

Closing the Gap

The Problem of Accessing Health Care

By Michelle Meadows

Paying for family health insurance would have lopped off \$200 from each paycheck, said Glynis, a 35-year-old African American beautician in Maryland. "The options through my company were outrageous," she said. "That's about \$400 a month that we really needed." So she and her three children lived without coverage for seven years.

"When my kids needed shots, I took them to free clinics," she said. "If they had to go to the emergency room, then I'd just end up with a big bill." Fortunately, one of her customers recently told her about the new Maryland Children's Health Insurance Program (see CHIP article on page 3).

Now, Glynis buys her individual health insurance through the hair salon at a price

of \$54 every two weeks. And her kids are covered through the Maryland program, which provides comprehensive services for eligible children and pregnant women in families with an income at or below 200 percent of the federal poverty level.

Experts say such insurance programs are critical because even though our economy is booming, lack of health insurance remains a significant problem. Americans at the bottom half of the income distribution feel the hardest hits.

Many under the median income of \$35,000 are uninsured, go without the care they need, have trouble paying medical bills, and report poor health, according to a new study called, *Can't Afford to Get Sick: A Reality for Millions of Working Americans*. The report is based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance (<http://www.cmwf.org>).

For many, the problem involves not having the option of obtaining health insurance from their jobs. According to the Commonwealth Fund study, two of five workers with incomes less than \$20,000 either weren't offered a plan through their employers or weren't eligible to participate. For others like Glynis, the only options are too expensive.

Hispanics are least likely to be insured

According to the Commonwealth Fund report, Hispanics were generally at high risk of being uninsured and lacking access to employer plans. That's in sync with the Health and Human Services' Agency for Health Care Policy and Research (AHCPR) report, *Racial and Ethnic Differences in Health 1996*. Released earlier this year, the report found that more than one-third of Hispanics had no insurance coverage. While Hispanics represent 11.6 percent of the U.S. population under age 65, they make up more than 21 percent of the uninsured.

"A main reason is that many Hispanics work in industries that don't offer health benefits," said Joan Jacobs, a policy analyst in the Office of Minority Health's Division of Policy and Data. According to the National Council of La Raza, many Hispanics are employed in manual labor and service occupations. More white men and women, however, are concentrated in managerial and professional specialty occupations.

According to E. Richard Brown, PhD, director of UCLA's Center for Health Care Policy Research, many Latino immigrants come to this country with low levels of education. "That is often exacerbated by a non-citizen status," he said. Many are scared to apply for health

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"Though the differences in insurance rates between Hispanics and other Americans are striking, racial and ethnic minorities generally fare worse than whites—a fact that often goes unmentioned in health coverage debates."

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The Office of Minority Health Resource Center (OMH-RC) provides free information on various health issues affecting U.S. minorities including cancer, heart disease, violence, HIV/AIDS and diabetes. The center also distributes information on funding sources for minority health programs. *Closing the Gap* is a free newsletter published by the Office of Minority Health, U.S. Department of Health and Human Services. Send all correspondence to: Editor, Closing the Gap, OMH-RC, PO Box 37337, Washington, D.C. 20013-7337. Or call OMH-RC toll-free, 1-800-444-6472.

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services for fear of possible penalties by the Immigration and Naturalization Service (INS), he adds. (See INS article on p. 14).

Though the differences in insurance rates between Hispanics and other Americans are striking, racial and ethnic minorities generally fare worse than whites—a fact that often goes unmentioned in health coverage debates, Dr. Brown said. His center recently released results from state studies that showed that while 76 percent of white non-elderly Californians had private health insurance in 1997, only 43 percent of Latinos, 60 percent of African Americans, and 65 percent of Asian Americans and Pacific Islanders were privately insured. As a result, minorities are at greater risk of being uninsured altogether.

“For Asians and Pacific Islanders, it’s important to understand the differences between subgroups,” Dr. Brown said. For example, those populations who are more acculturated into the American society, such as the Japanese, tend to have higher levels of education and health coverage comparable to whites. But newly arrived immigrants, such as those from Southeast Asia, have lower education levels and much higher uninsured rates than whites.” UCLA’s Center for Health Policy Research will release a national study in October. Look for it on the Web: <http://www.healthpolicy.ucla.edu>

Insurance isn’t the only barrier

A basic issue in health care access is coverage versus no coverage, OMH’s Jacobs said. “Then we have to look at the fact that when there is coverage or when care is available, many Americans still aren’t

getting it. Access to insurance doesn’t necessarily mean access to care, or even high-quality care for that matter.”

Carrie Jones, executive director of the Family Services Institute, Wichita, KS, said she finds that residents in her area face considerable transportation barriers. Through the Institute’s Black Infant Mortality Project, case workers use community outreach to help African American women navigate the health system and get their babies off to a healthy start. “Many women don’t have cars or have to deal with our limited public transportation system,” Jones said. “So we go pick them up and take them to appointments because that’s the only way they’ll get there.” Jones said one woman died in her home during labor because she couldn’t get to a hospital. “She didn’t even have a phone to call for help.”

Other times, women don’t know about available services. “The free clinics are there, but they might not know it,” Jones said. “So we do a lot of connecting—connecting them to the providers and helping them with the paperwork they have to fill out to obtain services.” Sometimes, women start to fill out papers and then put them aside because it’s too much to deal with.

For minorities, it’s important that programs are offered in a community setting that makes them comfortable, Jones said. That could involve speaking the right language, respecting a patient’s cultural beliefs, or using appropriate body language. “But it has to be a culturally sensitive environment,” Jones added. “And we’ll get the best results, if the decision-makers find out from the community what the community needs.”~

Study Explores Minorities’, Whites’ Opinions on Health

Minorities express lower satisfaction with the care they have received recently, but they express similar levels of confidence about future care, according to a recent Health Confidence Survey from the nonprofit Employee Benefit Research Institute (EBRI) in Washington, DC.

Key findings include:

- Though most Americans give health care high ratings, most minorities rate it as poor.
- Minorities are more inclined to express lower levels of satisfaction with most aspects of health care they received over the past two years, especially the quality of care received and their choice of doctor.
- Working minorities have more confidence than

working whites that Medicare will provide them health insurance benefits through retirement.

- Minorities are more likely to label their health plans as health maintenance organizations, while whites are more likely to identify their plans as traditional health insurance.
- Among those with private insurance, minorities are more likely to be enrolled in HMO-type plans.
- While a majority of minorities (55 percent) favor increased government regulation of health insurance plans, less whites (44 percent) favor it.

EBRI conducts public policy research and education on economic security and employee benefits. *For more information, call 202-659-0670, <http://www.ebri.org>.*~

Insuring America's Children

More children than ever—11.3 million—are now uninsured, according to the U.S. Bureau of the Census. Every day the number of children without private health insurance continues to grow. Since 1989, children have lost private health coverage at twice the rate of adults. Two-thirds of these children have family incomes above the poverty level, but 70 percent have incomes below \$26,660 a year for a family of three.

This puts the majority of uninsured children into a category that disqualifies them for Medicaid. Unfortunately, these same families are earning too little to afford private health care coverage.

