

# **RULES OF OPERATION FOR THE RAND HEALTH INSURANCE STUDY**

PREPARED UNDER A GRANT FROM THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

**LORRAINE CLASQUIN  
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**R-1602-HEW  
MAY 1977**



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## PREFACE

This report describes the Rules of Operation of the Rand Health Insurance Study (HIS), which is supported by a grant from the Department of Health, Education, and Welfare. The HIS is a research project designed to determine, in part, the effects of alternative health insurance plans upon the demand for medical services and the health status of the population. Part of the project involves an experiment in which families are enrolled in various health insurance plans administered as the "Family Health Protection Plan" (FHPP).

The Rules of Operation define the concepts and operations essential to the experimental portion of the HIS. This report deals primarily with the definitions of the family unit, income, and the accounting period. The report presents the major rules in these three areas and describes the reasons for the rules. Rules dealing with definitions of the family unit, income, and the accounting period are emphasized in the report because they are among the most significant of the design decisions made; they are subjects of general interest in the current debate over whether national health insurance should contain income-related benefits.

The report also describes decisions on provisions of the rules that deliberately depart from rules that might be desirable under a national health insurance plan. These decisions should be of interest to persons designing social experiments, since they were made to increase the amount and quality of information collected during the HIS.

Experience from the HIS is only now beginning to accumulate; 20 percent of the total study "family years" have so far been completed. A later report will describe the significance for the rules of the experience gained through administrative operations.

The complete Rules of Operation appear in Sec. VI.



## SUMMARY

The Health Insurance Study (HIS) is a research project designed to improve the formulation of public policy in health care financing by evaluating the potential effects of variations in the costs to the patient of medical care. This goal will be pursued through both the analysis of existing data and the operation of the Health Insurance Study experiment. One of the primary purposes of the experimental portion of the HIS is to determine the effects of variations in the coinsurance and deductible provisions of health insurance plans on the demand for medical care. To do so, approximately 2,700 families in four sites in the United States will be enrolled in the HIS and assigned to 15 different health insurance plans administered as the "Family Health Protection Plan" (FHPP).

The administration of the FHPP required decisions on the composition of the insured unit and the eligibility criteria to be used in specifying who may receive health care coverage under the plan. A unique feature of the FHPP is that each insured unit's potential out of pocket expenditures for medical care are given an upper bound, which in most plans is a function of the unit's income. It was therefore necessary to decide which components of family income were to be included for this purpose and to define an accounting period during which this upper bound would be in effect. In addition, the plans were created as part of a social experiment, and certain special features not common to other health insurance plan operations had to be incorporated into FHPP operations.

The definitions of these key concepts and special features are set forth in the Rules of Operation of the Health Insurance Study. The purpose of this report is to present those rules and the rationale behind them. This report should serve not only as a historical record of the resolution of those issues of primary concern in formulating the rules for the Health Insurance Study but also as a reference of policy and regulatory considerations for promulgators and administrators of similar state or federal insurance programs.

In Sec. I we present the background information on the HIS and the FHPP that the reader will need to fully understand the materials in Secs. II through IV. Particularly important is the description of the upper bound on the insured unit's potential out of pocket medical expenditures mentioned above. This upper bound is called the "maximum dollar expenditure" (MDE) and is calculated as 5, 10, or 15 percent of the insured unit's income, depending on the plan in which the unit is enrolled.

The FHPP insured unit is defined in Sec. II. Because of the MDE provision, it is desirable that the FHPP insured unit approximate as closely as possible a unified decisionmaking body with respect to the allocation of funds for health care. Ideally the unit should be composed of persons who draw out of a common income pool to finance their medical expenditures. On the assumption that most families behave in this way, the family rather than the individual was selected as the FHPP insured unit. This unit is called the "economic family unit" and is composed of a family head and individuals residing with the head who are either married to or, if under 18 years old, related to or financially dependent upon the head. In addition to these

dependency and relationship criteria, to be included in the FHPP, persons and families must meet certain eligibility requirements rising out of the analytical goals of the HIS. For example, those whose health care options differ from options available to the rest of the sample population—such as members of the armed forces—are ineligible for the FHPP.

The definition of income for purposes of calculating the MDE is discussed in Sec. III. FHPP income is defined primarily as gross income reported on participants' tax returns. This definition was chosen to take advantage of the Internal Revenue Service as an income information collection system with standardized, established methods for measuring income.

The definition of income chosen influenced the selection of an accounting period, or period of time to which the MDE applies. Gross taxable income is measured on the basis of income received during the previous calendar year. The FHPP accounting period is therefore one year. Section III also deals with situations where a person leaves or joins an FHPP unit during the accounting period, since changes in family composition often affect family income and hence the MDE. In general, changes in family composition are not "recognized" in the sense of triggering a recomputation of family income and MDE until the end of the accounting period during which the change occurred.

Section IV describes certain rules provisions peculiar to the FHPP. These include payments to families to insure that they are not financially worse off as a result of their participation in the Health Insurance Study, a pledge to maintain the confidentiality of any information collected on families, and arbitration procedures to reconcile any differences that may arise between persons enrolled in FHPP and plan administrators.



## ACKNOWLEDGMENTS

The Rules of Operation were initially drafted in 1972. Since that time, several revisions have been made. The authors wish to acknowledge the contributions of many colleagues who contributed to each of those revisions, and to thank the following persons in particular: Barbara Woodfill for her review of an earlier version of the report; Michael Rich for his review of the current version; William Klein of the University of California at Los Angeles, who wrote the initial draft of the rules and who also reviewed an earlier draft of the report; Susan Marquis for her suggestions and contributions to this version of the report; and Joseph P. Newhouse for his review of several drafts and for ideas that shaped the design and content of the rules.



## CONTENTS

PREFACE.....	iii
SUMMARY .....	v
ACKNOWLEDGMENTS .....	vii
Section	
I. THE HEALTH INSURANCE STUDY AND THE FAMILY HEALTH PROTECTION PLAN.....	1
The Health Insurance Study.....	1
The Family Health Protection Plan.....	1
Field Operations: Interviews and Surveys .....	2
II. THE ECONOMIC FAMILY UNIT.....	4
Defining the Economic Family Unit .....	4
Eligibility of Individuals.....	6
Eligibility of Family Units.....	9
Changes in Family Composition.....	11
III. INCOME AND THE ACCOUNTING PERIOD.....	13
The Definition and Measurement of Income .....	13
The Accounting Period .....	15
Changes in Family Composition and Their Effects on FHPP Benefits.....	16
IV. EXPERIMENTAL OPERATIONS AND PROCEDURAL RULES ....	20
Payments to Families .....	20
Confidentiality .....	21
Hearings Procedures .....	22
Policy Decisions and Amendments .....	23
V. CONCLUSION .....	24
VI. RULES OF OPERATION OF THE FAMILY HEALTH PROTECTION PLAN.....	26



## **I. THE HEALTH INSURANCE STUDY AND THE FAMILY HEALTH PROTECTION PLAN**

### **THE HEALTH INSURANCE STUDY**

The Health Insurance Study (HIS) is a research project designed to improve the formulation of public policy in health care financing through analysis of existing data and operation of the Health Insurance Study experiment. The experiment is intended primarily to measure the effects of variations in the costs of health care services on the demand for such services and on the health status of individuals and to collect information on the effects of various health insurance plans on the quality of medical care received. An additional objective of the experiment is to gain experience with the administration of family-oriented health insurance plans having an income-related ceiling on out of pocket medical care expenditures. This experience will be useful in the formulation of national health insurance policy.<sup>1</sup>

During the HIS a sample of approximately 8,000 people in 2,700 families will be enrolled in 15 different health insurance plans. The families will be selected from four different sites: Dayton, Ohio; Seattle, Washington; Fitchburg and Franklin County, Massachusetts; and Charleston and Georgetown County, South Carolina. Seventy percent of the families will be enrolled for three years, 30 percent for five years.

### **THE FAMILY HEALTH PROTECTION PLAN**

The 15 experimental plans are administered under the name of the Family Health Protection Plan (FHPP). The plans differ from one another in the coinsurance rate and the upper limit to the insured's out of pocket medical expenditures. The coinsurance rates (percentages of each medical bill the insured is required to pay out of pocket) range from 0 to 95 percent. One plan has no coinsurance provisions; it involves enrollment of the families in a Health Maintenance Organization with all services provided free of charge.

The upper limit on expenditures is called the "maximum dollar expenditure" (MDE), and it is calculated as a percentage of the family's income—5, 10, or 15 percent, depending upon the plan to which the family is assigned. The coinsurance and MDE provisions of the FHPP plans are shown in Table 1. The cost sharing provisions and scope of benefits (medical services covered) of each family's plan are set forth in the Certificates of Benefits given to families at the time of their enrollment.

Families submit claims or Medical Expense Reports (MERs) to the FHPP just as they would to a private health insurance company. The FHPP processes and pays these claims. The MERs are a major source of data on the family's use of medical care and the prices it pays. Families are also required to submit biweekly

<sup>1</sup> The objectives of the HIS are described in detail in Joseph P. Newhouse, *The Health Insurance Study: A Summary*, The Rand Corporation, R-965-1-OEO, March 1974.

Table 1

CHARACTERISTICS OF THE EXPERIMENTAL  
INSURANCE PLANS

Insurance Plan	Coinsurance Percentage	Maximum Dollar Expenditure Limit <sup>a</sup> (Percentage of Income)
1	0	NA <sup>b</sup>
2	25	5
3	25	10
4	25	15
5	50	5 <sup>c</sup>
6	50	10 <sup>c</sup>
7	50	15
8	95	5
9	95	10
10	95	15
11	95 <sup>d</sup>	1 <sup>e</sup>
12	25/50 <sup>f</sup>	5
13	25/50 <sup>f</sup>	10
14	25/50 <sup>f</sup>	15
15	0 <sup>g</sup>	NA <sup>b</sup>

<sup>a</sup>The maximum dollar expenditure (MDE) limit is the maximum amount that a family must pay out of pocket in any one year before the experimental plan begins to pay for covered services and supplies. It is never more than \$1000.

<sup>b</sup>NA = Not applicable.

<sup>c</sup>Plan used only in first site.

<sup>d</sup>Applies only to outpatient.

<sup>e</sup>I = Individual liability of \$150 per year subject to family liability of \$450 per year.

<sup>f</sup>Twenty-five percent coinsurance for all services except dental and mental health, where there is 50 percent coinsurance. Plans used only in third and fourth sites.

<sup>g</sup>Health Maintenance Organization.

health reports to the FHPP, brief questionnaires that collect information on use of health care services and restricted activity days.

### FIELD OPERATIONS: INTERVIEWS AND SURVEYS

The field operations carried out as part of the HIS experiment can be divided into three major processes:

1. Pre-enrollment interviews,
2. Enrollment,
3. Post-enrollment interviews and surveys.

A baseline interview is administered to a sample of households at each experimental site prior to the selection of any families for enrollment in the HIS. This interview obtains data on the respondent's health care use, health insurance, income, employment, and demographic characteristics. The health insurance information is verified by the respondent's employer or insurance carrier. During the baseline interview the people within the household are grouped into "families" in accordance with rules specified in Sec. II. In most cases an individual is treated as a member of that family for the remainder of his association with the HIS.

The families actually offered enrollment in the FHPP are selected on the basis of the information they report on the baseline interview so as to be representative of the larger community. An interviewer returns to the household of each family to be offered enrollment and administers the Enrollment Verification Form, which confirms that the family composition, insurance, employment, etc. have not changed since the baseline survey. If there have been no changes, the interviewer describes the FHPP to the family and asks it to enroll in the Health Insurance Study. (If there have been changes, information is updated, and enrollment proceeds.)

To enroll, the head or heads of a family must sign three legal documents:

1. An enrollment agreement that acknowledges both the family's obligations to the FHPP and the FHPP's obligations to the family.
2. A health care information release form that allows the FHPP to collect information on participants' health care benefits and use of health care services.
3. An assignment of benefits, which entitles FHPP administrators to file claims against the family's other health insurance for those medical care expenses incurred by the family and covered by the FHPP. Additionally, by signing this document the family agrees not to file claims against this other insurance—to file only with the FHPP. This insures that the price the family faces for medical care will be determined by the FHPP plan to which it is assigned.

Between the time it signs these documents and the date it begins to file claims with the FHPP (effective date of coverage), each enrolled family must complete medical history questionnaires, and roughly 60 percent of the families must take a physical (screening) examination. The questionnaires and the screening exam collect important benchmark health status and pre-enrollment health care utilization data for health status and quality of care analysis.

Once the families have fulfilled these requirements, they begin to file MERs with and submit health reports to the FHPP. Additionally, throughout their period of participation in the HIS (three or five years), enrolled families will be expected to complete certain questionnaires and personal interviews primarily designed to gather information that is important analytically but that is not collected on the MERs and health reports. This includes data on participants' other health insurance, family composition, employment, and income, as well as detailed health status information.

## II. THE ECONOMIC FAMILY UNIT

### DEFINING THE ECONOMIC FAMILY UNIT

One facet of the HIS involves the operation of several health insurance plans. Defining an insured or beneficiary unit for these plans was an integral part of the process of designing the HIS and developing the FHPP. The benefit structure of most of these plans includes a provision for a limit on the insured unit's out of pocket health care expenditures. The most common limit, called the maximum dollar expenditure, is a function of the unit's income.

Because most of the FHPP plans are income related, it is desirable that the FHPP insured unit be one that in theory acts as a unified decisionmaking body with respect to the allocation of funds for health care. That is, the unit should be composed of persons who draw out of a common income pool to finance their medical expenditures. The demand for health care services of each person in such a unit is thus constrained by the demand of others in the unit and is a function of the *pooled incomes* of unit members rather than simply his or her own income.

For example, assume that the yearly income of a three-person family is \$25,000. The family consists of a husband earning \$15,000 a year, a wife earning \$5,000, and the wife's father who earns \$5,000. If they are a "unified decisionmaking body" as we have described it, each individual will act as if he were part of a family earning \$25,000 per year in planning his use of medical care. It would therefore be inappropriate to assign the wife's father, for instance, to his own insurance plan with an MDE based solely on his own income of \$5,000. The definition of the FHPP beneficiary unit is based on the assumption that families usually behave in this fashion. Hence, the plans' benefit structures are oriented toward families rather than individuals.

