

HB

409

File No. 3

State of Rhode Island and Providence Plantations

JANUARY SESSION, 1974

CHAPTER 50.

AN ACT to Protect the Public Health of the People  
of the State of Rhode Island and Providence Plan-  
tations.

74-S 2230 A  
Approved  
Apr. 26, 1974.

PREAMBLE

Whereas, The state of Rhode Island has the right  
and the obligation to promote the public health, safety,  
morals and general welfare; and

Whereas, The high cost of health services can serve  
as a barrier to persons in need of health care, all to  
the detriment of the public health; and

Whereas, promotion of the public health, safety  
and welfare requires that all citizens have equal ac-  
cess to health services and a means to protect them-  
selves against the extraordinary costs of serious ill-  
ness or injury; and

Whereas, promotion of the public health, safety  
and welfare further requires that employers be en-  
couraged to provide the best quality of health cov-

erage to their employees and their dependents, and that all other persons be encouraged to obtain the best quality of health coverage for themselves and their dependents; and

Whereas, Promotion of the public health, safety, and welfare further requires that persons or other entities which provide health services or which provide for the prepayment and insurance of health services, or which assist in the payment of health services; do so in furtherance of the public interest, now therefore,

It is enacted by the General Assembly as follows:

Section 1. Title 42 of the general laws entitled "State affairs and government" as amended is hereby further amended by adding thereto the following chapter:

## CHAPTER 62

### Catastrophic Health Insurance

42-62-1. **SHORT TITLE.**—This act shall be known and designated as the Rhode Island catastrophic health insurance plan ("CHIP") act.

42-62-2. **PURPOSES.**—The purposes of this chapter are to assure that each person residing in the state of Rhode Island shall have access to needed diagnostic, curative, and rehabilitative health services at reasonable costs and that each person shall have a reasonable means of protecting himself against the unusually high costs of receiving such health services. For these purposes the general assembly finds that promotion of the public health, safety and general welfare re-

quires that the conditions and responsibilities for the payment and provision of such health services be established.

**42-62-3. EXERCISE OF POLICE POWER.**—This chapter shall be deemed an exercise of the police power for the protection of the health, safety and general welfare of the people of the state.

**42-62-4. DEFINITIONS.**—

(a) The term "employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Rhode Island and each city and town therein, which has in its employ one or more individuals during any calendar year after the effective date of this chapter. For purposes of this section, the term "employer" shall refer only to an employer with persons employed within the state of Rhode Island.

(b) The term "employee" means any person who has entered into the employment of or works under contract of service or apprenticeship with any employer. It shall not include a person who has been employed for less than thirty days by his employer, nor shall it include a person who works less than an average of thirty hours per week. For purposes of this chapter, the term "employee" shall mean a person employed by an employer as defined in section 42-62-4 (a). Except as otherwise provided herein the terms "employee" and "employer" are to be defined according to the rules and regulations of the department of employment security.

(c) The term "insurer" shall include all persons, firms or corporations offering and/or insuring health services on a prepaid basis, including, but not limited to policies of accident and sickness insurance, as defined by chapter 18 of title 27, general laws of Rhode Island, 1956 as amended, nonprofit hospital or medical service plans, as defined by chapters 19 and 20 of title 27, general laws of Rhode Island, 1956 as amended, or any other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population on the basis of a periodic premium. It shall include all persons, firms, or corporations providing health benefits coverage for employees on a self-insurance basis without the intervention of other entities.

(d) The term "health maintenance organization" means an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of, an agreed upon set of comprehensive health maintenance and treatment services, for a voluntarily enrolled group of persons in a geographic area and is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

(e) The term "health services" means those medical, professional, and paraprofessional services provided to a person to prevent disease, to maintain health, to detect disease and disability in early stages, to diagnose and treat illness, and to rehabilitate a person to his fullest capacities.

(f) The term "benefit" or "health benefit" means a health service financed for a person by a third party such as an insurer or the state.

(g) The term "allowable income" means the adjusted gross income as defined pursuant to section 44-30-12 of the Rhode Island general laws, 1956 as amended, minus any personal exemptions allowed pursuant to such chapter.

(h) The term "state" means the State of Rhode Island and Providence Plantations.

(i) The term "United States" means the government of the United States of America or any of its instrumentalities.

(j) The term, "departmental health advisory councils" means those councils which have been appointed to serve in an advisory capacity for various specific health matters which are a responsibility of the director of department of health or the director of the department of mental health, retardation, and hospitals.

(k) The term "maternity benefits" shall mean benefits rendered for normal obstetrical care. It shall include benefits for completion of obstetrics, prenatal care, care of the newborn infant, labor, delivery, and puerperium care. The term shall include benefits for normal deliveries or for any complications of pregnancy which do not result in delivery of a viable fetus.

(l) The term "medicare" means part A and part B of the United States social security act, title XVIII, as amended, 42 U.S.C. sections 1394, et seq.

(m) The term "physician" means any person duly licensed to practice surgery or medicine pursuant to the provisions of chapters 29, 31 of title 5 and chapters 36, and 37 of title 6 of the general laws of Rhode

Island, 1956 as amended (except dental hygienists), and comparable laws of other countries.

(n) The term "eligible person" means a person who has established permanent residency in the state for three months and who has the legal responsibility for the payment of eligible health costs incurred on his or her behalf or the behalf of persons for whom he or she is legally responsible. A person who has moved to the state for the primary purpose of receiving benefits provided pursuant to this chapter shall not be considered to be a permanent resident unless such residency has been established pursuant to a judicial order to be a permanent residency.

(o) The term "eligible health service" means a health service which would be covered within the type of qualified program an eligible person would be expected to have by the director of health in order to incur the smallest personal resource payment applicable under this chapter.

(p) The term "personal resource payment" means the money an eligible person is obligated to pay from his or her own wages, salary, income or assets for eligible health services which are not otherwise reimbursable under a health benefits plan unless such person is covered under provisions of section 42-62-9.

(q) The term "qualified program" means those health benefits plans which provide for the payment of health services by insurers through plans which have been certified as qualified by the director of the department of business regulation pursuant to this chapter.

(r) The term "health benefits plan" means any plan by which health benefits are paid by an insurer, the state, or the United States.

(s) The term "costs of eligible health service" means those usual and customary costs, or charges or rates of vendors at levels which have been approved in a qualified program by the director of business regulation, and which shall serve as the basis for the costs, rates or charges for which the state would be liable to pay pursuant to the provisions of this chapter.

## ARTICLE I

### Entitlement to Health Benefits Protection

42-62-5. ENTITLEMENT.—Each person residing in the state regardless of age, sex, race, religion, occupational status, or previously existing physical condition shall be entitled

(a) To receive financial protection from costs of health services under conditions and limitations established by this chapter.

(b) To have access to available diagnostic, curative and rehabilitative health services which are medically necessary; and

(c) To obtain through insurers financial protection against the costs of such health services provided by qualified programs.

### 42-62-6. DUTY OF THE STATE.—

(a) The state shall pay for the costs of eligible health services of an eligible person when such costs are determined to be catastrophic.

(b) The costs of eligible health services shall be determined to be catastrophic when an eligible person has incurred an obligation for payment in an amount of money determined pursuant to section 42-62-7.

(c) Any person who becomes eligible for payment for the costs of eligible health services determined to be catastrophic shall remain eligible for such coverage during the calendar year in which he becomes so entitled and during the following calendar year if such person incurs an obligation during such following calendar year for the payment of eligible health costs which are at least equal to twenty-five percent (25%) of the amount of what such person's personal resource payment would have otherwise been during the preceding year of catastrophic coverage. Said amount shall then be an eligible cost for catastrophic coverage during such following calendar year.

(d) Beginning at October 1, 1974, costs of eligible health services incurred on and after October 1 of any preceding year shall be construed as costs incurred in such following year.

(e) In the case of a dispute as to the eligibility of a type of health service for coverage as a catastrophic cost, the director of the department of health may determine, on the basis of an appeal by an eligible person and written comment by the appropriate insurer, whether or not such health service is an eligible health service.

(f) In the case of a dispute as to the eligibility of a person for coverage of catastrophic costs by the state, the director of the department of health shall determine said eligibility after an appeal by a person from a decision by an insurer.

#### 42-62-7. PERSONAL RESOURCE PAYMENTS.—

(a) To be eligible for payment by the state pursuant to section 42-62-6 of his or her health services

of a catastrophic nature, an eligible person must have incurred an obligation to make the applicable personal resource payment computed pursuant to this section. Such payment shall not be a cost payable by the state pursuant to subsections 42-62-6 (a) and (b).

(b) The applicable personal resource payment shall be determined on a calendar year basis and shall not include the payments made to meet the deductible of a major medical plan or the premium costs of a health benefits plan. It shall include the co-insurance payments made under a major medical plan.

(c) The applicable personal resource payment applies to the obligation for payment of health services that are not covered under any health benefit plan, except for health maintenance organization plans.

(d) The applicable personal resource payments shall be determined in relation to the extent of coverage for health benefits, if any, to which an eligible person is otherwise entitled according to the following categories:

(i) An eligible person

(A) Who has a qualified program must have incurred an obligation to pay an amount equal to five hundred dollars (\$500.00) or to ten percent (10%) of his or her allowable income, whichever amount is greater;

(B) Who has a program that would have otherwise been qualified, except for a qualified major medical health benefits plan, must have incurred an obligation to pay an amount equal to twelve hundred fifty dollars (\$1250.00) or to twenty-five percent (25%) of his or her allowable income, whichever amount is greater;

(C) Who has a plan or plans of health benefits which is not a qualified program must have incurred an obligation to pay an amount equal to (1) the difference between costs covered by his plan or plans of coverage and a qualified program, or (2) an amount which does not exceed five thousand dollars (\$5,000.00) or fifty percent (50%) of his or her allowable income, whichever is greater;

(ii) An eligible person who has medicare coverage and

(A) Who has a qualified supplemental program must have incurred an obligation to pay an amount equal to five hundred dollars (\$500.00);

(B) Who does not have a qualified supplemental program must have incurred an obligation to pay an amount equal to one thousand dollars (\$1000.00);

(iii) An eligible person who is not otherwise entitled to coverage under any other health benefits plan must have incurred an obligation to pay an amount equal to either five thousand dollars (\$5,000.00) or to fifty percent (50%) of his or her allowable income, whichever amount is greater.

**42-62-8. EXCLUSIONS.**—All services and charges within any of the following classifications are excluded from the financial protection provided pursuant to section 42-62-6 and shall not be included as applicable personal resource payments pursuant to section 42-62-7.

(a) Benefits provided pursuant to the laws of the United States including, but not limited to military service-connected disabilities, medical services pro-

vided for employees of the armed forces of the United States, medical services financed for the benefit of persons over the age of 65 years of age and for persons with insufficient income and assets to purchase benefits pursuant to the laws of the United States, and medical services which may be financed in the future on behalf of all citizens by the United States;

(b) Care which is primarily for custodial or domiciliary purpose and is not medically necessary;

(c) Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(d) Dentistry and optometry unless prescribed as medically necessary as the result of an injury or serious illness or disability;

(e) Chiropractic and psychological therapy and social counseling unless prescribed as medically necessary;

(f) Corrective appliances and artificial aids, such as hearing aids, corrective lenses and eyeglasses, unless such appliances and aids are medically necessary for the purpose of rehabilitation;

(g) Drugs and medication legally requiring prescriptions unless such items are medically necessary;

(h) Drugs and medication not legally requiring prescription;

(i) Outpatient psychiatric care in excess of fifty percent (50%) of the cost incurred of such eligible health services as may be incurred in a calendar year;

(j) Services delivered in facilities which have not been certified by the director of the department of health as qualified to provide such services.

**42-62-9. EMPLOYEES' HEALTH BENEFIT PLANS.—**

(a) Each employer shall, in accordance with regulations promulgated by the director of the department of business regulation in consultation with the director of the department of health, offer the opportunity for his employees to enroll in any available qualified health maintenance organization on the same absolute dollar cost sharing terms which may be provided for other health benefits plans made available for employee enrollment.

(b) The fair value of services rendered by a health maintenance organization to a subscriber after such subscriber has exhausted the services provided by the health maintenance organization's qualified program shall be recognized as eligible health care expenditures by the subscriber in computing his personal resource payment pursuant to section 42-62-7.

**42-62-10. QUALIFIED HEALTH PROGRAM.—**

(a) Upon application by an insurer for certification of a health insurance plan or plans as a qualified program for the purpose of this chapter, the director of business regulation, after consultation with the director of health, shall make a determination within ninety days (90) as to whether the applicant's plan or plans are qualified, and shall publish in the major newspapers of the state on a semi-annual basis thereafter a notice that such plan or plans are qualified.

(b) A program may be certified for a period of two years, if, at least,

(i) It meets the minimum standards of this chapter,

(ii) Its insurer meets the duties established by this chapter and the laws of the state,

(iii) It provides coverage for diagnostic, curative and rehabilitative health services for illness and for injuries for the subscriber and his dependents, which the director of the department of health, after consultation with the appropriate departmental health advisory councils, has recommended as being in the public interest.

(iv) It provides benefits which are approximately equal in scope and in actuarial value to the benefits described in subsection 42-62-10 (c).

(c) Any plan or combination of plans which provide the following benefits or their actuarial equivalent may be deemed to be a qualified program for purposes of the operation of this chapter:

(i) Hospital Services

1. One hundred twenty (120) days of inpatient care in short-term general hospitals, or forty-five (45) days in a specialized hospital, including the full cost of a semi-private room accommodation; meals and dietary services; general nursing care, and intensive care; use of the operating room; drugs and medications used in the hospital; medical and surgical supplies; diagnostic tests including laboratory examinations, pulmonary function, basal metabolism, electroencephalograms and electrocardiograms, insulin and shock therapy; diagnostic and therapeutic x-ray, radiotherapy and radioisotopic services; inhalation and oxygen therapy; blood derivatives, plasma, and charges for administration, typing and cross-matching (but not charges for whole blood); physical therapy, occupational therapy, speech and hearing therapy.

2. Coverage of all necessary services as defined in subsection (i) (1) for the inpatient maternity care, except that an insured or subscriber may be liable for the first one hundred dollars (\$100.00) of cost of such services, after which the qualified plan pays the balances.

3. The full cost of outpatient care from a hospital, if it is for an accidental injury occurring not more than seventy-two (72) hours after a poisoning or traumatic accident, and the use of an operating room for an operation involving (a) a cutting procedure; (b) use of general anesthesia; or (c) reduction of a fracture of dislocation.

4. The full cost of outpatient radiological services including diagnostic x-ray, radiotherapy and diagnostic and therapeutic radioisotopic services.

(ii) Physicians Services

Physicians' usual and customary charges for the following services:

1. Surgical services, consisting of operative and cutting procedures, including routine pre- and post-operative care, provided in a hospital, hospital outpatient department, physician's office, or the patient's home.

2. Services of an assisting physician in connection with such an operative procedure when the nature of such procedure is such that an assisting physician is medically necessary.

3. Services of a physician-anesthetist if anesthesia is administered by a physician other than the surgeon or assisting surgeon.

4. Diagnostic services as listed below, whether performed in a physician's office, approved and licensed medical laboratory or in a hospital, when required for the diagnosis of any condition due to illness or injury:

(a) Diagnostic x-ray and radioisotopic examinations;

(b) Electroencephalograms, basal metabolism tests and electrocardiograms;

(c) Laboratory tests, including pathological examinations;

(d) Radiation treatments by x-ray, radium, external radiation or radioactive isotopes.

5. Physicians' visits to care for a bed patient in a short-term general hospital up to 120 days per period of illness, or for 45 days per period of illness in specialized hospitals, except for routine pre-operative and post-operative physical examinations.

6. Consultation services, where medically necessary in the opinion of the attending physician, at one consultation per specialty per period of illness.

7. Obstetrical delivery services, including pre- and post-natal care, after the first fifty dollars (\$50.00) of charges, which shall be the liability of the patient.

8. Newborn baby care, when the examination and care is provided by a physician other than the physician making the delivery or administering anesthesia related to delivery.

9. Emergency accident services performed by a physician within 72 hours of a traumatic or poisoning accident are covered in full.

(iii) Major Medical Coverage

1. To supplement the protection provided by subsections (c) (i) and (c) (ii), the following additional coverages may be required as a condition for a program being certified as qualified:

(a) It provides up to ten thousand dollars (\$10,000.00) in coverage for payment of eligible health services;

(b) It provides such coverage for at least eighty percent (80%) of the usual and customary charges, or costs, as applicable, of health services described in subsection (c) (i) and (c) (ii) after an insured or subscriber has paid an annual deductible of one hundred dollars (\$100.00) per person or two (2) one hundred dollar (\$100.00) deductibles per family for covered services.

(c) Such covered service provided under subsection (b) shall include:

1. Physicians' services, including home and office visits.

2. Professional ambulance services locally to or from a hospital for inpatients, or to a hospital accident room following an accident.

3. Drugs and medications which by law require a written prescription.

4. Rental or purchase, whichever costs less, or wheelchairs and other durable equipment used for medical treatment exclusively.

5. Out-of-hospital speech therapy and physical therapy.

6. Multiphasic screening and other diagnostic screening examinations.

7. Orthopedic braces, prosthetic appliances, such as artificial limbs and eyes, including replacement, repair or adjustment.

8. Full time or visiting nurse services by a registered nurse or licensed practical nurse when ordered by an attending physician and when medically necessary, up to maximum charges of seven hundred fifty dollars (\$750.00) per year.

9. Services for diagnosis and treatment of mental and nervous disorders, provided, however, that an insured shall be required to make a fifty percent (50%) co-payment, and that the payment of the insurer shall in no event exceed one thousand dollars (\$1,000.00) in a case involving outpatient psychiatric treatment.

(d) Any plan or combination of plans which provides benefits to persons over the age of sixty-five years may be deemed to be a qualified supplemental program for purposes of this chapter after the effective date of this chapter if such plan or combination of plans is designed to supplement medicare and provide the following coverages:

1. The full cost of the hospital deductible and co-payment of part A of medicare as amended annually by actions of the secretary of the United States department of health, education and welfare;

2. The full cost of the physicians' deductible and co-payment amounts of part B of medicare;

3. Payments of amounts equivalent to parts A and B of medicare for services rendered outside the United States;

4. Hospital outpatient treatment for accidents and medical emergencies; and

5. X-ray and other diagnostic tests in the hospital's outpatient department and in the doctor's office.

**42-62-11. DUTIES OF PROVIDERS OF HEALTH SERVICES.—**

(a) Persons and other entities providing health services in the state have a duty to provide those services to any person in need of health services without regard to the person's race, sex, religion, age, or occupational status.

(b) On the basis of the duties required by this act and on the basis of existing legal requirements, the director of the department of health shall provide by regulations promulgated hereunder for the certification of providers and vendors of health services. Such persons or entities found to be not meeting the duty prescribed by subsection (a) may after a hearing, be denied by the director of health certification required for eligibility for reimbursements by insurers, for periods of not more than one (1) year for each determination.

**ARTICLE II**

**Minimum Standards Protection**

**42-62-12. MINIMUM STANDARDS.—**

(a) It shall be the duty of all corporations or other legal entities providing for payment for health services under any contract entered into with an employer, person, state or a political subdivision thereof, pursuant to the requirements of this chapter to comply with

minimum standards established by regulations promulgated by the director of business regulation. The director of business regulation shall promulgate such regulations within one year of the effective date hereof.

(b) Such minimum standards shall be designed to carry out the following purposes:

(i) The reasonable standardization and simplification of coverages to facilitate consumer understanding and comparisons;

(ii) The elimination of provisions which may be misleading or unreasonably confusing to the consumer in connection with the purchase of such coverages or with the settlement of claims;

(iii) The elimination of deceptive practices in connection with the sale of such coverages;

(iv) The elimination of provisions which may be contrary to the health needs of the public;

(v) The availability of qualified plans to persons residing in the state who apply therefor regardless of age, sex, race, occupational status or medical condition;

(vi) The promotion of efficient management of health services within the state;

(vii) The elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof;

(viii) The addition of coverages, the sale of which is required by the public interest to protect the health of persons residing in the state.

(c) Within sixty (60) days after promulgation of said minimum standard regulations by the director of business regulation, each insurer or other entity referred to in this section shall file with the director of business regulation a sample of each of said contracts which it proposes to use. A notice of a receipt of filing shall be delivered to the Rhode Island consumers' council. If requested by the Rhode Island consumers' council the director shall hold a hearing upon not less than ten days' written notice prior to said hearing. A notice of such hearing shall be sent to the filing party and to the Rhode Island consumers' council. The director shall issue a written decision as soon as is reasonably possible following completion of the hearing or at his review if there is no hearing. Said decisions may approve, disapprove or modify the contract offered by the filing party. Thereafter, all insurers or other entities referred to in this section 42-62-12 shall file any modifications of contracts which they propose to offer with the director of business regulation. The director shall thereupon follow the procedure prescribed by this section 42-62-12 (c).