Under a program called the Children's Health Insurance Program (CHIP), new funding is available for uninsured children. CHIP, which was enacted under the Balanced Budget Act of 1997, will provide \$48 billion over 10 years to cover uninsured children. A state can use these funds to expand Medicaid, create a state child health insurance program, or a combination of both. CHIP allows states to set their own eligibility rules, define covered benefits, determine subsidy levels, set payment rates, and select which health plans and providers participate in the program.

Census Bureau statistics on children and health insurance:

- As recently as 1980, the majority of employees at medium-to-large companies had employers who paid 100 percent of family health insurance costs; today less than a quarter do.
- More than three-fourths of workers must pay some or all of those costs.
- The employee's share averages \$1,900 a year, even for HMOs offered by the very largest employers.
- One in four workers today has no access to employment-based family coverage at any price.
- One in four uninsured children either uses the hospital emergency room as a regular source of health care or has no regular source of health care.
- Uninsured children are 25 percent more likely to miss school.

Watch for stories about CHIP and related outreach efforts in a future issue of *Closing the Gap*. Call 1-877-KIDS for information about CHIP and Medicaid for families in all states, or browse HCFA's Web site at: <http://www.hcfa.gov/init/children.htm>. ~

Minority Health Perspective

Improving Minority Health by Improving Access to Care

By Nathan Stinson, Jr., PhD, MD, MPH, Deputy Assistant Secretary for Minority Health

The partnerships we form are key to improving the health of minority communities.

The Office of Minority Health (OMH) administers 44 grants that link community partners to help reduce health risk factors. But, we believe, in order to improve the health of a population, you must improve its access to health care.

Through OMH's Bilingual/Bicultural Demonstration Grant Programs (Managed Care), a variety of community-planned efforts increase access to health care for people with different cultural and language backgrounds, particularly among Hispanic, Asian American, and Pacific Islander communities.

For example, the *Language and Cultural Access Program* increases the supply and utilization of culturally and linguistically competent managed care education and medical interpretation services for the Asian American and Pacific Islander and Hispanic communities in Oakland, California.

And, OMH has a cooperative agreement with Central State University to support a *Family and Community Violence Prevention Program* at 25 institutions of higher education, including 21 Historically Black Colleges and Universities (HBCU), two Tribal Colleges and Universities, one Hispanic

Serving Institution, and the University of Hawaii.

These Family Life Centers collaborate with local schools, churches, and other community-based organizations to develop and maintain a violence prevention network; examine the factors and conditions associated with violence, alcohol, and drug abuse among community families; and provide academic enrichment, cultural heritage, community service, and mentoring programs.

Healing bilingual and racial and ethnic communities is a big job. It took generations of economic, political, and social neglect to create the health problems that confront these disenfranchised communities.

So it's imperative that we continue to build a strong network of supporters who can help mobilize resources and build powerful coalitions to close the gap in health disparities in this country. We cannot make America a healthy nation unless we improve access to quality health care for all Americans.

For minority health information, call our Office of Minority Health Resource Center, 1-800-444-6472; <http://www.omhrc.gov>. ~

Minorities Less Likely to Have Employer-Sponsored Health Insurance

By Houkje Ross

Minorities in full- or part-time jobs are less likely than whites to obtain insurance offered by their employers, according to a recent study conducted by The Commonwealth Fund. *Employer-Sponsored Health Insurance: Implications for Minority Workers* examines the relationship between minority status and the use of employer-sponsored health insurance.

The study reveals that in small companies (those with less than 100 workers), 63 percent of whites receive health coverage from their employers, compared with 47 percent of blacks and 38 percent of Hispanics. In medium-sized companies (those with 100 to 1,000 workers), 84 percent of whites have coverage, compared with 68 percent of blacks and 61 percent of Hispanics. In large companies (those with more than 1,000 workers), whites are covered at a rate of 85 percent, compared to blacks at 76 percent and Hispanics at 72 percent.

The findings are surprising because the country's economy is strong, said Karen Scott Collins, MD, MPH, co-author of the study and assistant vice president at The Commonwealth Fund. "All the factors that facilitate the coverage of health insurance should be there," she said. "We expect most people will get health insurance when they have full-time employment." But disparities exist even between minorities and whites in similar positions.

Racial and ethnic disparities in coverage exist in many industries such as manufacturing and transportation, Dr. Collins said. Even within professions that typically have high rates of employer-sponsored health insurance, such as executive management positions and specialty occupations, minorities—especially Hispanics—are less likely to have coverage. Compared with 83 percent of whites in executive positions who have health insurance, only 70 percent of Hispanics in similar jobs have health insurance, according to the study.

The study also shows that the odds of having employer-sponsored health insurance increase with educational level. Workers

with advanced degrees are almost twice as likely to have coverage than workers with less than a high school education. Of those workers without a high school education, 48 percent have insurance through their employers. That rate jumps to 68 percent for those with a high school diploma.

Other findings reveal that workers who live in suburban areas are more likely to have health coverage than inner city and rural residents. Those living in the Southwestern and South central states are less likely to have coverage than workers in the North. Lower

wage workers are less likely than higher paid workers to have health insurance though their employer, with minorities showing the lowest rates in all wage subgroups.

The Commonwealth study reveals that for minorities, having a job does not even the chances of obtaining employer-sponsored health insurance. While the Fund's study doesn't pinpoint definitive reasons for these racial differences, researchers suggest that barriers could include issues of cost sharing and premiums. The authors point to out-of-pocket costs—the portion of costs paid by employees—as a possible barrier to obtaining health coverage. Out-of-pocket-costs can represent a significant expense, especially for low-wage workers.

"This is one hypothesis we are going to test with further data analyses," Dr. Collins said. Understanding the barriers minority workers face will play a key role in dealing with these

inequities.

The Commonwealth Fund plans to obtain data from the HHS Agency for Health Care Policy and Research (AHCPR) to further explore this research. A new study analyzing these data will be available early next year, Collins said.

The Commonwealth Fund is a private foundation in New York that supports independent research on health and social issues.

For more information about Commonwealth Fund studies, contact: Mary Mahon, Public Information Officer, (212) 606-3853, or visit its Web site at: <http://www.cmwf.org>.

Commonwealth Fund Report Focuses on Minorities

The Commonwealth Fund recently released a 160-page report on the status of minority health care in the United States. *U.S. Minority Health: A Chartbook* reports that minority Americans fall behind on almost every health indicator, including health care coverage, access to care, life expectancy, and disease rates. The chartbook compares findings from several Commonwealth Fund surveys and national data sources. Chart topics include: life expectancy, trends in births to teenage mothers, leading causes of death, receipt of vaccines and, enrollment in managed care.

For more information about the chartbook, call Mary Mahon, Public Information Officer, The Commonwealth Fund, 212-606-3853, or visit its Web site at: <http://www.cmwf.org>.

Native Americans Pay High Cost for Health Care

By Houkje Ross

One of the largest barriers to health care for American Indian and Alaska Natives (AI/ANs) has been a lack of adequate federal funding, according to the National Indian Health Board (NIHB). “Despite new technological advances, Indian people are suffering and dying premature deaths, due in large part to under funding of the Indian Health Service,” said Buford L. Rolin, Chairman of NIHB, before the U.S. Senate Committee on Indian Affairs this past summer. Rolin spoke in support of S. 299, a bill that would elevate the Director of Indian Health Service (IHS) to Assistant Secretary for Indian Health.