The basic FHPP beneficiary unit is called the "economic family unit," which includes: (1) the head of the family, defined as a person 18-61 years old (three-year plan) or 18-59 years old (five-year plan) who is not dependent for more than half of his support on any other member of his household; (2) the spouse of the head; (3) unmarried minors (under 18 years old) related to the head; and (4) any other members of the head's household who are dependent on the head for more than half of their support. A person may be "related" to the head through blood, marriage, or adoption.<sup>1</sup>

This definition means that a head is designated by family members for each family participating in the FHPP and persons are assigned to a family on the basis of their dependency on and relationship to the head. These criteria were designed to include in the head's family those persons most likely to rely on the head as the chief wage earner and primary financial decisionmaker on the premise that centralized control of family finances increases the probability that family members will

<sup>1</sup> In this report the term "household" means a group of persons living together at the same address. Therefore, the terms "family" and "household" do not necessarily refer to the same group of persons. For example, an unrelated and financially independent person may still live with the head. According to the dependency and relationship criteria, such a person would not be assigned to the head's family. Hence, in some cases the term "household" may refer to a larger group of persons than does the term "family." For definitions of these and other terms, see Sec. VI.



act as a unified decisionmaking body with respect to the allocation of income for health care.

Not all dependents of the head are included in the head's family—for example, students living away from home. In addition to meeting the dependency and relationship criteria, those assigned to the head's family must have the same "principal place of abode" as the head. This restriction was added primarily for reasons of experimental convenience; it would be costly and difficult to enroll and gather information on individuals not living with the family.<sup>2</sup> Further, information on income available for medical expenditures as well as on the nature and extent of those expenditures is more easily and accurately exchanged among persons living together than it is among persons not living together. The transfer of this kind of information among family members is essential if each member of the unit is to be aware of the amount of the unit's aggregated medical expenditures and the associated distance from its MDE.<sup>3</sup> This distance indicates the amount of out of pocket health care expenditures that must be met by the unit before such expenditures are completely covered by the FHPP. A family's demand for medical care is assumed to be a function of this distance.<sup>4</sup> It is important, therefore, that the assumption that all persons in the unit have the same perception of their unit's distance from its MDE at any given point in time be approximately correct. The restriction on the principal place of abode also helps to insure that the rules' definition of an economic family unit approximates as closely as possible a unified decisionmaking unit with respect to health care financing decisions.

Two other qualifications to the dependency and relationship criteria used for assigning persons to families exemplify practical issues that will have to be resolved by any national health insurance plan that requires a definition of some type of family unit. First, all natural or adopted children of the head are assigned to the head's family if they are unmarried and under 18 years old. All other unmarried persons under 18 years of age who are related to the head are assigned to the head's unit *unless* they are more closely related to another economic family unit head who is living in the same household. (If there are two or more individuals in a household who may be defined as a "head" and such individuals do not claim each other as spouses, then each individual is designated as head of his own family unit, and other people within that household are assigned to one of the units according to the dependency and relationship criteria.) This qualification of the relationship criterion prevents, for example, the assignment of a child to his uncle's family when his own parents are part of that same household. Second, only *unmarried* minors are assigned to the head's family unit. This distinction between married and unmarried minors was drawn to avoid assigning a married minor who is dependent on his or her own spouse to another head's family.

<sup>2</sup> A difficult sampling issue is also raised if individuals not living with the family are eligible to be enrolled as part of the family unit. Because the sampling strategy is based on dwelling units, those not living with their family would have a double chance of being included, if their dwelling unit fell within the sampling area.

<sup>3</sup> A unit's "distance from its MDE" is calculated by subtracting the total out of pocket medical expenditures incurred by the unit during the year from its MDE for the relevant year. For example, if a family's MDE is \$1000 and it has incurred \$600 in out of pocket medical expenditures since the beginning of the year, its distance from its MDE is \$400.

<sup>4</sup> E. Keeler, J. Newhouse, and C. Phelps, *Deductibles and the Demand for Medical Service: The Theory of the Consumer Facing a Variable Price Schedule Under Uncertainty*, The Rand Corporation, R-1514-OEO/NC, December 1974.

During the course of the HIS payments are made on a family unit basis. The head of the unit is responsible for completing HIS and FHPP related forms and for responding to interviews for the family. The head receives the FHPP benefits payments and other HIS related payments (see Sec. III) and must sign all legal agreements necessary for his family's participation in the FHPP. Therefore, the head of a family unit must be at least 18 years old. (To avoid sexual bias, the spouse of the head or any person the head claims as his spouse is considered a head for payment and contractual purposes.) The choice of the "family" as the basic FHPP administrative unit and the designation of a head with these responsibilities facilitated data collection by reducing the number of persons with whom the FHPP had to interact to obtain information about the family and to disburse payments. This in turn minimized the number of data collection instruments required and the costs of interviewing.

## ELIGIBILITY OF INDIVIDUALS

The rules specify certain categories of ineligible persons; that is, individuals who will not be covered by the FHPP even though they are members of an economic family unit enrolled in the HIS. These eligibility criteria are discussed below. Other eligibility requirements that families must meet are described later in this section.

The eligibility requirements for individuals were developed for largely analytic reasons, which made it necessary to exclude from participation in the FHPP people who fall primarily into one of two categories:

1. Persons 18 years old or older who are dependent on, but not related to, the head. For both administrative and analytical reasons, it is desirable that the insured unit be as stable a unit over time as possible. Although the incidence of such persons in a household is statistically rare, on the assumption that these nonrelated dependents are usually *temporary* household members they were excluded from the FHPP. This rule increased the comparability of the FHPP insured unit to the beneficiary unit of most private insurance plans, which usually offer family-oriented policies covering the holder, his spouse, and other related dependents. Most of these policies also exclude unrelated dependents. When families enroll in the HIS, they are asked to stop using their private plans and to assign the benefits of these plans over to the FHPP, so the similarity between the FHPP insured unit and the insured unit of private plans smoothed the transition from private health insurance to the FHPP plans. In most cases family members covered by a private plan were also covered by the FHPP plan.

2. Persons whose health care options differ from those available to the rest of the sample population, such as military personnel. The usefulness of the results of the HIS depends in part on how well the study can manipulate certain health care market parameters faced by participants and on how accurately the study can measure the associated demand for medical care. The price of medical care services is the most important of these parameters. Coinsurance rates and deductibles of the FHPP plans are designed to alter the prices paid by participants, which would be difficult in the case of individuals with options that differ markedly from those available to the majority of the sample. Further, it would be difficult to measure that person's use of health care services.

The application of these criteria, along with certain additional considerations discussed below, resulted in the following categories of ineligible persons:

- a. Persons 62 years of age or older at the time of enrollment (for families selected to participate for three years) or persons 60 years of age or older at the time of enrollment (for families selected to participate for five years).
- b. Persons of any age who are eligible for disability or chronic kidney disease benefits or supplies to the extent they are available under Medicare.
- c. Persons on active duty and persons who are retired from active duty with full benefits in any of the uniformed federal services and their dependents or survivors who are eligible for free medical care provided by the armed forces or CHAMPUS as a result of such duty.
- d. Foster children (defined in Sec. VI).
- e. Veterans with service-connected disabilities who are eligible to receive care through the Veterans Administration.  
Veterans with non-service-connected disabilities or with no disabilities are eligible for coverage under the Certificate of Benefits of the FHPP, provided, however, that they sign a waiver stating that they will not receive medical care from any Veterans Administration facility for the period of their participation in the FHPP.
- f. Dependents and survivors of veterans with 100 percent service-connected disabilities who are eligible for CHAMPVA.
- g. Students whose principal place of abode is usually separate from that of the family unit.
- h. A person enrolled in a prepaid group health plan or Health Maintenance Organization (HMO).
- i. Employees of the HIS or the FHPP and persons related (as defined in Sec. VI) to employees of the HIS or the FHPP.
- j. Persons eligible for medical care through Indian Health Services, Bureau of Indian Affairs.
- k. Persons employed as officers or crew on a ship that is at sea for a continuous period of 30 days or more at least once a year.

Persons on active duty or retired with full benefits from active duty in the military and their dependents can receive free medical care at an armed forces base. Controlling the prices and measuring the use of care received through the military would be very difficult. Hence, such persons are ineligible. (If the head of a family is on active duty or is retired with full benefits, the whole unit is ineligible.) Categories d, e, f, h, j, and k above are the result of similar reasoning.

Category a, persons 62 years old or older (three-year plan) and persons 60 years old or older (five-year plan) at the time of enrollment are ineligible since they would become eligible for Medicare during their period of participation in the FHPP. While Medicare is an example of a health care program available to only a segment

of the population, there were two additional reasons for making such persons ineligible for FHPP. First, health care problems of the aged are qualitatively different from those of younger people. Information gathered on the majority of the sample would be substantially different from the information collected on this group. To collect enough information to say anything meaningful about their use of health care services would have required oversampling the aged, which would either have significantly increased the cost of the Health Insurance Study or lessened the precision of measurement on the rest of the sample. Second, some difficulty was expected in obtaining informed consent from some aged people at the time of their enrollment. Therefore, persons eligible for Medicare and persons who would become eligible for Medicare during the course of the study are ineligible for FHPP coverage.

Rule III.A.6. refers to persons temporarily living away from home at the time the first offer of enrollment is made to their family. If such a person has not returned before the family's effective date of coverage<sup>5</sup> and therefore has not completed the requisite questionnaires and screening exam prior to the beginning of the family's participation in the FHPP, he is ineligible to be covered by FHPP. This rule eliminates the administrative complexities of keeping track of these absent persons and enrolling them with an effective date different from that of the rest of their family.

The category of "persons temporarily living away from home at the time of the first offer of enrollment" includes persons confined to government supported institutions that assume full responsibility for the individual's health care, such as persons in state mental institutions. The health care options available to such persons are significantly different from those available to the rest of the sample, another reason why these persons are excluded from FHPP coverage if they have not returned home by their family's effective date of coverage.

Anyone initially enrolled in the FHPP who experiences a change in circumstances that puts him into one of the initially ineligible categories is dropped from the FHPP. Eligibility for Medicare or for care through the Veterans Administration is permanent. Persons who become eligible for this kind of care lose their FHPP coverage immediately. It is possible, however, for an individual to fall into one of the other categories of initial ineligibility only temporarily during the course of his participation, primarily people who are called into active duty or who are confined to penal or other government supported institutions. Because of the size of the investment required to enroll individuals in the FHPP, if their change in circumstances is truly temporary and it would be possible to gather useful data on them for a reasonably lengthy period, it is desirable to keep them enrolled.

The concept of suspension was developed to allow FHPP administrators to monitor the duration of these changes in circumstances. A suspended person may no longer file claims with the FHPP, yet he remains in the administrative records and his status is inquired about on the interviews administered periodically to his family during the course of the HIS. If such people do not regain full FHPP eligibility before the end of the accounting year<sup>6</sup> during which they were suspended, they

<sup>5</sup> The FHPP effective date of coverage is the date the family's coverage under FHPP begins. Coverage begins only after the family has completed a series of interviews and has taken a physical screening examination (if requested to do so).

<sup>6</sup> The term "accounting year" is defined as the annual period of time beginning on the family's effective date of coverage by the FHPP and ending one year later, and subsequent annual periods beginning and ending on that date.

are dropped from the record of persons enrolled. This procedure gives administrators a uniform standard to use in deciding which changes in circumstances should be considered permanent and which temporary. Also, dropping suspended persons only at the end of an accounting year avoids the difficulties involved in mid-accounting-year recalculations of the MDE and other HIS-specific payments. Categories of persons suspended during the HIS are listed below.

1. A resident of a country other than the United States;
2. A person on active duty or retired from active duty and his or her dependents or survivors, or dependents and survivors of a veteran with a total service-connected disability if such persons become eligible for CHAMPUS or CHAMPVA benefits for a period of 30 days or more;
3. A person whose health care options are significantly different from those of the general population, including but not limited to:
  - a. Persons confined under sentence to a penal institution for a period of time the Plan Administrator or his designee expects to last for 30 days or more;
  - b. Persons confined, voluntarily or involuntarily, in a governmentally supported or controlled institution that assumes full responsibility for the health care of its patients or inmates at no charge to the institutionalized person, for a period of time the Plan Administrator or his designee expects to last for 30 days or more.
  - c. Persons employed as officers or crew on a ship at sea for a continuous period of 30 days or more at least once a year.

## ELIGIBILITY OF FAMILY UNITS

The economic family unit is designed to approximate as closely as possible a unified decisionmaking body with respect to the allocation of resources for medical care. All eligible members of this unit are covered by the FHPP.

The rules define a second family concept—the relationship group, which is used to determine initial eligibility of the *family* rather than the initial eligibility of *persons*. The relationship group consists of the following members of a head's household:

1. The spouse of the head or any person whom the head claims to be his or her spouse;
2. Any person who is related to the head(s);
3. Any other person who receives more than half of his or her support from the head.

Relationship groups with incomes greater than \$25,000<sup>7</sup> are ineligible for enrollment. This rule avoids the use of tax money to make payments to families with

<sup>7</sup> 1973 limit. Adjustments in the income eligibility limit are made for each subsequent year.

high incomes. Even with the exclusion of these families the results of the HIS will still be generalizable to over 90 percent of the population.<sup>8</sup>

The relationship group is actually a combination of economic family units. That is, because of the absence of a dependency criterion in category 2 above, there can be several economic family units in one relationship group. For example, a single relationship group would include a father and his son, if they were living together, even if the son is 21 and financially independent. Yet the same household would contain two separate economic family units; the father and son would be covered by two distinct FHPP plans. The relationship group was defined in this way to insure comparability of the HIS sample to a national sample of family units with incomes less than the FHPP income cutoff. Most national family-oriented income statistics are based on the census unit, which consists of the head and all persons related to the head by blood, marriage, or adoption, regardless of their dependency on the head.<sup>9</sup> The relationship group is a much better approximation of this unit than is the economic family unit. A comparison made between the relationship groups and census units in the Dayton sample found the units to be identical for 99.9 percent of the families.

Other eligibility criteria in the rules apply to families as a whole. These criteria are analogous to the criteria for individuals (see rule III.A.4). Additionally, the continued eligibility of families covered by the FHPP is contingent upon the fulfillment by the families of certain special obligations. Enrolled families must:

- a. Maintain residence in the United States;
- b. Participate in interviews conducted by representatives of the FHPP;
- c. Prepare and promptly submit a Medical Expense Report form to the FHPP whenever medical services are used by those eligible family members listed in the family's Enrollment Agreement;
- d. Prepare and submit regular reports on medical care received, health status, and income, as well as changes in address, medical care coverage, or family composition, as stated in the Enrollment Agreement;
- e. Take a screening examination, for which the family will not be charged, at the beginning and the end of the family unit's participation, if so requested by the Plan Administrator or his designee, as stated in the Enrollment Agreement;
- f. Maintain the health insurance or medical care coverage in existence at the time of their enrollment in the FHPP for as long as they are eligible to do so or until they obtain substantially equivalent or better coverage, and assign or otherwise pay over to the FHPP all benefits from all other health insurance and medical care coverage in force at any time during their participation;
- g. Comply with such other requests for information and fulfill such other obligations of the FHPP as the Plan Administrator or his designee may reasonably request.