42-62-13. RATES CHARGED.—The rates proposed to be charged or a rating formula proposed to be used by any insurer hereunder to employers, the state of Rhode Island or any political subdivision thereof or individuals shall be filed by such insurer at the office of the director of business regulation. Within thirty (30) days after receipt of such application, the director may hold a hearing upon not less than ten (10) days' written notice prior to the hearings. Said notice shall contain a description of the rates proposed to be charged and a copy of said notice shall be sent to the applicant and to the Rhode Island consumers' council.

At any hearing held hereunder, the applicant shall be required to establish that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public. Any documents presented in support of a filing of proposed rates hereunder shall be made available for public examination at such time and such place as the director may deem reasonable. The director upon such hearing may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and shall have the power to subpoena witnesses, compel their attendance and require the production of all books, papers, records, correspondence, or other documents which he deems relevant. The director shall issue a decision as soon as is reasonably possible following completion of the hearing. Said decision may approve, disapprove or modify the rates proposed to be charged by the applicant. Insurers requesting changes in rates shall underwrite the reasonable expenses of the department of business regulation in connection with the aforesaid hearing including any costs related to advertisements, stenographic reporting, and expert witnesses fees.

**42-62-14. DUTIES OF REIMBURSEMENT AND SALE.—**

(a) It shall be the duty of insurers: (i) to offer to any person regardless of age, sex, race, occupational status or of physical condition any plan of health benefits it offers to other individual persons, and to offer to any employer regardless of age, sex, race, occupational status, physical condition, and number of persons employed, any plan of health benefits it offers to other employers; (ii) to promote efficient management; and (iii) to reimburse only vendors of

health services certified by the director of the department of health.

(b) It shall be the duty of vendors of eligible health services to provide those services to insurers and other persons at costs, charges, or rates which are equitable, non-discriminatory and in the public interest. In the event that the director of the department of business regulation shall determine that a vendor is discriminating unlawfully against any insurer with respect to costs, charges or rates, the director shall advise said vendor in writing to cease such discriminatory practices forthwith.

(c) At any hearing conducted pursuant to section 42-62-13, the director of the department of business regulation may disallow any payments made by an insurer to a vendor not certified by the department of health, or to a vendor which has failed to cease discriminatory practices against any insurer after having received a notice from the director of business regulation pursuant to section 42-62-14.

#### 42-62-15. FACILITY REINSURANCE POOL.—

(a) To be eligible to offer plans meeting minimum standards, insurers which are for profit entities or self insurers may enter an agreement to form a facility reinsurance pool within which losses are shared among the insurers on an annual basis in proportion to the number of persons insured pursuant to articles I and II of this chapter.

(b) Such agreements shall not be effective until approved by the director of the department of business regulation as being in the public interest and in con-

formance with regulations issued by the department of business regulation.

(c) If, after a sixty (60) day notice to all such insurers and after a public hearing, the director of the department of business regulation makes a finding that there is lack of fair competition among such insurers or that the public interest is not being served by existing agreements, or by a lack of an agreement, he may require such insurers as a condition of doing business within the state to participate in such facility reinsurance pool established under regulations issued pursuant to this chapter.

### ARTICLE III

#### Health Resources Development Fund

#### 42-62-16. HEALTH RESOURCES DEVELOPMENT FUND.—

(a) There is hereby established in the department of health the health resources development fund to be administered by the director of the department of health pursuant to the terms and for the purposes stated in section 42-62-16 and 42-62-17.

(b) Monies in such fund or for a project authorized pursuant to section 42-62-17 may be expended by contract, loan or grant, to maintain, to expand, and to improve health facilities, health services, and health education in the state of Rhode Island. Such purposes shall include the following: Construction or modernization of health facilities, the education or training of persons who would be qualified to provide professional health services, meeting the start-up costs of new forms of health delivery systems, such as health maintenance organizations, benefits for persons lacking adequate

insured coverage, and the development and implementation of experiments in lower costs or to improve the quality, availability, and accessibility of health services.

(c) Monies provided by loan shall be disbursed for periods not exceeding twenty-five (25) years and at an annual rate of interest not exceeding five percent (5%).

(d) Monies may be made available for scholarships to schools of medicine or dentistry on the condition that for each year of educational cost provided by the fund the recipient is required to serve as an employee of the department of health or the department of mental health, retardation, and hospitals for a period of two years.

(e) Monies disbursed from the fund or for projects authorized by section 42-62-17 shall be for purposes in conformance with state plans for comprehensive health, health services, manpower, and land use, as approved by the governor.

(f) The director of the department of health in consultation with the appropriate departmental advisory councils shall establish criteria for eligible capital projects and eligible education and training projects which are consistent with the comprehensive health, manpower and land use plans approved by the governor.

#### 42-62-17. AUTHORIZATIONS.—

(a) The director of health is authorized to expend from the health resources development fund such monies as may be appropriated by the general assembly or

received from insurers or other entities for the purposes of section 42-62-16.

(b) Notwithstanding any provision of their articles of incorporation, by-laws, or other enabling documents or laws to the contrary, an insurer is hereby authorized to allocate sums of money, derived from the collections of premiums, to the health resources development fund.

(c) Notwithstanding any provision of their articles of incorporation, by-laws, or other enabling documents or law to the contrary, an insurer is further authorized to expend on an annual basis a sum of monies equal to not more than five (5) percentum of its previous year's premium income for a project approved by the director of health, with the concurrence of the director of business regulation. The director of health is authorized to approve projects which are in conformance with purposes of section 42-62-16 and with the criteria further established pursuant to 42-62-16.

#### ARTICLE IV

##### ADMINISTRATION

##### 42-62-18. DESIGNATION OF RESPONSIBILITIES.—

(a) The director of the department of health shall have responsibility for the implementation of the duty of the state established pursuant to sections 42-62-6 and 42-62-7. The director is authorized to enter into contracts with insurers to carry out the duties of the state established by said sections. The director is further authorized to establish by regulation procedures for the collection of benefits to which a person becomes entitled pursuant to said sections, time for

filing claims, review of claims, and such other procedural matters as may be necessary to carry out the purposes of said sections.

(b) To the extent not otherwise designated in this chapter, the governor may designate a department as having responsibility for the implementation of a specific duty required by this chapter. The governor shall report such designation to the general assembly no later than the following year, and each house of the general assembly shall have thirty (30) days within which to disapprove any of the designated delegations and to substitute by passage of new legislation different delegations.

(c) To the extent that existing health related functions within departments or divisions need to be removed to another department for the purposes of more efficient administration, or to the extent that new divisions need to be established to meet the purposes of this chapter, the governor shall make such determinations shall include such determinations within his report to the general assembly.

42-62-19. IMPLEMENTATION OF CHAPTER.— The governor may delay the implementation of any provision of this chapter for one year after he makes a finding to be reported to the first subsequent session of the general assembly that such a section(s) of this chapter has been found to be unconstitutional or has been superseded or modified by an act of the United States.

42-62-20. INTERSTATE AGREEMENTS. — The governor is authorized to enter into agreements with

appropriate officials of a sister state or of the United States to carry out any of the duties of this chapter.

**42-62-21. HEALTH COST REPORT.**—The governor shall provide for a health cost to be made not later than December 31 to the general assembly on legislative and administrative steps required (i) to provide a more comprehensive protection against the costs of health services their provided pursuant to this chapter to persons without health insurance, (ii) to control the rising cost of health services, (iii) to provide for more efficient administration of health services by the state, (iv) to establish more efficient and uniform rate setting processes for the state's purchase of health services and goods, (v) to reduce out-of-pocket costs of health services to persons residing in the state, (vi) to establish a uniform reporting system for vendors for the costs of health services, and (vii) to respond to other changes in health finance, planning, and regulation that may be required in Rhode Island in the event of the passage of a national health insurance act.

(b) Such report shall be made in consultation with the budget officer, the director of the department of health, the directors of the departments of mental health, retardation, and hospitals, social and rehabilitative services, and of business regulation, and the executive director of the consumers' council, and with representatives of insurers, of the Rhode Island Medical Society, of the Hospital Association of Rhode Island of employers' organizations and of employees' organizations.

42-62-22. ANNUAL REPORT ON THE HEALTH CONDITION OF THE STATE AND HEALTH EXPENDITURES.—The director of the department of health shall make an annual report to the governor and the members of the general assembly not later than January 30 of each year outlining in specific detail the health conditions of the people of the state, the level of health services available to the people of the state, the amount of funds spent in the previous year by public and private agencies and consumers for health services, and unmet health needs of the people of the state, the amounts of monies disbursement for the entitlements established under this act, and the amounts of monies which may be needed according to actuarial estimates to meet those entitlements in the following two years.

Sec. 2. Unless otherwise specified herein, this act shall take effect on January 1, 1975.

A true copy,

Attest:



*Robert V. F. Burns*

Secretary of State

THE FOLLOWING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU, ALASKA 99811  
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

February 17, 1978

MEMORANDUM

SUBJECT: Comprehensive Health Insurance Legislation

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley  
Research Analyst 

Attached you will find the completed report on health care coverage in Alaska. This report is intended to outline for you the possible state approaches to comprehensive health coverage. It was conceived as a necessary step toward developing legislation on the subject of comprehensive health care for Alaska, as you requested last May.

This is the final report and contains the firmest cost estimates available at this time. Please destroy the draft copy I released to you earlier, as the figures the draft contains are less reliable and differ substantially.

Please indicate your wishes for the future handling of this report on the attached release form.

Attachments  
SH:dh

TO: The Honorable Thelma Buchholdt

FROM: Gregg K. Erickson  
Director of Research

Please indicate your directions concerning future handling of the attached information, which you requested under W0# 4206 (Subject: Health Care Assistance).

- I approved the release of this information to any requesting party.
- I do not approve the release of this information; maintain confidentiality
- I approve the release of this information under the following conditions:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

THIRD PARTY HEALTH COVERAGE IN ALASKA

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## SUMMARY

With the costs of health care continuing to rise, third party health coverage is becoming increasingly crucial for the protection of people's health and financial security. A variety of state and federal health programs and private health insurance policies provide piecemeal third party coverage for Alaska's civilian population. It is estimated that 20 to 25 percent of Alaska's non-Native, non-military-dependent civilian population are without third party health coverage of any kind. The comprehensiveness of coverage or level of coverage provided the covered population is not known; in some cases the coverage may be inadequate to protect people from financial hardship or inappropriate levels of medical care. There are a variety of approaches the legislature may consider to improve or extend third party health coverage in Alaska. These options include: state subsidized health insurance, state mandated employer subsidized health insurance, state regulation of health insurance carriers, and expansion of the state's Medicaid program. While plugging these coverage gaps would not cure all the ills of the health care system, it would be a step.

## I. INTRODUCTION

With the dramatic increases in health care costs in the last decade or two, routine medical care has become for many an unaffordable luxury. A serious illness or accident for them would be a financial catastrophe. More and more people are relying on health insurance and other kinds of third party health coverage to finance the major part of their unpredictable health expenses. To an ever growing extent people are demanding third party coverage for routine health expenses as well. Third party health coverage has become an integral and crucial part of the health care system.

Because public and private third party payers foot the bill for two-thirds of the nation's personal health care expenditures, their policies profoundly affect the nature and terms of the health care itself. For example, many insurance policies will pay for hospital care, but not nursing care; so patients are hospitalized in many cases where nursing care would be sufficient, and less costly. Similarly, many people will not see a doctor until health conditions become acute, because preventive care is not customarily covered. The policies of third party payers also affect providers in terms of the rates they charge, the quality of care they provide, and the services they can afford to develop.

As third party health financing becomes paramount to ensure financial access to health care, the gaps in third party coverage become more glaring. The following chapters of this report address themselves to

these gaps in third party coverage. Sections II and III describe all the major public programs and private plans which currently provide third party health coverage in Alaska. Section IV analyzes available data on the extent of existing coverage and identifies some of the gaps both in terms of the covered population and services covered. Section V outlines a smorgasbord of legislative remedies to plug some of these gaps. The concluding chapter indicates other areas which may be of concern to the legislature.

## II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

As this report is concerned primarily with comprehensive health care, only the public programs which cover a broad range of health services and serve a significant portion of the population are described here. There are a number of programs which cover only specific health services, such as family planning or treatment of occupational injuries, or serve only a narrowly defined segment of the population, such as crippled children, which are not described here.

### Alaska Area Native Health Service

The Alaska Area Native Health Service (AANHS) is a regional administrative unit of the Indian Health Service, which is a branch of the U. S. Public Health Service. It serves an estimated 65,000 eligible Alaska Natives, spouses, and dependents.

Primary care is provided in villages by 216 community health aides, each selected by the village council and paid under contract with AANHS. These aides are responsible for giving first aid in emergencies, examining the ill, reporting their symptoms to the physician, carrying out the treatment recommended, instructing the family in giving nursing care, and conducting on-going health education in the villages. Routine primary care is also delivered in the villages by itinerant doctors, nurses, dentists, and other health professionals.

If the injury or illness is serious enough to require inpatient care or more specialized diagnosis and treatment, the patient is referred to the nearest of the seven field hospitals. This secondary level of

care includes routine hospital admissions for common illnesses or injuries, for minor surgical conditions, or for pregnancy. The field hospital staff also provides primary care for their immediate community.

Serious or life-threatening illnesses or injuries are referred to Alaska Native Medical Center in Anchorage for treatment under the immediate direction of a specialist. Major surgery and complex diagnostic procedures are performed at the Medical Center. The Alaska Native Medical Center also provides primary health care for the Anchorage area AANHS eligibles and secondary health care for the Anchorage Service Unit.

In areas where direct health care by AANHS is not available, or for services which AANHS is unable to provide, health care is purchased under contract from private physicians, dentists, optometrists, hospitals, and pharmacies by AANHS on behalf of Native patients. Highly specialized treatments, such as heart surgery or kidney transplants, are referred out-of-state. In areas of the state where private health services exist, contractual care is an important component of the AANHS delivery system.

Despite the comprehensive design, there are gaps in this delivery system. Budgeted funds for contractual services are limited, and frequently become depleted long before the next allocation. If it is not an emergency condition, the patient must wait, or else pay for the treatment himself. If it is an emergency condition, transportation is usually arranged to another delivery point.

### U. S. Public Health Service

The Bureau of Medical Services, a division of the U. S. Public Health Service akin to Indian Health Services, provides direct comprehensive health care for the Coast Guard and merchant seamen, and provides occupational health care and safety services for all federal employees. Federal health care responsibility for seamen derives from a 1798 act of Congress providing for the "relief of sick and disabled seamen".

In Alaska this care is delivered by the Alaska Area Native Health Service under contract with the BMS. In addition to an estimated 24,000 Coast Guard personnel and dependents, and bonafide merchant seamen, many fishermen are eligible for Public Health Services. Fishermen and other boaters qualify if they are owners or principal operators of a documented vessel. A documented vessel is a seaworthy power boat registered with the Coast Guard which could be utilized by the Coast Guard in case of a national emergency. There are an estimated 3,750 documented vessels in Alaska, including fishing boats and pleasure boats. There may be more than one principal operator of a boat. Dependents are not covered.

### Uniformed Services Health Benefits Program

The military provides comprehensive health care to enlisted personnel through military medical facilities and staff. They also provide comprehensive health care to retirees and military dependents through the Uniformed Services Health Benefits Program (USHBP). USHBP provides health services to military dependents in two ways: through military medical facilities and staff on a space-available basis, and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) when necessary medical services are not available through

military facilities. CHAMPUS is a supplementary health insurance plan purchased from a private carrier. CHAMPUS will reimburse 75 - 80 percent of allowable charges for necessary medical care. A \$50 deductible is also collected on outpatient services. The CHAMPUS carrier in 1975 estimated that 55,000 dependents and retirees were covered in Alaska.

### Medicare

Medicare is a federal health insurance program for people 65 and over, and certain disabled people under 65. It is financed by a combination of employee contributions, employer contributions, monthly premiums and federal funds, and is administered by the Social Security Administration.

Part A of Medicare is hospital insurance which is provided at no premium charge to those who have worked long enough under social security, and provided to others over 65 for a monthly premium of \$54. Medicare Part A only helps pay for medically necessary covered services up to a specified number of inpatient days or home health visits. The Medicare patient must pay a deductible and a scheduled percentage of the covered costs, as well as the costs of uncovered services and services beyond the limits of Medicare coverage. The Part A hospital insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility when it is medically necessary following a hospital stay, and certain prescribed services from a home health agency following a hospital stay. Medicare does not pay for custodial or long-term care.

Part B of Medicare is medical insurance. Anyone eligible for Part A hospital insurance is eligible for Part B medical insurance at a monthly premium of \$7.70. Medicare medical insurance can help pay for doctors' services, outpatient hospital care, outpatient physical therapy

and speech pathology, and many other health services and supplies which are not covered by Part A hospital insurance. The medical insurance enrollee must pay the first \$60 worth of covered services each year. After that the medical insurance pays 80 percent of "reasonable charges" for covered services and supplies. "Reasonable charges" are computed each year by Aetna (the Medicare carrier in Alaska) based on billings the previous year. The actual charges by the provider may exceed the "reasonable charges" covered by Medicare, and the patient must pay the difference, as well as paying the uncovered 20 percent of the "reasonable charges". Among the services not covered by Part B medical insurance are: routine physical exams, prescription drugs, eye glasses, hearing aids, dentures, dental care, and chiropractic services.

Though people over 65 must have accumulated sufficient work under the social security system to automatically be eligible for hospital insurance, the 1966 law "grandfathered in" all the social security ineligible at that time. It is estimated that now 99 percent of the non-Native population in Alaska over 65 are enrolled in Medicare.

#### Medicaid

Medicaid is a medical assistance program funded jointly by the state and federal governments. In Alaska it is open to public assistance clients and eligibles, and certain other needy people in nursing homes, or inpatient psychiatric hospitals. Medicaid clients receive care from participating private providers, who then bill the Medicaid program. Alaska's Medicaid program covers all the federally mandated services: inpatient and outpatient hospital services, physicians services, x-ray and lab services, skilled nursing home services, home health

services, family planning services, transportation, and early and periodic screening, diagnosis and treatment (EPSDT) for eligible people under the age of 21. In addition, the state program covers a few optional services: inpatient psychiatric care for those over 65 or under 22, intermediate nursing home care, eye glasses, treatment for speech, hearing and language disorders, and approved outpatient mental health care. The state Medicaid program does not cover the following services for which federal match is available: prescription drugs, dental care or dentures for those over 21, prosthetic devices for those over 21, physical therapy, chiropractor's services, or preventive care for those over 21.

In FY 1976, 22,952 Alaskans, or 5 percent of the civilian population, were enrolled in the categorical public assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children, and Supplemental Security Income) and eligible for Medicaid.

To be eligible for public assistance, and therefore Medicaid, a person must not only meet income criteria, but categorical criteria of need, such as over 65, blindness, mental or physical disability, under 18 and deprived of the care of one or both parents, or a person related to and caring for eligible dependent children. Many Alaskans, such as low income families with both parents present, meet the income criteria for public assistance but do not meet the categorical criteria, and are therefore not eligible for Medicaid.

Because Natives receive much of their medical care from the U. S. Public Health Service, Native eligibles account for only one-third of Medicaid expenditures even though nearly two-thirds of the Medicaid

eligibles are Native. This may change with the implementation of the Indian Health Care Improvement Act of 1976. This federal law requires that medical care provided to Native Medicaid eligibles by the U. S. Public Health Service be billed to the state Medicaid program, with the state receiving 100 percent reimbursement from the federal government for Medicaid expenditures in behalf of Natives. This new billing procedure has not yet been implemented in Alaska.

#### General Relief Medical

The state-funded General Relief Medical program covers needy people and services not covered under Medicaid, as funding permits. People who meet the income criteria for Medicaid but do not meet the program criteria and have no prior health resource (such as Indian Health or health insurance) are eligible for all General Relief Medical covered services. Any Medicaid eligible is also eligible for those General Relief Medical services not covered under Medicaid. The GRM program covers the same services as Medicaid (inpatient and outpatient hospital care, physicians services, x-ray and laboratory services, nursing home care, home health care, mental health care, eyeglasses, treatment for speech, hearing, and language disorders, and transportation) plus many more not covered by Medicaid, such as drugs, physical therapy, prosthetic devices, hearing aids, chiropractors, podiatrists, emergency dental care, wheelchairs and other equipment. Nearly all services except hospital and physician care must be pre-authorized by the state program administration, and most services are subject to strict limitations. Medically justified services will be refused when funds are not available. The budget is established by the legislature.