A federal agency within HHS, the IHS provides health services to roughly 1.5 million AI/ANs who belong to more than 557 federally recognized tribes and live on reservations in 34 states. For many AI/ANs, the Indian health care system—a partnership of federal, tribal, and urban Indian operated health care programs—is their only source of health care services.

The federal funding that is provided for the Indian health care system fulfills the government’s treaty obligations to the tribes.

Estimating level of need

The Indian health care system depends on annual discretionary appropriations. A defined package of health care services is not assured to eligible Indians who need services. The level of services provided by the Indian health care system varies depending on funding. According to part one of a Congressionally mandated study, *Level of Need Funded Cost Model—Indian Health Service*, the IHS appropriation provides only 59 percent of the necessary funding for the Indian health system. Raising that percentage one point would cost \$30 million. The cost to raise the level of needed funds to 100 percent for the IHS/Tribal user population is \$1.2 billion.

The study looked at what it would cost to provide the AI/AN population with adequate health care based on typical health benefits, such as doctors and hospital care, according to Cliff Wiggins, Senior Operations Research Officer at IHS. “This does not include the larger health programs that are extremely important to Indian people, such as the sanitation, safe water, and public health programs,” Wiggins said.

The study found that it would cost approximately \$2,900 per person to provide Indian people with the health care services found in typical, mainstream health insurance plans. Researchers determined this number by starting with a benchmark figure of \$2,100 per person, determined by averaging a range of three independent sources of private health care premiums for the non-elderly. That figure was then adjusted for the cost of co-payments and deductibles, and for the costs associated with the elderly. The total cost was then \$3,391 per person. This is the total expected cost per person if the characteristics of Indian people were the same as for the U.S. general population.

The costs for Indians was then revised to account for the ways the Indian population differs from the general U.S. population. A younger and significantly rural Indian population lowered the costs, while a higher incidence of disease and medical conditions raised the cost.

Other findings:

- A mainstream package of health care services for all 2.4 million AI/AN would cost \$7.4 billion.
- The cost for mainstream services for the IHS/tribal user population, 1.34 million AI/AN, would cost \$4 billion. Approximately 25 percent of this would be expected from third party payers such as Medicare, Medicaid, and private insurance. The cost for urban and all other Indians is \$3 billion, of which IHS appropriations provides less than \$30 million. No data exist to estimate the third

party contributions for these populations.

IHS is reviewing the report and will receive feedback from the Office of Management and Budget.

For additional information about the report or the services of IHS, contact: IHS, Public Affairs Office, 301-443-3593, or visit their Web site at www.ihs.gov.

IHS Services

The IHS administers health services in three ways: through IHS facilities, through tribally-operated facilities, and by contracting out for health services. IHS’s services include:

- preventive health services to help reduce the need for acute medical care;
- emergency medical services, where a community health representative responds within 15 minutes;
- environmental health and engineering services that address the environmental conditions that contribute to morbidity and mortality among AI/ANs;
- pharmacy services;
- health education program to help AI/ANs live healthier lifestyles;
- community-based programs to combine the principles of public health with traditional medicine;
- alcohol and substance abuse programs;
- diabetes and nutritional programs;
- school-based programs;
- mental health programs that take into account traditional Indian ways of life, philosophy, and languages;
- community health representative programs that train AI/ANs to become paraprofessionals through IHS, but they are employed and supervised by their tribes and communities;
- dental programs; and
- accident/ injury reduction programs.

Whose Rights Are We Protecting Anyway?

By Jennifer Brooks

For more than two years, members of the U.S. House of Representatives have been haggling—mostly along party lines—over what has now become known as *The Patients' Bill of Rights*. While most of the Congress agrees a patient protection bill is needed, no consensus has been reached on what protections should be included in such a bill. In fact, there are several comprehensive patient protection bills currently before the House and Senate.

Some key consumer protections under debate in Congress are: access to emergency care and specialty services, access to out-of-network providers, access to clinical trials, the right of doctors to define medical necessity, the right to an external appeal, disclosure of treatment options, disclosure of financial incentives to deny care, and the right to sue health plans for damages.

The Senate bill

In July 1999, the Senate narrowly passed the new Republican Patients' Bill of Rights Plus Act (S. 1344) by a 53-47 vote. The bill, delivered by Senate Majority Leader Trent Lott (R-MS), provides language on the right of an external appeals process. This would allow the federal government to slap \$10,000 fines against any health plan that does not comply with review deadlines and an additional \$10,000—awarded to the patient—if the health plan does not comply with a reviewer's decision.

The Senate bill also includes rights to emergency care, access to specialists, points-of-service, direct access to OB/GYNs, continuity of care, access to clinical trials, provider non-discrimination, prohibition of gag clauses, and protection against genetic discrimination and disclosure of consumer information.

While the revised Republican bill is more comprehensive than prior versions, opponents argue it leaves off several essential protections like a patient's right to sue a health plan, a physician's authority to determine medical necessity, and coverage for all 161 million health care consumers. Senate Republicans argue their bill is reasonable in that it protects people but preserves their freedom to choose and keeps costs down.

The Democrats call the bill a "sham." Their proposal, which failed in the Senate by a 53-47 vote, allows patients to sue health plans in state court if their plans' denial or delay in benefits caused them harm. And the Senate Democrats' bill covers all 161 million privately insured Americans. The Senate Republican bill only protects 48 million Americans enrolled in self-funded health plans for most provisions; some are broader. Republicans say individual states should regulate health insurance for the remaining 113 million Americans with private insurance who are not exempt from state regulation.

President Clinton has held to his position that any patient protection bill must cover everyone with private health insurance. Such legislation must include the ability of physicians to make necessary treatment and medical decisions. And he insists it must have managed care liability provisions, including a patient's right to sue, before he signs it into law.

A House compromise?

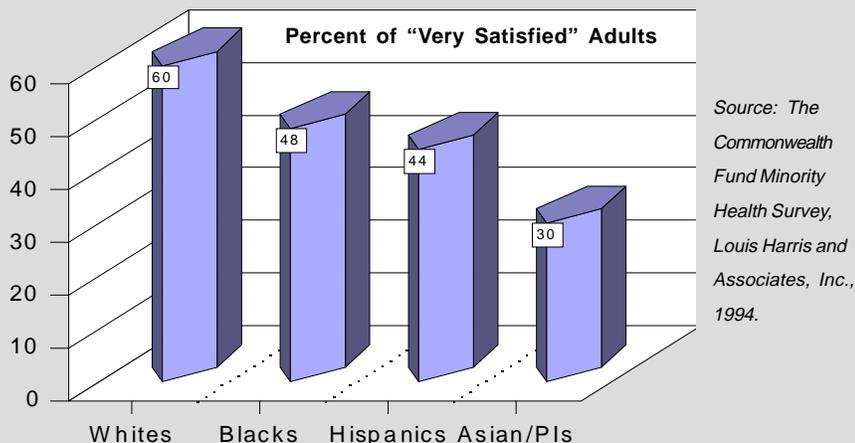
In August 1999, House Commerce Committee member Charlie Norwood (R-GA) and the panel's ranking Democrat, John Dingell, Jr. (D-MI), came up with a managed care bill that is generating bipartisan support in the House. The Norwood-Dingell bill, the Bipartisan Consensus Managed Care Improvement Act (HR 2723), would provide protection for all 161 million privately insured Americans and include the right to sue managed care companies in state court for damages. The plan also includes a "whistleblower" provision that would prevent managed care companies from retaliating against doctors and nurses who raise concerns about their patients' care.