<sup>8</sup> U.S. Department of Commerce/Bureau of the Census, *Income in 1970 of Families and Persons in the United States*, Series P-60, No. 80, October 4, 1971.

<sup>9</sup> Ibid.

Paragraph f above involves two unique administrative operations—reclaiming and pass-through. Families covered by the FHPP are required to maintain the health insurance coverage they hold at the time of their enrollment for as long as they are eligible to do so. This provision helps to guarantee that families will not become uninsurable during their participation in the FHPP. Additionally, it allows family members ineligible for FHPP coverage to continue to claim benefits under the family's private insurance. The families are reimbursed for their out of pocket premium payments for these plans; however, they are also required to assign the benefits of these private plans to the FHPP during their period of participation.

When the FHPP pays a claim from a family, the FHPP files a duplicate claim with and receives payment from the family's private insurance. Reclaiming from private insurance carriers reduces FHPP operating costs and prevents families from receiving double coverage for medical care expenditures. If a particular type of expenditure is covered by a family's private plan but not by its FHPP plan, plan administrators will file a claim for this expenditure with the private insurance company and return or "pass through" to the family any payment received.

## CHANGES IN FAMILY COMPOSITION

Families agree to participate in the FHPP for periods of three or five years. In many cases persons will either join the family's household or move away during that period of time. Because of the dependency and relationship criteria used to form the economic family unit, changes in the dependency or marital status of a unit member can also change the composition of the family. Additions to and departures from economic family units have different implications and are dealt with separately in the rules.

The amount of information that can be collected on persons joining a family during the course of the HIS is often significantly less than the amount collected on those initially enrolled in that unit. Additionally, it would be costly and administratively inconvenient to collect any benchmark health status and pre-enrollment health care utilization data on such persons. The analytic usefulness of data on new family members is not great enough to justify the costs of collecting it, especially since the HIS was designed to observe behavior in the health care market over a long period of time. For this reason, FHPP coverage is not extended to any persons who join a family unit subsequent to the initial enrollment of that unit.

The only exceptions to this rule are newborns and adopted children under one year of age. These exceptions were made to allow information on these categories of individuals to be collected during the HIS.<sup>10</sup> Also, the possibility of adverse selection (for example, sick people becoming members of units with the most generous plans) does not exist in the case of newborns or young adopteds. If adults were extended FHPP coverage subsequent to enrollment, any resultant adverse selection would both bias the data collected and increase administrative costs.

Although new spouses are excluded from the unit for the experimental reasons given above, in no case will this exclusion cause a family to be worse off either

<sup>10</sup> The age limit on adopted children excludes only 16 percent of all children adopted by nonrelatives. National Center for Social Statistics, Report E-10 (1970), DHEW Publication No. (SRS) 72-03259, June 26, 1972.

financially or in terms of health insurance coverage. The new spouse is free to maintain coverage under his or her existing insurance, while the HIS-specific payments made to participants will reflect any coverage potentially available to family members under the new spouse's private insurance.

The treatment of a person who leaves a family or who no longer has the family's household as his principal place of abode depends on the person's age and marital status:

- a. Whenever an enrolled person under 18 years of age ceases to have as his or her principal place of abode the household of the head of his or her unit, that person shall remain a member of that unit if he or she continues to participate in the FHPP.
- b. Whenever enrolled spouses who are heads of a family unit provide the Plan Administrator or his designee with satisfactory evidence that they are divorced or separated they are eligible to form two separate units if such spouses otherwise meet the eligibility requirements of these rules.<sup>11</sup>
- c. Whenever any other enrolled person over 18 years ceases or has ceased to have as his or her principal place of abode the household of the head of his or her unit, or ceases or has ceased to receive more than half of his or her support from the head of that unit, that person shall form a new unit at the beginning of the next accounting year (i.e., the anniversary date of the effective date of initial enrollment), if he or she otherwise meets the eligibility requirements of these rules.

Persons under 18 cannot legally sign the documents required for enrollment as a head. Therefore, they cannot form their own FHPP unit.

<sup>11</sup> These procedures for handling the departure of a spouse were used during the first two years of study operations for operational convenience. Analytical reasons have now dictated a review of this procedure, and the policy of treating such cases as a single family unit until their next anniversary date is now being considered. The main problem with the existing procedure is that the price of medical expenditure in certain plans has an element of endogeneity if there is a split; whether this is of practical significance is now being reviewed.



### III. INCOME AND THE ACCOUNTING PERIOD

#### THE DEFINITION AND MEASUREMENT OF INCOME

The benefits of most FHPP plans are in part a function of the income available to the FHPP insured unit for medical care. The MDE or upper bound on the unit's medical expenditures is a percentage of that income. It was designed as a way of insuring that the amount a unit pays for health care is not excessive relative to its ability to pay for such care. Income is used as a proxy for ability to pay; hence, income is a central administrative concept that had to be defined.

Calculating a family's MDE involves four separate steps:<sup>1</sup>

1. Defining income—i.e., selecting such components as interest, dividends, and gifts to include in the FHPP income measure.
2. Collecting information on those components from participants.
3. Calculating family income on the basis of that information.
4. Taking the appropriate percentage of the family's income to arrive at the MDE.

This section discusses the first three steps. Step four was explained in Sec. I.

Since income is used as a proxy for ability to pay, an ideal definition would include all possible components of family income. Such a definition is, however, too broad and general to be put into operation. A complete accounting of income would be costly and burdensome on the participants. The administrative feasibility of the MDE provision depends on the ease, accuracy, and uniformity with which income can be calculated. Therefore, income for FHPP purposes should include such components as wages, dividends, and interest, which are quantifiable, easily identifiable, and have fairly standardized definitions. The Internal Revenue Service (IRS) income components as reported by FHPP participants on their federal income tax returns meet these criteria.

Most employers, brokers, insurance companies, etc. furnish individuals with information on income they have earned during the most recent federal tax year. Any attempt to measure income over a different time period or to include other, less precisely defined components such as gifts implies extra recordkeeping and computational tasks that would increase the reporting burden on participants and decrease the accuracy of the information reported. Additionally, the IRS provides a system that is familiar to most people. It may very well be used as an information collection device under any income-related national health insurance plan. For these reasons, FHPP income is defined primarily as gross income reported on federal income tax returns.

There are three categories of nontaxable income included in the rules' definition of income: (1) that portion of dividends excluded from IRS gross income,<sup>2</sup> (2) welfare payments, including Aid to Families with Dependent Children and Supple-

<sup>1</sup> The MDE assigned to a unit during its first year of participation is based on an estimate provided by a family head of family income for the previous calendar year.

<sup>2</sup> Internal Revenue Code of 1954, §116 (hereafter referred to as Code).

mental Security Income, and (3) court ordered child support payments.<sup>3</sup> These income sources have standard definitions and are easily identifiable. Recipients usually have official documentation on such payments, which means that their reports of income received are quite accurate.

Equity considerations were important in the decision to include welfare and child support. At lower income levels, government transfer payments often represent a substantial portion of the family's income. Omitting welfare payments would thus cause a systematic underestimation of the resources available to a significant segment of the sample population.

For tax purposes, court ordered child support is neither included in the recipient's income nor deducted from the income of the person making the payments.<sup>4</sup> The IRS measures income to collect tax revenues for the Treasury. This can be done without tracing child support payments from payor to recipient. The purpose of defining income for the FHPP, however, is to measure the insured unit's ability to pay for medical care. Child support payments are income available to the unit receiving the payments, not to the unit making the payments. Hence, the FHPP income definition excludes such payments from the income of the person making the payments and includes them in the income of the recipient. Court ordered alimony payments are deducted from the income of the person making the payments for the same reason.<sup>5</sup> (Court ordered alimony is included in the gross taxable income of the person receiving the payments under Code §71(a).)

The inclusion of nontaxable income sources in the FHPP measure of income meant that the plan administrators could not rely exclusively on federal tax returns to collect income information. Information on other sources of nontaxable income is also necessary for analytical purposes. These additional sources were selected on the basis of their significance in the incomes of persons enrolled in the HIS. The HIS annual income report was developed to collect information on participants' taxable and certain nontaxable sources of income. This report is completed by the participants once a year. Its format is so similar to that of a federal tax return that in most cases all the respondent has to do is transfer figures from his return to the HIS report. The families' incomes and MDEs are calculated on the basis of this report.

The federal income tax return collects information on an individual's income for the previous calendar year. Defining FHPP income as primarily IRS-reported income means that the FHPP income measure is retrospective rather than prospective and covers a fixed annual period—the previous calendar year. MDEs for the current year actually reflect the insured unit's ability to pay for health care services in the previous calendar year since they are based on this income measure.

Sensitivity of the MDE to *current* ability to pay could be increased by measuring income over, say, a future six month period. But to base the MDE on future income, participants would have to forecast this income, which would probably result in an inaccurate measure of ability to pay both because it is impossible to predict future events perfectly and because this system creates an incentive for families to overestimate expected income. The higher its reported income, the

<sup>3</sup> Code §61(a) (8) and §71 include alimony and separate maintenance payments in gross income, but child support payments are specifically excluded by §71(b).

<sup>4</sup> See Code §71(b).

<sup>5</sup> Code §215 treats court ordered alimony payments similarly.

greater the family's MDE based on this income would be, and certain special payments it would receive from the FHPP would increase. Additionally, adopting this method of measuring income would mean abandoning the IRS as an income information source and forgoing all the benefits of using that system. The increase in sensitivity of the MDE to current ability to pay is not worth the cost.

Usually, income is calculated by summing the incomes, as defined in the rules and reported on the annual income report, of all members of the economic family unit. However, economic family units may sometimes include persons ineligible for FHPP coverage, such as those in the military, or nonrelated dependents of the head. It seems inequitable to include the incomes of these ineligible family members in family income used for calculating the MDE since their medical expenditures do not count toward the MDE, yet excluding their incomes would underestimate the family's true ability to pay. Consequently, a formula was developed for adjusting family income on the basis of the number of ineligible family members (see Attachment I to the Rules of Operation). The formula yields an adjustment factor by which the unit's income is multiplied before its MDE is calculated. For a prototypical family of four with one ineligible adult, the family's income would be adjusted by a factor of .72. Thus, if the family's income was \$10,000 and its MDE was 10 percent of its income, the resultant MDE of \$1,000 would be adjusted to \$720.

## THE ACCOUNTING PERIOD

Once the family's income has been measured, its MDE can be calculated as a percentage of that income. A necessary prerequisite to this process was the definition of an "accounting period" or period of time to which the MDE applies. The FHPP accounting period is defined as the annual period of time beginning on the date of the family's participation in the HIS (the effective date of the family's enrollment agreement) and ending at 12 a.m. one year later (the anniversary of the effective date of enrollment), and subsequent annual periods beginning and ending on the anniversary of the effective date of enrollment. Therefore MDEs are recalculated annually. Each insured unit is assigned a new MDE on the anniversary of its effective date of coverage. The unit's out of pocket medical expenditures, which are deducted from the MDE to arrive at the unit's "distance to its MDE," are aggregated over the same accounting period.

The fact that income is measured over a fixed 12 month period does not mean that MDEs had to be calculated on a yearly basis. For example, they could be recalculated quarterly and the families assigned a new MDE every three months. Given the possibility of seasonal or other fluctuations in family income, quarterly calculations would increase the sensitivity of the MDE to ability to pay under certain circumstances. However, the MDE is based on the income participants report on their federal tax returns, which does not reflect variations in income during the year. Hence, calculating the MDE more frequently would serve only to increase administrative costs.

An accounting period longer than a year is also possible, but less frequent recalculations would result in larger MDEs. Families would have to incur greater out of pocket expenses before their medical care would be entirely paid for by the

FHPP. At some point, the additional risk would eliminate the advantages of an income-related health insurance plan for all families except those with the largest incomes or asset holdings. All of these considerations led to the selection of a year for the FHPP accounting period.

## **CHANGES IN FAMILY COMPOSITION AND THEIR EFFECTS ON FHPP BENEFITS**

Changes in the composition of the economic family unit may change family income. In such cases the MDE calculated on the basis of the income of the economic family unit before the change in composition will no longer accurately reflect the unit's ability to pay for health care. This implies that family income should be recomputed when there is a change in family composition and the unit should be assigned a new MDE. Yet if this change in composition occurs during an accounting period, recalculating the unit's MDE at the time of the change would increase administrative costs and complicate the analysis of data collected on the unit.<sup>6</sup> In general, therefore, incomes and MDEs are not recalculated during an accounting period even though there has been a change in family composition.

New spouses and other persons joining a household are assigned to economic family units and are treated as ineligible family members. Their incomes therefore are included for purposes of calculating the MDE but not until the beginning of the next accounting year.

It was more difficult to formulate rules to deal with departures of family members. A departure potentially affects family income, and because the departing persons are often eligible for FHPP coverage, decisions had to be made on FHPP coverage of and benefits payments to such persons. To limit adjustments to the MDE during an accounting period, persons 18 years old or older who are not heads of a unit and who leave their unit during the year are not made heads of their own unit until the beginning of the next accounting period (see rules III.C.2.c and IX.B.1). Therefore, until the new accounting period starts, such persons' medical expenditures will be limited by the MDE of the family unit in which they were originally enrolled, and they will continue to be covered by the same FHPP plan. That unit's MDE will remain unchanged for the balance of the accounting period. If the head of the FHPP unit and the departing member agree, reimbursement by the FHPP for that member's medical expenses may be made to him directly. Persons over 18 who cease to be economically dependent on the head yet remain part of his household are treated analogously. This treatment of departures of nonheads is somewhat artificial, especially in the case of a person who has actually moved out of the household. Any national health insurance plan would probably make this person a head of his own unit at the time of the move. However, the analytic problems this would create outweighed such considerations.

If a head of a unit leaves that unit, he is made a head of his own family unit at the time of the move even if it takes place during an accounting period.<sup>7</sup> This

<sup>6</sup> The unit's demand for medical care is in part affected by the distance to its MDE. If the MDE changed during an accounting period, the analyst would face the difficult problem of determining whether this change was in any way anticipated.