The General Relief Medical program ensures that all Alaskans under the income limits for public assistance have some health care resource. For a single adult paying over \$35 rent per month, that income limit is \$334 per month; for a couple it is \$490. For a family the formula is based on adjusted net income; the first \$30 of earned income, one-third of every dollar of earned income after that, and reasonable work-related expenses are deducted from the net income to maintain an incentive for cash assistance recipients to work. Therefore, there is no simple dollar figure for General Relief Medical eligibility for a family. While the estimated 22,950\* Alaskans below the federal poverty level might meet the income criteria for General Relief Medical, it should be noted that many of these are Alaska Natives or Medicaid eligibles, and so have a prior health resource. In FY 77, \$3.7 million was expended in the GRM program, and \$4 million was budgeted for FY 78.

#### Catastrophic Illness Program

The state Catastrophic Illness Committee administers a program that provides financial aid for persons of all income levels who have suffered a catastrophic illness--an illness that incurs high medical expenses. Total medical bills related to the illness must exceed \$1000 in a 12 month period after all sources of third party payment, such as state and federal medical assistance programs, private and military health insurance, and awards in legal actions, have been exhausted. The Committee

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\* U. S. Department of Commerce, 1976 Survey of Income and Education Preliminary Results.

meets twice a month to determine the eligibility of applicants and the amount of medical assistance to be awarded, using a formula based on annual income, number of dependents, amount of assets, and the assumption that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

In its second year of operation, the program has granted aid to over 80 persons with the number of applicants steadily increasing as the program becomes better known. The largest portion of applicants are those in lower income brackets who do not qualify for other forms of aid. While applicants would have to be refused aid if funds were depleted, it is anticipated that the \$450,000 appropriation for FY 78 will be adequate to meet this year's needs.

### III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

#### Private Health Insurance

Health insurance pays benefits on an indemnity basis. When covered health expenses are incurred, the subscriber submits a claim to the insurance carrier. Benefits are normally paid to the subscriber. Normally, benefits are calculated on the basis of "reasonable charges" for each service or a schedule of maximum fees, rather than actual charges, and the subscriber must pay the difference if actual charges are higher.

Hospital expense coverage is the core of health insurance, because hospital care is the largest single medical expense. Hospital costs have risen faster in the last ten years than any other item in the consumer price index, and they continue to rise. Similarly, surgery has become a highly technological and expensive component of medical care, and the expansion of surgical expense coverage has followed closely the expansion of hospital expense coverage. Regular medical expense coverage is the third component of what is known as "Basic Protection", and covers physicians' services, and other medical services such as x-rays and lab tests. Basic protection policies are designed to cover one or more of these key medical services and the bulk of unpredictable medical expenses. Basic protection policies typically have limits on the number of days, dollars or visits covered, as well as a schedule of maximum benefits for services.

Major medical is the other main category of health insurance, and is designed to protect the subscriber from very large, unpredictable

medical expenses. It covers virtually any kind of health care prescribed by a physician. The maximum benefits under major medical is characteristically high, and the subscriber is typically required to pay a deductible and co-insurance as a disincentive for unnecessary utilization of medical care. Major medical insurance can either be designed to supplement a basic protection policy, or to incorporate basic protection and provide comprehensive coverage.

### Blue Cross

Blue Cross is not an insurance company, but a hospital/medical service corporation, along with Fairbanks Physicians' Service and Delta Dental. As well as being non-profit, a hospital/medical service corporation differs from an insurance company in that it contracts with health care providers to deliver services to subscribers. The providers bill the corporation directly for the services provided, according to a fee schedule established in the contract. The subscribers pay a flat monthly premium for the coverage.

Blue Cross is specifically a hospital service corporation and maintains contracts with all the general hospitals in the state (not military or PHS hospitals). Fairbanks Physicians' Service is a medical service corporation and contracts with local physicians for services. Delta Dental is a dental service corporation and contracts with local dentists.

Blue Cross, however, covers more than just hospital expenses. Blue Cross provides major medical coverage, and subscribers are required to pay deductibles and co-payments, just like an insurance policy. Covered

expenditures delivered by providers not under contract with the service corporation are handled like insurance claims, on an indemnity basis. Benefits are based on "reasonable charges" and the subscribers must pay the difference if actual charges exceed "reasonable charges".

Pre-paid hospital/medical service plans are typically less expensive than health insurance through private carriers for several reasons: 1) they are non profit corporations, and any money in excess of their benefit payments and operating expenses usually goes toward equipment purchases for participating providers; 2) through their contracts with providers they are able to exert some cost and quality control pressure on providers, however, the effectiveness of this is mitigated by the extensive use of cost-plus contracts; and 3) though they do advertise, they do not deal through insurance agents and do not pay commissions. The end result is that an estimated 90 percent of subscriber premiums to an established hospital medical service plan are paid out in benefits, while only 50 to 80 percent of subscriber premiums to a private insurance carrier are paid out in benefits.\*

#### Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a full range of health care services to enrollees either directly through plan-owned facilities and plan-employed providers, or by contract with private facilities and providers. Enrollees pay a flat monthly rate for compre-

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\* Source: Don Koch, Alaska Department of Commerce and Economic Development, Division of Insurance.

hensive health care, with no deductibles or co-payments. HMOs have proven to be the most cost effective form of comprehensive health care services, because they are the only form of health care delivery which has built-in cost controls and an orientation toward preventive health care. HMOs have demonstrated significantly lower hospital utilization rates than any other kind of health care plan. Hospitalization continues to be the largest and fastest growing component of health care expenses nationwide.

The federal government has taken a great deal of interest in HMOs. There is a federal loan program for planning and establishing qualified HMOs, there is a federal law requiring large employers in HMO service areas to offer HMO coverage as an alternative to health insurance benefits, and DHEW is currently organizing a conference of labor and industry leaders to promote the HMO concept.

Alaska has one HMO in the planning stage, the Greater Anchorage Health Plan.

#### Teamsters

In most union health plans, employer contributions for health benefits are paid into a trust fund, and the trustees of the fund purchase group insurance for eligible union members. The Alaska Teamster-Employer Welfare Trust is unlike other union health trusts in that it is a self-insurer. In other words, the Teamster trustees do not purchase health coverage from a private health insurance carrier; they are their own carrier, and pay health insurance benefits to qualifying Teamsters directly from their own trust fund. In addition to a health insurance plan, the Alaska Teamster-Employer Welfare Trust offers an alternate

HMO-type plan called the Alaska Health Plan. The Alaska Health Plan is not officially an HMO under federal law because it does not offer open enrollment and does not provide the full range of services required of a qualified HMO. However, its operation is similar to an HMO. The Alaska Health Plan contracts with the Alaska Clinic and the Alaska Hospital and Medical Center to provide preventive, curative, and rehabilitative health services to plan members. The relationship between the Teamsters and the Alaska Hospital is more than just contractual, however, as Teamsters financed the hospital and serve on the board. The Teamster Alaska Dental Plan is also on an HMO model, but it differs from the health plan in that the Alaska Dental Clinic is directly owned and the dentists are directly employed by the Teamsters.

There are an estimated 28,000 Teamsters Local 959 members in Alaska, though they are not all eligible for health benefits. Eligibility is determined by the number of hours worked, and with the high post-pipeline unemployment, some Teamsters have exhausted their health benefits.

#### IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

##### The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

## Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.<sup>1</sup>

<sup>1</sup> "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

## V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

There are several measures which have been conceived to fill some of the gaps in health care coverage. Maine, Connecticut, Rhode Island, Minnesota, and Alaska have all enacted some form of state assistance for catastrophic illnesses. Connecticut and Minnesota have also made some cautious steps toward more comprehensive coverage with legislation that regulates health insurance carriers, mandating minimum benefit standards, controlling premium rates, and mandating pooled coverage for high risk subscribers. Hawaii has taken the boldest step toward expanding health coverage by mandating that all employers subsidize health coverage for their employees. These states are pioneers. Their state health insurance programs are new, and are being watched with interest by other states.

No state has instituted a universal or a state subsidized comprehensive health insurance program. While universal coverage is the goal for proponents of government sponsored health coverage, no one has been able to develop an acceptable scheme of financing universal coverage, either at the state or national level. If universal coverage is not yet a viable option for states, we are left with a patchwork approach to health coverage, covering only the holes we can reach. The following is an inventory of some of the "patches" available to state legislatures, in order of decreasing cost to the state.

### Universal Coverage

Uniform and universal coverage for all residents is the fairest and most expensive approach to state sponsored health insurance. If group coverage comparable to the plan for state employees was purchased by the state for all state residents without federal health coverage, it would cost about 87 million dollars. Such broad coverage is certainly unnecessary because it duplicates and discourages coverage from other sources. It could also cause a substantial migration of people seeking free health coverage into Alaska. No state has tried such a plan.

### Coverage for the Uncovered

State sponsored health insurance for all residents without coverage from other sources would avoid the problem of duplicating coverage, but it would still discourage private coverage and cause in-migration. Groups and individuals would drop their private coverage because they know the state would pick them up. In the long run, the program would approach universal coverage. Using estimates of the currently uncovered population, the cost for such state purchased coverage could be anywhere from \$27 million to \$40 million dollars in 1977. No state has tried such a plan.

### Coverage for Non-Wage Earners and the Marginally Employed

State sponsored health insurance for defined groups of people who have no practical access to private health care coverage is the most limited approach to state sponsored health insurance. Under this ap-

proach state subsidies could be targeted for those who need them most. The main target groups to be considered would be the unemployed, part time, employed, and the low income self-employed--people without access to group coverage, or the financial resources to pay for private insurance. This plan avoids some of the problems of the broader coverage as discussed above, because it is not likely that significant numbers of people would leave their jobs to get state subsidized health insurance, nor is it likely the unemployed people from out-of-state could afford to move to Alaska just to get coverage. This approach would dovetail well with mandatory employer coverage as discussed later.

The cost to the state of subsidizing health care premiums for these groups would be substantial, but it could be contained in at least two dimensions: the eligible population could be limited by definition, and the state's rate of subsidy could be set at any desired level. To discourage in-migration, the state subsidy could vary according to length of residency, with first year residents getting little or no subsidy, and long term residents getting a more substantial subsidy. Or the state subsidies could vary according to the income of the subscriber with a higher subsidy for low income people and a lower subsidy for higher income people.

A sliding scale of premium subsidization would provide a continuum of access to health care insurance up and down the income scale, avoiding the injustices of an arbitrary threshold. However, it would also require an extensive investigation into each subscriber's income to determine which rate they are eligible for, much like the eligibility determination for welfare. Eligibility would constitute the largest administrative task under this plan.

The total premium costs for group coverage for the unemployed, self-employed and the non-labor force population without coverage from public sources would be an estimated \$25 million. If the state opted for less than 100% subsidization, some members of the target groups would not enroll. The resulting savings to the state would not be as large as one might expect, however, because with any voluntary plan in which subscribers bear some costs, the premiums would be higher than with a universal plan. This is due to the fact that subscribers would be self selecting toward higher use of medical care. In other words, people who do not expect to use much medical care would be less likely to purchase the insurance, while people who expect high medical expenses would be very likely to purchase the insurance. Also, many low income people who have immediate needs and expenses are less likely to purchase insurance, because the benefits of medical insurance are deferred and uncertain. Low enrollment on the whole would save the state money, but it would also contradict the purpose of state subsidized health insurance, namely to make health care available to more people. No state has ever instituted a direct health insurance subsidy program.

#### Income Tax Credit

A state income tax credit for health insurance would be an indirect way for the state to subsidize health insurance, and avoids many of the administrative problems associated with direct subsidy programs. The Alaska tax forms would provide a line for the taxpayer to enter the appropriate credit against their Alaska state taxes. The credit would be equally available to all state residents filing income tax returns,

including employers. Yet at the same time, if it were a fixed dollar amount, it would be a relatively greater benefit to low income people than to higher income people. If a fixed dollar tax credit were offered, the state would probably want to require evidence that the health insurance purchased meets minimum state standards. This would ensure that state dollars would subsidize only health coverage of acceptable quality, and no one could collect the credit for just token coverage costing less than the credited amount.

If the credit were computed as a percentage of the premium cost, with an upper limit provided, no minimum benefit level would need to be established, because the state would be contributing only a token amount to token coverage, and a more substantial amount to more substantial coverage.

This alternative would not reach low income people who do not file tax returns, nor those who cannot afford even a percentage of the premiums for health insurance. It would be extremely difficult to estimate how many people would respond to such an incentive program. A higher credit could predictably get more response. The current state employee health plan has an annual premium well over \$800. If an \$800 tax credit were offered currently covered taxpayers, the initial costs would be an estimated \$68 million, and would rise as more people responded to the incentive. If a \$250 credit were offered, the initial cost to the state would be around \$21 million.

### Medicaid Medically Needy Program

"Medically needy" is an optional Medicaid program with federal matching dollars. Currently Medicaid provides medical care to anyone eligible for public assistance grants under categorical programs: Aid to families with Dependent Children, Old Age Assistance, Aid to the Blind, and Aid to the Disabled. These public assistance programs have program criteria (blindness, age, disability, dependent children) as well as income criteria for eligibility. There are many Alaskans who meet these categorical criteria, but have incomes a few dollars above the income threshold for public assistance eligibility. These Alaskans are able to meet their daily living expenses out of their own incomes, but medical expenses put a severe strain on their budgets, and often deplete their resources to the point that they must again resort to public assistance grants and Medicaid.

Under the medically needy option, people who meet program criteria but have incomes within a limited range above the income threshold for public assistance grants, are also eligible for Medicaid. Twenty nine states, two territories, and the District of Columbia currently participate in the medically needy option. Medically needy includes a "spend down" provision. This means that people categorically eligible but financially ineligible can become eligible for medical assistance if their income above the medically needy threshold is spent on medical bills. The difference between the person's income and the medically needy threshold is essentially an income-related deductible which must be met to be eligible for Medicaid. The medically needy program and the spend down provision soften the line between people eligible for both

public assistance grants and Medicaid, and those ineligible for either due to a few dollars more income. It also serves as an emergency medical resource for low income people with categorical eligibility who cannot afford adequate health insurance.

Originally, the Alaska Medicaid program was limited to the federally mandated target groups and benefits. The primary reason for this was that 65% of Medicaid eligibles have another medical resource--the Alaska Native Health Service--which is 100% federally funded. Medicaid is funded jointly by the state and federal governments. The state has kept its 100% state funded General Relief-Medical program which can pay for medically necessary services not provided by Medicaid, or ANHS, subject to state administrative controls.

Since the Indian Healthcare Improvement Act of 1976, the federal government must reimburse the State for Medicaid expenditures on behalf of Natives. This act has not yet been implemented in Alaska, but when it is implemented, it will significantly reduce the fiscal liability of the State for Medicaid. A program expansion such as Medically needy would then become much more feasible. Some of the medical assistance now provided under the state's General Relief-Medical program could be paid for jointly by the state and federal governments under the Medicaid medically needy program. HEW Region X estimated that, based on Washington State experience, a medically needy program would expand the current Medicaid budget by 10-13%.

Unlike other Medicaid eligibles, for "spend downers" (those who must spend their excess income on medical bills to become eligible for Medicaid under the medically needy option) there is a dual liability for

medical bills - the person is responsible for medical bills until the deductible is met, then Medicaid takes over. This dual liability causes administrative problems. It is difficult to determine exactly when the deductible has been met and when eligibility commenced, which bills the patient is liable for, and which Medicaid is liable for. The only states that have developed an efficient system of administering the spend down program are out of compliance with federal regulations.

#### Mandatory Employer Coverage

Of the various approaches open to the Legislature for extending health care coverage, the program with the least impact on the state budget for the greatest increase in coverage would be mandating employer sponsored coverage available to all employees. Such legislation would stipulate minimum benefit standards for employee group plans and would set minimum rates for employer contributions to the premium costs. To make such a program more palatable the legislation could also provide that the state subsidize premiums when necessary in small, marginal businesses.

Hawaii for example requires that employers pay at least 50% of the premium. Employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, are entitled to state subsidies in the amount that the excess over 1.5% of the payroll exceeds 5% of the employers income from the business. Though several employers applied for state subsidies under the Hawaii legislation, none were found to be eligible according to these criteria.

Mandating employer coverage however has potential side effects. Mandatory group health plans would be similar to raising the minimum wage - it would be more expensive for employers to employ people, so fewer people would be hired. Though the resulting unemployment would probably not be significant among skilled and experienced workers, teenage workers would certainly be hit hardest. On the positive side, mandating employer coverage would be most beneficial to women and minorities who often work in the non-union low paid jobs without fringe benefits such as health insurance.

#### High Risk Reinsurance Pools

Many people are unable to purchase full health insurance coverage because existing health conditions (a weak heart, chronic illness, etc.) make them a bad insurance risk. To fill this gap in health insurance availability, two states, Minnesota and Connecticut, have established mandatory carrier reinsurance pools. All health insurance carriers in each state are mandated to offer a health insurance package to high risk subscribers at a reasonable premium. Such coverage is reinsured by the carriers association, in which membership is mandatory, so that the risk is pooled among all carriers in the state.

Because premiums are limited to affordable levels, the high risk coverage does not necessarily pay for itself. Any deficit must either be absorbed by the insurance carriers, or by the state. Connecticut and Minnesota both have established such reinsurance pools with virtually no administrative or premium expenses for the state.

### Minimum Benefits Standards

Legislation establishing minimum standards for health benefits is a form of consumer protection. It is designed to insure that purchasers of state approved plans have the recommended range of coverage to protect them from financial hardship due to large medical expenses. The legislation can either mandate that all plans sold in the state meet minimum standards, or that all carriers offer a state qualified plan. Another variation is mandating that all employment related group health plans meet minimum benefit standards.

Such standard setting legislation would be an extension of existing state regulatory powers. The impact of such regulation on the state's major carriers would probably be minimal, but some small carriers may decide to drop their health insurance business rather than comply with such regulations. The more stringent regulation, setting minimum benefit standards for all health insurance plans, may also make it more difficult for low income people to afford health insurance, because low priced, low benefit insurance would be prohibited.

The Ninth Legislature considered minimum benefit legislation in their second session. House Bill 792 would have required that health insurance policies written in the state cover less costly alternatives to hospitalization, such as nursing care and home health care.

## VI. CONCLUSION

The possible legislative approaches outlined in this report are only partial. They are not solutions to the problems of the health care system in this country. The health care system has many other major problems not addressed in this report, such as: cost control, quality control, appropriate levels of care, unnecessary treatment, and access to providers. The remedies discussed in this report don't even resolve the issue that they address: that of financial access to health care. It is not likely that all these problems of the health care system can be resolved on a state by state level.

However, states can take significant steps in each of these areas, and in doing so contribute to the body of knowledge and experience on which a national solution may be built. The intent of this report is to provide the legislature with the information they need to consider whether or not state intervention to improve third party coverage in Alaska is desirable, and what, if any, the next step will be.

There are three general philosophies of state intervention in service delivery. One assumes that the private sector is capable of meeting the demand for services, and that the state need only subsidize the purchase of services to ensure the satisfactory delivery of services to the desired target group. The second assumes that additional state intervention is necessary, in the form of regulation to ensure quality or accountability, or centralized planning to ensure coordination of service delivery, or technical or financial assistance to aid the private provider, to ensure that the private sector will deliver services

to the desired target group to the satisfaction of the state. The third philosophy assumes that it is to the state's and the public's advantage, for whatever reason, to deliver the desired services directly.

The first four remedies discussed in this report, three levels of state sponsored coverage and the income tax credit, would subsidize consumers to purchase health coverage from private providers. They reflect the first philosophy, that the private sector is capable of satisfactorily meeting the expanded demand. The last four approaches, Medicaid medically needy, mandatory employer coverage, high risk pools, and benefits regulation, embody the second philosophy, that intervention on a policy level is required. The Catastrophic Illness Program, already enacted by the state, reflects the third philosophy of direct state service delivery. The state is directly providing a form of catastrophic health insurance to all state residents.

Any of these alternatives that significantly expand health care coverage would increase the demand for health care, and as a result, health care costs would tend to rise. It would therefore be prudent to accompany any legislation substantially expanding coverage with legislation instituting cost controls on the health care industry. Though cost control legislation is not within the scope of the analysis presented here, it also deserves consideration.

The alternatives discussed in this report are not exclusive or exhaustive. Many of the ideas can be re-combined with each other or with other ideas not explored in this report. State intervention in third party coverage is a subject for pioneering.

