharmacology, antibiotics, and cosmetics is discussed. Included also are outlines of the functions of the administrative scientists and the field service.

This section carries announcements of new publications prepared by the Public Health Service and of selected publications prepared with Federal support.

Unless otherwise indicated, publications for which prices are quoted are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order and should fully identify the publication. Public Health Service publications which do not carry price quotations, as well as single sample copies of those for which prices are shown, can be obtained without charge from the Public Inquiries Branch, Office of Information, Public Health Service, Washington 25, D. C.

The Public Health Service does not supply publications other than its own.