<sup>7</sup> These procedures for handling departures of heads were used during the first two years of study operations for administrative convenience. The policy of treating departed heads as a single family unit

exception to the general principle was allowed to insure that each economic family unit would continue to act as a unified decisionmaking body with respect to the allocation of income for health care. The probability of cooperation and continued communication between original members of a family is significantly less when a head departs than when a nonhead leaves. It is less likely that information will continue to flow between such persons and that they will continue to pool their incomes and share their medical expenses after the split. Thus, two families headed by persons who were once heads of the same unit should be treated as two separate decisionmaking bodies.

Decreased cooperation between heads would also present administrative problems if the heads were kept in the same family unit after one left. One reason for selecting a family head was to minimize the number of persons with whom plan administrators had to deal to operate the FHPP. In some cases administrators would be forced to arbitrate disputes as to who was to receive certain benefits payments or how these payments should be allocated. Additionally, it seems inequitable to continue to reimburse a head for medical expenses incurred by a departed head. The assumed decrease in communication also implies that a single head could no longer be relied on as an accurate source of data on all unit members.

The head of a new unit becomes the payee of benefit checks and other payments to his unit and is treated as an information source distinct from his old family unit. The new unit must also be assigned an MDE, and the old unit's MDE must be adjusted to reflect the change in family composition and any related change in income. This required definition of an accounting period over which the new and adjusted MDEs apply and division of the income between the old and the new units.

The "short accounting period" is defined as follows: "When a new unit is formed because of the separation or divorce of the spouse of a head of an enrolled family unit, each separate unit will initially use a short accounting period beginning on the effective date stated in the documentation referred to in rule IX.C.1 and ending on the date on which the accounting period of the original unit would have ended (the anniversary of the effective date of initial enrollment)." The recalculated MDEs are in effect during this short accounting period. Thereafter, the two units have a standard FHPP accounting period. The short accounting period is relevant only in the case of the departure of a head of a family unit, since this is the only time new family units are formed during an accounting period.

For purposes of calculating new MDEs for the two new units, the income of their old single unit is divided between them as follows:

- a. The income that had been earned in the most recent calendar year by performance of services by the members of each economic unit will be allocated to such members' unit;
- b. If after a separation or divorce, one spouse provides the other with alimony or child support payments in cash by court order or by agreement, the amount of such support or alimony will be allocated to the income of the recipient and deducted from the income of the payor, for the period of the most recent calendar year preceding the separation;

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until their next anniversary date is now being considered. The price of medical expenditure in certain plans has an element of endogeneity if there is a departure; whether this is of practical significance is now being reviewed.

- c. If the allocation of any other income cannot readily be determined by the Plan Administrator or his designee, then such other income will be allocated to the separate units in proportion to the number of members in each unit.

This division of income (with the exception of current period alimony and child support payments) is made on the basis of information on the old unit's most recent annual income report. Medical expenses incurred by the old unit must also be divided between the two new units. They are allocated in the same proportion that income is assigned to the two new units rather than on the basis of each head's *actual* past expenditures, because of the assumption that the old unit acted as a single decisionmaking unit. Its members pooled their resources and shared their health care expenses up to the date of the separation. This method is more equitable and less administratively complex and costly than attempting to determine the exact amount of past out of pocket medical expenditures incurred by each unit member.

The following example should clarify the use of the FHPP income and expense allocation formulas. Assume that a family unit consisting of a husband and wife whose joint annual income is \$6,000 (husband earns \$5,000 per year; wife, \$1,000) was originally assigned to a plan with an MDE equal to 10 percent of the unit's income, or \$600. If the couple were divorced or separated during an accounting period and if the husband was required to pay \$1,000 per year in alimony to the wife, the income allocated to the husband for purposes of calculating his new MDE during the short accounting period would be  $\$5,000 - \$1,000 = \$4,000$ . The wife would be allocated  $\$1,000 + \$1,000 = \$2,000$ . Since each new unit is assigned to the same plan as the original unit, the husband's MDE would now be 10 percent of \$4000 or \$400; the wife's, 10 percent of \$2000 or \$200. The ratio of the husband's new income to the wife's is two to one. Therefore, if total medical expenditures of the old unit at the date of the separation were \$300, the wife would be allocated \$100 of those expenditures and the husband \$200. The husband's distance to his MDE is now  $\$400 - \$200$  or \$200; the wife's  $\$200 - \$100$  or \$100.

Five changes in family composition could be defined as departures of heads: death, desertion, formal separation, informal separation (where no legal proceedings for separation have been instituted), and divorce. The rules define a deserting spouse as one whose whereabouts are unknown, or one whose whereabouts are known but who refuses to participate in the Health Insurance Study. By definition, then, the deserting head will no longer be participating in the FHPP. The possibility of inequities and administrative difficulties inherent in most such cases does not arise here; therefore, such a case is not considered an official departure. No short accounting period is created, and the unit's MDE is not recalculated until the beginning of the next accounting period. Death of one head is treated similarly. The other changes are accepted as official FHPP departures and the heads involved form their own separate units after the split.

A national health insurance plan might not allow persons informally separated to form separate units without at least imposing a waiting period, because there is an incentive for heads facing heavy medical expenditures to separate temporarily. Each new unit would then be assigned a smaller MDE than the old unit had since the old unit's income is divided between the two new units, which would increase

the amount of the upcoming expenditures that will be completely covered by insurance.

Enforcing a waiting period for the FHPP would involve administrators in monitoring the family's behavior during the period. The costs of and inconvenience to the families from such monitoring would outweigh its benefits to the FHPP. The rules simply require separating heads to file an Affidavit of Separation declaring that they no longer expect to reside in the same household in order to be designated as heads of separate FHPP families.

## IV. EXPERIMENTAL OPERATIONS AND PROCEDURAL RULES

### PAYMENTS TO FAMILIES

Families participating in the FHPP agree to give up their private health insurance plans temporarily for FHPP plans that may or may not provide comparable coverage. The FHPP is temporary and experimental. It is essential that people who participate in the FHPP not be financially worse off as a result of that participation and that they not be without health care coverage at the end of the Health Insurance Study. To guarantee the above and to insure that the HIS sample is not biased by the refusal of persons on generous private plans to take part, participating families receive regular payments. These payments are called Participation Incentives and consist of:

1. A Payment Guarantee (PG), which assures families that they will not become financially worse off because of their participation in the HIS.
2. A Premium Reimbursement (PR), which reimburses the families for the premium payments they are required to make to maintain their private coverage. This is especially necessary since plan administrators reclaim against these private policies.

$$PG = \text{Max} [WC - PR, 0],$$

where WC is the worst case or maximum amount a family could pay out of pocket for medical care under the FHPP during an accounting period that it would not be liable for under its private insurance plan. WC is a function of the family's MDE and is determined independently of the family's actual medical expenditures in any year. For example, assume that a family is assigned to a plan with a \$500 MDE, and its private insurance provides first dollar coverage (no coinsurance or deductible provisions). The family would therefore be liable under the FHPP for \$500 a year it would not have to pay under its private insurance. This family's WC would be \$500.

The PR is subtracted from the worst case since participants would have to make these payments with their own funds if they were not enrolled in the FHPP. If families stand to gain financially from participation ( $PR > WC$ ) their  $PG = 0$ . In no case will the PG exceed the MDE since this is the maximum amount FHPP families would ever have to pay for their medical expenses during any accounting period.

The yearly participation incentive ( $PI = \text{Max} [K \times PR, PR]$ ). K is 75 percent for a three-year family and 85 percent for a five-year family, unless it is the last year of the family's participation in the HIS. In that case, K is 100 percent.<sup>1</sup> If  $K \times PR$  is less than the PR, then the entire PR is paid to the families to assure that they

<sup>1</sup> To measure the responsiveness of families to these payments, K will be made to equal 100 percent in the next to last year as well for a subset of participating families.



are able to maintain their existing private insurance without being financially worse off as a result.

PIs are calculated yearly and are paid in 13 installments. The installment plan was adopted primarily to maximize the probability that families would treat these payments as any other income. A basic analytical assumption is that participants will see the prices they pay for medical services during the experiment as the market (or billed) price modified by the effect of the coinsurance and deductible provisions of the FHPP and adjust their demand for such services accordingly. This assumption would be invalidated if participants in fact treated PI payments as special funds earmarked for medical care, since this might cause them to perceive medical care as being free. Lump sum PI payments appear to raise the probability of such earmarking.

The 25 percent or 15 percent of the PIs withheld during the nonterminal years are paid in a lump sum to families completing their last year of participation in the HIS as an incentive for them to remain for their full term. As additional encouragement, each family receives a completion bonus if it finishes this term. The completion bonus is defined as:

The greater of (i) the largest participation incentive for any one accounting year to which the family, as it is configured at the time of its termination, would have been entitled during its participation in the FHPP, minus the withheld portion of the family's participation incentive, or (ii) \$120.

Although families are, of course, encouraged to remain in the HIS, they are free to drop out at any time without fear of financial loss. Families leaving before their full term is over are paid the difference between total PIs they have received up to the date of their termination and total medical expenses they have paid for out of their own funds under the FHPP that they would not have had to pay for under their private insurance plans. For example, assume a family decides to end its participation after 2-1/2 years, during which it has incurred out of pocket medical expenses of \$2,000 and received \$1,800 in PI payments. If the family would have had to pay only \$100 out of pocket under its private plan for those same services, it would receive a lump sum payment of  $(\$2,000 - \$100) - \$1,800 = \$100$  from the FHPP upon termination.

In addition to these incentive payments, participants are paid for filing regular reports on their health care use and for taking interviews administered as part of the HIS. These payments are to reimburse families for their time and to encourage them to submit timely reports and to participate willingly in the interviews.

## CONFIDENTIALITY

The HIS interviews and the reports and claims submitted by participants collect a large amount of personal information. Ethical considerations require that this information be kept strictly confidential. Additionally, assuring participants that the information they give to the HIS will be treated as privileged encourages them to participate and increases the accuracy of any information they do supply. Detailed procedures for preventing linkage of the identity of participants to the data collected on them have been made an integral part of HIS operations.

The confidentiality pledge in rule II states the obligations of plan administrators to participants. It is printed on all interviews and reports as well as in the Enrollment Agreement signed by participants and the booklet describing the Health Insurance Study distributed to them at the time of their enrollment. The pledge contains three primary limitations on the plan administrators' obligation to keep information strictly confidential:

1. The information will be used for purposes of evaluating and operating the HIS. This permits limited release of a participant's identity and other information to medical care providers and insurance companies where this release is essential to HIS operations (for example, reclaiming or claims processing).
2. The information may be disclosed for other purposes if prior written consent for such disclosure is obtained from the individuals.
3. Information will be disclosed without prior written consent if study administrators are required to do so by law. This caveat was added in case there should be a successful subpoena of information collected during the HIS. Participants are thus put on notice that privileged information they supply may be released.

## HEARINGS PROCEDURES

As with any insurance company, disputes about decisions and payments will probably arise between plan administrators and participants. Some method for resolving such disputes had to be developed and incorporated into the rules. Because the FHPP is part of a social experiment, it is desirable to provide participants with an option for impartial settlement other than court. A court dispute risks the premature release of study data, which could jeopardize the long-term success of the HIS. Additionally, it is less probable that families will drop out early if all participants have an equal opportunity to contest FHPP actions. The costs involved in taking a case to court would be prohibitive for many families. Laws vary across the experimental sites; therefore, the same set of circumstances might be resolved differently at each site. There is an administrative advantage to having rulings that apply uniformly to all participants regardless of their location. For these reasons, if disputes cannot be resolved between plan administrators and participants, participants have the option of being heard by the American Arbitration Association (AAA). Of course, if they are not satisfied with the results of the AAA hearing, they are free to take the matter to court.

Rules governing FHPP/AAA hearings are largely the same as those of the AAA with some exceptions designed to meet HIS-specific needs. If a participant requests an AAA hearing, FHPP will assume the responsibility for making the necessary arrangements with the AAA. The hearings will be held in the county of the participant's residence. The participant must advance the first \$50 and the FHPP pays the balance of the costs.

Before a dispute can be taken to the AAA, the participant must make an attempt to discuss the matter with plan administrators. Such direct contact should resolve many smaller problems or disagreements arising from misunderstandings.

## POLICY DECISIONS AND AMENDMENTS

The Rules of Operation are intended to provide general guidelines applicable to most foreseeable situations. The Certificates of Benefits (COB) are broadly written, unlike many private insurance plans. At the time the rules and the COBs were written, the HIS was a very new concept and there were few precedents to follow. Predictably, therefore, amendments to both have been necessary as plan administrators gain in experience.

Amendments are incorporated in both the rules and COBs through policy decisions. The decisions have a standardized format that includes the information upon which the decision to amend was based, as well as the amendment itself and the person responsible for it. Policy decisions are also used to record interpretations of rules and COB provisions and decisions on how special cases should be handled. These detailed decisions are not considered general or significant enough to be added to the rules or COBs as amendments. Recording them as policy decisions preserves them for historical and audit purposes and insures that similar situations arising during the course of the HIS will be treated analogously.

Policy decisions are *not* retroactive. Plan administrators are required to notify affected families of these changes in writing. This is usually done through a newsletter distributed periodically to participants at each site. Families are allowed 30 days in which to protest the decision.

## V. CONCLUSION

In this report we have described some of the major provisions of the Rules of Operation of the Health Insurance Study and pointed out their most important operational and analytical implications. We have also attempted to present the rationale behind these rules. Some of them, such as the family/person eligibility criteria and the special procedures, stem from purely analytic experimental considerations. Others are the result of the unique feature of the FHPP, the maximum dollar expenditure, which imposed certain constraints on the choice of the FHPP beneficiary unit and meant that the rules had to include a precise definition of income. The HIS experience with the administration of this rule will be useful in the design and operation of any national health insurance plan with income-related benefits.

The selection of the family as the basic FHPP insured unit was made for both equitable and analytic reasons on the basis of the assumption that members of families pool their incomes and share their medical expenditures. Additionally, the "family" as insured unit has administrative advantages over the individual since one or two persons can report the medical expenses of and receive payments for all family members. An income-related national health insurance plan may well designate the family as the insured unit, and policymakers will have to make some provisions for handling changes in family composition and the effect of these changes on family income. If income is to reflect ability to pay, family income should be reduced when an income-earning family member departs and increased if an income-earning individual joins the unit.

The HIS rules are designed to minimize the number of family composition changes recognized during the accounting period and hence the number of times it is necessary to recalculate income and allocate medical expenses. Although this results in families that are probably too "artificial" to be feasible under a comprehensive national health insurance program, it greatly facilitates the analysis of the responsiveness of demand to price. For example, the FHPP family excludes new spouses. A national health insurance plan will probably make allowances for many more changes in family composition. However, for several reasons, departures of heads are recognized during an accounting period. The "short accounting period" and the income and expense allocation formulas were created in response to this situation. It is only one of several possible ways to deal with changes in family composition occurring under an income-related, family-oriented insurance plan. The HIS experience in the operation of this system should provide information useful to national health insurance policymakers evaluating these various alternatives.