VII APPENDIX

<u>Program</u>	<u>Who It Would Cover</u>	<u>State Administrative Tasks</u>	<u>Estimated Annual Premium Costs To The State*</u>	<u>Other Payers</u>
Universal State sponsored coverage	All state residents without federal health coverage (267,500)	Verification of residency, enrollment, accounting, and financing	\$87 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
State sponsored coverage for the uncovered	All state residents not covered under other public or private plans and their dependents (56,000-71,000 estimated)	Eligibility determination, enrollment, accounting, and financing	\$27 - \$41 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
State sponsored coverage for non-wage earners without coverage from public sources	The unemployed, self-employed, and the non-labor force and their dependents (60,000 estimated)	Eligibility, determination, enrollment, accounting, and financing	\$25 million (if 100% subsidized)	Taxpayers (optional cost sharing with subscribers)
Income tax credit	All residents filing tax returns (124,000 estimated) and their dependents	Negligible	\$21 million (assuming a flat \$250 credit)	Taxpayers and subscribers
Medicaid medically needy program	Categorically needy with income above the public assistance level (1,580 estimated)	Eligibility determination, enrollment, accounting, and financing	\$1.1 - \$ 4 million (cost savings in GRM not included)	Federal government, federal taxpayers, and Alaska taxpayers
Mandatory employer coverage	All non-agricultural wage and salary employed people, and their dependents (200,000 estimated)	Regulation of Employers	\$0 (state cost sharing optional)	Employers and their clients (optional cost sharing with subscribers)
High risk reinsurance pool	People who are unable to obtain health insurance at a reasonable premium due to health conditions	Investigation on a complaint basis	\$0 (state cost sharing optional)	Subscribers, insurance companies and their clients
Health insurance regulation	Better coverage for current subscribers; possible decline in the number of low-income subscribers	Regulation of carriers	\$0	Subscribers (including employers and other sponsors)

These estimates are based on estimates of the current extent of coverage. Presumably alternatives 2, 3, & 4 would provide incentives for increasing health coverage, and therefore the state's premium costs would tend to rise over time.

Prepared by Legislative Affairs Agency Research Division 2/17/78

TABLE II ESTIMATED PREMIUM COSTS OF STATE-WIDE HEALTH COVERAGE  
WITH BENEFITS EQUIVALENT TO THE STATE EMPLOYEE HEALTH  
PLAN

Total FY '77 Civilian Population	398,000
U. S. Public Health Service Eligibles	( 70,000)
CHAMPUS Eligibles	( 55,000)
Medicaid Eligibles (excluding USPHS)	( <u>5,500</u> )
Eligible Population	267,500

	<u>19 and Under (32.5%)</u>	<u>Over 19 (67.5%)</u>
Number eligible	86,900	180,600
Premium Rate	<u>\$12.40</u>	<u>\$34.10</u>
Monthly Premium	\$1,078,000	\$6,158,000

ESTIMATED ANNUAL PREMIUM \$86,800,000

TABLE III

ESTIMATED RANGE OF INITIAL<sup>1</sup> PREMIUM COSTS OF HEALTH  
COVERAGE FOR THE UNCOVERED POPULATION

	<u>High</u>	<u>Low</u>
Uncovered Population	71,000	56,000
19 and Under (32%)	23,000	18,000
Premium Rate <sup>2</sup>	<u>\$22.00</u>	<u>\$19.00</u>
Monthly Premium	\$506,000	\$342,000
Over 19 (68%)	48,000	38,000
Premium Rate <sup>2</sup>	<u>\$60.00</u>	<u>\$51.00</u>
Monthly Premium	\$2,880,000	\$1,938,000
ESTIMATED ANNUAL PREMIUM	\$41,000,000	\$27,000,000

- 
1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.
  2. The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

TABLE IV ESTIMATED RANGE OF PREMIUM COSTS OF HEALTH COVERAGE FOR  
NON-WAGE EARNERS AND DEPENDENTS WITHOUT HEALTH COVERAGE  
FROM PUBLIC SOURCES

Unemployed	18,300
Self-employed	15,000
Non-labor Force	244,000
Wage earner dependents	(105,000)
CHAMPUS eligibles	( 46,000)
Medicaid eligibles	( 14,800)
U. S. Public Health Service Eligibles	( <u>51,500</u> )
TOTAL	60,000

	<u>High (+30%)</u>	<u>Low (+20%)</u>
19 and Under (32.5%)		19,500
Premium Rate	<u>\$16.12</u>	\$14.88
Monthly Premium	\$314,000	\$290,000
Over 19 (67.5%)		40,500
Premium Rate	<u>\$44.33</u>	<u>\$40.92</u>
Monthly Premium	\$1,795,000	\$1,657,000
TOTAL ANNUAL PREMIUM	\$25,300,000	\$23,400,000

TABLE V ESTIMATED COST OF INCOME TAX CREDIT FOR PRIVATE HEALTH  
COVERAGE

Tax Returns Filed	124,000
Filers with Private Health Coverage (68.5%)	85,000
Annual Tax Credit	<u>\$250.00</u>
TOTAL	\$21,000,000

Blue Cross  
of Washington and Alaska



John M. Hopkins  
Vice President, Marketing

15700 Dayton Avenue North/P. O. Box 327  
Seattle, Washington 98111  
206/361-3586

November 30, 1977

Ms. Sharman Haley  
Research Analyst  
Legislative Affairs Agency  
State of Alaska  
Pouch Y, State Capitol  
Juneau, Alaska 99811

Dear Sharman:

On September 29, you requested information concerning projected costs of a Blue Cross medical package for various classifications of State residents.

Three alternative approaches were requested in your letter. The attached proposal is applicable only for the first alternative, "coverage for all residents". The second alternative, to cover "all residents not currently covered under comprehensive group health plans", would present problems in defining and administering eligibility and in developing a controlled risk. Rates for the second alternative would probably be 50% to 75% higher than the rates for the first alternative.

The third alternative, to cover "the unemployed, the temporarily or seasonally employed, and the self-employed (mandating employer-sponsored coverage for all regular employees and their dependents)", would present fewer problems in controlling risk but would still require rates 20% to 30% higher than the first of the three alternatives and probably would have the least economic impact on the State's health care system.

We recognize that you may have many questions concerning the information contained in this letter. Please give me a call and we will try to help in any way we can.

Sincerely,

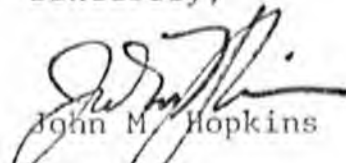
  
John M. Hopkins  
JMH:lb

EXHIBIT 'A'

Blue Cross medical coverage extended from the Alaska State Employees to eligible residents of Alaska, given the following assumptions:

- I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.
- II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:
  - a. Federal Employee Health Programs
  - b. United States Armed Forces
  - c. CHAMPUS
  - d. Medicaid
  - e. United States Public Health Service
- III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.
- IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.
- V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.
- VI. At the end of each contract year the Plan would provide a summary of Income, Incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.
- VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

VIII. If the first contract year is from 7-1-78 through 6-30-79, one of the following options could be used in determining the monthly funds due to the Plan:

A. Rates by eligible resident-

1. Adult (age 19 and over) = \$34.10/month
2. Child (under age 19) = \$12.40/month

B. Rates by type of family unit-

1. Single Adult = \$34.10/month
2. Husband & Wife = \$68.20/month
3. Husband, Wife & one or more Children = \$96.70/month
4. Husband, or Wife and one or more Children = \$62.60/month

C. Rate for any Family Unit = \$71.40/month

Each family unit would coincide with one of the categories itemized in section VIII, B., above. Children must be unmarried and meet the IRS definition of a dependent to be considered an eligible member of any covered family unit.

The above rates assume all eligible residents will participate in the Program.

IX. To minimize the chance of duplicate coverage and benefit payments each eligible resident should be assigned a unique membership number under the Program. This procedure would also facilitate computerized surveillance of medical utilization under the Program. Surveillance programs could be used to detect abnormal utilization of benefits by covered members and abnormal patterns of service by healthcare providers.

X. The Program should provide coverage for services rendered within the State of Alaska. For services outside the state, coverage should be limited to emergencies and to referrals by Alaska physicians for conditions that, in the opinion of the attending physician, cannot be adequately treated in the State's healthcare facilities.

THE PRECEDING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.



# LAWS OF ALASKA

1978

Source

SCS CSHB 409

Chapter No.

107

## AN ACT

Relating to catastrophic illness; and providing for an effective date.

### BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

\* Section 1. AS 47 is amended by adding a new chapter to read:

#### CHAPTER 8. CATASTROPHIC ILLNESS ASSISTANCE.

Sec. 47.08.010. REIMBURSEMENT OF PROVIDERS. According to the provisions of this chapter, the Department of Health and Social Services shall reimburse providers of medical care for unpaid costs incurred in the treatment of a person suffering an illness or accident which results in financial catastrophe to the person or his family.

Sec. 47.08.020. CATASTROPHIC ILLNESS COMMITTEE. There is created the Catastrophic Illness Committee, consisting of a medical review officer from the Department of Health and Social Services, a member appointed by the governor who has suffered a catastrophic illness, and a representative of the Department of Commerce and Economic Development appointed by the governor.

Sec. 47.08.030. NOTICE. The committee shall enlist the assistance of medical providers in making the public aware of the catastrophic illness assistance program.

Sec. 47.08.040. APPLICATIONS FOR ASSISTANCE. An application for financial assistance under this chapter may be filed by a person who has suffered catastrophic illness or by a parent, spouse, or legal guardian of that person, or by any other interested party with the written consent of the person who has suffered the catastrophic illness.

Sec. 47.08.050. SERVICES EXCLUDED FROM COVERAGE. Annually, the committee shall determine in light of appropriated funds and expected need the medical expenses reimbursable under this chapter, except that the following are not reimbursable:

- (1) dentistry and optometry unless prescribed by a licensed dentist or physician as medically necessary as the result of the injury or illness;
- (2) elective medical or surgical procedures;
- (3) drugs and medications not prescribed by a licensed physician;
- (4) services received as a result of a pregnancy or birth without unusual complications;
- (5) private psychological or psychiatric treatment or private alcoholism treatment, unless no, available from public agencies or programs;
- (6) chiropractic services;
- (7) services not of a medical nature;
- (8) medical services currently provided to persons in the custody of the division of corrections;
- (9) costs incurred before July 1976.

Sec. 47.08.060. CALCULATION OF APPLICANT'S SHARE.

(a) As frequently as necessary the committee shall adopt, in light of appropriated funds and expected need, a formula to be used in determining the applicant's share of total medical expenses incurred as a result of a catastrophic illness, based on the applicant's annual gross income, number of dependents, amount of assets, and forthcoming third-party payments, all considered in light of the requirement that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

(b) For the purposes of applying the formula to determine the applicant's share, multiple catastrophic illness occurring within a 12-month period to the applicant or other members of the applicant's family shall be treated as one catastrophic illness.

(c) In applying the formula to determine the applicant's share, the total gross income and the total assets of the family of the applicant may be taken into account, with the following exceptions:

- (1) the applicant's permanent place of abode;
- (2) one noncommercial vehicle;
- (3) tools, equipment, vehicles and other assets required in a trade or business;
- (4) ordinary household and personal effects;

(5) \$1,000 of liquid assets;

(6) all nonliquid assets unless such an exclusion would bring about an inequitable result; however, all income derived from such property shall be taken into consideration in determining the recipient's gross income;

(7) inalienable shares in a Native corporation created under the Alaska Native Claims Settlement Act, P.L. 92-203; 43 U.S.C. 1601 et seq., for the period of their inalienability as specified in the Act;

(8) Alaska longevity bonus payments;

(9) any other assets specifically restricted for the use of the recipient by state or federal law.

(d) Assets received by the applicant as a custodian, guardian, conservator, or trustee for another are not considered assets of the custodian, guardian, conservator, or trustee himself.

(e) The applicant's share shall be reduced in the amount of any premiums paid for disability insurance or a prepaid medical plan up to \$500 if incurred in the 12-month period beginning with the occurrence of the injury or the onset of the illness.

(f) Notwithstanding the provisions of this section, the committee may waive payment of an applicant's share when the catastrophic illness is the proximate result of an immunization required by law.

Sec. 47.08.070. STANDARDS FOR REIMBURSEMENT TO PROVIDERS. The amount that the committee reimburses providers for medical services rendered to a person who has suffered catastrophic illness may not be greater than 100 per cent of the total unpaid bills related to the catastrophic illness and shall be determined by the following standards:

(1) Only unpaid medical expenses for periods not to exceed 12 months, and related to catastrophic illness, may be considered. The initial 12-month period begins with the date of the first charges incurred because of the illness.

(2) The committee may not reimburse a provider if the applicant's total medical expenses related to the catastrophic illness are less than \$1,000 in any period not exceeding 12 months described in (1) of this section after all sources of third-party payment have been exhausted by the applicant or by someone acting on behalf of the applicant.

(3) The committee may not reimburse a provider for the applicant's share of the total medical expenses, moreover, a reimbursement to the provider shall be conditioned on the provider's agreement that the provider enter into a payment schedule with the applicant which will result in full liquidation of the applicant's share. Payment schedules may not be for a term of less than three years.

Sec. 47.08.080. RECONSIDERATION OF DECISION BY

**COMMITTEE.** The committee shall promptly notify an applicant of its decision with written reasons for the amount of the award or denial. An applicant who is dissatisfied with a decision of the committee may apply to the committee for reconsideration within 30 days of receipt of the decision. The request for reconsideration must include a written statement of grounds for reconsideration and any supporting documentation which was not available to the committee for its original decision. Within 30 days after receipt of a request for reconsideration, the committee shall affirm, amend, or reverse its original decision. The committee shall promptly notify the applicant of its decision upon reconsideration with written reasons for its action. Information describing hearing rights and procedures must be furnished with the written notification of denial.

**Sec. 47.08.090. HEARING.** An applicant who is dissatisfied with the committee's decision upon reconsideration may request a hearing in accordance with procedures established under AS 47.25.180.

**Sec. 47.08.100. FINALITY OF DECISIONS.** Decisions as to catastrophic illness awards are final

(1) 30 days after the applicant receives the committee's decision unless a reconsideration is requested during that time;

(2) 30 days after the applicant receives the committee's decision upon reconsideration unless a hearing is requested during that time;

(3) 15 days after the applicant receives the hearing authority's decision if that decision is not appealed to the director during that time;

(4) upon being notified of the decision of the director if an appeal is taken to the director under AS 47.25.180.

**Sec. 47.08.110. EXTENSION OF TIME LIMITS.** Time limits for reconsideration or for requesting an appeal may be extended, at the discretion of the committee, upon application or upon the committee's own motion. A request for reconsideration or for a hearing shall be considered made on the date when the request is dispatched rather than the date when it is received by the committee.

**Sec. 47.08.120. RECOVERY FROM A COLLATERAL SOURCE.** If the applicant or a provider receives payment from any other source for medical expenses which have been paid by the committee, the applicant or provider is liable to the committee in the amount of that payment. An application may not be considered by the committee unless the applicant agrees to this provision. A provider may not be paid by the committee under this chapter unless the provider agrees to this provision.

**Sec. 47.08.130. REGULATIONS.** The department may adopt regulations, in accordance with the Administrative Procedure Act, which establish rates of reimbursement to providers for medical expenses incurred, as well as other regulations necessary to carry out the purposes of this

chapter.

**Sec. 47.08.140. DEFINITIONS.** In this chapter

(1) "applicant" means a person who has suffered a catastrophic illness and is applying for assistance under this chapter or is the subject of an application for assistance under this chapter;

(2) "applicant's share" means the amount of the total medical expense related to the catastrophic illness which the committee determines the applicant can reasonably be expected to pay based on income, assets, and number of dependents under sec. 60 of this chapter;

(3) "catastrophic illness" means illness or injury which result in medical expenses of over \$1,000 during a period not to exceed 12 months, after all other sources of third-party payment have been exhausted;

(4) "committee" means the Catastrophic Illness Committee, created under sec. 20 of this chapter;

(5) "elective medical or surgical procedures" means treatment which is not essential to the life or health of a person;

(6) "family" means two or more persons related by blood or marriage or adoption living as one economic unit;

(7) "liquid assets" means assets which can be readily converted to cash;

(8) "medical expense" means any financial obligation incurred in the course of treatment of illness as prescribed by a physician, including bills for ancillary services, patient transportation, transportation of a medical or family escort when reasonably necessary, or living expenses while receiving outpatient treatment in a community to which the applicant is not reasonably able to commute from his permanent place of abode;

(9) "nonliquid assets" means all assets which are not liquid assets;

(10) "permanent place of abode" means a dwelling, or a dwelling unit in a multiple dwelling, including lots and outbuildings or an appropriate portion of these, which are necessary to convenient use of the dwelling unit;

(11) "provider" means a licensed physician, pharmacist, dentist, or other health service worker or a licensed hospital, clinic, skilled nursing home, intermediate care facility or health maintenance organization which has provided services not excluded by sec. 50 of this chapter to an applicant as a result of a catastrophic illness;

(12) "third-party payments" means payments of medical expenses related to a catastrophic illness by sources other than the applicant or the committee, including but not limited to state and federal medical assistance programs, private health insurance, employment-related

Chapter 107

health insurance, military health insurance, workmen's compensation, violent crimes compensation, Indian Health Service of the United States Department of Health, Education and Welfare, and awards in legal actions.

\* Sec. 2. AS 47.25.255 is repealed.

\* Sec. 3. This Act takes effect immediately in accordance with AS 01.10.070(c).



# LAWS OF ALASKA

1978

Source

Chapter No.

CSSSB 59(Rules) am H

108

## AN ACT

Relating to forest resources and practices; and providing for an effective date.

### BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

\* Section 1. AS 41 is amended by adding a new chapter to read:

#### CHAPTER 17. FOREST RESOURCES AND PRACTICES.

Sec. 41.17.010. DECLARATION OF INTENT. The legislature declares that

(1) the forest resources of Alaska are among the most valuable natural resources of the state, and furnish timber and wood products, fish and wildlife, tourism, outdoor recreation, water, soil, air, minerals, and general health and welfare;

(2) economic enterprises and other activities and pursuits derived from forest resources warrant the continuing recognition and support of the state;

(3) the state has a fundamental obligation to insure that management of forest resources guarantees perpetual supplies of renewable resources, provides nonrenewable resources in a manner consistent with that obligation, and serves the needs of all Alaska for the many products, benefits, and services obtained from them;

(4) government administration of forest resources should combine professional management services, regulatory measures, and economic incentives in a complementary fashion, and should draw upon the expertise of professional foresters in conjunction with other disciplines;

ONE STATE'S RESPONSE TO  
CATASTROPHIC ILLNESS:  
THE RHODE ISLAND APPROACH



**THE COUNCIL OF STATE GOVERNMENTS**

36 WEST 44TH STREET  
NEW YORK, NEW YORK 10036

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## I N T R O D U C T I O N

"Catastrophic Illness: The Rhode Island Approach" is the latest in a series of reports prepared by my office. Their purpose is to provide information to state government leaders in the Northeast regarding significant legislative enactments by states in the region.

We seek to highlight the more important elements of the statute and present pro and con arguments with respect to it, and the experience to date in administering the Act.

The report is the culmination of many hours of reading both the statute itself and the legislative debate as well as interviewing those legislators and departmental officials who were intimately involved with its drafting and administration. Our purpose is to present a factual analysis of a statute which illustrates one approach to handling a particular problem but not to present it as the only alternative. For further background, we have included the statute itself as an appendix to this report.

Special thanks are in order for Representative Rocco A. Quattrocchi, Kevin McKenna, Deputy Attorney General, and Brian Keeler, Assistant Administrator, Department of Health, the three Rhode Island officials who took time from their very busy schedules to allow us to interview them about their views on the catastrophic illness law. Further, I wish to extend my thanks to Jane Parks, Assistant to the Director, Eastern Office, and to Nancy Kessler, a graduate student intern, who prepared this report.



ALAN V. SOKOLOW  
Director, Eastern Office  
COUNCIL OF STATE GOVERNMENTS

*Projections:*

- given the present application rate, fewer cases can be expected to be opened in Fiscal Year 1979, as compared to Fiscal Year 1978
- unless this trend changes, costs to the state for providers' services should drop significantly in Fiscal Year 1980

CHEPP-2

*During the period July 1, 1977 through June 30, 1978:*

- 10 different counties took CHEPP-2 applications
- 13 CHEPP-2 applications were taken; one was denied
- patients ranged from 50 to 65 years of age
- three-quarters of the patients were females
- three-quarters of the patients had a diagnosis of either multiple sclerosis or stroke
- 50 percent of the patients had been in nursing homes from 3 to 5 years; the others from 5 to 15 years
- over one-half of the patients had no health care coverage
- incomes ranged from \$1,500 to \$30,000
- 6 of the 12 patients had incomes between \$12,000 and \$16,000
- the deductible ranged from \$310 to \$6,094
- two-thirds of the patients paid \$2,000 to \$4,000 out-of-pocket expenses to meet the 20 percent CHEPP-2 deductible
- the 12 patients paid \$39,935 to meet the CHEPP-2 deductible
- \$55,323 was paid by the state in Fiscal Year 1978 for the nursing home care of the 12 patients

*Projections:*

- the majority of the patients eligible in Fiscal Year 1978 will be eligible in the future; death or reaching age 65 will be the terminating factors rather than income and the deductible as in CHEPP-1

A bill encompassing these objectives was enacted in July 1974 with an effective date of January 1, 1975 but a benefit package retroactive to October 1, 1974.