The bill has the support of President Clinton, as well as the American Medical Association and more than 30 other physician, labor, and consumer groups.

In response, Tom Coburn (R-OK) and John Shadegg (R-AZ) announced plans to offer an alternative Republican bill that would also cover all privately insured

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Racial and Ethnic Minorities are Less Likely Than Whites to Be Satisfied with the Quality of Their Health Care



Americans. The bill would include the right to sue health plans, although lawsuits would only be allowed in federal rather than state court to eliminate the threat of exorbitant jury awards.

The Coburn-Shadegg proposal includes a portion of the Republican tax relief package (H.R. 2488), which allows people to get deductibility for health insurance and long-term insurance expenses if they pay at least half the premiums. Their bill also includes provisions to expand medical savings accounts, but it has yet to generate the kind of support it needs to pass.

Foes of the Norwood-Dingell plan, including business and health insurance groups, have been running advertisements against the bill. But these groups are not exactly thrilled about the Coburn-Shadegg bill either. They are trying to encourage House Republicans to consider an alternative bill that excludes liability altogether, according to a report from the Bureau of National Affairs.

Twenty-one House Republicans—many of whom are physicians—said they would vote against the Coburn-Shadegg bill unless its patient protection provisions are strengthened. These Republicans, along with the House Democrats—all of whom are expected to support the bill—would produce enough votes to pass the Norwood-Dingell bill.

Where do we go from here?

Everyone will have to wait and see how the House proposals play out when the leadership allows votes to be brought to the House floor. If either of the House bills pass, the House and Senate will be in direct conflict.

The Republican leadership in the Senate has expressed strong opposition to liability provisions because they say it would only drive up health care costs. But the President has promised to veto the Senate bill because it excludes liability.

And the House Democrats, along with the 21 Republicans, won't endorse any House bill that does not include liability.

So the fate of the patients' bill of rights will be left up to action in the House and then to the House-Senate conference committee who will face the difficult task

President's Commission Identifies Key Consumer Protections

Not everyone who has health insurance feels confident his or her health plan will be there when needed. In fact, one of the biggest problems many insured Americans face is that their health coverage lacks some of the basic protections that should be afforded to everyone.

Responding to complaints by the American public about managed care and its impact on the quality of health care, President Clinton appointed the Advisory Commission on Consumer Protection and Quality in the Health Care Industry in 1997. The Commission informed the President of changes occurring in the health care system, and recommends necessary measures to promote and assure health care quality and value.

The 34-member Commission, co-chaired by Donna E. Shalala, Secretary of Health and Human Services, and Alexis M. Herman, Secretary of Labor, was made up of individuals from a variety of backgrounds including: consumers, health care providers, businesses, health plans, state governments, and health care quality experts.

A major undertaking of the Commission was to draft a "consumer bill of rights." In March 1998, the Commission released a report that identified some key consumer protections. These protections included:

- **Information Disclosure.** Consumers have the right to receive accurate, easily understood information—including information on health plans, health professionals, and health care facilities—to help them make informed health care decisions.

- **Choice of Providers and Plans.**

Consumers have the right to access emergency services when and where the need arises.

- **Participation in Treatment Decisions.**

Consumers have the right and responsibility to fully participate in all decisions related to their health care, or be represented by parents, guardians, or other conservators if they are unable to do so.

- **Respect and Nondiscrimination.**

Consumers have the right to considerate, respectful care from all members of the health care system at all times and under all circumstances.

- **Confidentiality of Health Information.**

Consumers have the right to communicate with health care providers in confidence and to have the confidentiality of their health care information protected. Consumers also have the right to review and copy their own medical records and request amendments to their records.

- **Complaints and Appeals.**

Consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review.

- **Consumer Responsibilities.**

Consumers are expected and encouraged to assume reasonable responsibilities. Greater individual involvement by consumers in their care increases the likelihood of achieving the best outcomes and helps support a quality improvement, cost-conscious environment.

of deciding what provisions to keep.

Consumer advocates fear the legislation will inevitably die because the conference committee will not be able to

reach consensus. Business groups do not want legislation passed that, they say, would only hurt consumers in the long run. ~

Small Businesses Make Big Strides in New York

By Jean Oxendine

Employees of small businesses are often left without health insurance coverage. A report from the Kaiser Family Foundation shows half of all uninsured workers are either self employed or work for firms with fewer than 25 employees. Small business owners want to provide insurance at a low cost to employees and they want to have a choice in plans, but very often these businesses don't have the ability to offer insurance in a cost-efficient way, said Rosa Gil, DSW, special advisor to the mayor for health policy and director of the Office of Health Services in New York City. But many small businesses are minority owned and operated, according to Gil.

Small Businesses on the Rise

The proportion of the workforce doing nontraditional work, such as part-time, contingent, and self-employment has grown in the last decade, according to the Kaiser Family Foundation. As jobs have shifted from high-paying industries like manufacturing to low-paying sectors like retail trade and services, health insurance coverage has declined and costs have risen.

The rise in health care costs has made it difficult for small businesses to begin or continue to provide coverage for their employees. The response of employers to rapidly rising health care costs has not always been to drop coverage, but to increase the employees' share of the premium, and by tightening eligibility requirements for part-time workers, and by replacing full-time employees with part-time workers. Employees working for small businesses who choose to buy their own insurance must pay very high prices, according to the Children's Defense Fund. As many individuals cannot afford these costs, they often go without insurance.

Furthermore, many insurers are unwilling to sell coverage to small firms, according to Kaiser. And in cases where they are willing, some insurer practices in this market have raised concern. Some companies have refused to sell policies to those whom they felt were of high risk, or they carefully scrutinized the medical histories of prospective enrollees. Unfortunately, the problem extends beyond small businesses, and seems to be worsening. In 1980, the majority of employees at medium and large companies had employers who paid the full cost of family coverage. By 1983, more than three-fourths of these employees were required to help pay such costs.

While the law makers in the federal government continue to hash out the problem of health care coverage (*see story, p. 6*),

individual states have been busy passing their own laws. Between 1989 and 1995, 45 states passed laws to make health insurance more accessible and attractive to small businesses. Some of the reforms of these new regulations include: allowing insurers to sell "bare-bones" insurance to small firms, which typically cost less; narrowing the range in premiums so that coverage will be more affordable for higher-risk firms; and adding new standards for underwriting and contracting practices that make coverage more attractive and available to employers.

New York State has made the most sweeping standards, starting with a full "community rating" in 1993. The community rating ensures that health insurance enrollment is open, there is no preexisting condition clause, and no physical examination is required. The insurer can not discriminate for any reason, including age or physical condition; all applicants must be charged the same.

New York City: Small Business Health Insurance

In February 1999, New York City Mayor Giuliani initiated a demonstration project called "Small Business Health Insurance" (SBHI), to make available comprehensive, low cost health insurance to the estimated 26,000 small employers (those with 2-50 employees) located in the predominately minority areas of East Harlem, South Bronx, and Northern Brooklyn.

"We decided to target small businesses after conducting market research of small employers in New York City," Gil said. The majority of these businesses want to offer insurance, but only 50 percent are currently able to do so. The insurance companies had not been focusing their efforts on small

businesses. This project created that competition.