Income is used as a proxy for families' "ability to pay" for medical care expenditures. The FHPP limits the expenditures the unit must pay out of pocket. Although a national plan would not necessarily include such a limit, it may very well relate coverage to income in several other ways. In that case, the plan's rules would have to define and provide for the measurement of income. FHPP income is defined as the gross income reported on participants' tax returns. This definition was selected so that the administration of the FHPP would be as simple as possible. IRS income

categories are, in general, quantifiable and easily identifiable, and they have fairly standardized meanings. But relying on the IRS in this way meant that the FHPP income measure was retrospective, covering a fixed annual period. Income thus defined reflects a family's "ability to pay," especially its *current* ability to pay, in a very limited way. National health insurance policymakers attempting to define income for an income-related plan will face a similar conflict between the ease and accuracy of the measurement of income itself and the adequacy of income as a measure of ability to pay. The actual operation of plans using the IRS income measure should shed useful light on the exact nature of the tradeoffs involved.

Tradeoffs between desirable goals will have to be made at all stages of structuring a national health insurance program and designing the procedures for carrying it out. Some of these conflicts have been identified in this report. Although several choices leading to the Rules of Operation for the Health Insurance Study were based on experimental considerations, the identification and discussion of the rationale for the various choices should be helpful in the design of a national health insurance program. In addition, the experience gained through the operation of the experimental portion of the HIS should provide practical information on the administrative feasibility and cost of options and identify areas requiring further consideration or research before informed decisions can be made.

## **VI. RULES OF OPERATION OF THE FAMILY HEALTH PROTECTION PLAN**

### **I. INTRODUCTION**

The Health Insurance Study (hereafter HIS) has been established by the U.S. government to answer important questions regarding health insurance and health care in the United States. The Family Health Protection Plan (hereafter FHPP) is a plan of health benefits provided to eligible families participating in the HIS.

### **II. CONFIDENTIALITY**

All information which would permit identification of individuals or families or which might be identified with individuals or families will be regarded as strictly confidential, will be used only for the purposes of operating and evaluating the Health Insurance Study, and will not be disclosed or released for any other purposes without prior written consent of such individuals or head(s) of families except as required by law. For the purpose of research, all information which would identify individuals will be deleted from interview materials. Identifying information will be destroyed following conclusion of the study.

### **III. ELIGIBILITY**

#### **A. INITIAL ELIGIBILITY**

The determination of initial eligibility for the FHPP is made from among all family units residing in designated sample areas chosen at random within a designated site. All people in a household at the time of the first offer of enrollment, and those people not present at that time but who may otherwise be eligible under rule III.A.6 (Eligibility of Persons Not Present at Enrollment), will be assigned to a family unit, which may consist of one or more persons. In a single household there may be more than one family unit. A household will contain as many family units as meet the criteria for forming units. No person may belong to more than one unit. To be considered for eligibility for the FHPP, a family unit must submit to a baseline interview.

#### **1. DETERMINATION OF THE HEAD(S) OF A FAMILY UNIT**

The head of a family unit in any household shall be that person aged 18 through 61 years inclusive (for a family unit participating in the FHPP for three years) or that person aged 18 through 59 years inclusive (for a family unit participating in the FHPP for five years) who is determined by the FHPP to be not dependent for more than half of his or her support on any other members of the household and who has that household as his or her principal place of abode. If no person who resides in the household is aged 18 through 61 inclusive (for a family unit participating in the FHPP for three years) or 18 through 59 inclusive (for a family unit participating in the FHPP for five years), then there is no head and no eligible family unit.

The spouse of any head of a family unit or any person whom the head claims to be his or her spouse, who resides in the same household, shall also be considered a head of that family unit for the purposes of the FHPP. All

references in these rules to a head shall be interpreted as referring where appropriate to both heads.

## 2. ASSIGNMENT OF OTHERS TO A HEAD'S INITIAL FAMILY UNIT

For the purposes of determining eligibility, two types of family units are defined, the "FHPP unit" and the "relationship group." Additionally the "economic unit" is defined to calculate the maximum dollar expenditure (MDE) (rule V and Attachment I). The "relationship group" is used to determine a family unit's income eligibility under rule III.A.4.a. The FHPP unit is used to determine the eligibility of that unit's members for participation in the FHPP. Only those family unit members who are part of the FHPP unit shall be eligible to participate in the FHPP. All references in these rules to a family unit shall refer to the FHPP family unit (except as noted in rules III.A.4.a, V, VII, IX.C.3 through IX.C.6, and Attachment I below).

After the head of a family unit has been determined, then from among all persons who have the household of the head of that family unit as their principal place of abode at the time of initial enrollment, the following persons shall be included in that head's:

### a. ECONOMIC FAMILY UNIT

- (1) The spouse of the head or any person whom the head claims to be his or her spouse;
- (2) Any unmarried person under 18 years old who is a child (natural, adopted, or stepchild) of either head;
- (3) Any other unmarried person under 18 years old who is related (defined in the appendix) to the head and not assigned to any other family unit by virtue of a closer relationship to the head of such other family unit;
- (4) Any other person who receives more than half of his or her support from the head.

### b. FHPP FAMILY UNIT

- (1) The spouse of the head or any person whom the head claims to be his or her spouse;
- (2) Any unmarried person under 18 years old who is a child (natural, adopted, or stepchild) of either head;
- (3) Any other unmarried person under 18 years old who is related (defined in the appendix) to the head and not assigned to any other family unit by virtue of a closer relationship to the head of such other family unit;
- (4) Any other person who is related (defined in the appendix) to the head and who receives more than half of his or her support from the head.

### c. RELATIONSHIP GROUP

- (1) The spouse of the head or any person whom the head claims to be his or her spouse;
- (2) Any person who is related (defined in the appendix) to the head(s);
- (3) Any other person who receives more than half of his or her support from the head.

### 3. FORMATION OF OTHER FAMILY UNITS

- a. After the application of rules III.A.1 and III.A.2 above, if there remain any persons who are residing in the household and who have not been assigned to a family unit, then additional units may be formed in accordance with rules III.A.1 and III.A.2 above.
- b. If no persons 18 years old or older remain, but there remain persons under 18, then those persons shall not belong to an eligible family unit and shall not be eligible to participate in the FHPP.

### 4. ELIGIBILITY OF FAMILY UNITS

All family units defined as above shall be eligible to participate in the FHPP with the following exceptions:

- a. If the income (as defined under rule VII) for the preceding calendar year of all members of a household's relationship group is greater than \$25,000 times the ratio of the GNP implicit price deflator for personal consumption expenditure in that year to the implicit price deflator in 1973, the family unit shall not be eligible.
- b. If any head of a family unit is on active duty or is retired with full benefits from active duty in any of the uniformed federal services, including, but not limited to, the Army, Navy, Air Force, Marines, Public Health Service, Coast Guard and Environmental Science Services Administration, and is eligible for free medical care as a result of such duty, then the entire family unit shall not be eligible.
- c. If any head of a family unit is receiving supplemental security income (SSI) benefits (aid to the aged, blind, and disabled), then the entire family unit shall not be eligible.
- d. If any head of a family unit is receiving disability or chronic kidney disease Medicare benefits, then the entire family unit shall not be eligible.
- e. If both heads of a family unit are eligible for free or reduced rate health care at a school clinic by virtue of one or both heads' student status, then the entire family unit shall not be eligible.

### 5. ELIGIBILITY OF PERSONS

All persons who are assigned to an eligible family unit in accordance with these rules shall be eligible to participate in the FHPP except the following:



- a. Persons 62 years of age or older at the time of enrollment (for families selected to participate for three years) or persons 60 years of age or older at the time of enrollment (for families selected to participate for five years).
- b. Persons of any age who are eligible for disability or chronic kidney disease benefits or supplies to the extent they are available under Medicare.
- c. Persons on active duty and persons who are retired from active duty with full benefits in any of the uniformed federal services and their dependents or survivors who are eligible for free medical care provided by the armed forces or CHAMPUS as a result of such duty.
- d. Foster children (defined in the appendix).
- e. Veterans with service-connected disabilities who are eligible to receive care through the Veterans Administration.  
Veterans with non-service-connected disabilities or with no disabilities are eligible for coverage under the Certificate of Benefits of the FHPP, provided, however, that they sign a waiver stating that they will not receive medical care from any Veterans Administration facility for the period of their participation in the FHPP.
- f. Dependents and survivors of veterans with 100 percent service-connected disabilities who are eligible for CHAMPVA.
- g. Students whose principal place of abode is usually separate from that of the family unit.
- h. A person enrolled in a prepaid group health plan or Health Maintenance Organization (HMO).
- i. Employees of the HIS or the FHPP and persons related (as defined in the appendix) to employees of the HIS or the FHPP.
- j. Persons eligible for medical care through Indian Health Services, Bureau of Indian Affairs.
- k. Persons employed as officers or crew on a ship that is at sea for a continuous period of 30 days or more at least once a year.

#### 6. ELIGIBILITY OF PERSONS NOT PRESENT AT ENROLLMENT

Any person assigned to an eligible family unit in accordance with these rules, but who is temporarily living away from the household at the time of the first offer of enrollment, shall not be eligible to be enrolled in the FHPP unless he or she actually returns to the family unit's household and maintains that household as his or her principal place of abode, submits to a screening examination, completes the medical history interview, and performs such other requirements (including those listed under rule III.B) as the Plan Administrator or his designee may request before the family unit's effective date of coverage under the FHPP, as noted in that unit's Enrollment Agreement. Such person may be enrolled as a member of the family unit only after he or she has actually returned to the family unit's household and complied with the requirements of this rule.

7. ENROLLMENT OF TWO OR MORE FAMILY UNITS IN A SINGLE HOUSEHOLD

- a. If more than one family unit in a household is enrolled in the FHPP, all such units shall be given the same plan of benefits.
- b. If any family is enrolled in the FHPP, then any other eligible family unit in the same household that is composed of at least one member related (defined in the appendix) to at least one member of the enrolled unit shall also be enrolled in the FHPP.
- c. If one or more family units refuse to enroll or participate, other units may still participate in the FHPP.

B. CONTINUED ELIGIBILITY

1. FAMILY UNITS

Family units enrolled in the FHPP are eligible to continue to participate as long as, but only as long as, they:

- a. Maintain residence in the United States;
- b. Participate in interviews conducted by representatives of the FHPP;
- c. Prepare and promptly submit a Medical Expense Report form to the FHPP whenever medical services are used by those eligible family members listed in the family's Enrollment Agreement;
- d. Prepare and submit regular reports on medical care received, health status, and income, as well as changes in address, medical care coverage, or family composition, as stated in the Enrollment Agreement;
- e. Take a screening examination administered by the FHPP, for which the family will not be charged, at the beginning and the end of the family unit's participation in the FHPP, if so requested by the Plan Administrator or his designee, as stated in the Enrollment Agreement;
- f. As described in rule VI, maintain the health insurance or medical care coverage in existence at the time of their enrollment in the FHPP for as long as they are eligible to do so or until they obtain substantially equivalent or better coverage, and assign or otherwise pay over to the FHPP all benefits from all other health insurance and medical care coverage of participating family members in force at any time during their participation;
- g. Comply with such other requests for information and fulfill such other obligations of the FHPP as the Plan Administrator or his designee may reasonably request.

2. PERSONS

- a. Persons enrolled as members of a family unit will no longer be eligible to participate in the FHPP if they become:
  - (1) A Medicare beneficiary (rule III.A.5.b) or a veteran with a service-connected disability (rule III.A.5.e).

(2) A veteran with a non-service-connected disability or with no disability who receives medical care from a Veterans Administration facility at any time during his or her participation in the FHPP;

(3) A person suspended under rule III.B.2.b who does not regain full FHPP eligibility before the end of the accounting year during which he or she was suspended (rule III.C.1.b).

b. Persons enrolled as members of a family unit will be suspended from participation in the FHPP and will not be permitted to file claims for medical expenses incurred during the period of their suspension if they become:

(1) A resident of a country other than the United States;

(2) A person on active duty or retired from active duty and his or her dependents or survivors (rule III.A.5.c) or dependents or survivors of a veteran with a total service-connected disability (rule III.A.5.f) if such persons become eligible for CHAMPUS or CHAMP-VA benefits for a period of 30 days or more;

(3) A person whose health care options are significantly different from those of the rest of the population (because they do not have access to the normal market for health care services) including but not limited to:

(a) Persons confined under sentence to a penal institution for a period of time the Plan Administrator or his designee expects to last for 30 days or more;

(b) Persons confined, voluntarily or involuntarily, in a governmentally supported or controlled institution that assumes full responsibility for the health care of its patients or inmates at no charge to the institutionalized person, for a period of time the Plan Administrator or his designee expects to last for 30 days or more.

(c) Persons employed as officers or crew on a ship that is at sea for a continuous period of 30 days or more at least once a year.

#### C. SUBSEQUENT ELIGIBILITY

##### 1. ADDITIONS TO UNITS AND RENEWED ELIGIBILITY OF Suspended Persons

The following persons who are determined by the Plan Administrator or his designee to have the household of the head of a family unit that is participating in the FHPP as their principal place of abode after the time of initial enrollment, and who otherwise meet the initial eligibility requirements of these rules, will be eligible for coverage under the FHPP:

a. Newborn children, or adopted children under one year of age at the time formal adoption proceedings are begun, of any member of the unit (whether or not such children receive half or more of their support from the head);

- b. A person who was previously enrolled, became suspended by virtue of rule III.B.2.b, and is no longer on active duty, a dependent of a person on active duty, confined in such institutions, or a resident of a foreign country, provided, however, that such person regains eligibility status before the end of the accounting year during which he or she became suspended from participation in the FHPP.

Such additions or renewals of eligibility may be conditioned upon the execution and delivery of such documents as the Plan Administrator or his designee may reasonably request. (See rule IX.A.)