The CHIP bill has been divided into three articles. Article 1 establishes a ceiling on catastrophic health costs while Article 2 provided the minimum standards for insurance companies. Article 3 created a health services development fund which authorizes insurance companies to allocate either general revenues or a percentage of their premium to projects designed to improve the health system. Most people have focused their attention on the catastrophic side of the bill, but in order to develop an efficient health system, it is important to recognize the significance of the other two articles, too.

#### WHO IS ELIGIBLE AND FOR HOW MUCH?

An individual is eligible for payment from the state if that person has established permanent residency in Rhode Island and has resided there for a minimum of three months. Such an individual must have legal responsibility for the payment of health costs incurred on his or her behalf or on behalf of persons for whom he or she is responsible. Furthermore, a person must have met the appropriate personal resource payments. A personal resource payment, as defined in the Act, is "the money an eligible person is obligated to pay from his or her own wages, salary, income or assets for eligible health services ...". The personal resource payment is computed on the basis of the amount of coverage for health benefits, if any, to which an eligible person is entitled. Parenthetically, the payment scale has been constructed so that it is more beneficial to those individuals with greater insurance coverage. For the exact breakdown of eligibility payments, see Section 42-62-7 part d of the bill and chart in the Appendix.

The appropriate personal resource payment is determined on a yearly calendar basis. Payments made to meet the deductible of a major medical plan on the premium costs of a health benefit may be excluded, but coinsurance payments made under a major medical plan must be included. In essence, an applicable personal resource payment requires that an individual meet his or her obligation to pay for health services not covered under a health benefit plan or a health maintenance organization plan. (Every employer must offer the opportunity for his or her employees to enroll in an available health maintenance organization).

#### EXCLUSIONS

Section 42-62-8 of the CHIP Act lists a number of services and charges that must be excluded from financial protection and which must not be considered when computing the personal resource payment.

Among the exclusions listed are those connected with disabilities incurred during military service and medical services financed by the state and federal government for persons over age sixty-five. In addition, medical services such as cosmetic surgery and dentistry must be excluded unless they are necessary as a result of an injury or serious illness. For the complete list of exclusions, see Section 42-62-8 of the bill.

There can be no third party which is liable for these expenses. Income basically means the federal adjusted gross income; income for the calendar year preceding the year in which a CHEPP application is filed is used to determine eligibility. If an applicant becomes an eligible person, s/he is responsible for a 10 percent co-payment on covered services, with the state paying 90 percent of qualified expenses. Eligibility includes the dependents of an eligible person and runs for 12 months starting on the first day of the month and year of the earliest service resulting in expenses used to satisfy the deductible. Eight million dollars were appropriated for Fiscal Year 1978 and ten million dollars for Fiscal Year 1979.

In 1977, the above CHEPP legislation was amended to include "qualified nursing home expense." This additional coverage with separate requirements for eligibility became known as CHEPP-2. This segment of CHEPP covers all nursing home expenses incurred on or after July 1, 1977, in excess of 20 percent of household income (preceding the year in which an application is filed) for persons 64 years of age or younger in long-term care facilities. In order to be eligible, persons must have already received at least 36 months of continuous care in a long-term care facility. "Nursing home" is defined as a skilled nursing facility or intermediate care facility I. Eligibility is from the date of satisfaction of the deductible until June 30 or not later than the last day of the month in which the patient becomes 65 years of age. After the 20 percent deductible is met, the state pays the reasonable cost of the eligible person's nursing home care. This payment is made to the patient, patient's family, or the nursing home after the end of the state fiscal year. If insufficient funds are appropriated for CHEPP-2 expenses, the payable amount will be prorated to all eligible individuals. The amount appropriated for CHEPP-2 was \$450,000 per year for Fiscal Years 1978 and 1979.

## MINIMUM STANDARDS

Up to this point our discussion has focused on Article 1 of the Act which deals primarily with the catastrophic illness benefits and those administering and receiving such benefits. Now we turn to a discussion of the fundamental standards which private insurance companies and other providers must comply with in order to be accredited.

Any provider of payments of health services must meet the minimum standards established by the Director of Business regulations. The Director has been given one year from the effective date of the bill to develop such standards based on the purposes set out in the act.

The purposes of such standards include the elimination of deceptive practices by insurance companies, the function of cooperation between insurers and the state and the clarification of confusing provisions of insurance plans to the consumer. The specific purposes are outlined in Section 42-62-12 of the bill.

Within sixty days after the Director of Business Regulation establishes the minimum standards, each provider of a health insurance plan must file their proposed plans with the Director. After each plan is filed, the Consumer Council must be informed. This Council can request that the Director hold a hearing on any plan they deem unsuitable. If a plan is found to be unacceptable upon completion of the hearing, the provider must modify the plan and submit it again.

## RATES CHANGED

The rates or rating formula proposed by any insurer of health costs must be filed with the Director of Business Regulations. Within thirty days after filing, the Director must hold a hearing to determine the equity of the rating system under investigation. Upon conclusion of the hearing, the Director must post a description of the agreed upon rates and notice must be given to the applicant and to the Rhode Island Consumers Council.

## FACILITIES REINSURANCE POOL

Insurers meeting the minimum standards of CHIP are entitled to join a facility reinsurance pool in which losses are shared among its members. The pool functions on an annual basis and losses are divided in proportion to the number of individuals insured by each insurance company.

No agreement among insurance companies to form a pool will be considered valid unless it is approved by the Director of Business Regulations. Reinsurance will only be approved if it is determined to be in the public interest and in compliance with the Department of Business Regulations. If after a sixty day warning and a public hearing, the Director concludes that there is unfair competition among insurers, he or she may require such insurers to participate in a reinsurance pool that complies with the regulations set forth in CHIP.



## ANNUAL REPORT ON THE HEALTH CONDITIONS OF THE STATE AND HEALTH EXPENDITURES

Prior to January 30 of each year, the director of Health must issue a report to the Governor and the General Assembly. The report must outline in detail the health conditions of the people in the state, the level of health services and unmet expenses for the previous year. The Director must also include exact expenditures for the past year and on the basis of those figures, he or she should project what expense will be for the next two years.

### REACTIONS TO THE BILL

For a bill of this importance, considering its impact on state policy in the health and fiscal areas, there was surprisingly little controversy either in public hearings or on the floor of the legislature. Certainly the measure had its advocates and detractors, but the debate was rather quiet. One interesting point is that the private insurers had little to say during the debate about its implications on their industry and the health care system generally. Parenthetically, in the section following this one vis-a-vis experience since passage, one does find negative reaction to the statute.

The major arguments in favor of the bill included the responsibility of the state to protect the health and welfare of its citizens, the need to act prior to a possible crisis rather than react after the fact, and the necessity to establish a mechanism to handle the problems related to catastrophic illness while at the same time anticipating its integration into a national program.

On the other hand, the criticisms of the bill dealt primarily with the cost of the program (fear of a run on the state treasury) and the desirability of waiting for federal action before establishing a state program.

In February of 1975, several large insurance companies stopped selling individual health insurance policies in Rhode Island due to objections to certain provisions of the CHIP law; it appears that other carriers would follow suit. They objected to Section 14 of the act in which commercial insurers are required to accept applicants without regard to physical condition.

An amendment to the law in the 1975 legislative session is now awaiting the Governor's signature. Those close to the scene believe that this modification will deal with the concerns of the insurers and assure that they will continue individual policies.

In concluding, it should be pointed out that for those who have lost their group insurance coverage due to loss of jobs, they may not be eligible for CHIP benefits since eligibility depends on large out-of-pocket medical expenses.

The preceding table shows that the majority (approximately 39%) of individuals eligible for CHEPP-1 are females between the ages of 45 and 65 years and almost two-thirds of all patients are between 45 and 65 years of age.

Diagnostic information on the 149 patients, when available, was obtained from county information contained in the case file. Diagnoses were not verified; accuracy of this information cannot be determined since it was self-reported. The major diagnostic categories are as follows:

<u>DIAGNOSIS</u>	<u>NUMBER OF PATIENTS</u>
Cancer	43
Heart conditions	31
Accidents (fractures, burns)	11
Stroke	8
Gastrointestinal disorders (ulcers, Crohn's disease, pancreatitis)	8
Genitourinary disorders (include kidney dialysis)	5
Respiratory disorders (asthma, emphysema)	5
Delivery/Newborn problems	4
Surgical joint repair	4
Psychiatric disorders	3
Arthritis and related problems	3
Liver diseases	2
Hernia	2
Multiple Sclerosis	1
Cystic Fibrosis	1
Chemical Dependency	1
Cellulitis	1
Phlebitis	1
Unknown	<u>15</u>
TOTAL	149

74-S 2259 Substitute "A"

State of Rhode Island and Providence Plantations

JANUARY SESSION, A.D. 1974

AN ACT to Protect the Public Health of the People of the State of Rhode Island and Providence Plantations.

It is enacted by the General Assembly as follows:

PREAMBLE

Whereas, The state of Rhode Island has the right and the obligation to promote the public health, safety, morals and general welfare; and

Whereas, The high cost of health services can serve as a barrier to persons in need of health care, all to the detriment of the public health; and

Whereas, promotion of the public health, safety and welfare requires that all citizens have equal access to health services and a means to protect themselves against the extraordinary costs of serious illness or injury; and

Whereas, Promotion of the public health, safety and welfare further requires that employers be encouraged to provide the best quality of health coverage to their employees and their dependents, and that all other persons be encouraged to obtain the best quality of health coverage for themselves and their dependents; and

Whereas, Promotion of the public health, safety, and welfare further requires that persons or other entities which provide health services or which provide for the prepayment and insurance of health services, or which assist in the payment of health services; do so in furtherance of the public interest, now therefore,

It is enacted by the General Assembly as follows:

Section 1. Title 42 of the general laws entitled "State affairs and government" as amended is hereby further amended by adding thereto the following chapter:

CHAPTER 62  
Catastrophic Health Insurance

42-62-1. SHORT TITLE.--This act shall be known and designated as the Rhode Island catastrophic health insurance plan ("CHIP") act.

42-62-2. PURPOSES.--The purposes of this act are to assure that each person residing in the state of Rhode Island shall have access to needed diagnostic, curative, and rehabilitative health services at reasonable costs and that each person shall have a reasonable means of protecting himself against the unusually high costs of receiving such health services. For these purposes the general assembly finds that promotion of the public health, safety and general welfare

The table below indicates occupational categories and number and percent of cases in each category.

<u>OCCUPATION</u>	<u>CASES</u>	
	<u>NUMBER</u>	<u>PERCENT</u>
Farmer	39	26.2
Retired	30	20
Own Business	28	19
Skilled Labor	14	9.4
Unskilled Labor	8	5.4
Sales	3	2
Unemployed-Disabled	2	1.3
College Student	1	.7
Other	9	6
Not Given	15	10
TOTALS	149	100.0

Approximately 45 percent of the cases that are or were open during the 14-month period were farmers or small businessmen. Almost two-thirds of the cases listed farmer, own business, or retired as the occupation.

Information from the CHEPP applications indicates whether the applicant and other family members are eligible for health insurance and Medicare. The following insurance information pertains only to the 149 individual patients whose conditions and status resulted in CHEPP eligibility. Individuals with insurance number 74; those without insurance number 75. Dependents of some of those 75 patients without insurance did have insurance, so the information given here does not pertain to entire cases regarding insurance. Fourteen patients were eligible for Medicare; of

f) The term "benefit" or "health benefit" means a health service financed for a person by a third party such as an insurer or the state.

g) The term "allowable income" means the adjusted gross income as defined pursuant to section 44-30-12 of the Rhode Island general laws, 1956 as amended, minus any personal exemptions allowed pursuant to such chapter.

h) The term "state" means the State of Rhode Island and Providence Plantations.

i) The term "United States" means the government of the United States of America or any of its instrumentalities.

j) The term, "departmental health advisory councils" means those councils which have been appointed to serve in an advisory capacity for various specific health matters which are a responsibility of the director of department of health or the director of the department of mental health, retardation, and hospitals.

k) The term "maternity benefits" shall mean benefits rendered for normal obstetrical care. It shall include benefits for completion of obstetrics, pre-natal care, care of the newborn infant, labor, delivery, and puerperium care. The term shall include benefits for normal deliveries or for any complications of pregnancy which do not result in delivery of a viable fetus.

l) The term "medicare" means part A and Part B of the United States social security act, title XVIII, as amended, 42 U.S.C. sections 1394, et seq.

m) The term "physician" means any person duly licensed to practice surgery or medicine pursuant to the provisions of chapters 29,31 of title 5 and chapters 36, and 37 of title 6 of the general laws of Rhode Island, 1956 as amended (except dental hygienists), and comparable laws of other countries.

n) The term "eligible person" means a person who has established permanent residency in the state for three months and who has the legal responsibility for the payment of eligible health costs incurred on his or her behalf or the behalf of persons for whom he or she is legally responsible. A person who has moved to the state for the primary purpose of receiving benefits provided pursuant to this act shall not be considered to be a permanent resident unless such residency has been established pursuant to a judicial order to be a permanent residency.

o) The term "eligible health service" means a health service which would be covered within the type of qualified program an eligible person would be expected to have by the director of health in order to incur the smallest personal resource payment applicable under this act.

p) The term "personal resource payment" means the money an eligible person is obligated to pay from his or her own wages, salary, income or

The following table indicates the percentage of all patients in each occupational category without any health care coverage.

<u>OCCUPATION</u>	<u>PATIENT TOTAL NUMBER</u>	<u>PATIENT NUMBER W/O COVERAGE</u>	<u>PERCENT OF TOTAL</u>
Farmer	19	22	56
Retired	30	5	16.7
Own Business	28	14	50
Skilled Labor	14	10	71.4
Unskilled Labor	8	3	37.5
Sales	3	1	33.3
Unemployed-Disabled	2	2	100
College Student	1	0	0
Other	9	6	66.7
Not Given	15	7	46.7
<b>TOTALS</b>	<b>149</b>	<b>70</b>	<b>47</b>

The above table suggests that those eligible for CHEPP-1 and indicating a skilled labor occupational category have the least health care coverage of employed groups, with farmers and small businessmen following.

The length of time an individual or family is eligible to have the state make payments for medical care ranges from less than one week to almost twelve months, depending upon the length of time it took to satisfy the deductible.

The following table indicates the number of months an individual or family was eligible to have medical expenses covered by CHEPP-1 and the number of cases in each category.

preceding year of catastrophic coverage. Said amount shall then be an eligible cost for catastrophic coverage during such following calendar year.

d) Beginning at October 1, 1974, eligible health services incurred on and after October 1 of any preceding year shall be construed as costs incurred in such following year.

e) In the case of a dispute as to the eligibility of a type of health service for coverage as a catastrophic cost, the director of the department of health may determine, on the basis of an appeal by an eligible person and written comment by the appropriate insurer, whether or not such health service is an eligible health service.

f) In the case of a dispute as to the eligibility of a person for coverage of catastrophic costs by the state, the director of the department of health shall determine said eligibility after an appeal by a person from a decision by an insurer.

#### 42-62-7. PERSONAL RESOURCE PAYMENTS.--

a) To be eligible for payment by the state pursuant to section 42-62-6 of his or her health services of a catastrophic nature, an eligible person must have incurred an obligation to make the applicable personal resource payment computed pursuant to this section. Such payment shall not be a cost payable by the state pursuant to subsections 42-62-6 (a) and (b).

b) The applicable personal resource payment shall be determined on a calendar year basis and shall not include the payments made to meet the deductible of a major medical plan or the premium costs of a health benefits plan. It shall include the co-insurance payments made under a major medical plan.

c) The applicable personal resource payment applies to the obligation for payment of health services that are not covered under any health benefit plan, except for health maintenance organization plans.

d) The applicable personal resource payments shall be determined in relation to the extent of coverage for health benefits, if any, to which an eligible person is otherwise entitled according to the following categories:

##### (1) An eligible person

A) Who has a qualified program must have incurred an obligation to pay an amount equal to five hundred dollars (\$500.00) or to ten percent (10%) of his or her allowable income, whichever amount is greater;

B) Who has a program that would have otherwise been qualified, except for a qualified major medical health benefits plan, must have incurred an obligation to pay an amount equal to twelve hundred fifty dollars (\$1250.00) or to twenty-five percent (25%) of his or her allowable income, whichever amount is greater;

Approximately 43 percent of the cases were required to meet the minimum deductible. About 81 percent of all cases met a deductible ranging from \$2500 to \$4500.

The annual income range for those patients required to meet the \$2500 deductible follows:

<u>ANNUAL INCOME</u>	<u>NUMBER OF CASES</u>
Minus Income	6
\$0 - 1000	6
\$1001 - 2000	2
\$2001 - 3000	7
\$3001 - 4000	14
\$4001 - 5000	16
\$5001 - 6000	11
\$6001 - 6127	<u>2</u>
TOTAL	64

The maximum difference in incomes of those required to meet the \$2500 deductible is approximately \$8300.

The following table indicates the ranges of the required deductible for each of the income ranges for the 149 cases:

<u>INCOME RANGES</u>	<u>NUMBER OF CASES</u>	<u>DEDUCTIBLE RANGES</u>
Minus Income	6	\$2500
\$0 - 4999	45	\$2500
\$5000 - 9999	61	\$2500 - 4000
\$10,000 - 14,999	24	\$4000 - 6000
\$15,000 - 19,999	8	\$6000 - 8500
\$20,000 - 24,999	4	\$8500 - 11,000
\$25,000 - 28,135	1	\$11,000 - 12,881

h) Drugs and medication not legally requiring prescription;

i) Outpatient psychiatric care in excess of fifty percent (50%) of the cost incurred of such eligible health services as may be incurred in a calendar year;

j) Services delivered in facilities which have not been certified by the director of the department of health as qualified to provide such services.

42-62-9. EMPLOYEES' HEALTH BENEFIT PLANS.--

a) Each employer shall, in accordance with regulations promulgated by the director of the department of business regulation in consultation with the director of the department of health, offer the opportunity for his employees to enroll in any available qualified health maintenance organization on the same absolute dollar cost sharing terms which may be provided for other health benefits plans made available for employee enrollment.

b) The fair value of services rendered by a health maintenance organization to a subscriber after such subscriber has exhausted the services provided by the health maintenance organization's qualified program shall be recognized as eligible health care expenditures by the subscriber in computing his personal resource payment pursuant to section 42-62-7.

42-62-10. QUALIFIED HEALTH PROGRAM.--

a) Upon application by an insurer for certification of a health insurance plan or plans as a qualified program for the purpose of this act, the director of business regulation, after consultation with the director of health, shall make a determination within ninety days (90) as to whether the applicant's plan or plans are qualified, and shall publish in the major newspapers of the state on a semi-annual basis thereafter a notice that such plan or plans are qualified.

b) A program may be certified for a period of two years if, at least.

i) It meets the minimum standards of this act,

(ii) Its insurer meets the duties established by this act and the laws of the state,

(iii) It provides coverage for diagnostic, curative and rehabilitative health services for illness and for injuries for the subscriber and his dependents, which the director of the department of health, after consultation with the appropriate departmental health advisory councils, has recommended as being in the public interest.

(iv) It provides benefits which are approximately equal in scope and in actuarial value to the benefits described in subsection 42-62-10 (c).

Approximately three-fourths of those eligible for CHEPP-1 met deductibles of \$2500 to \$4000.

Providers Utilized by CHEPP-1 Patients

Payments were made to the following provider types under the CHEP Program. The number in parentheses indicate the number of CHEPP-1 patients receiving a service from this provider type. In 80 percent of the cases, a patient received services from more than one provider type.

- Inpatient hospitals (89)
- Physicians (141)
- Pharmacies (96)
- Outpatient hospitals (48)
- Medical equipment and oxygen suppliers (10)
- Nursing homes (7)
- Ambulances (10)
- Laboratories (2)

Physicians, pharmacies and hospitals were the providers most frequently utilized by the CHEPP-1 patients.

CHEPP-1 Caseload

During the July, 1977 through August, 1978 period, there was CHEPP-1 activity on 173 cases. The application dates and case status in relation to number of cases is shown below.

APPLICATION DATE	NUMBER OF CASES AND STATUS		
	OPENED	DENIED	TOTAL STATUS
1977: July	1	0	1
August	4	0	4
September	9	0	9
October	12	1	13
November	13	0	13
December	22	1	23
1978: January	11	3	14
February	7	0	7
March	14	1	15
April	14	3	17
May	20	2	22
June	14	2	16
July	8	2	10
August	0	0	0
<b>TOTALS</b>	<b>149</b>	<b>15*</b>	<b>164**</b>

\*Excludes data on seven CHEPP-1 denied cases.