The percentage of small businesses in New York City owned by minorities is very large. Hispanics are much more likely to be uninsured in part because they are more likely to own their own businesses. Among Hispanics ages 18-34, almost 50 percent are uninsured. The lack of insurance affects minorities and immigrants disproportionately, according to Gil.

The New York SBHI program provides health insurance through brokers by Group Health Incorporated (GHI), which was awarded the contract. Most covered services must be obtained within two networks: Generations+ Health Network (Metropolitan and Lincoln Hospitals and affiliated providers), and North Brooklyn Health Network (Woodhull Hospital and affiliated providers).

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"Small business owners want to provide insurance at a low cost to employees and they want to have a choice in plans, but very often these businesses don't have the ability to offer insurance in a cost-efficient way."

SBHI is purchased by small employers for themselves and their employees, and the employer chooses what (if any) portion of the premium they plan to pay for the employee. The amount of the monthly premium is \$99.80 per employee, or \$235 for a family policy. This is less than the average cost for small businesses in New York, which averages \$255 per month.

SBHI is unique in that this is not a government subsidized program, but a market-based product sold like other health insurance through brokers, and available to any small employer. Anyone is eligible for the program, including immigrants, as long as they are employees of small businesses, said Gil. The SBHI program has minimized unnecessary paperwork, thanks in part to the State's community rating.

The program has sparked a lot of interest in New York's small business community. Since February, 23 formerly uninsured small businesses have applied to enroll. If enrolled, this would cover 280 individuals who are now uninsured. In addition, over 350 other businesses have expressed an interest in the program, including those located outside of the demonstration project area. Several hospitals are also interested in attempting a project like SBHI. The Mayor's Office is working to develop the SBHI model for Staten Island.

SBHI has developed strong outreach efforts to spread its word. It has assigned insurance specialists to work on outreach campaigns to educate the community about the program. GHI, along with the Health and Hospital Corporation (New York City's public hospital system), publicized the SBHI program through traditional marketing techniques, such as newspaper ads, posters, brochures and direct mailings. To attract small businesses, a health insurance specialist hired by each of the hospitals went door-to-door in area neighborhoods. They also canvassed health fairs and community centers.

To determine the effectiveness of the marketing and outreach and analyze utilization by new enrollees, SBHI is undergoing an independent evaluation by Pricewaterhouse Coopers, an independent professional services company.

New York Health Purchasing Alliance

SBHI is not the only program helping the uninsured in New York. Starting this fall, the New York Health Purchasing Alliance will offer small businesses a total of 16 HMO, POS, and PPO options from four health plans. Business with as few as three employees may choose from the 16 plans, according to Gil.

New York City awarded the New York Business Group on Health a \$1 million grant last year to develop more health benefit options for small businesses. The Group's Health Purchasing Alliance unit—a private, non-profit business group established through the support of the Mayor's office—will administer the grant.

The Health Purchasing Alliance will provide employees a choice of insurance carriers that will offer a standard benefit package called a "Health Pass." Employees then choose a plan and become enrolled in a centralized system through their employer.

The Alliance will assist employees in choosing a plan by offering comparative customer satisfaction and quality information on the plans. Small business owners will set the premium contributions at a level the employees can afford. This allows the employers to control benefit costs and increase employee satisfaction.

The Health Purchasing Alliance benefits all involved, according to Gil. Health plans will be able to increase their share of the small group market by enrolling new plan members.

Insurance brokers and general agents will now be able to offer customers a product for which there is a demonstrated demand.

The program will reduce premiums paid by New York employers and will make small businesses more competitive and better able to attract and retain employees. And, the overall quality of health coverage for small businesses will be improved.

Many of New York City's more than 200,000 small businesses with two to 50 employees will begin enrollment in September 1999. The Alliance will be sold exclusively through certified general agents and brokers.

Number of Uninsured is on the Rise

Though the economy is strong, the numbers and rates of the uninsured continues to go up, according to a study conducted by researchers at The Cambridge Hospital/Harvard Medical School in Massachusetts.

The study was published earlier this year in the *American Journal of Public Health* (January 1999, vol. 89, no. 1). Researchers concluded that most affected groups were African Americans, Hispanics, children, young adults, and poor and middle income families.

Key facts:

- Between 1989 and 1996, the number of uninsured persons increased by 8.3 million.
- Because Hispanics are the fastest growing segment of population, they accounted for 36.4 percent of the increase in the number of uninsured.
- Blacks and Hispanics together accounted for more than 50 percent of the increase in the number of uninsured.
- By the year 2000, the number of uninsured is expected to reach 44 million.
- Families with incomes below \$25,000 had the highest rates of uninsurance.
- From 1994 through 1996, the largest increase in the uninsured both in absolute numbers and percentage uninsured was among middle income families.

For more information on either the SBHI program or the New York Health Alliance, call Dr. Rosa Gil at (212) 788-2888. Employers interested in the SBHI may call (212) 501-4HHC.~

Addressing the Health Needs of Gay and Lesbian Patients

By Matthew Murguía

When it comes to gay and lesbian health issues, the first topic that often comes to mind is HIV/AIDS. But as more and more research shows, gay and lesbian health issues include more than AIDS.

While gays and lesbians suffer from the same health issues as other individuals, issues such as substance abuse, mental health, cancer, suicide, and smoking may affect gays and lesbians disproportionately. We don't know for sure because not enough research has been done.

Combine these concerns with health care access issues that racial and ethnic minorities face and the social stigma that still surrounds homosexuality, and you end up with a potent mix of factors that impact the health of gay and lesbian minorities.

Last year, the policy committee of the Gay and Lesbian Medical Association discussed the "Catch 22" that lesbian, gay, bisexual, and transgender patients face. First, in order for their specific health needs to be adequately addressed, gays and lesbians must discuss their sexual orientation with their health care provider. But by doing so they risk facing hostility, denial of care, and substandard care.

Unless a gay or lesbian patient knows that a health provider will treat them with the same respect and dignity that all patients deserve (and the literature suggests that the health field is still not gay "friendly"), many gays and lesbians will continue to conceal their sexual orientation, especially in situations where the patient does not get to choose the doctor.

Other articles in this issue of *Closing the Gap* highlight the challenges of improving access to health care for racial and ethnic minorities. Issues such as insurance coverage, cultural and linguistic competency, institutional policies, and the "isms" are all important. However, rarely is homophobia or training on gay and lesbian issues addressed in medical schools or health care settings.

Not enough data

The lack of training for health professionals may be due in part to a lack of data about specific health care needs of gays and lesbians, and whether being gay or lesbian increases one's risk for certain diseases or health conditions.

A recent report from the Institute of Medicine, *Lesbian Health: Current Assessment and Directions for the Future*, underscored that while lesbians were not at higher risk for any particular health problems because of their sexual orientation, some risk factors for certain diseases may be more common among lesbians. One key finding of the report was the lack of data on the role that sexual orientation may play in access to health care.

The Gay and Lesbian Medical Association (GLMA) also recently highlighted the need for more research on this issue in its response to the U.S. Department of Health and Human Services' draft *Healthy People 2010* (HP2010) for the nation.