## 2. CHANGE OF STATUS

- a. Whenever an enrolled person under 18 years of age ceases to have as his or her principal place of abode the household of the head of his or her unit, that person shall remain a member of that unit if he or she continues to participate in the FHPP.
- b. Whenever enrolled spouses who are heads of a family unit provide the Plan Administrator or his designee with satisfactory evidence that they are divorced or separated (as defined in the appendix), they are eligible to form two separate units if such spouses otherwise meet the eligibility requirements of these rules. (See rule IX.C.)
- c. Whenever any other enrolled person over 18 years ceases or has ceased to have as his or her principal place of abode the household of the head of his or her unit, or ceases or has ceased to receive more than half of his or her support from the head of that unit, that person shall form a new unit at the beginning of the next accounting year (the anniversary date of the effective date of initial enrollment), if he or she otherwise meets the eligibility requirements of these rules. (See rule IX.B.)
- d. Any other previously enrolled person who has as his or her principal place of abode the household of the person described in paragraphs III.C.2.b or III.C.2.c above and who fulfills the requirements of rule III.A.2 (the FHPP family unit) shall be included in that person's unit when the new unit is formed.
- e. If, after initial enrollment, the head of a family unit enrolled in the FHPP becomes ineligible to continue to participate (by virtue of rule III.B.2) or is deceased, and no person remaining in the unit is eligible to become the head of the family unit under rule III.A.1, the FHPP may appoint an acting head. Such head shall not be eligible for coverage under the plan of benefits (rule IV) of that family unit, but may participate in the interviews administered by the FHPP and submit medical reports on the remaining eligible members of the family unit.

## IV. BENEFIT PLANS

All family units that are eligible and agree to participate in the FHPP will receive a plan of benefits for medical expenses. The coverage and scope of benefits of these plans is described in the unit's Certificate of Benefits. The Plan Administrator, in

his discretion, or his designee, in his discretion, may waive any prior authorization or exclusion stated in the Certificate of Benefits.

#### V. MAXIMUM DOLLAR EXPENDITURE

A. Certain Certificates of Benefits provide for a Maximum Dollar Expenditure (MDE), which is related to the family unit's income (as defined in rule VII), in connection with coinsurance features, or for a fixed dollar limit (FDL). The MDE or FDL is the maximum amount that a family unit must pay in any accounting year for medical expenses (except for services not covered, as defined in the unit's Certificate of Benefits) incurred by all family unit members participating in the FHPP.

B. The MDE is the lesser of (i) a certain percentage (5, 10, or 15 percent, depending on the variation to which the family unit is assigned) of the unadjusted income, as determined under rule VII, of all members of the economic unit for the preceding calendar year (with appropriate adjustments described under rule V.C and Attachment I below), or (ii) \$1000.

C. In the event that there is a member of the economic family unit who is ineligible for the FHPP family unit, an appropriate adjustment in income used to determine the MDE shall be made in accordance with Attachment I to these rules.

D. The MDE or FDL shall be set at the outset of each initial unit's coverage under the FHPP and annually thereafter on the same date (the anniversary of the effective date of enrollment).

#### VI. MAINTENANCE AND ASSIGNMENT OF OTHER HEALTH INSURANCE OR MEDICAL CARE COVERAGE

All benefits payable under health insurance and medical care coverage under which a person is covered at any time during such person's participation in the FHPP must be assigned and paid over to the FHPP. If a participating family's health insurance or medical care coverage covers services or items that the FHPP does not cover (excluding the absence of coverage by reason of coinsurance or deductible requirements), the FHPP will pay over to the family the benefits that are actually paid by the family's medical care coverage for such services or items. In addition, in plans with a coinsurance feature, the FHPP shall pay over to the family certain amounts actually paid by the family's medical care coverage for outpatient psychiatric services as specified in the family's Certificate of Benefits.

Family unit members who are eligible for the FHPP are required to maintain the health insurance or medical care coverage in existence at the time of the family's enrollment in the FHPP (including those listed in the family's Enrollment Agreement) for as long as they are eligible to do so or until they obtain substantially equivalent or better coverage. If a family member loses such health insurance or medical care coverage through a change of employment or other circumstance, that person must use his or her best efforts to obtain substantially equivalent coverage. In the event that such family member is not able to purchase substantially equivalent or better coverage, or if a participating family member does not have health insurance or other medical care coverage at the time of such person's enrollment

in the FHPP, the FHPP may, but shall not be obligated to, purchase medical care coverage for such person or make a medical care coverage plan available for purchase by such person. The FHPP will reimburse premiums for such health insurance or medical care coverage, as provided in rule VIII.B.

## VII. DEFINITION OF INCOME

For purposes of these rules, the term "income" is defined as gross income (specified in A. below) less deductions allowed (specified in B. below) of all members of the household relationship group (for purposes of rule III.A.4.a) or the economic family unit (for purposes of rule V and the appendix) during the most recent calendar year, whether or not such family unit or relationship group, as defined under rule III.A.2 and determined by the FHPP, was so configured during the most recent calendar year.

### A. GROSS INCOME

Gross income includes those receipts that are included in gross income under the then current federal income tax laws, except as modified below, including, but not limited to, the following items:

1. Wages, salaries, bonuses, tips, and other compensation for services, including fees, commissions, and similar items, excluding amounts received from other members of the family unit or relationship group.
2. Dividends including that portion of dividends excluded from taxable gross income.
3. Interest income, including earnings from savings and loan associations, mutual savings banks, cooperative banks, and credit unions as well as interest on bank deposits, bonds, tax refunds, etc. PLUS income other than wages, dividends, and interest, such as:
4. Net income derived from a business.
5. Fifty percent of the net long-term gain and 100 percent of the net short-term gain from sales or exchanges of capital assets.
6. The taxable portion of any payment received as an annuity or pension.
7. Trust distributions of capital, except to the extent such distributions represent a return of the recipient's contribution.
8. Rent and royalty income, excluding amounts received from other members of the same family unit.
9. Income derived from partnerships, estates, or trusts.
10. Court ordered alimony or separate maintenance payments, plus court ordered child support payments received from persons (including an ex-spouse) who are not members of the same family unit or relationship group.
11. The amount of value of prizes and awards that are defined as included in gross income under the Internal Revenue Code.
12. Aid to Families with Dependent Children or Supplemental Security Income.

## B. ITEMS DEDUCTED FROM GROSS INCOME

1. Court ordered alimony or separate maintenance payments, and court ordered child support payments paid to persons not members of the same family unit or relationship group.
2. Losses from sales or exchanges of capital assets to the extent of the gains from such sales or exchanges, plus (if losses exceed such gains) whichever of the following is smallest:
  - a. The taxable income for the taxable year,
  - b. \$1000, or
  - c. The sum of
    - (1) The excess of the net short-term capital loss over the net long-term capital gain, and
    - (2) One-half of the excess of the net long-term capital loss over the net short-term capital gain.

## VIII. TYPES AND METHODS OF PAYMENTS TO FAMILY UNITS

### A. PAYMENT GUARANTEE

1. The amount of the payment guarantee is equal to the maximum amount that could be paid for covered services by a family unit participating in the FHPP that would not be payable by the unit under all health insurance or medical care coverage policies covering the eligible members of the unit at the time of enrollment or at the time of recomputation of the payment guarantee (see rule VIII.A.2), less the amount that was currently being paid by members of the unit for such health insurance or medical care coverage as is taken into account in setting this amount, and is then being reimbursed by the Family Health Protection Plan (see rule VIII.B). The computation of the payment guarantee shall exclude FHPP-purchased policies (cf. rule VI). The amount of the payment guarantee in any accounting year shall not exceed a family's MDE or FDL for that accounting year.
2. The payment guarantee will be recomputed only on the anniversary of the effective date of enrollment, except that the amount of the payment guarantee may be recomputed during the accounting year at such times as a family unit informs the Plan Administrator or his designee that its insurance has changed because of job changes, government action, the addition to the unit of a subsequently eligible person (defined in rule III.C.1), or the change of status of a member defined in rule III.C.2).
3. The payment guarantee will be paid in cash installments.

### B. PREMIUM REIMBURSEMENT

Health insurance and medical care coverage premiums will be reimbursed during a family's participation, but in the case of premium payments made in advance, reimbursement will be made only for that portion of the premium covering the period of the family's enrollment, subject to the following restrictions:

1. The FHPP shall not reimburse a family for any coverage that the Plan Administrator or his designee determines to be double or excessive;
2. The FHPP shall not reimburse a family without authorization by the Plan Administrator or his designee for premiums for health insurance or medical care coverage policies not assigned to the FHPP (as provided in rule VI) or not listed in the family's Enrollment Agreement; and
3. The FHPP shall not reimburse a family for any increased premiums resulting from changes in any health insurance or medical care coverage policies without authorization by the Plan Administrator or his designee.

#### C. PARTICIPATION INCENTIVE

1. The participation incentive for each accounting year is composed of the payment guarantee and the premium reimbursements and is paid in installments according to the following rules:
  - a. For a family participating in the FHPP for three years, the greater of (1) 75 percent of the participation incentive for each of the first two accounting years or (2) the full amount of the premium reimbursement (rule VIII.B) for each such year will be paid during each such year, and 100 percent of the participation incentive for the third and final year will be paid during that year.
  - b. For a family participating in the FHPP for five years, the greater of (1) 85 percent of the participation incentive for each of the first four accounting years or (2) the full amount of the premium reimbursement (rule VIII.B) for each such year will be paid during each such year, and 100 percent of the participation incentive for the fifth and final year will be paid during that year.

The remaining withheld portion will be paid at the end of the family's period of participation, as specified in the family unit's Enrollment Agreement, as part of the family's completion bonus (defined in rule VIII.G).

2. If a family elects to discontinue its participation in the FHPP at any time before the completion date specified in its Enrollment Agreement, then it will receive the difference, if any, at the date of withdrawal between (a) the amount the family unit paid for covered services up to the date of its termination that would not have been payable by the unit under all health insurance or medical care coverage policies in effect when such expenses were incurred, and (b) the sum of the participation incentives the family unit has received in installments up to the date of its termination.

#### D. PAYMENT FOR FILING

A regular payment of a set amount will be made to all families participating in the FHPP for submitting the information reports.

#### E. INTERVIEW PAYMENT

Each family head who participates in the interviews administered by FHPP representatives will be paid each time an interview is given.



#### F. PAYMENT OF BENEFITS

Payment of benefits in accordance with the Certificate of Benefits will be made to the family, but the FHPP will make payment directly to the person or organization providing the service if requested in writing to do so by the head of the family and if direct payment is accepted by the provider of the covered service.

#### G. COMPLETION BONUS

If a family completes its period of participation as specified in its Enrollment Agreement, it will receive a lump sum completion bonus, which will equal the greater of (i) the largest participation incentive for any one accounting year to which the family, as it is configured at the time of its termination, would have been entitled during its participation in the FHPP, minus the withheld portion of the family's participation incentive, or (ii) \$120, subject to the following exceptions:

1. If after the spouse of the head of a unit forms a new unit (as described in rule IX.C), and both of the units are still participating at the end of the original unit's period of participation, as described in that unit's Enrollment Agreement, and the sum of the incomes of the two separate units for the calendar year immediately preceding the end of the original unit's period of participation is 60 percent or less than the income of the original unit would have been for such calendar year, then at the discretion of the Plan Administrator or his designee, the income of the original unit may be used to compute the completion bonus, to be divided between the two separate units in proportion to their incomes during the calendar year immediately preceding the end of the original unit's period of participation.
2. If two separate units join to form a new family unit, and if the income for the calendar year immediately preceding the formation of the new unit is 60 percent or less than the sum of the incomes of the previous two separate units would have been for such calendar year, then at the discretion of the Plan Administrator or his designee, the sum of the incomes of the previous two separate units may be used to compute the completion bonus.

#### H. METHOD OF PAYMENTS

1. All amounts payable to a family will be paid to the head of the family or, in appropriate circumstances, to some other family member designated by the Plan Administrator or his designee, and all members of the family are bound to accept payment to the head or such other person as full satisfaction of the obligation of the FHPP to make any payments.
2. At the discretion of the Plan Administrator or his designee, payments for the participation bonus and premium reimbursements may be combined and paid in installments over each accounting year, as specified in rule VIII.C.
3. The amount of any overpayment made by the FHPP or the HIS to a participant or a provider of health care services or supplies may be recov-

ered by the FHPP by offsetting such overpayments against subsequent payments due such participant or provider, or otherwise.

#### I. REPORTING REQUIREMENTS

Participants must report changes in insurance or employment to the Plan Administrator no later than 30 days after the end of the accounting year during which the change occurred. If such changes are not reported within this time limit and are subsequently discovered, and if the participation incentive when recalculated based on these changes is greater than the participation incentive the participant is currently receiving, the Plan Administrator shall not be obligated to compensate the participant for the difference. If the recalculated participation incentive is less than that the participant is currently receiving, the Plan Administrator will be entitled to deduct the amount of any previous participation incentive overpayments from subsequent participation incentive payments due the participant.

### IX. SPECIAL RULES FOR CHANGES IN UNIT MEMBERSHIP

#### A. ADDITIONS TO UNITS

##### 1. COVERAGE UNDER THE FHPP

A person who becomes eligible to be added to a participating family unit after that unit's enrollment (as defined in rule III.C.1) will be effectively covered by that family unit's Certificate of Benefits under the FHPP as of the effective date determined by the Plan Administrator or his designee and provided in written notification to the family, provided:

- a. Such person is determined by the Plan Administrator or his designee to be eligible to be added to the family unit; and
- b. Such person is determined by the Plan Administrator or his designee to be eligible to participate in the FHPP.

##### 2. ADJUSTMENTS IN INCOME AND THE MDE OR FIXED DOLLAR LIMIT

Whenever a subsequently eligible person (defined in rule III.C.1) becomes a member of an enrolled family unit, adjustments in income and the MDE or FDL will be made only at the beginning of the next accounting year (the anniversary of the effective date of initial enrollment).

#### B. DELETIONS FROM ENROLLED FAMILY UNITS AND FORMATION OF NEW FAMILY UNITS

##### 1. COVERAGE UNDER THE FHPP

Subsequent eligibility rules (III.C) shall determine which members of the unit are eligible to participate in the FHPP or the HIS. A person whose status has changed, as defined in rule III.C.2.c, will continue to be a member of the family unit to which he or she was assigned at the time of the change and will continue to be covered by the Certificate of Benefits of that family unit until the end of the accounting year, if he or she continues to participate in the FHPP. On the anniversary of the effective date of enrollment, when a separate family unit may be formed, the new family unit will be

given the same Certificate of Benefits as such person's previous family unit. If two or more previously enrolled persons with different benefit plans become part of the same unit, they will be assigned to the plan of the head of the newly created family unit. If there are two heads who previously held different plans of benefits, the new unit that they form will be assigned to whichever of these two plans it prefers.

## 2. ADJUSTMENTS IN INCOME AND THE MDE OR FIXED DOLLAR LIMIT

An adjustment in the MDE or FDL of a participating family unit shall be made only on the anniversary of the unit's effective date of enrollment. A determination of the MDE or FDL of the new unit shall also be made at this time.