\*\*The application dates of the two cases with "application pending" status are not known.

- a) Diagnostic x-ray and radioisotopic examinations;
- b) Electroencephalograms, basal metabolism tests and electrocardiograms;
- c) Laboratory tests, including pathological examinations;
- d) Radiation treatments by x-ray, radium, external radiation or radioactive isotopes.

5. Physicians' visits to care for a bed patient in a short-term general hospital up to 120 days per period of illness, or for 45 days per period of illness in specialized hospitals, except for routine pre-operative and post-operative physical examinations.

6. Consultation services, where medically necessary in the opinion of the attending physician, at one consultation per specialty per period of illness.

7. Obstetrical delivery services, including pre- and post-natal care, after the first fifty dollars (\$50.00) of charges, which shall be the liability of the patient.

8. Newborn baby care, when the examination and care is provided by a physician other than the physician making the delivery or administering anesthesia related to delivery.

9. Emergency accident services performed by a physician within 72 hours of a traumatic or poisoning accident are covered in full.

#### iii) Major Medical Coverage

1. To supplement the protection provided by subsections (c) (i) and (c) (ii), the following additional coverages may be required as a condition to a program being certified as qualified:

a) It provides up to ten thousand dollars (\$10,000.00) in coverage for payment of eligible health services;

b) It provides such coverage for at least eighty percent (80%) of the usual and customary charges, or costs, as applicable, of health services described in subsection (c) (i) and (c) (ii) after an insured or subscriber has paid an annual deductible of one hundred dollars (\$100.00) per person or two (2) one hundred dollar (\$100.00) deductibles per family for covered services.

c) Such covered service provided under subsection (b) shall include:

- 1. Physicians' services, including home and office visits.
- 2. Professional ambulance services locally to or from a hospital for inpatients, or to a hospital accident room following an accident.
- 3. Drugs and medications which by law require a written prescription.

Current CHEPP-1 Costs

Costs to Patients - July, 1977 to August, 1978

The 149 CHEPP-1 families paid (or owe) a total of \$534,775.68 in order to meet the program deductible. In addition, any bills submitted to and paid by the state required a 10% co-payment by the patient or patient's family, which totalled \$47,370.7. Therefore, patients' out-of-pocket expenses to meet deductibles and co-payments were \$582,146.15.

Costs to State - July, 1977 to August, 1978

The state payments made to providers as of September 1, 1978, totalled \$469,489.79. Monthly county remittance management and fiscal reports indicate the state paid providers \$426,331.75, during the 14-month period, through the centralized disbursement system. The first payments were made in November, 1977. A total of 1,796 claims have been processed by the state at a claims processing charge of \$1,711.99. During this same 14-month period, the state paid a total of \$43,158.04 outside the centralized disbursement system in order to reimburse patients for payments made for services which were to be covered under the CHEP Program or providers when both patient and CHEPP-1 were making partial payments on the same date (i.e. patient is meeting the deductible).

For Fiscal Year 1978, \$8 million was appropriated for CHEPP-1 and the administrative budget was \$56,475. For Fiscal Year 1979, \$10 million is appropriated for CHEPP-1 and the administrative costs are budgeted at \$57,115.

During Fiscal Year 1978, \$252,351.35 was paid to providers for services rendered which were covered under the CHEPP-1 program. Payments made by the state outside the centralized disbursement system were \$19,969.87. Therefore, the total amount paid for CHEPP-1 covered services during Fiscal Year 1978 was \$272,321.22.

denied by the director of health certification required for eligibility for reimbursements by insurers, for periods of not more than one (1) year for each determination.

## ARTICLE II

### Minimum Standards Protection

#### 42-62-12. MINIMUM STANDARDS.--

a) It shall be the duty of all corporations or other legal entities providing for payment for health services under any contract entered into with an employer, person, state or a political subdivision thereof, pursuant to the requirements of this act to comply with minimum standards established by regulations promulgated by the director of business regulation. The director of business regulation shall promulgate such regulations within one year of the effective date hereof.

b) Such minimum standards shall be designed to carry out the following purposes;

i) The reasonable standardization and simplification of coverages to facilitate consumer understanding and comparisons;

ii) The elimination of provisions which may be misleading or unreasonably confusing to the consumer in connection with the purchase of such coverages or with the settlement of claims;

iii) The elimination of deceptive practices in connection with the sale of such coverages;

iv) The elimination of provisions which may be contrary to the health needs of the public;

v) The availability of qualified plans to persons residing in the state who apply therefore regardless of age, sex, race, occupational status or medical condition;

vi) The promotion of efficient management of health services with the State;

vii) The elimination of coverages which are so limited in scope as to be of no substantial economic value to the holder thereof;

viii) The addition of coverages, the sale of which is required by the public interest to protect the health of persons residing in the state.

c) Within sixty (60) days after promulgation of said minimum standard regulations by the director of business regulation, each insurer or other entity referred to in this section shall file with the director of business regulation a sample of each of said contracts which it proposed to use. A notice of a receipt of filing shall be delivered to the Rhode Island consumers' council. If requested by the Rhode Island consumers' council the director shall

Eligibility for state coverage of care for the majority of patients began later in the fiscal year. Fourth, a number of the initial bills submitted by providers were rejected; many of these bills are being and will be resubmitted for payment. As with new programs, it takes the providers' billing personnel some time to learn the mechanics of billing the program properly. Fifth, during the first six months of 1978, the greatest number of cases were open for CHEPP benefits. Theoretically, the largest total payments to providers may be made through June of 1979. Unless the number of applicants who become eligible for CHEPP-1 increases in the future, costs to the state for providers' services should drop significantly in Fiscal Year 1980.

that a vendor is discriminating unlawfully against any insurer with respect to costs, charges or rates, the director shall advise said vendor in writing to cease such discriminatory practices forthwith.

c) At any hearing conducted pursuant to section 42-62-13, the director of the department of business regulation may disallow any payments made by an insurer to a vendor not certified by the department of health, or to a vendor which has failed to cease discriminatory practices against any insurer after having received a notice from the director of business regulation pursuant to section 42-62-14.

#### 42-62-15. FACILITY REINSURANCE POOL.--

a) To be eligible to offer plans meeting minimum standards, insurers which are for profit entities or self insurers may enter an agreement to form a facility reinsurance pool within which losses are shared among the insurers on an annual basis in proportion to the number of persons insured pursuant to articles I and II of this act.

b) Such agreements shall not be effective until approved by the director of the department of business regulation as being in the public interest and in conformance with regulations issued by the department of business regulation.

c) If, after a sixty (60) day notice to all such insurers and after a public hearing, the director of the department of business regulation makes a finding that there is lack of fair competition among such insurers or that the public interest is not being served by existing agreements, or by a lack of an agreement, he may require such insurers as a condition of doing business within the state to participate in such facility reinsurance pool established under regulations issued pursuant to this act.

### ARTICLE III

#### Health Resources Development Fund

#### 42-62-16. HEALTH RESOURCES DEVELOPMENT FUND.--

a) There is hereby established in the department of health the health resources development fund to be administered by the director of the department of health pursuant to the terms and for the purposes stated in sections 42-62-16 and 42-62-17 of this act.

b) Monies in such fund or for a project authorized pursuant to section 42-62-17 may be expended by contract, loan or grant, to maintain, to expand, and to improve health facilities, health services, and health education in the state of Rhode Island. Such purposes shall include the following: Construction or modernization of health facilities, the education or training of persons who would be qualified to provide professional health services, meeting the start-up costs of new forms of health delivery systems, such as health maintenance organizations, benefits for persons lacking adequate insured coverage,

Three-fourths of the patients had diagnoses of multiple sclerosis or stroke.

The income of those eligible for CHEPP-2 ranges from \$1,548.00 to \$30,469.13.

Income ranges and number of cases in each range were:

<u>INCOME</u>	<u>NUMBER OF CASES</u>
\$1,548	1
\$12,000 to 16,000	6
\$16,000 to 20,000	2
\$20,000 to 30,470	3

Information from the CHEPP application indicates that four of the CHEPP-2 eligible patients had Medicare and one additional patient had other health insurance coverage. Therefore, seven of the twelve CHEPP-2 patients had no health care coverage of any type.

After meeting the 20 percent CHEPP-2 deductible, the number of months that individuals were eligible to have nursing home expenses covered is as follows:

<u>NUMBER OF MONTHS ELIGIBLE</u>	<u>PATIENTS</u>
1 to 2 months	1
2 to 3 months	0
3 to 4 months	1
4 to 5 months	1
5 to 6 months	1
6 to 7 months	2
7 to 8 months	4
8 to 9 months	2

One-half of the patients had nursing home expenses covered during a seven to nine month period.

42-62-6 and 42-62-7. The director is authorized to enter into contracts with insurers to carry out the duties of the state established by said sections. The director is further authorized to establish by regulation procedures for the collection of benefits to which a person becomes entitled pursuant to said sections, time for filing claims, review of claims, and such other procedural matters as may be necessary to carry out the purposes of said sections.

b) To the extent not otherwise designated in this act, the governor may designate a department as having responsibility for the implementation of a specific duty required by this act. The governor shall report such designation to the general assembly no later than the following year, and each house of the general assembly shall have thirty days within which to disapprove any of the designated delegations and to substitute by passage of new legislation different delegations.

c) To the extent that existing health related functions within departments or divisions need to be removed to another department for the purposes of more efficient administration, or to the extent that new divisions need to be established to meet the purposes of this act, the governor shall make such determinations shall include such determinations within his report to the general assembly.

42-62-19. IMPLEMENTATION OF ACT.-- The governor may delay the implementation of any provision of the act for one year after he makes a finding to be reported to the first subsequent session of the general assembly that such a section (s) of this act has been found to be unconstitutional or has been superseded or modified by an act of the United States.

42-62-20. INTERSTATE AGREEMENTS.--The governor is authorized to enter into agreements with appropriate officials of a sister state or of the United States to carry out any of the duties of this act.

42-62-21. HEALTH COST REPORT.--The governor shall provide for a health cost to be made not later than December 31 to the general assembly on legislative and administrative steps required (i) to provide a more comprehensive protection against the costs of health services thus provided pursuant to this act to persons without health insurance, (ii) to control the rising cost of health services, (iii) to provide for more efficient administration of health services by the state, (iv) to establish more efficient and uniform rate setting processes for the state's purchase of health services and goods, (v) to reduce out-of-pocket costs of health services to persons residing in the state, (vi) to establish a uniform reporting system for vendors for the costs of health services, and (vii) and other changes in health finance, planning, and regulation that may be required in Rhode Island in the event of the passage of a national health insurance act.

b) Such report shall be made in consultation with the budget officer, the director of the department of health, the directors of the departments of mental health, retardation, and hospitals, social and rehabilitative services, and of business regulation, and the executive director of the

### CHEPP-2 Caseload

The CHEP-2 Program requires that eligibility for benefits be terminated each June 30, or when the patients become 65 years of age. As of September 1, 1978, no cases were yet eligible for Fiscal Year 1979 CHEPP-2 benefits, probably because the deductible was not yet met.

The application dates and case status in relation to number of cases is shown below.

APPLICATION DATE	NUMBER OF CASES AND STATUS		
	OPENED	DENIED	TOTAL
1977: September	3	0	3
October	2	1	3
November	2	0	2
December	0	0	0
1978: January	0	0	0
February	2	0	2
March	1	0	1
April	0	0	0
May	2	0	2

Eleven patients remained eligible through June 30, 1978; one patient died in May, 1978.

### Current CHEPP-2 Costs

#### Costs to Patients

The twelve CHEPP-2 patients paid a total of \$39,935.40 for nursing home care in order to meet the program deductible. Any health care services, other than

EXPLANATION

This act establishes the Rhode Island catastrophic health insurance plan, which is declared to be an exercise of the police power for the purposes of assuring that each person residing in the state shall have access to needed health services and to assure that each person shall have a reasonable means of protecting himself against the costs of catastrophic illness or injury.

Article I entitles each person to access to health services which are medically necessary and to obtain through insurers financial protection against health costs through "qualified programs" as defined. It also defines the duty of the state to pay for catastrophic eligible health costs after the person has used whatever benefits that his health insurance provides for him together with his own personal resource payment, as defined by the act. Employers are required to include the option of membership in health maintenance organizations to employees in any health benefits plan which they offer.

Article II requires all insurers and health maintenance organizations to comply with minimum standards established by regulations promulgated by the director of business regulation. The act provides that contracts be used by insurers and health maintenance organizations and rates to be charged are subject to review by the director of business regulation. Insurers are required to offer plans meeting minimum standards on a non-discriminatory basis and vendors are required to provide services for charges which are equitable, non-discriminatory and in the public interest. A facility reinsurance pool is established to assure coverage to persons without undue burden to either the carriers or the insured.

Article III establishes a health resources development fund for research and development purposes or for promotion of health care or new systems of health delivery.

Article IV provides for administration of the act.

## PROJECTED USAGE OF CHEPP PRIOR TO IMPLEMENTATION

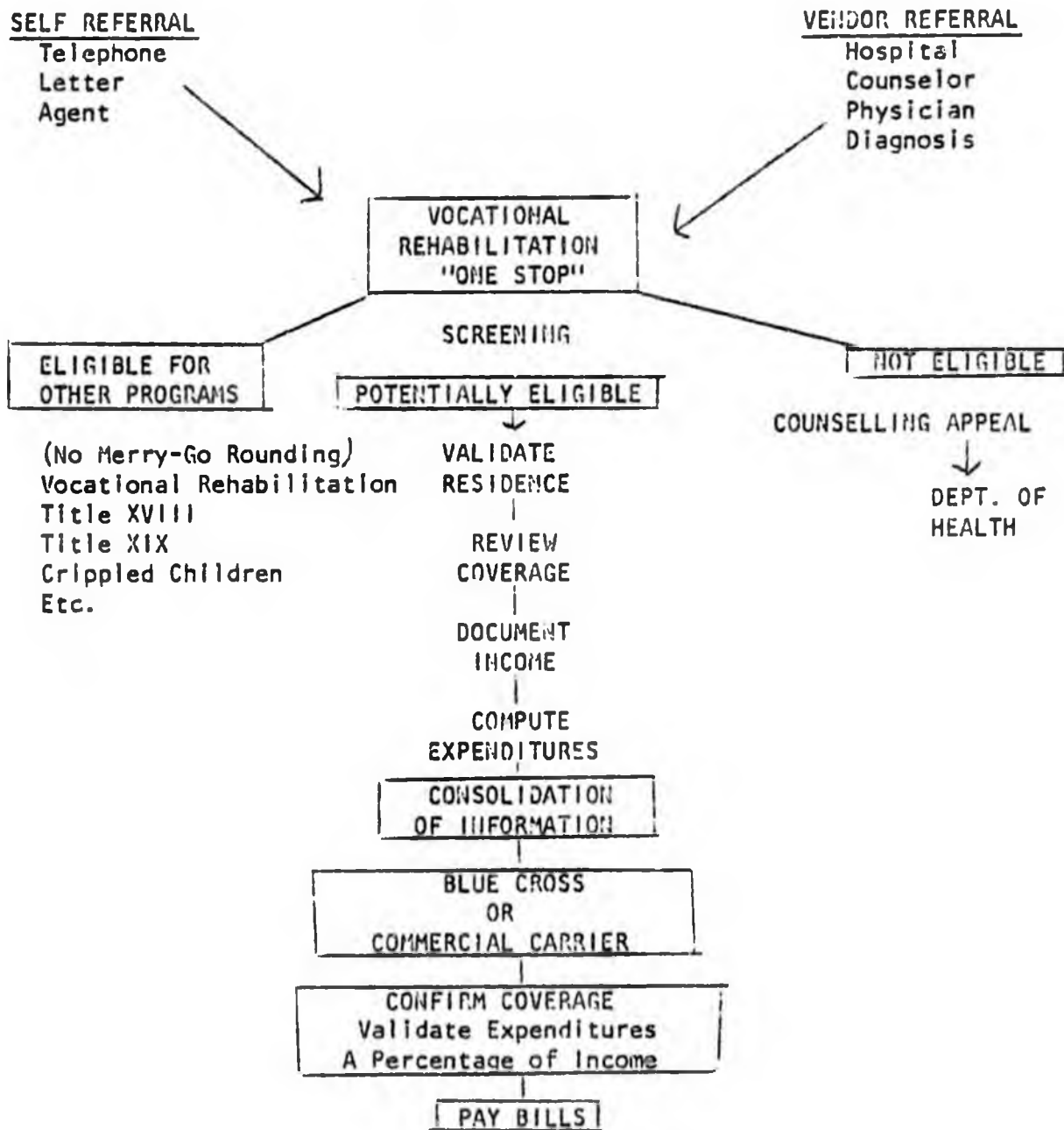
During the three-year period prior to the enactment of CHEPP legislation, legislative staff obtained information and data from numerous sources in order to attempt to project need, utilization and costs of a catastrophic health care program in Minnesota. Information and data collected included: national and Minnesota medical care cost increases over time; data upon which congressional bills were based; type of insurance coverage provided by large Minnesota employers; national research estimates on catastrophic health expenses; estimates of Minnesota's uninsured and underinsured population; review of catastrophic health care coverage in other states; and, data from a computer study done by the Tax Study Commission regarding medical deductions from 20,000 tax returns for 1974.

During the years of data collection and analysis, it was recognized that data available was fragmented, not at all conclusive; and allowed, at best, for only rough approximations of need, utilization and costs. Several estimates on each of these subjects were made.

It appears that the two primary sources of data used in projecting cost and utilization for a Minnesota catastrophic health program were the Tax Study Commission reports and the actual experience of Rhode Island's Catastrophic Health Insurance Plan which became effective in 1975.

The Tax Study Commission resulted in the estimates and projections for a Minnesota program as follows:

"THE PROCESS"



Minnesota's actual experience with the CHEP Program, as has been shown, is considerably different than what was projected. In fact, the present experience appears to parallel the initial experiences of Rhode Island's program.

The following is information on Rhode Island's Program:

	<u>FY '75</u>	<u>FY'76</u>	<u>FY'77</u>	<u>FY'78</u>
Total Budget	\$1,500,000	\$980,568	\$1,362,489	\$1,426,852
Claim Expenditures	\$ 197,946	\$682,532	1,095,937	\$1,537,761
Eligible Families	58	133	173	396
New Applications	176	N/A	N/A	257

Since the inception of Rhode Island's program, "mental disorders" have been the primary diagnostic category reported by families. With the exception of this category, the ranking of the rest of the diagnostic categories appears to be similar to Minnesota's experience.

THE FOLLOWING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.

SUMMARY OF 1976 COMPREHENSIVE HEALTH INSURANCE ACT  
Chapter 296, Minnesota Laws of 1976  
Amended by Chapter 409, Minnesota Laws of 1977

Objectives

The 1976 law consists of three articles: Article I (a) establishes minimal standards for health insurance policies and (b) creates the Comprehensive Health Association which administers a "state insurance pool" for persons who are unable to buy insurance because of existing health problems. The objective of this article is to upgrade health insurance policies and to increase the availability of health insurance.

Article II establishes a hospital rate review system. This provision requires licensed hospitals to be subject to rate review by an approved voluntary, peer review organization. The Department of Health is authorized to "publicly review and comment" on the rates charged by hospitals. The objective of this article is to reduce rates charged by hospitals by monitoring those charges via a rate review system.

Article III provides financial assistance to persons who incur high medical expenses. The Catastrophic Health Expense Program is designed to protect households from being bankrupted by medical care expenses.

Summary

Article I - Minnesota Comprehensive Health Insurance Act of 1976

Part A - Minimum benefits for health insurance coverage

Duties of Insurance Companies

All health insurers doing business in the State of Minnesota are required to offer a "qualified" health policy to applicants for insurance. The article defines three levels of "qualified" plans-- number one (low), number two (standard), and number three (high). The minimum benefits of a number three plan "shall be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed \$150." The coverage shall also include a limitation of \$3000 per person on total annual out-of-pocket expenses for covered services. The maximum lifetime benefit cannot be less than \$250,000. The article also itemizes the services to be covered by the "qualified" plan. The three levels of "qualified" plans vary only in the amount of deductible required: number three - \$150; number two - \$500; and number one - \$1000. A health maintenance plan is defined as a number three qualified plan. Insurers are not prohibited from developing and selling an "unqualified" plan, however, the insurance companies must "affirmatively" offer coverage for major medical expenses to an applicant for a new "unqualified" plan. This major medical coverage shall be payable, subject to any copayment, up to a maximum lifetime limit of \$250,000 for out-of-pocket expenses incurred within a calendar year, exceeding \$5000.