Nearly 400 comments on the need to address gay and lesbian health issues were submitted during the public comment period, many by GLMA and its members. GLMA was especially concerned that gay and lesbian health issues were only addressed in the objectives related to HIV/AIDS.

GLMA recommended that measures dealing with sexuality be incorporated into HP2010 areas such as sexually transmitted diseases, injury/violence prevention, substance abuse, access to quality health services, health communication, and tobacco use.

Other public comments focused on a report that showed that up to one third of youth who attempt suicide do so because of issues dealing with sexuality, and the need for HP2010 to track this health measure.

Dangerous assumptions

Without data, health care professionals operate in a vacuum that may lead to assumptions about patients and their needs, including assumptions about a person's sexual orientation. This in turn may mean that treatment decisions are based on assumptions and not on fact.

For example, health care professionals may assume that because a person is male and married, he has not engaged in sexual activity with other males. Or, health professionals may assume that because a woman acknowledges she is a lesbian, she has not engaged in sexual activity with men. This may mean that a full sexual history will not be obtained, and risk factors for STDs and other issues may not be identified.

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"The issue of cultural competency as it relates to gays and lesbians may be a new concept for many, but it is an important step in ensuring effective provider-patient interaction."

In *Health Care News of Gay Men and Lesbians in the United States* (Report 89 of the Council of Scientific Affairs), the American Medical Association (AMA) committed to taking a leadership role and called for educating physicians on the current state of research in and knowledge of homosexuality, along with the need to record an adequate sexual history.

AMA states that these efforts should start in medical school, but must also be part of the continuing medical education. It also stressed the need to educate physicians about recognizing the physical and psychological needs of gay and lesbian patients. The AMA encouraged physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the needs of this population.

Steps toward improvement

One area where additional work is needed is in the training of health care professionals on how to interact with gay and lesbian patients in a fair and nonjudgmental way. The issue of cultural competency as it relates to gays and lesbians may be a new concept for many, but it is an important step in ensuring effective provider-patient interaction.

The first step in this process will be for health care providers to learn about the specific health care needs of gays and lesbians, and then to put that training into practice. Training could be offered to current students through the current health professions training programs educational system, and for those who are already involved in health care delivery, offered as CME and CEU credits required as part of ongoing staff training.

Nine ways to improve care for gay and lesbian patients

1. Make sure all staff—from the janitor to the doctor—understand that a patient's known or perceived sexual orientation should not have any effect on how patients are treated or services provided.

New Study on Patient/Physician Relationships

African American patients rated their visits as less participatory than whites in models adjusting for age, gender, education, marital status, health status, health status, and length of the patient-physician relationship, according to a study published in the August 11, 1999 issue of the *Journal of the American Medical Association* (JAMA).

Researchers also found that patients seeing physicians of their own race rate their physicians' decision making (PDM) styles as more participatory.

Researchers conducted a telephone survey between November 1996 and June 1998 of 1,816 adults aged 18 to 65 years.

This study shows that female physicians had more participatory visits with patients than male physicians. The authors suggest that all patients prefer participatory visits because patient satisfaction was linked to PDM scores for patients across all ethnic groups.

Researchers recommend patient and physician interventions to improve communication in primary settings. This requires interventions that empower minorities to become more involved and active consumers of care, along with increasing the number of minority physicians.

The authors also state that communication training programs for medical students, residents, and practicing physicians emphasize the importance of understanding our increasingly diverse population. ~

2. Teach health care providers to ask about sexual history rather than make assumptions about a patient's sexual orientation.
3. Promote the use of "gender-neutral" terms between patient/provider to enhance the level of communication.
4. Make and distribute gender-neutral brochures and materials so the patient will feel more comfortable and can identify with health messages.
5. Consider posting a statement of nondiscrimination based on sexual orientation in the patient waiting and exam rooms.
6. Prior to taking a sexual history, repeat a pledge of confidentiality.
7. Participate in training on gay and lesbian health concerns conducted by local gay and lesbian health organizations.
8. Make an on-site resource directory available for use in referrals to other providers in case a patient decides to obtain a specific service elsewhere.
9. Conduct patient satisfaction surveys with gays and lesbians who have disclosed their sexual orientation to determine if there are ways to improve health services.

All patients, regardless of sexual orientation, face myriad challenges in navigating the health care system. Regardless of whether a patient has private insurance or receives services through publicly funded sources, each deserves to be treated with dignity and respect. It is in the best interest of both the provider and patient.

Specific action should be taken to ensure that all patients, regardless of sexual orientation, feel free to share risk factors without concern for how a health care provider will react. Research that focuses on health needs of gays and lesbians must be enhanced so that special needs can be identified and addressed. That research must be translated into practice. ~

Major Sources of Health Insurance

By Michelle Meadows

Keeping up with health insurance choices can be tough. Start a new job and you might have to switch from a plan you've relied on for years. Lose your job and you might not know where to turn after employer-sponsored coverage runs out. And what would happen if you became too sick to work or couldn't afford private insurance?

Here's a look at your major health insurance options—public and private. *We tapped federal government agencies, the National Association of Insurance Commissioners (<http://www.naic.org>), and the Health Insurance Association of America (<http://www.hiaa.org>).*

Medicare-Health Care Financing Administration (HCFA). Medicare is a federal health insurance program that covers 39 million Americans and insures people who are at least 65, who are disabled, and people with permanent kidney failure.

Medicare has two parts. Part A covers inpatient hospital services, skilled nursing facilities, home health services, and hospice care. Medicare Part B helps pay the cost of physician services, outpatient hospital services, medical equipment and supplies, and other health services and supplies.

You can apply through your local Social Security Administration Office (1-800-772-1213; <http://www.ssa.gov/>). To learn more about Medicare health plan options, call the Medicare phone line at 1-800-633-4227 or visit HCFA's Medicare web site at <http://www.medicare.gov>. The site offers Medicare Compare, an interactive database that gives details on health plan options.

Women account for more than half of all Medicare beneficiaries, according to a report released in July by President Clinton and the Older Women's League (OWL). "Medicare: Why Women Care" also concludes that preventive benefits such as Medicare-covered mammograms are underutilized by older women. *To obtain the report, visit OWL's web site: <http://www.owl-national.org/>. Or, call OWL's national office at 202-783-6686.*

Medicaid-HCFA. Medicaid is a joint federal-state health insurance program run by states. Eligibility and services vary for each state. Medicaid is open to people of all ages and covers some who receive low income or have disabilities. Eligibility groups include low-income families with children as described in Section 1931 of the Social Security Act.

In many states, those who receive Supplemental Security Income benefits are automatically eligible for health benefits under Medicaid. All states cover a minimum set of services including hospital, physician, and nursing home services. States have the option of covering an additional 31 services including prescription drugs and hospice care.

Medicaid serves about 19 million children, 8 million adults who care for these children, 4 million elderly, and 6 million with disabilities. To apply for Medicaid, contact your state Medicaid agency. *The address and toll-free number to your state Medicaid official is on the Web: <http://www/hcfa.gov/medicaid/meligib.htm>.*

Children's Health Insurance Program (CHIP)-HCFA. CHIP is considered the most significant improvement in access to health care for children since creation of Medicaid in 1965. Part of the Balanced Budget Act of 1997, the public program expands coverage to uninsured children whose families earn too much for Medicaid but too little to be able to purchase private health insurance. CHIP allocates \$24 billion over five years to states. Nearly one million children received coverage in the first year.