## 3. ADJUSTMENTS IN THE PARTICIPATION INCENTIVE

An adjustment may be made in the family unit's participation incentive if the family unit's health insurance or medical care coverage has changed because of the change of status of one of its members. Such an adjustment will be effective beginning with the first payment following the change in the family's health insurance coverage and subject to rule VIII.A.2. Payment of the participation incentive shall continue to be made to the head(s) of the family unit.

## 4. PAYMENT OF BENEFITS

Following the change of status of an eligible family member, as defined in rule III.C.2.c, payment for the claimant's medical expenses covered under his or her family's Certificate of Benefits will be made to the claimant, commencing not later than five days after the head(s) of the family unit and the member whose status has changed sign agreements to effect such change in the payment of benefits for the claimant's medical expenses, or, in lieu thereof, upon the completion of such other documentation as the Plan Administrator or his designee may require.

# C. SPOUSE OF HEAD FORMS A NEW UNIT

## 1. COVERAGE UNDER THE FHPP

Subsequent eligibility rules (III.C) shall determine which members of the unit are eligible to participate. A spouse who is a head of a family unit and whose status has changed, as defined in rule III.C.2.b, will be eligible to form a separate family unit following a separation or divorce (as defined in the appendix), when documents reflecting such change are signed by each of the original spouses or such persons as the Plan Administrator or his designee may require. Each new unit will continue to be covered by the same Certificate of Benefits as the original family unit for the remainder of the accounting year, provided each unit continues to participate in the FHPP. If two or more previously enrolled persons with different benefit plans become part of the same unit, they will be assigned to the plan of the head of the new family unit. If there are two heads who previously held different Certificates of Benefits, the new unit that they form will be assigned to whichever of these two plans it prefers.

In the case of a desertion (defined in the appendix), the remaining spouse shall be entitled to continue to participate in the FHPP as the sole head of the family unit.

## 2. ACCOUNTING PERIOD

- a. When a new unit is formed because of the separation or divorce of the spouse of a head from an enrolled family unit, each separate unit will initially use a short accounting period beginning on the effective date stated in the documentation referred to in rule IX.C.1 and ending on the date on which the accounting period of the original unit would have ended (the anniversary of the effective date of initial enrollment), after which each unit will revert to a normal 12-month accounting period.
- b. It will be assumed that the original unit was the appropriate unit in the past, so there will be no retroactive adjustments for any earlier period based on what would have been calculated for the new units had they existed for the entire normal accounting period.

## 3. ADJUSTMENTS IN INCOME

In determining the income of the family units for purposes of calculating the MDE, the following rules shall apply:

- a. The income that had been earned in the most recent calendar year by performance of services by the members of each separate economic unit will be allocated to such members' economic unit;
- b. If after a separation or divorce, one spouse provides the other with alimony or child support payments in cash by court order or by agreement, then the amount of such support or alimony will be allocated to the income of the recipient and deducted from the income of the payor, for the period of the most recent calendar year preceding the separation;
- c. If the allocation of any other income cannot readily be determined by the Plan Administrator or his designee, then such other income will be allocated to the separate units in proportion to the number of members in each unit.

## 4. ADJUSTMENTS IN THE MDE OR FDL

The MDE or FDL for a full accounting period will be calculated according to rules V.B and V.C on the basis of the economic family units' incomes determined by the above rules. This MDE or FDL will be effective on a pro rata basis for the duration of the short accounting periods of each unit.

## 5. ALLOCATION OF MEDICAL EXPENSES

Once income is determined by the above rules, medical expenses incurred by the original unit prior to the short accounting period will be allocated between the two separate economic family units in proportion to such determined incomes.

## 6. ADJUSTMENTS IN THE PARTICIPATION INCENTIVE

Once income is determined according to rule IX.C.3, the amount of the participation incentive of the original family unit prior to the short accounting period will be allocated between the two separate economic family units in proportion to such income, except where the health insurance or medical care coverage of either separate unit has changed because of separation or divorce, or where the amount of the participation incentive is otherwise divided between the two original spouses in a separation or divorce decree, or by agreement. The adjustment in the participation incentive of the original unit will be effective in the first payment following the effective date of the separation or divorce documentation referred to in rule IX.C.1.

## 7. PAYMENTS OF BENEFITS

Following a separation or divorce of the heads of a family unit, payment for medical expenses covered under each unit's Certificate of Benefits will be made to the head of each new unit, commencing not later than five days after the FHPP receives the documentation referred to in rule IX.C.1.

## 8. AGREEMENTS

In the event that no agreements are reached by the heads of the separate units to effect the adjustments and changes in the payment of benefits provided for in rules IX.C.1 through IX.C.7, the Plan Administrator or his designee may make adjustments as deemed advisable in income, the MDE or FDL, the participation incentive, the allocation of medical expenses, and the changes in the payments of benefits.

# X. RESPONSIBILITY FOR FILING MEDICAL EXPENSE REPORTS AND REPORTING

## A. FILING MEDICAL EXPENSE REPORTS

Families participating in the FHPP are responsible for promptly filing Medical Expense Reports each time any member of the family unit who is so required by the family's Enrollment Agreement incurs a medical expense. The FHPP reserves the right not to pay claims asserted in Medical Expense Reports received by the claims office more than 30 days after the date of billing.

## B. REGULAR REPORTS

Families participating in the FHPP are responsible for filing regular reports with the local FHPP office. Families must report medical care received, health status, and income, as well as changes in medical care coverage, address, or family composition, and such other information as the Plan Administrator or his designee may reasonably request, as stated in the Enrollment Agreement. The FHPP reserves the right not to pay for reports that are not properly completed or postmarked (received in the FHPP office) on time.

## C. INTERVIEWS

All families participating in the FHPP must submit to interviews conducted by the FHPP or the HIS.

## XI. TERMINATION OF PARTICIPATION

Subject to the requirements of continued eligibility set forth in rule III.B above, a family's or person's participation in the FHPP is guaranteed for the period of time specified in the family unit's Enrollment Agreement, provided, however, that participation may be terminated upon written notice in the event:

- A. Of failure of the family or person to fulfill all obligations of participation; or
- B. Of fraud or misrepresentation; or
- C. That sufficient funds have not been or will not be made available to the FHPP.

## XII. AMENDMENTS TO THE RULES OF OPERATION AND POLICY DECISIONS

A. The terms of the Certificates of Benefits and the Rules of Operation are subject to amendment by the Plan Administrator or his designee. Any such amendments, however, will not be retroactive. The FHPP will notify participating families of all material amendments to the Certificates of Benefits or the Rules of Operation that affect such families, and such amendments shall be effective following written notice and shall have the same force as an original rule or original term of the Certificates of Benefits.

B. The Rules of Operation and Certificates of Benefits are subject to interpretation on a case-by-case basis by issuance of policy decisions. These decisions are to be issued and numbered consecutively by city. When issued by the Plan Administrator or his designee, a policy decision becomes part of the Rules of Operation or the Certificates of Benefits and is to have the same force as an original rule or term of the Certificates of Benefits.

## XIII. HEARINGS PROCEDURES

### A. DISPUTES

A head of a family unit or a covered person may contest a decision, payment, or other action by personnel administering the FHPP. However, any decision, payment, or other action by the FHPP shall be final and binding upon a participating family or person unless appealed or contested in writing by the affected family or person within 30 days of receipt of notice by the family or person of such decision, payment, or other action.

### B. PAYMENT STATUS OF FAMILIES CONTESTING A DECISION

1. A family or person shall be considered to be contesting a decision at the time of receipt, in the local FHPP office within the time period specified in paragraph A of this rule, of written notice by the family or person stating that such family or person is challenging a decision and describing the disputed item(s).

2. A family or person in the process of disputing an item with the local office will retain its usual rights and obligations, except as to the disputed item.

3. Any related dispute(s) will be consolidated for consideration. Any unrelated disputes may be so consolidated or may be considered separately at the option of the Plan Administrator or his designee.

#### C. ADMINISTRATIVE REMEDIES

1. The Plan Administrator or his designee will make arrangements to discuss the matter with the disputant in an effort to achieve a mutually satisfactory disposition. The disputant may be accompanied by any representative he or she chooses to assist him or her in such discussion, and the Plan Administrator or his designee may be accompanied or assisted by other FHPP staff members or any representative.

2. In the event that the discussion does not result in a disposition of the matter that is satisfactory to the disputant, the Plan Administrator or his designee shall inform the disputant of his or her right to have the matter resolved through arbitration.

Any and all such controversies, claims, or disputes not resolved by the Plan Administrator or his designee to the satisfaction of the disputant shall be settled by arbitration at the initiation of the disputant in accordance with the Rules of the American Arbitration Association, except insofar as such rules are inconsistent with the provisions set forth in particular in subsection D below, and judgment upon the award rendered by the arbitrators shall be a final and binding determination of the controversy and may be entered in any court having jurisdiction thereof. In the event the disputant does not initiate arbitration in accordance with rule XIII.D.7 below, the decision of the Plan Administrator or his designee shall be final and binding.

#### D. ARBITRATION

1. RULES OF AMERICAN ARBITRATION ASSOCIATION — Arbitration shall be conducted through the American Arbitration Association (hereinafter "AAA") in accordance with its Rules except as such Rules are inconsistent with the provisions set forth below. The Rules of the AAA and any amendment thereof shall apply in the form obtaining at the time the arbitration is initiated.

2. NAME OF TRIBUNAL — The tribunal for the settlement of disputes shall be called the Commercial Arbitration Tribunal.

3. ADMINISTRATOR — The AAA shall be the administrator of the arbitration. The authority and obligations of the administrator are prescribed in these rules and in the Rules of the AAA.

4. DELEGATION OF DUTIES — The duties of the AAA may be carried out through the Tribunal Administrator, or such other officers or committees as the AAA may direct.

5. NATIONAL PANEL OF ARBITRATORS — The AAA has established and maintains a National Panel of Arbitrators and shall appoint Arbitrators therefrom as hereinafter provided.

6. **OFFICE OF TRIBUNAL** — The general office of a Tribunal is the headquarters of the AAA, which may, however, assign the administration of an arbitration to any of its Regional Offices.

7. **INITIATION OF ARBITRATION** — Arbitration under these rules shall be initiated in the following manner:

a. The disputant shall give notice, within 60 days of written notice to the disputant of the Plan Administrator's decision (pursuant to the initial dispute), to the local Plan Office (Agency) of his intention to arbitrate (Demand), which notice shall contain a statement setting forth the nature of the dispute, the amount involved, if any, and the remedy sought; and

b. Upon receipt of such notice, the Agency shall forward within two (2) days to any regional office of the AAA two (2) copies of said notice together with two (2) copies of the arbitration provisions of these rules, together with the appropriate Administrative Fee Schedule.

If it so desires, the Agency upon whom the Demand for arbitration is made may file an answering statement in duplicate with the AAA within seven (7) days after receipt of said Demand, in which event it shall simultaneously send a copy of its answer to the disputant. If no answer is filed within the stated time, it will be assumed that the claim is denied. Failure to file an answer shall not operate to delay the arbitration.

8. **CHANGE OF CLAIM** — After filing of the claim, the disputant may amend his original claim provided that said amended claim is related to the original claim. Such amendment must be filed in the manner prescribed for the filing of an original claim. No unrelated claim may be entertained by amendment or otherwise. The Agency shall have the same rights and responsibilities as to its answer to this amendment as are provided for with respect to an answer to an original claim. Whether an amended claim is related to the original claim shall be within the sole discretion and determination of the Arbitrator. After the Arbitrator is appointed, no new claim may be submitted except with the consent of the Arbitrator.

9. **LOCALE OF ARBITRATION** — The arbitration shall be held in the county in which the disputant resides, unless otherwise stipulated by the parties.

10. **QUALIFICATIONS OF ARBITRATOR** — No person shall serve as an Arbitrator in any arbitration if he has any financial or personal interest in the result of the arbitration, unless the parties, in writing, waive such disqualification.

11. **APPOINTMENT FROM PANEL** — The Arbitrator shall be appointed in the following manner: Immediately after the filing of the Demand, the AAA shall submit simultaneously to each party to the dispute an identical list of persons chosen from the Panel. Each party to the dispute shall have seven (7) days from the mailing date in which to cross off any names to which he objects, number the remaining names indicating the order of his preference, and return the list to the AAA. If a party does not return the list



within the time specified, all persons therein shall be deemed acceptable. From among the persons who have been approved on both lists, and in accordance with the designated order of mutual preference, the AAA shall invite the acceptance of an Arbitrator to serve. If the parties fail to agree upon any of the persons named, or if an acceptable Arbitrator is unable to act, or if for any other reason the appointment cannot be made from the submitted lists, the AAA shall have the power to make the appointment from other members of the Panel without the submission of any additional lists to the parties.

12. **NUMBER OF ARBITRATORS** — The dispute shall be heard and determined by one Arbitrator, unless the AAA, in its discretion, directs that a greater number of Arbitrators be appointed.

13. **NOTICE TO ARBITRATOR OF HIS APPOINTMENT** — Notice of the appointment of the Arbitrator, appointed as herein above described, shall be mailed to the Arbitrator by the AAA, together with a copy of the AAA Rules, and these rules and the signed acceptance of the Arbitrator shall be filed prior to the opening of the first hearing.

14. **DISCLOSURE BY ARBITRATOR OF DISQUALIFICATION** — Prior to accepting his appointment, the prospective Arbitrator shall disclose any circumstances likely to create a presumption of bias or which he believes might disqualify him as an impartial Arbitrator. Upon receipt of such information, the AAA shall immediately disclose it to the parties who, if willing to proceed under the circumstances disclosed, shall so advise the AAA in writing. If either party declines to waive the presumptive disqualification, the AAA shall disqualify such Arbitrator and the vacancy thus created shall be filled in accordance with the applicable provisions of these rules and those of the AAA.

15. **VACANCIES** — If any Arbitrator should resign, die, withdraw, refuse, be disqualified or be unable to perform the duties of his office, the AAA may, on proof satisfactory to it, declare the office vacant. Vacancies shall be filled in accordance with the applicable provisions of these rules and those of the AAA and the matter shall be reheard unless the parties shall agree otherwise.

16. **TIME AND PLACE** — The Arbitrator shall fix the time and place for each hearing. The AAA shall mail to each party notice thereof at least five (5) days in advance, unless the parties by mutual agreement waive such notice or modify the terms thereof.