Any insurance company issuing a Medicare supplement plan shall offer a "qualified" Medicare supplement plan to each eligible applicant. A plan is deemed "qualified" if it provides coverage of 50 percent of the deductible and copayment required under Medicare and 80 percent of the charges for "qualified plan" covered services which are not paid by Medicare. This plan includes a \$1000 per person limit on annual out-of-pocket expenses.

\* Note: As of July 1, 1979, covered services must include a second opinion on surgical procedures expected to cost a total of \$500 or more.

Duties of Employers

Each employer who makes available to his employees a health insurance plan must offer at least a number two plan. The employer does not necessarily have to finance the qualified plan. It can be financed from funds contributed solely by the employer or solely by the employees; or a combination thereof. For the purposes of this article, an employer is defined as employing ten or more residents of the state. The employer may supplement the existing health plan in order to meet the number two plan requirement.

The penalty for noncompliance is the exclusion of the employer's costs for health benefits as a state income deduction. A non-profit employer would lose its tax exempt status if the requirement is not met.

Any employer with 100 or more employees must offer a dual option to obtain either an accident and health insurance policy or a health maintenance organization contract, if one is available.

Conversion Privileges

The law requires group accident and health insurance policies and health maintenance organization contracts to include the right to convert to an individual coverage "qualified" plan without the addition of underwriting restrictions. The person leaving the group has 30 days in which to exercise his right to convert.

Each health insurance plan must also include a provision allowing, upon the death of an insurance holder, other individuals covered under the plan to continue coverage.

Part B - Comprehensive Health Insurance Plan

Article I also creates the Comprehensive Health Association which must offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan to individuals who cannot otherwise obtain standard insurance coverage because of health problems. The Association is comprised of all insurers, self insurers, fraternal, and health maintenance organizations doing business in Minnesota. These policies are referred to as the Comprehensive Health Insurance Plan or State Plan.

Comprehensive Health Insurance Plan

The Comprehensive Health Association is responsible for selecting a writing carrier to administer the Comprehensive Health Insurance Plan. The Association may select separate writing carriers for each type of "qualified" plan.

The state plan is open for enrollment at all times. An eligible person may apply to the Association or to the writing carrier. For the first 18 months of the plan's operation, premiums were determined by averaging the premium rates charged by the five largest insurers in each plan category. Subsequent premium determination will be based on actuarial experience. Not more than 12.5% of the premiums may be expended by the writing carrier for administration costs.

Each member of the Association is responsible for sharing the losses due to claim expenses of the state plan. Members shall share those costs on a pro-rated basis, determined as a ratio of premiums received by a member to the total amount of total premiums received by the Association members.

If there are any net gains from the operation of the state plan, it shall be used to offset future losses or reduce premiums.

Public Education

The Association is responsible for disseminating information to the public regarding the availability of the state plan.

Referral Fee

The writing carrier shall pay an agent's referral fee of \$25 to each agent who refers an applicant to the state plan. This fee is included in the 12.5% administration expense limit.

Pre-Existing Condition Clause

An enrollee of the state plan is not covered for any pre-existing condition during the first six months of coverage if the condition was diagnosed or treated within 90 days prior to the filing of an application.

Reinsurance

A member of the Association may elect to reinsure the risks involved with being required to offer (a) individual qualified plans, (b) group conversions, (c) group qualified plans with fewer than 50 members, or (d) major medical coverage. The member would be reinsured through the Association. The Association administers the policies that are reinsured by a member. Any income in excess of the costs incurred for providing the reinsurance service shall be used to offset losses in the state plan or reduce the premiums.

Article II - Hospital Administration Act

Article II establishes a system by which hospital rates are reviewed. A licensed hospital may agree to submit its financial reports and rate schedules to a voluntary, non-profit rate review organization

for review. If the hospital does not report to this rate review organization, it will be subject to review by the Department of Health, the administrative agency for this act.

The Department of Health shall prescribe standards for purposes of approving a rate review organization. The Department is authorized to collect financial information which includes (a) a balance sheet, (b) a statement of income and expenses, (c) a copy of the most recent Medicare cost report, and (d) a schedule of rates. The Department also has the right to inspect hospital records and audits. Any modifications to a hospital's rate schedule must be reported to the Department of Health 60 days in advance of their effective date. If a hospital is subject to review by the Department of Health, the Department may conduct a public hearing on any rate increases which they consider excessive and may publicly comment on any increase.

Insurance Rates

This article also requires actuarial justification of any premium increase for a nongroup policy at the time of filing the insurance plan with the Commissioner of Insurance.

Another provision directs the Commissioner of Insurance to disapprove a filed health plan "if the proposed premium rate is excessive because the insurer has failed to exercise reasonable cost control."

Article III - Catastrophic Health Expense Protection Act

This program offers financial relief to households which incur large medical expenses. The state will pay for 90% of "qualified" expenses, for which no third party is liable, in excess of a threshold figure which is calculated by an income-related formula. "Qualified" expenses are those charges for covered services itemized as minimum benefits in the Comprehensive Health Insurance Act (Article I).

The above mentioned formula is as follows: (a) calculate 40% of household income up to \$15,000, plus 50% of household income up to \$25,000, plus 60% of household income in excess of \$25,000; or, (b) \$2,500, whichever is greater. If, for example, the household income is \$10,000 the threshold figure is \$4000. In this case the state would pay 90% of "qualified" expenses in excess of \$4000.

Nursing Home Provision

The 1977 Legislature amended the Catastrophic Act to provide assistance to persons under the age of 65 who have resided in a nursing home for more than three years. The state will pay for all nursing home expenses which exceed 20% of household income.

Reasonableness of Rates

The Commissioner of Public Welfare is granted the authority to determine the reasonableness of provider charges. The Commissioner may also determine the "medical necessity" of a health service. In order to carry out that authority, the Commissioner may contract with a professional standard review organization to make these determinations.

## Experience

### Article I - Comprehensive Health Insurance Plan

The state plan went into effect on January 1, 1977. As of June 30, 1978, the plan had 1,074 policies in force. The total premiums earned for the first 18 months of the plan's operation was \$441,107.73. As indicated earlier, the premium rate for this time period was based on the average of premiums charged by the five largest insurers in each category. The total claims paid for this period is \$392,412.93. A reserve for incurred but not reported claims has been set at \$220,000.

The 1978 State Legislature appropriated \$200,000 to reimburse the Comprehensive Health Association for the first \$200,000 of claims expenses incurred after June 30, 1978 which are in excess of earned premiums. The premium will be determined by generally accepted actuarial principles subsequent to June 30, 1978 except that the new premium rate cannot exceed 125% of the average premium charged by the five largest insurers in each policy category. This premium limit was enacted by the 1978 Legislature.

### Article II - Hospital Administration Act

All licensed hospitals have opted to be subject to review by a voluntary, non-profit rate review organization. This is the peer review organization of the Minnesota Hospital Association. It is estimated that if the hospitals comply to the proposed budgets developed through rate review the increase in hospital charges will be between 10% to 11% compared to an historical increase of nearly 14% per year.

### Article III - Catastrophic Health Expense Protection Act

This Article went into effect July 1, 1977. Eighteen million dollars was appropriated for the biennium 1978-1979 for the medical care portion of the program. \$900,000 was appropriated for the nursing home section. To date there have been 148 approved applications for the medical care program for an expenditure of \$441,299. For fiscal year 1978, twelve applications were approved for the nursing home expense program, totaling \$55,323.65.

AN ANALYSIS OF THE DEPARTMENT OF  
PUBLIC WELFARE'S CATASTROPHIC  
HEALTH EXPENSE PROTECTION PROGRAM

Prepared by:  
Office of Policy Analysis and Planning  
Department of Public Welfare  
October 31, 1978

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CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM (CHEPP) SUMMARY

CHEPP-1 and CHEPP-2

*During the 14-month period July 1, 1977 through August 31, 1978:*

- 161 individuals participated in CHEPP
- \$524,812 in state funds were paid under CHEPP; \$307,674 was paid during Fiscal Year 1978
- 64 out of the 87 counties have taken CHEPP applications

CHEPP-1

*During the 14-month period July 1, 1977 through August 31, 1978:*

- 62 counties have taken CHEPP-1 applications
- 173 CHEPP-1 applications were taken; 149 were eligible and opened, 22 were denied and 2 are "pending"
- 149 eligible CHEPP-1 cases 345 individuals--149 patients and their dependents
- almost two-thirds of the 149 patients were between 45 and 65 years of age
- 58 percent of the patients were female; the majority of the patients were females between the ages of 45 and 65 years
- one-half of the patients had either cancer or a heart condition
- two-thirds of the cases listed farmer, own business, or retired as occupation
- almost one-half of the patients had no health care coverage of any type; of these, two-thirds were farmers, small businessmen and skilled laborers
- incomes ranged from \$0 to \$28,000
- 87 percent of all cases had federal adjusted gross incomes of less than \$15,000, while 41 percent of the cases had federal adjusted gross incomes between \$5,000 and \$10,000
- the deductible ranged from \$2,500 to \$12,881
- 43 percent of the cases paid the minimum out-of-pocket expenses of \$2,500 to meet the deductible
- the 149 patients paid (or owe) a total of \$534,775 to meet the CHEPP-1 deductible
- state payments to providers totalled \$469,489; of this \$252,351 was paid during Fiscal Year 1978

*Projections:*

- given the present application rate, fewer cases can be expected to be opened in Fiscal Year 1979, as compared to Fiscal Year 1978
- unless this trend changes, costs to the state for providers' services should drop significantly in Fiscal Year 1980

CHEPP-2

*During the period July 1, 1977 through June 30, 1978:*

- 10 different counties took CHEPP-2 applications
- 13 CHEPP-2 applications were taken; one was denied
- patients ranged from 50 to 65 years of age
- three-quarters of the patients were females
- three-quarters of the patients had a diagnosis of either multiple sclerosis or stroke
- 50 percent of the patients had been in nursing homes from 3 to 5 years; the others from 5 to 15 years
- over one-half of the patients had no health care coverage
- incomes ranged from \$1,500 to \$30,000
- 6 of the 12 patients had incomes between \$12,000 and \$16,000
- the deductible ranged from \$310 to \$6,094
- two-thirds of the patients paid \$2,000 to \$4,000 out-of-pocket expenses to meet the 20 percent CHEPP-2 deductible
- the 12 patients paid \$39,935 to meet the CHEPP-2 deductible
- \$55,323 was paid by the state in Fiscal Year 1978 for the nursing home care of the 12 patients

*Projections:*

- the majority of the patients eligible in Fiscal Year 1978 will be eligible in the future; death or reaching age 65 will be the terminating factors rather than income and the deductible as in CHEPP-1

## THE CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM (CHEPP)

### General Description of CHEPP

The CHEP Program is comprised of two parts, CHEPP-1 and CHEPP-2, which differ significantly in their requirements and coverage.

The original CHEPP, later to be called CHEPP-1, became effective July 1, 1977 after enactment by 1976 legislation (M.S. 62E.51 to M.S. 62E.55). Basically, CHEPP-1 may cover expenses for the following services for Minnesota residents when received on or after July 1, 1977:

1. hospital services
2. physician and physician-directed services excluding outpatient mental or dental
3. prescription drugs
4. nursing home care for not more than 120 days per year if placement occurs within 14 days following a hospital stay of at least 3 days for the same condition (skilled nursing facility only)
5. home health agency (up to 180 visits per year)
6. radium or other radioactive materials
7. oxygen
8. anesthetics
9. prostheses
10. rental or purchase of durable medical equipment
11. X-rays and laboratory tests
12. oral surgery (under specific conditions)
13. physical therapy
14. ambulance to nearest qualified health care institution

The above services are covered when an individual owes for himself and any dependents an amount, incurred in any 12 consecutive months, exceeding:

40% of household income up to \$15,000

plus 50% of household income between \$15,000 and \$25,000

plus 60% of household income in excess of \$25,000;

or \$2500, whichever is greater.

Since CHEPP eligibility is based on household income, it provides an option to reducing assets in order to become eligible for Medicaid or general assistance medical care, i.e. eligible families can retain their \$70,000 in a savings account or the \$200,000 farm.

There can be no third party which is liable for these expenses. Income basically means the federal adjusted gross income; income for the calendar year preceding the year in which a CHEPP application is filed is used to determine eligibility. If an applicant becomes an eligible person, s/he is responsible for a 10 percent co-payment on covered services, with the state paying 90 percent of qualified expenses. Eligibility includes dependents of an eligible person and runs for 12 months starting on the first day of the month and year of the earliest service resulting in expenses used to satisfy the deductible. Eight million dollars were appropriated for Fiscal Year 1978 and ten million dollars for Fiscal Year 1979.

In 1977, the above CHEPP legislation was amended to include "qualified nursing home expense." This additional coverage with separate requirements for eligibility became known as CHEPP-2. This segment of CHEPP covers all nursing home expenses incurred on or after July 1, 1977, in excess of 20 percent of household income (preceding the year in which an application is filed) for persons 64 years of age or younger in long-term care facilities. In order to be eligible, persons must have already received at least 36 months of continuous care in a long-term care facility. "Nursing home" is defined as a skilled nursing facility or intermediate care facility I. Eligibility is from the date of satisfaction of the deductible until June 30 or not later than the last day of the month in which the patient becomes 65 years of age. After the 20 percent deductible is met, the state pays the reasonable cost of the eligible person's nursing home care. This payment is made to the patient, patient's family, or the nursing home after the end of the state fiscal year. If insufficient funds are appropriated for CHEPP-2 expenses, the payable amount will be prorated to all eligible individuals. The amount appropriated for CHEPP-2 was \$450,000 per year for Fiscal Years 1978 and 1979.

## County Referrals to the CHEP Program

During the period July, 1977 through August, 1978, sixty-four counties have taken applications for CHEPP-1 and/or CHEPP-2, resulting in one of the three following initial determinations of case status: open, application pending, or denied case. The total number of CHEPP case applications taken, with information on same provided to the state, is 186 cases. Of these 186 cases from 64 different counties, 149 cases were open for some period of time during the 14 months from July, 1977 through August, 1978 for CHEPP-1. Twenty-two cases during this same period were denied eligibility for CHEPP-1, and two cases, according to the case information file, continue to have "application pending" status for CHEPP-1.

Under CHEPP-2, twelve cases were open during the period July, 1977 through June, 1978. One additional applicant during that same period was denied eligibility.

The map on page 6 shows the total case activity of each county. Those counties with no CHEPP-1 or CHEPP-2 case activity as of September 1, 1978 are:

Aitkin	Lake
Beltrami	Lake of the Woods
Chisago	Mahnomen
Cook	Mille Lacs
Cottonwood	Mower
Goodhue	Nicollet
Hubbard	Norman
Itasca	Olmsted
Kanabec	Sibley
Kittson	Steele
Koochiching	Wabasha
	Wilkin



## CHEPP-1

### Introduction

The information on CHEPP-1 usage and patient characteristics was obtained from 100 percent case record review covering the 14-month period of July, 1977 through August, 1978. Discrepancies exist between information in the case records and that produced by the state computerized system. These discrepancies are typical of those found regarding other programs and are primarily due to inaccuracy, lack of updating information, or differences in defining data elements.

### Patient Characteristics

During the 14-month period, July, 1977 through August, 1978, 149 cases were opened representing 345 individuals. Not all family members potentially eligible for CHEPP-1 have become eligible. At times, all family members are listed on the application but not on the case information file. Occasionally, some families chose to have only the "patient" eligible.

The following patient characteristics pertain only to the 149 individuals having catastrophic health expenses resulting in their (and their family's) eligibility for CHEPP-1. Characteristics of their eligible dependents are not included.

The age and sex of the 149 patients is as follows:

<u>AGE AND SEX</u>				
<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>	<u>PERCENT OF TOTAL</u>
Under 21 years	7	2	9	6
21 - 44 years	14	16	30	20
45 - 64 years	37	58	95	64
65 and over	4	11	15	10
<u>TOTALS</u>	<u>62</u>	<u>87</u>	<u>149</u>	<u>100</u>

The preceding table shows that the majority (approximately 39%) of individuals eligible for CHEPP-1 are females between the ages of 45 and 65 years and almost two-thirds of all patients are between 45 and 65 years of age.

Diagnostic information on the 149 patients, when available, was obtained from county information contained in the case file. Diagnoses were not verified; accuracy of this information cannot be determined since it was self-reported. The major diagnostic categories are as follows:

<u>DIAGNOSIS</u>	<u>NUMBER OF PATIENTS</u>
Cancer	43
Heart conditions	31
Accidents (fractures, burns)	11
Stroke	8
Gastrointestinal disorders (ulcers, Crohn's disease, pancreatitis)	8
Genitourinary disorders (include kidney dialysis)	5
Respiratory disorders (asthma, emphysema)	5
Delivery/Newborn problems	4
Surgical joint repair	4
Psychiatric disorders	3
Arthritis and related problems	3
Liver diseases	2
Hernia	2
Multiple Sclerosis	1
Cystic Fibrosis	1
Chemical Dependency	1
Cellulitis	1
Phlebitis	1
Unknown	<u>15</u>
TOTAL	149

Cancer and heart conditions account for 50 percent of the diagnoses. At least 75 percent of those eligible for CHEPP-1 have had catastrophic expenses resulting from treatment of a chronic disease.

Income information on the 149 cases eligible for CHEPP-1 was self-reported on the CHEPP-1 application. The income used for eligibility determination is the sum of the federal adjusted gross income and all nontaxable income of the husband, wife and dependent children 23 years of age and older for the calendar year prior to the year of application for CHEPP-1 benefits.

The incomes for CHEPP-1 cases ranged from \$-2,189.00 to \$28,135.00 per year. The table below shows number and percent of cases in relation to income ranges.

<u>INCOME RANGES</u>	<u>NUMBER OF CASES</u>	<u>PERCENT OF ALL CASES</u>
Minus Income	6	4
\$0 - 4,999	45	30.2
\$5,000 - 9,999	61	41
\$10,000 - 14,999	24	16
\$15,000 - 19,999	8	5.4
\$20,000 - 24,999	4	2.7
\$25,000 - 28,135	1	.7
TOTALS	149	100.0

Approximately 87 percent of all the cases eligible for CHEPP-1 had incomes within the \$0 to \$15,000 range. The income range with the greatest number of cases (approximately 41 percent) was the \$5,000 to \$10,000 range.

The information on occupations of the 149 cases was obtained, when supplied, on the copies of tax returns or in copies of county notes on applicants when submitted with other application materials.

The table below indicates occupational categories and number and percent of cases in each category.

<u>OCCUPATION</u>	<u>CASES</u>	
	<u>NUMBER</u>	<u>PERCENT</u>
Farmer	39	26.2
Retired	30	20
Own Business	28	19
Skilled Labor	14	9.4
Unskilled Labor	8	5.4
Sales	3	2
Unemployed-Disabled	2	1.3
College Student	1	.7
Other	9	6
Not Given	15	10
TOTALS	149	100.0

Approximately 45 percent of the cases that are or were open during the 14-month period were farmers or small businessmen. Almost two-thirds of the cases listed farmer, own business, or retired as the occupation.

Information from the CHEPP applications indicates whether the applicant and other family members are eligible for health insurance and Medicare. The following insurance information pertains only to the 149 individual patients whose conditions and status resulted in CHEPP eligibility. Individuals with insurance number 74; those without insurance number 75. Dependents of some of those 75 patients without insurance did have insurance, so the information given here does not pertain to entire cases regarding insurance. Fourteen patients were eligible for Medicare; of

these fourteen patients, nine had other health insurance. Of the 75 patients without health insurance, five were eligible for Medicare resulting in 70 patients with no health care coverage of any type. The insurance status of the 149 patients is indicated on the table below.

Health Insurance Only	65
Medicare Only	5
Health Insurance and Medicare	83
No Health Insurance or Medicare	70

The self-reported occupations of the 70 individuals with no health care coverage are indicated below.

<u>OCCUPATION</u>	<u>PATIENTS</u>	
	<u>NUMBER</u>	<u>PERCENT</u>
Farmer	22	31.4
Own Business	14	20
Skilled Labor	10	14.3
Retired	5	7
Unskilled Labor	3	4.3
Unemployed-Disabled	2	3
Sales	1	1.4
Other	6	8.6
Not Given	7	10
TOTALS	70	100.0

Farmers, small businessmen and skilled laborers are two-thirds of all those individuals with no health care coverage.

The following table indicates the percentage of all patients in each occupational category without any health care coverage.