The program is expected to enroll more than 2.5 million children by September 2000. *Call the toll-free hotline at 1-877-KIDS for state-specific information about CHIP and Medicaid to families in all states. Or, visit these web sites: <http://www.insurekidsnow.gov/>; and <http://www.hcfa.gov/init/children>.*

TRICARE-U.S. Department of Defense. TRICARE is a regionally-managed public health care program for active duty and retired members of the uniformed services, their families, and survivors. TRICARE brings together resources of the Army, Navy and Marine Corps, Air Force, and networks of civilian professionals. Eligible groups include active duty members and their families, retirees and their families, and survivors of all uniformed services who are not eligible for Medicare.

Beneficiaries have three main choices—TRICARE Prime, where military treatment facilities are the principal source of health care; TRICARE Extra, a preferred provider option; and TRICARE standard, a fee-for-service option. *For more information, look up TRICARE on the web: <http://www.tricare.osd.mil/>.*

Veterans-Department of Veterans Affairs. Veterans generally must be enrolled with the VA to receive health care benefits. There are several eligibility groups including veterans with service-connected conditions who are rated 50 percent or more. *You can access the Federal Benefits Manual for Veterans and Dependents 1999 on the web: <http://www.va.gov/benefits.htm>.*

Coverage includes nursing home care, long-term care, pharmacy services, and dental care. Those who aren't eligible for TRICARE or Medicare Part A may be eligible for CHAMPVA—the VA Civilian Health and Medical Program, which shares the cost of care for dependents and survivors of veterans. Eligibility groups include the spouse or child of a veteran with a permanent and service-connected disability and the spouse or child of a veteran who died of a service-connected disability.

Contact the VA Health Administration Center, PO Box 65023, Denver, CO 80206. Call 1-800-733-8387.

Employer-Sponsored Insurance. People who work can typically choose from group health insurance programs offered by their employers. You can join or change plans during an open enrollment period each year. There was a time when fee-for-service or indemnity plans were widely used. Under these plans, you could choose any provider, and after paying a deductible, the insurance

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plan covers some portion of the various services you may need. Now, more than half of Americans with health insurance are enrolled in some kind of managed care plan.

The most common managed care arrangements are health maintenance organizations (HMO), preferred provider organizations (PPO) and point of service plans (POS). An HMO provides services through a network of doctors, hospitals, and laboratories. These plans pay providers a monthly fee (capitation fee) regardless of the amount of services performed. You choose a primary care physician to serve as gatekeeper, manage your care, and refer you to specialists.

A PPO is a group of doctors, hospitals, and others who provide services to health plan members for discounted fees. POS plans are like HMOs but you don't need approval from a network doctor if you want services out of the network.

As you decide on a plan, look to your employer's benefits office for information on what services are covered, including preventive care and prescriptions, and what limits on pre-existing medical conditions might affect you.

And what happens if you lose your job, either voluntarily or otherwise? Under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985, group plans offered by employers with 20 or more employees must continue your coverage for 18 months after you leave. You may need individual insurance if your company doesn't fit into this category.

Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Act is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. HHS, the Departments of Labor and Treasury issued interim final rules for these provisions on April 8, 1997. For updates of HCFA HIPAA-related activities, browse its Web site: <http://www.hcfa.gov/HIPAA/>.

Individual Insurance. This insurance usually costs more than group insurance. If you're self-employed, between jobs, or work for an employer that doesn't offer insurance, you can purchase your own from many professional associations, social, and civic groups. ~

Got Pesticide Questions? EPA Has Answers

"My son ate berries from a field that was recently treated with pesticides. Now, he has a rash. Is this a direct result of pesticide poisoning? If so, what should I do?"

"I'm an expectant mother and my home is scheduled to be treated by an exterminator this week. What precautions should I take to protect my baby?"

These are just some of the many questions the National Pesticide Telecommunications Network (NPTN) can answer.

A cooperative effort between Oregon State University and the Environmental Protection Agency (EPA), NPTN handles over 23,000 calls a year on topics ranging from toxicology to pesticide poisoning.

NPTN is the most comprehensive and reliable source of pesticide information in the U.S. Its staff of pesticide professionals—including toxicologists and a physician—provide objective, science-based yet easily understood information on pesticides to the general public, medical, and veterinary communities. Staff are trained to:

- interpret human health and environmental questions about pesticides;
- answer questions about pesticide label information;
- supply general information on pesticide regulation in the U.S.;
- make referrals for laboratory analyses, investigation of pesticide incidents, and emergency medical treatment;
- confer with private physicians to determine an appropriate treatment plan in the event of poisonings; and
- provide information on safety practices for field/farm workers and handlers.

NPTN's toll-free phone service provides a variety of information on pesticides to anyone in the U.S., Puerto Rico, and Virgin Islands. Call NPTN at 1-800-858-7378; or browse its Web site: <http://ace.orst.edu/info/nptn>.

NPTN also operates the National Antimicrobial Information Network (NAIN). Antimicrobial pesticides are pesticides that serve as disinfectants, sanitizers, or sterilants used to kill bacteria on surfaces, in sponges, and on hospital utensils.

NAIN's services include providing antimicrobial information to medical and other professionals, trade associations, and the general public. NAIN's trained staff can:

- interpret product labels and permitted uses;
- provide lists of products registered as sterilants, tuberculocides, and HIV virucides;
- provide toxicology, health effects, and safety information on specific antimicrobial chemicals;
- supply information on regulations and registration of antimicrobials in the U.S.;
- field complaints on product efficacy and forward information to EPA; and
- refer requests that are outside of NAIN's expertise to appropriate agencies and resources.

EPA works closely with NPTN and NAIN to track and respond to the general and specific concerns of the average citizen, as well as the medical practitioner.

Still, one of the biggest challenges continues to be informing the public about the availability of these services and the variety of experts and services available.

EPA would like to ask your assistance in encouraging people and businesses in your community to take advantage of these free services.

NAIN, also a toll-free telephone service, provides callers with information about antimicrobial pesticides. Call NAIN at 1-800-447-6349; or browse their Web site at: <http://ace.orst.edu/info/nain>. ~

The editors of *Closing the Gap* welcome your story ideas. If you have a community program, special event, or news item you would like featured, please send a fax or e-mail to: Houkje Ross at (301) 589-0884; houkje@omhrc.gov.

INS Guidelines Clarify Public Charge Issue

By Sibyl Bowie

Recent immigration and welfare reform laws have left many immigrants confused. As a result, many have not accessed some of the health, nutritional and non-cash public benefits available to them for fear of deportation, refusal of permanent residency status, or jeopardizing their ability to sponsor their family members into the United States. But a new proposed rule will help non-citizens and their families make informed choices about receiving public assistance.

The Immigration and Naturalization Service's (INS) new guidelines (*Federal Register*, May 26, 1999) define, for the first time, "public charge" and state which public benefits non-citizens may receive without jeopardizing their immigration status. "Public charge," an immigration law term that describes persons who cannot support themselves and who depend on cash assistance benefits for income, is a ground of inadmissibility and deportation.

Benefits That May Cause Problems

Using *cash* welfare, such as Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), or General Assistance *might* affect immigration status or ability to travel outside of the U.S.