17. **REPRESENTATION BY COUNSEL** — Any party may be represented by counsel. A party intending to be so represented shall notify the other party and the AAA of the name and address of counsel at least three (3) days prior to the date set for the hearing at which counsel is first to appear. When arbitration is initiated by counsel, or where an attorney replies for the other party, such notice is deemed to have been given.

18. **STENOGRAPHIC RECORD** — The AAA shall make the necessary arrangements for the taking of a stenographic record whenever such record is requested by a party.

19. **INTERPRETER** — The AAA shall make the necessary arrangements for the services of an interpreter upon the request of one or more of the parties.

20. **ATTENDANCE AT HEARINGS** — Persons having a direct interest in the arbitration are entitled to attend hearings. The Arbitrator shall otherwise have the power to require the retirement of any witness or witnesses during the testimony of other witnesses. It shall be discretionary with the Arbitrator to determine the propriety of the attendance of any other persons.

21. **ADJOURNMENTS** — The Arbitrator may take adjournments upon the request of a party or upon its own initiative and shall take such adjournment when all of the parties agree thereto.

22. **OATHS** — Before proceeding with the first hearing or with the examination of the file, each Arbitrator may take an oath of office, and if required by law, shall do so. The Arbitrator may, in his discretion, require witnesses to testify under oath administered by any duly qualified person or, if required by law or demanded by either party, shall do so.

23. **ORDER OF PROCEEDINGS** — A hearing shall be opened by the filing of the oath of the Arbitrator, where required, and by the recording of the place, time and date of the hearing, the presence of the Arbitrator and parties, and counsel, if any, and by the receipt by the Arbitrator of the claim and answer, if any.

The Arbitrator may, at the beginning of the hearing, ask for statements clarifying the issues involved.

The disputant shall then present his claim and proofs and his witnesses, who shall submit to questions or other examination. The Agency shall then present its defense and proofs and its witnesses, who shall submit to questions or other examination. The Arbitrator may in his discretion vary this procedure but he shall afford full and equal opportunity to all parties for the presentation of any material or relevant proofs.

Exhibits, when offered by either party, may be received in evidence by the Arbitrator.

The names and addresses of all witnesses and exhibits in order received shall be made a part of the record.

24. **ARBITRATION IN THE ABSENCE OF A PARTY** — Unless the law provides to the contrary, the arbitration may proceed in the absence of any party who, after due notice, fails to be present or fails to obtain an adjournment. An award shall not be made solely on the default of a party. The Arbitrator shall require the party who is present to submit such evidence as he may require for the making of an award.

25. **EVIDENCE** — The parties may offer such evidence as they desire and shall produce such additional evidence as the Arbitrator may deem necessary to an understanding and determination of the dispute. When the Arbitrator is authorized by law to subpoena witnesses or documents, he may do so upon his own initiative or upon the request of any party. The Arbitrator shall be the judge of the relevancy and materiality of the evidence offered, and conformity to legal rules of evidence shall not be necessary. All evidence shall be taken in the presence of the Arbitrator and of all the parties,

except where any of the parties is absent, in default or has waived his right to be present.

**26. EVIDENCE BY AFFIDAVIT AND FILING OF DOCUMENTS** — The Arbitrator shall receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as he deems it entitled to after consideration of any objections made to its admission.

All documents not filed with the Arbitrator at the hearing, but arranged for at the hearing or subsequently by agreement of the parties, shall be filed with the AAA for transmission to the Arbitrator. All parties shall be afforded the opportunity to examine such documents.

**27. INSPECTION OR INVESTIGATION** — Whenever the Arbitrator deems it necessary to make an inspection or investigation in connection with the arbitration, he shall direct the AAA to advise the parties of his intention. The Arbitrator shall set the time and the AAA shall notify the parties thereof. Any party who so desires may be present at such inspection or investigation. In the event that one or both parties are not present at the inspection or investigation, the Arbitrator shall make a verbal or written report to the parties and afford them an opportunity to comment.

**28. CONSERVATION OF PROPERTY** — The Arbitrator may issue such orders as may be deemed necessary to safeguard the property which is the subject matter of the arbitration without prejudice to the rights of the parties or to the final determination of the dispute.

**29. CLOSING OF HEARINGS** — The Arbitrator shall specifically inquire of all parties whether they have any further proofs to offer or witnesses to be heard. Upon receiving negative replies, the Arbitrator shall declare the hearings closed and a minute thereof shall be recorded. If briefs are to be filed, the hearings shall be declared closed as of the final date set by the Arbitrator for the receipt of briefs. If documents are to be filed, as provided for in Section 26, and the date set for their receipt is later than that set for the receipt of briefs, the later date shall be the date of closing the hearing. The time limit within which the Arbitrator is required to make award shall commence to run, in the absence of other agreements by the parties, upon the closing of the hearings.

**30. REOPENING OF HEARINGS** — The hearings may be reopened by the Arbitrator on his own motion, or upon application of a party at any time before the award is made, and the Arbitrator shall have thirty (30) days from the closing of the reopened hearings within which to make an award.

**31. WAIVER OF ORAL HEARING** — The parties may agree by written stipulation to waive the oral hearings. In the event that they so stipulate, the parties shall then agree as to the procedure to be followed in the resolution of the dispute. If the parties are unable to so agree as to such procedure, the AAA shall specify a fair and equitable procedure.

**32. WAIVER OF RULES** — Any party who proceeds with the arbitration after knowledge that any provision or requirement of these rules or the Rules of the AAA have not been complied with or who fails to state his objection thereto in writing shall be deemed to have waived his right to object.

33. **EXTENSIONS OF TIME** — The parties may modify any period of time by mutual agreement. The AAA for good cause may extend any period of time established by these provisions or its own Rules except the time for making the award. The AAA shall notify the parties of any such extension of time and its reason therefor.

34. **COMMUNICATION WITH ARBITRATOR AND SERVING OF NOTICES**

a. There shall be no communication between the parties and the Arbitrator other than at oral hearings. Any other oral or written communications from the parties to the Arbitrator shall be directed to the AAA for transmittal to the Arbitrator.

b. Each party to the arbitration shall be deemed to have consented that any papers, notices or process necessary or proper for the initiation or continuation of an arbitration under these rules and for any court action in connection therewith or for the entry of judgment of any award made thereunder may be served upon such party by mail addressed to such party or his attorney at his last known address or by personal service, within or without the state wherein the arbitration is to be held (whether such party be within or without the United States of America), provided that reasonable opportunity to be heard with regard thereto has been granted such party.

35. **TIME OF AWARD** — The award shall be made promptly by the Arbitrator and, unless otherwise agreed by the parties, or specified by law, no later than thirty (30) days from the date of closing the hearings, or if oral hearings have been waived, from the date of transmitting the final statements and proofs to the Arbitrator.

36. **FORM OF AWARD** — The award shall be in writing and shall be signed by the Arbitrator. It shall be executed in the manner required by the Rules of the AAA or otherwise if required by law.

37. **SCOPE OF AWARD** — The Arbitrator may grant any remedy or relief which he deems just and equitable and within the scope of these rules, including but not limited to an award of monetary damages and an award of costs and reasonable attorney's fees.

38. **AWARD UPON SETTLEMENT** — If the parties settle their dispute during the course of the arbitration, the Arbitrator, upon their request, may set forth the terms of the agreed settlement in an award.

39. **DELIVERY OF AWARD TO PARTIES** — Parties shall accept as legal delivery of the award the placing of the award or a true copy thereof in the mail by the AAA, addressed to such party at his last known address or to his attorney, or personal service of the award, or the filing of the award in any manner which may be prescribed by law.

40. **RELEASE OF DOCUMENTS FOR JUDICIAL PROCEEDINGS**

The AAA shall, upon the written request of a party, furnish to such party certified facsimiles of any papers in the AAA's possession that may be required in judicial proceedings relating to the arbitration.

#### 41. APPLICATIONS TO COURT

- a. No judicial proceeding by a party relating to the subject matter of the arbitration which is terminated without prejudice prior to the rendering of judgment of shall be deemed a waiver of the party's right to arbitrate.
- b. The commencement of arbitration proceedings pursuant to these rules shall be deemed a waiver of the disputant's right to any other remedies or redress in a court of law or otherwise.
- c. The AAA is not a necessary party in judicial proceedings relating to the arbitration.

42. **ADMINISTRATIVE FEES** — As a non-profit organization, the AAA shall prescribe an administrative fee schedule and a refund schedule to compensate it for the cost of providing administrative services. The schedule in effect at the time of filing or the time of refund shall be applicable.

The first \$50.00 of administrative fees shall be advanced by the disputant and the balance by the Agency, subject to final apportionment by the Arbitrator in his award.

When a matter is withdrawn or settled, the refund shall be made in accordance with the refund schedule.

The AAA, in the event of extreme hardship on the part of any party, may defer or reduce the administrative fee.

43. **FEE WHEN ORAL HEARINGS ARE WAIVED** — Where all oral hearings are waived under Section 31 the Administrative Fee Schedule shall apply.

44. **EXPENSES** — The expenses of witnesses for either side shall be paid by the party producing such witnesses.

The cost of the stenographic record, if any is made, and all transcripts thereof, shall be prorated equally among all parties ordering copies unless they shall otherwise agree and shall be paid for by the responsible parties directly to the reporting agency.

All other expenses of the arbitration, including required traveling and other expenses of the Arbitrator and of AAA representatives, and the expenses of any witness or the cost of any proofs produced at the direct request of the Arbitrator, shall be borne equally by the parties, unless they agree otherwise, or unless the Arbitrator in his award assesses such expenses or any part thereof against any specified party or parties.

45. **ARBITRATOR'S FEE** — The Arbitrator shall be compensated according to the Rules of the AAA.

46. **DEPOSITS** — The AAA may require the parties to deposit in advance such sums of money as it deems necessary to defray the expense of the arbitration, including the Arbitrator's fee if any, and shall render an accounting to the parties and return any unexpended balance to the parties.

47. **INTERPRETATION AND APPLICATION OF RULES** — The Arbitrator shall interpret and apply these rules and the Rules of the AAA insofar as they relate to his powers and duties. All other rules shall be interpreted and applied by the AAA.

48. **CONFIDENTIALITY** — These proceedings shall be private. Only the parties, their representatives, witnesses and the necessary administrative personnel shall be permitted access to the hearings, deliberations, records and findings therein, and these matters and records, and the identity of the parties, shall be kept in strictest confidence by all participants except insofar as disclosure is necessary for the enforcement of the award.

49. **EFFECT OF AWARD** — After the Arbitrator has made the award, the parties shall be bound thereby and all payments and benefits shall be based thereon.

#### E. SETTLEMENT

When the matter is settled appropriate adjustments shall be made, if necessary, but if this requires a recovery from the family, such recovery shall be made in such a manner as to avoid undue hardship to the family.

#### APPENDIX: DEFINITIONS

"Accounting year" is the annual period of time beginning on the date of the family's participation in the HIS (the effective date of the family's Enrollment Agreement) and ending at 12 a.m. one year later (the anniversary of the effective date of enrollment), and subsequent annual periods beginning and ending on the anniversary of the effective date of enrollment.

"Certificate of Benefits" (COB) is the booklet provided to FHPP participants describing the medical services and supplies that are covered by the FHPP.

"Deserted"—A spouse shall be considered as "deserted" if: (a) he or she does not know the whereabouts of his or her spouse and has applied to a court of jurisdiction for appropriate process to compel the deserting spouse to pay support or otherwise comply with the law or a judicial order; or (b) he or she declares by affidavit that his or her spouse has deserted or left the household, that he or she does not know the whereabouts of the deserting spouse, and that his or her spouse cannot reasonably be expected to return; or (c) a departed spouse refuses to continue to participate.

"Divorced"—A spouse shall be considered as "divorced", "formally separated," or "informally separated" if: (a) he or she is legally separated from his or her spouse under a decree of divorce or dissolution of marriage or of separate maintenance; or (b) a proceeding for divorce or dissolution of marriage or legal separation has been instituted; or (c) one spouse has left the household to reside in a separate household, and both spouses declare by affidavit that they no longer expect to reside in the same household.

"Effective date of enrollment" is the date on which enrollment in the HIS begins, as specified in a family's Enrollment Agreement.

"Family Health Protection Plan" (FHPP) is a plan of health insurance benefits of the Health Insurance Study (HIS) provided to families and persons meeting the eligibility requirements set forth herein.

"Foster child" is defined as a child whose medical care is provided or whose medical expenses are reimbursed by a government agency other than a Medicaid agency.

"Health Insurance Study" (HIS) is a program established by the U.S. government to study important questions regarding health insurance and health care in the United States.

"Household" is a dwelling place or residence composed of one or more family units, each of which has the same mailing address. Apartment building units that have different numbers shall not be considered as having the same mailing address.

"Participant" is a family unit member enrolled in and eligible to receive benefits under the FHPP.

"Principal place of abode" is the household where a person usually lives and sleeps.

"Related"—For purposes of rule III.A.2 and III.A.7.b, the term "related" shall include the following: child (legal or adopted), stepchild, mother, father, grandparent, brother, sister, grandchild, stepbrother, stepmother, stepsister, stepfather, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, and daughter-in-law, and, if related by blood, uncle, aunt, nephew, or niece.

"Separation"—See "Divorced."

"Student" is an individual who during at least five calendar months during a calendar year: (a) is a full-time student at an educational institution; or (b) is pursuing a full-time course of institutional on-farm training under the supervision of an accredited agent of an educational institution or of a State or political subdivision of a State.

("Educational institution" means only an institution that normally maintains a regular faculty and curriculum and normally has a regularly organized body of students in attendance at the place where its educational activities are carried on.)

#### ATTACHMENT I

##### MDE Adjustment Factors for Economic Family Units Composed of One or More Persons Who Are Not Eligible to Participate in the FHPP

For purposes of determining the MDE of an economic family unit when a member who is ineligible for the FHPP is present (according to rule V.C), the total unadjusted income of all members of the economic family unit will be multiplied by factor F1, where:  $F1 = .37 + .18Ae + .15Ce1 + .12Ce2 + .10Ce3 + .10Ce4 + \dots$ , and divided by factor F2, where  $F2 = .37 + .18At + .15Ct1 + .12Ct2 + .10Ct3 + .10Ct4 + \dots$ , where Ae = the number of persons in the FHPP unit who are 18 years or older, Ce1, Ce2, Ce3, etc. = the number of 1st, 2nd, 3rd, etc. children in the FHPP unit who are under 18 years of age, At = the total number of persons in the economic unit who are 18 years or older, and Ct1, Ct2, Ct3, etc. = the total number of 1st, 2nd, 3rd, etc. children in the economic unit who are under 18 years of age.