The INS and Department of State (DOS) also considers the receipt of public assistance, including Medicaid to support long-term care—such as a mental health institution or nursing home—as part of the public charge analysis.

Safe Benefits

Short-term, institutionalized rehabilitation is not a public charge concern. Use of non-cash assistance health insurance programs like Medicaid (except for long-term care), the Children's Health Insurance Program (CHIP), or nutritional programs such as school lunch, WIC, or food stamps will not affect immigration status.

Other non-cash programs, for example, housing, job training, child care, disaster relief, and health clinics, will not cause a public charge problem.

Who Is Exempt?

Each public charge determination is made on a case-by-case basis. By law, a number of factors must also be considered by INS and DOS officials, including the alien's age, health, family status, assets, resources financial status, education and skills.

The use of health care or other non-cash benefits by children or other family members will not be considered in a public charge decision unless it is the family's only income.

Immigrants who have used cash benefits for income maintenance or been institutionalized for long-term care are not automatically inadmissible, ineligible to adjust status to legal permanent resident, or deportable on public charge grounds.

In addition, public charge is not an issue for persons seeking naturalization, refugees, individuals granted asylum, and certain immigrant groups granted admission to the U.S. under special circumstances.

For instance, when they first arrived in the U.S., Amerasians from Vietnam who were admitted as legal permanent residents were exempt from the public charge test. However, if away for longer than 180 days, they would be subject to the public charge test for subsequent re-admission to the country.

To view a copy of the letter to health officials informing them on the new INS guidelines, browse the HCFA Web site: www.hcfa.gov/init/ch052699.htm. You can also access information on public charge through the National Immigration Law Center's Web site: <http://www.nilc.org/ciwc/ciwcindex.htm>.

National Cancer Institute Seeks Nominations for Members to Serve on NCI Director's Consumer Liaison Group

The National Cancer Institute (NCI) is seeking nominations for five new members to serve three-year terms on the Director's Consumer Liaison Group (DCLG).

The DCLG is an advisory committee of 15 consumer advocates who are involved in cancer advocacy and who reflect the diversity among those whose lives are affected by cancer.

Members make recommendations to the NCI director on issues, programs, and research. **The deadline for nominations is November 1, 1999.**

For further information, please view the "Announcements" section on the NCI Web site: (URL: <http://deainfo.nci.nih.gov/ADVISORY/dclg/nominations.htm>).

To receive a nomination package, send your name, advocacy/voluntary organization affiliation (if any), address and phone number to the Office of Liaison Activities, NCI, c/o Palladian Partners, 1010 Wayne Avenue, Suite 1200, Silver Spring, MD 20910; or fax information to (301) 650-8676.

Organizations

Center for Health Services Policy and Research

George Washington University
2021 K Street, NW, Suite 800,
Washington, D.C. 20052
202-296-6922

The Commonwealth Fund

One East 75th Street
New York, NY 10021-2692
212-535-0400
<http://www.cmf.org>

The National Rural Health Association

One West Armour Boulevard, Suite 203
Kansas City, MO 64111
816-756-3144
<http://www.nrharural.org>

Rural Information Center Health Service

National Agricultural Library
10301 Baltimore Avenue
Beltsville, MD 20705
1-800-633-7701
<http://www.nal.usda.gov/ric/richs>

Center for Managed Care

Health Resources and Services Administration
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
301-443-1550
<http://www.hrsa.gov/cmhc>

Center on Budget and Policy Priorities

820 First Street, NE, Suite 510
Washington, DC 20002
202-408-1080
<http://www.cbpp.org>

National Managed Health Care Congress

PO Box 102713
Atlanta, GA 30368
1-888-882-2500
<http://www.nmhcc.org>

American Public Health Association

800 I St., NW
Washington, DC 20001
202-777-2742
<http://www.apha.org>

Managed Care Technical Assistance Center

John Snow Inc.
1555 Wilson Boulevard, Suite 520
Arlington, VA 22209
877-832-8635
www.jsi.com/hrsamctac

Kaiser Commission on Medicaid and the Uninsured

1450 G Street, NW, Suite 250
Washington, D.C. 20005
1-800-656-4533
<http://www.kff.org>

Asian and Pacific Islander American Health Forum

942 Market Street, Suite 200
San Francisco, CA 94102
415-954-9959
<http://www.apiahf.org>

Indian Health Services Managed Care Committee

c/o Anna Albert
Phoenix Indian Medical Center
4212 North Sixteenth St.,
Phoenix, AZ 85016
602-263-1645

Publications

Medicaid Managed Care: Opportunities and Challenges for Minority Americans, 1998, 52-page report. Call the Kaiser Publications Line, 1-800-656-4533.

Racial and Ethnic Differences in Access to Medical Diagnosis and Treatment, 1997, 39-page report. Call the Morehouse School of Medicine, Morehouse Medical Treatment Effectiveness Center, 404-752-1873.

Managed Care in American Indian and Alaska Native Communities, 1999, 195-page book. Call American Public Health Association's publication sales department, 202-777-2742.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Office of Minority Health Resource Center
P.O. Box 37337
Washington DC 20013-7337

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DHHS/OPHS
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Closing the Gap

Conferences: 1999-2000

Oct. 10-13: National Black Child Development Institute's 29th Annual Conference, *Bridging the Divide for Children: Access, Equity, and Opportunity*, in Houston, TX. Contact: 1-800-556-2234.

Oct. 17-20: 3rd National Managed Health Care Congress: *Innovative Managed Care Strategies*, in Los Angeles, CA. Sponsored by National Managed Health Care Congress. Contact: 1-888-882-2500.

Oct. 18-21: *A Gathering of Wisdom*, Anaheim, CA. Sponsored by the Institute for Community Health Outreach. Contact: 916-443-0218.

Oct. 20-22: *Healthy Aging in the Next Millennium* conference, held in San Padre Island, TX. Sponsored by the Texas-Mexico Border Health Coordination Office. Contact: 956-381-3687.

Oct. 27-29: *Diabetes in American Indian Communities*, Albuquerque, NM. Sponsored by the American Diabetes Association. Contact: 703-549-1500.

Nov. 3-5: *National Conference on African American Health, Spirituality, and Healing*, Cleveland, OH. Sponsored by Olivet Health and Education Institute. Contact: 216-721-2850.

Nov. 3-5: *8th Annual Public Housing Primary Care Conference*, in Washington, DC. Sponsored by the Health Resources Services Administration. Contact: 1-800-277-3281.

Nov. 5-8: *United States Conference on AIDS*, Denver. Sponsored by the National Minority AIDS Council. Contact: 202-483-6622, ext. 317.

Nov. 7-11: *American Public Health Association's 127th Annual Conference*, Chicago. Contact: Conference Office, 202-789-5661 (Fax).

Nov. 30- Dec. 2: *14th National Conference on Chronic Disease Prevention and Control*, Dallas. Sponsored by the Centers for Disease Control and Prevention. Contact: Kevric Company Inc., 301-588-6000.

Dec. 5-7: *1999 Minority Health Issues Conference*, Columbia, S.C. Sponsored by the South Carolina Department of Health and Environmental Control, Office of Minority Health. Contact: 803-898-3808.

Dec. 6: *4th HIV/AIDS & Diversity Conference*, held in New York. Sponsored by the Wurzweiler School of Social Work. Contact: 212-960-0800.