<u>OCCUPATION</u>	<u>PATIENT TOTAL NUMBER</u>	<u>PATIENT NUMBER W/O COVERAGE</u>	<u>PERCENT OF TOTAL</u>
Farmer	39	22	56
Retired	30	5	16.7
Own Business	28	14	50
Skilled Labor	14	10	71.4
Unskilled Labor	8	3	37.5
Sales	3	1	33.3
Unemployed-Disabled	2	2	100
College Student	1	0	0
Other	9	6	66.7
Not Given	15	7	46.7
<u>TOTALS</u>	<u>149</u>	<u>70</u>	<u>47</u>

The above table suggests that those eligible for CHEPP-1 and indicating a skilled labor occupational category have the least health care coverage of employed groups, with farmers and small businessmen following.

The length of time an individual or family is eligible to have the state make payments for medical care ranges from less than one week to almost twelve months, depending upon the length of time it took to satisfy the deductible.

The following table indicates the number of months an individual or family was eligible to have medical expenses covered by CHEPP-1 and the number of cases in each category.

NUMBER OF MONTHS ELIGIBLENUMBER OF CASES

Less than 1 month	1
2 months	0
3 months	2
4 months	5
5 months	5
6 months	5
7 months	4
8 months	16
9 months	11
10 months	19
11 months	41
12 months	40

Approximately two-thirds of all the cases were eligible for CHEPP-1 benefits for 10 to 12 months, indicating that meeting the deductible generally occurs rapidly.

The minimum CHEPP-1 deductible is \$2,500. The deductible category each case met is shown on the following table:

<u>DEDUCTIBLE</u>	<u>CASES</u>	
	<u>NUMBER</u>	<u>PERCENT</u>
\$2500	64	43
\$2501 - 3500	33	22
\$3501 - 4500	24	16
\$4501 - 5500	11	7.4
\$5501 - 6500	7	4.7
\$6501 - 7600	4	2.7
\$7501 - 8500	1	.7
\$8501 - 9500	2	1.4
\$9501 - 10,500	1	.7
\$10,501 - 11,500	1	.7
\$11,501 - 12,500	0	--
\$12,501 - 12,881	1	.7
<u>TOTALS</u>	<u>149</u>	<u>100.0</u>

Approximately 43 percent of the cases were required to meet the minimum deductible. About 81 percent of all cases met a deductible ranging from \$2500 to \$4500.

The annual income range for those patients required to meet the \$2500 deductible follows:

<u>ANNUAL INCOME</u>	<u>NUMBER OF CASES</u>
Minus Income	6
\$0 - 1000	6
\$1001 - 2000	2
\$2001 - 3000	7
\$3001 - 4000	14
\$4001 - 5000	16
\$5001 - 6000	11
\$6001 - 6127	<u>2</u>
TOTAL	64

The maximum difference in incomes of those required to meet the \$2500 deductible is approximately \$8300.

The following table indicates the ranges of the required deductible for each of the income ranges for the 149 cases:

<u>INCOME RANGES</u>	<u>NUMBER OF CASES</u>	<u>DEDUCTIBLE RANGES</u>
Minus Income	6	\$2500
\$0 - 4999	45	\$2500
\$5000 - 9999	61	\$2500 - 4000
\$10,000 - 14,999	24	\$4000 - 6000
\$15,000 - 19,999	8	\$6000 - 8500
\$20,000 - 24,999	4	\$8500 - 11,000
\$25,000 - 28,135	1	\$11,000 - 12,881

Sixty-three cases made application for CHEPP-1 from July 1 to December 30, 1977; 101 cases applied in the first seven months of 1978.

The small number of recent cases opened may be deceptive; at times the determination of eligibility is a lengthy process and the state is generally not informed of case information until the case status has been determined by the county. Therefore, it is possible that additional case applications have been taken by the county welfare departments and are not yet entered into the state system.

The reason for denial of eligibility for 15 of the 22 CHEPP-1 cases is available and follows. Twelve cases were not able to meet the CHEPP-1 deductible. Two of the cases could not meet the minimum \$2500 deductible; other cases had higher deductibles which they could not meet. Two cases had received the majority of services prior to July 1, 1977, and one case did not reside in Minnesota. The reason for denial of eligibility for the remaining seven cases is not known.

As of September 1, 1978, 63 of the 149 CHEPP cases were open; 86 cases had been closed.

Following are the months in which the 149 cases opened under CHEPP-1 became eligible to have 90 percent of the cost of their medical care services covered by the state.

<u>DATE ELIGIBLE FOR BENEFITS</u>	<u>NUMBER OF CASES</u>
1977: July	13
August	12
September	21
October	12
November	18
December	13
1978: January	14
February	8
March	13
April	13
May	8
June	4
July	0
August	0

This pattern indicates how rapidly the deductible is met, since medical care which can be covered must have been provided on or after July 1, 1977.

Approximately three-fourths of those eligible for CHEPP-1 met deductibles of \$2500 to \$4000.

Providers Utilized by CHEPP-1 Patients

Payments were made to the following provider types under the CHEP Program. The number in parentheses indicate the number of CHEPP-1 patients receiving a service from this provider type. In 80 percent of the cases, a patient received services from more than one provider type.

- Inpatient hospitals (89)
- Physicians (141)
- Pharmacies (96)
- Outpatient hospitals (48)
- Medical equipment and oxygen suppliers (10)
- Nursing homes (7)
- Ambulances (10)
- Laboratories (2)

Physicians, pharmacies and hospitals were the providers most frequently utilized by the CHEPP-1 patients.

CHEPP-1 Caseload

During the July, 1977 through August, 1978 period, there was CHEPP-1 activity on 173 cases. The application dates and case status in relation to number of cases is shown below.

APPLICATION DATE	NUMBER OF CASES AND STATUS		
	OPENED	DENIED	TOTAL STATUS
1977: July	1	0	1
August	4	0	4
September	9	0	9
October	12	1	13
November	13	0	13
December	22	1	23
1978: January	11	3	14
February	7	0	7
March	14	1	15
April	14	3	17
May	20	2	22
June	14	2	16
July	8	2	10
August	0	0	0
<b>TOTALS</b>	<b>149</b>	<b>15*</b>	<b>164**</b>

\*Excludes data on seven CHEPP-1 denied cases.

The length of eligibility of the 149 CHEPP-1 cases, when plotted out, indicates the number of cases open each month; information below pertains to all cases which had been or were open prior to September 1, 1978:

	<u>DATE</u>	<u>NUMBER OF CASES OPEN</u>
1977:	July	13
	August	25
	September	46
	October	58
	November	76
	December	89
1978:	January	103
	February	111
	March	124
	April	137
	May	145
	June	149
	July	95
	August	78
	September	63
	October	47
	November	35
	December	27
1979:	January	21
	February	14
	March	6
	April	3

As of September 1, 1978, all cases of "open" status would be closed at least by April, 1979. When the program became effective in July, 1977, many patients selected that date as the start of their eligibility year resulting in numerous cases being closed at the end of June, 1978. Due to the high deductible requirements to be met annually, it seems unlikely that many patients would be determined eligible in consecutive years. Therefore, eligible patients in Fiscal Year 1979 would probably not be reapplicants. At this time, the number of cases open each month during the second year of operation (starting July 1, 1978) is considerably less than during the first year. The option available to CHEPP patients to select the 12-month period for which state payment of medical expenses is to occur will continue to affect the pattern of cases open at any time, and one more year of experience will provide trend indications.

## Current CHEPP-1 Costs

### Costs to Patients - July, 1977 to August, 1978

The 149 CHEPP-1 families paid (or owe) a total of \$534,775.68 in order to meet the program deductible. In addition, any bills submitted to and paid by the state required a 10% co-payment by the patient or patient's family, which totalled \$47,370.47. Therefore, patients' out-of-pocket expenses to meet deductibles and co-payments were \$582,146.15.

### Costs to State - July, 1977 to August, 1978

The state payments made to providers as of September 1, 1978, totalled \$469,489.79. Monthly county remittance management and fiscal reports indicate the state paid providers \$426,331.75, during the 14-month period, through the centralized disbursement system. The first payments were made in November, 1977. A total of 1,796 claims have been processed by the state at a claims processing charge of \$1,711.99. During this same 14-month period, the state paid a total of \$43,158.04 outside the centralized disbursement system in order to reimburse patients for payments made for services which were to be covered under the CHEP Program or providers when both patient and CHEPP-1 were making partial payments on the same date (i.e. patient is meeting the deductible).

For Fiscal Year 1978, \$8 million was appropriated for CHEPP-1 and the administrative budget was \$56,473. For Fiscal Year 1979, \$10 million is appropriated for CHEPP-1 and the administrative costs are budgeted at \$57,115.

During Fiscal Year 1978, \$252,351.35 was paid to providers for services rendered which were covered under the CHEPP-1 program. Payments made by the state outside the centralized disbursement system were \$19,969.87. Therefore, the total amount paid for CHEPP-1 covered services during Fiscal Year 1978 was \$272,321.22.

## Projections - CHEPP-1

### Utilization

Given the present application and eligibility patterns for CHEPP-1, it appears that fewer cases can be expected to be opened during Fiscal Year 1979, as compared with Fiscal Year 1978, if there are no changes in program administration or requirements.

The number of reapplications will probably be few because catastrophic health expenses generally do not continue to be incurred over a long period of time. Either the patient dies or improves; the need for CHEPP would be on a sporadic basis for those patients improving after having a catastrophic health problem. While patients' medical care expenses may continue to be high over the years, the annual deductible required would probably make continuing annual CHEPP-1 eligibility unlikely.

### Costs

The total amount the state will reimburse providers during Fiscal Year 1979 will be significantly greater than the amount in Fiscal Year 1978 which was \$272,321.22. During the first two months of Fiscal Year 1979, the state reimbursed providers a total of \$197,168.57. But payments to providers do not correspond to utilization of the program for several reasons:

First, providers have up to one year from the date of service to bill the program. Therefore, the large amount paid to providers in July and August, 1978, includes payments for services provided in July and August, 1977. Second, large total payments to providers during one month may reflect three, rather than the usual two, state warrant writings in a month. Third, the catastrophic health expenses had to be incurred on or after July 1, 1977, to be used in meeting the deductible.

Eligibility for state coverage of care for the majority of patients began later in the fiscal year. Fourth, a number of the initial bills submitted by providers were rejected; many of these bills are being and will be resubmitted for payment. As with new programs, it takes the providers' billing personnel some time to learn the mechanics of billing the program properly. Fifth, during the first six months of 1978, the greatest number of cases were open for CHEPP benefits. Theoretically, the largest total payments to providers may be made through June of 1979. Unless the number of applicants who become eligible for CHEPP-1 increases in the future, costs to the state for providers' services should drop significantly in Fiscal Year 1980.

## CHEPP-2

### Introduction

The information on CHEPP-2 usage and patient characteristics was obtained from review of all case records which were opened during the July, 1977 through June, 1978 Fiscal Year. The CHEP-2 Program is operated on a manual basis to a much greater degree than is the CHEP-1 Program. The patients are not included in the case information files of eligibles, and payments are manually made to the patients at the end of the fiscal year.

### Patient Characteristics

During Fiscal Year 1978, twelve individuals were eligible for CHEPP-2. Age, as of June 30, 1978, and sex of the twelve nursing home residents follow:

<u>AGE AND SEX</u>			
<u>AGE</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
50 to 55 years	1	2	3
55 to 60 years	-	4	4
60 to 65 years	2	3	5
<u>TOTALS</u>	<u>3</u>	<u>9</u>	<u>12</u>

Three-fourths of the patients were females and ages ranged from 50 to 64 years.

Diagnostic information available for eleven of the twelve patients is as follows:

<u>DIAGNOSIS</u>	<u>MALE</u>	<u>FEMALE</u>	<u>TOTAL</u>
Multiple Sclerosis	-	5	5
Stroke	2	2	4
Encephalitis	1	-	1
Huntington's Chorea	-	1	1
Unknown	-	1	1
<u>TOTALS</u>	<u>3</u>	<u>9</u>	<u>12</u>

Three-fourths of the patients had diagnoses of multiple sclerosis or stroke.

The income of those eligible for CHEPP-2 ranges from \$1,548.00 to \$30,469.13.

Income ranges and number of cases in each range were:

<u>INCOME</u>	<u>NUMBER OF CASES</u>
\$1,548	1
\$12,000 to 16,000	6
\$16,000 to 20,000	2
\$20,000 to 30,470	3

Information from the CHEPP application indicates that four of the CHEPP-2 eligible patients had Medicare and one additional patient had other health insurance coverage. Therefore, seven of the twelve CHEPP-2 patients had no health care coverage of any type.

After meeting the 20 percent CHEPP-2 deductible, the number of months that individuals were eligible to have nursing home expenses covered is as follows:

<u>NUMBER OF MONTHS ELIGIBLE</u>	<u>PATIENTS</u>
1 to 2 months	1
2 to 3 months	0
3 to 4 months	1
4 to 5 months	1
5 to 6 months	1
6 to 7 months	2
7 to 8 months	4
8 to 9 months	2

One-half of the patients had nursing home expenses covered during a seven to nine month period.

The deductibles to be met by the twelve families ranged from approximately \$310 to \$6,094, and are shown in the following table:

<u>DEDUCTIBLE RANGE</u>	<u>PATIENTS</u>
\$309.60	1
\$2,000 to 3,000	4
\$3,000 to 4,000	4
\$4,000 to 5,000	1
\$5,000 to 6,000	1
\$6,093.80	1

Two-thirds of the patients met deductibles ranging from \$2,000 to \$4,000.

The length of time the twelve patients have resided in nursing homes ranges from three years to fifteen years. The range of nursing home stays in relation to number of patients is as follows:

<u>YEARS IN NURSING HOME</u>	<u>PATIENTS</u>
3 to 5 years	6
5 to 7 years	3
7 to 15 years	3

#### County Referrals to CHEP-2 Program

During the period July, 1977 through June, 1978, thirteen applications were taken for CHEPP-2 from ten different counties. Twelve cases were opened and one case was denied because the patient was over 65 years of age.

The counties which have referred cases to CHEPP-2 are:

Anoka	- 2 cases	Meeker	- 1 case denied
Hennepin	- 3 cases	Murray	- 1 case
Houston	- 1 case	Pine	- 1 case
Kandiyohi	- 1 case	Ramsey	- 1 case
Le Sueur	- 1 case	Yellow Medicine	- 1 case

### CHEPP-2 Caseload

The CHEPP-2 Program requires that eligibility for benefits be terminated each June 30, or when the patients become 65 years of age. As of September 1, 1978, no cases were yet eligible for Fiscal Year 1979 CHEPP-2 benefits, probably because the deductible was not yet met.

The application dates and case status in relation to number of cases is shown below.

APPLICATION DATE	NUMBER OF CASES AND STATUS		
	OPENED	DENIED	TOTAL
1977: September	3	0	3
October	2	1	3
November	2	0	2
December	0	0	0
1978: January	0	0	0
February	2	0	2
March	1	0	1
April	0	0	0
May	2	0	2

Eleven patients remained eligible through June 30, 1978; one patient died in May, 1978.

### Current CHEPP-2 Costs

#### Costs to Patients

The twelve CHEPP-2 patients paid a total of \$33,935.40 for nursing home care in order to meet the program deductible. Any health care services, other than

skilled nursing facility or intermediate care facility I services, must be paid for by the family or, if eligible, through other health care coverage. These costs are not known.

#### Costs to State

The state payments to families or nursing home providers for the twelve CHEPP-2 patients for FY1978 totalled \$55,323.65. The amount paid per patient ranged from \$1,348.00 for a patient eligible one and one-half months to \$9,085.04 for a patient eligible for approximately nine months. The average payment per patient was \$4,610.30.

#### Projections - CHEPP-2

##### Utilization

Holding all factors constant, such as household income, it appears that nine of the twelve patients eligible for CHEPP-2 in Fiscal Year 1978 could be eligible for the same time period in Fiscal Year 1979. Of the three patients with reduced or no eligibility, two will become 65 years of age during the fiscal year so eligibility will be terminated, and one patient has expired. In general, the patients eligible for CHEPP-2 will continue to be eligible until they turn age 65. The fact they have already met an eligibility requirement of a three-year continuous stay in a nursing home indicates their chronic diseases are long-term conditions. Therefore, the majority of patients will be eligible each year, until 65 years of age, resulting in a cumulative patient count over a period of time.

##### Costs

Given the same household incomes and nursing home per diem rates as in Fiscal Year 1978, the state dollars which could be expended in Fiscal Year 1979 on the eleven CHEPP-2 patients (two with limited eligibility) would be approximately \$44,500.

## PROJECTED USAGE OF CHEPP PRIOR TO IMPLEMENTATION

During the three-year period prior to the enactment of CHEPP legislation, legislative staff obtained information and data from numerous sources in order to attempt to project need, utilization and costs of a catastrophic health care program in Minnesota. Information and data collected included: national and Minnesota medical care cost increases over time; data upon which congressional bills were based; type of insurance coverage provided by large Minnesota employers; national research estimates on catastrophic health expenses; estimates of Minnesota's uninsured and underinsured population; review of catastrophic health care coverage in other states; and, data from a computer study done by the Tax Study Commission regarding medical deductions from 20,000 tax returns for 1974.

During the years of data collection and analysis, it was recognized that data available was fragmented, not at all conclusive; and allowed, at best, for only rough approximations of need, utilization and costs. Several estimates on each of these subjects were made.

It appears that the two primary sources of data used in projecting cost and utilization for a Minnesota catastrophic health program were the Tax Study Commission reports and the actual experience of Rhode Island's Catastrophic Health Insurance Plan which became effective in 1975.

The Tax Study Commission resulted in the estimates and projections for a Minnesota program as follows:

PROJECTED COSTS AND UTILIZATION OF THE CHEP PROGRAM BASED ON TAX STUDY COMMISSION  
DATA FROM 1974 TAX RETURNS, AVAILABLE TO LEGISLATIVE STAFF IN 1976

Calendar Years	Gross State Program Costs (In Millions)	Net State Cost* (Due to 15% Savings in Other Programs)
1975	9.5	7.9
1976	10.2	8.5
1977	10.9	9.1
1978	11.6	9.7
1979	12.4	10.3

\*A 15 percent savings in the medical assistance and general assistance programs as a result of the state catastrophic health insurance program was predicted.

In addition, it was projected that about 1,750 households would have benefited from a catastrophic health expense program in 1974. Approximately 72 percent of the projected households would involve a senior citizen. It also was estimated that the utilization and costs would increase 15 percent annually.

At the same time in 1976, Minnesota estimates were made based on data from the Rhode Island program as shown below:

MINNESOTA ESTIMATES

	<u>COSTS</u>	<u>CASES</u>
First six months	\$1,250,000	230
Second six months	\$1,920,000	415
Third six months	\$2,415,000	1045

In making the estimates based on Rhode Island's program, the following factors were taken into account: Rhode Island has about one-quarter the population of Minnesota and a higher percentage of their population has health insurance.

The Department of Public Welfare based its 1978-1979 biennial CHEPP budget request for \$23 million on the calculations from the Tax Study Commission reports rather than on the Rhode Island-based projections. The legislature appropriated \$18 million for the biennium; \$8 million for the first year and \$10 million for the second.

Minnesota's actual experience with the CHEP Program, as has been shown, is considerably different than what was projected. In fact, the present experience appears to parallel the initial experiences of Rhode Island's program.

The following is information on Rhode Island's Program:

	<u>FY '75</u>	<u>FY'76</u>	<u>FY'77</u>	<u>FY'78</u>
Total Budget	\$1,500,000	\$980,568	\$1,362,489	\$1,426,852
Claim Expenditures	\$ 197,946	\$682,532	1,095,937	\$1,537,761
Eligible Families	58	133	173	396
New Applications	176	N/A	N/A	257

Since the inception of Rhode Island's program, "mental disorders" have been the primary diagnostic category reported by families. With the exception of this category, the ranking of the rest of the diagnostic categories appears to be similar to Minnesota's experience.

## FACTORS IMPEDING USAGE OF CHEPP

Two factors which appear to have an impact on the utilization of CHEPP are the program requirements for eligibility and the CHEPP publicity and training activities.

The eligibility requirements, particularly the high deductible and the 36-month nursing home residency requirements, limit the number of persons who can use the program. If the primary purpose of CHEPP-1 is to provide assistance to families on a one-time or episodic basis, rather than for chronic disease expenses on an ongoing basis, the program appears to be effective. However, at this time, there is no information available to determine if present utilization is reflecting the need for the CHEP Program.

Soon after the CHEP Program became operational, ten "training sessions" were held in August, 1977, in various areas of the state for purposes of informing and training county welfare agency personnel about CHEPP. Attendance records for these sessions are no longer available. Since that time, one additional training session was held and five meetings were attended for purposes of presenting information about CHEPP. One news article was published in a metro paper and three news releases were distributed to numerous papers, but it is not known if they were used. CHEPP informational brochures have been distributed to county welfare departments, all providers, each district social security office, each information and resource office, the St. Paul Area Chamber of Commerce, the State Cancer Society and the state medical association. Providers and counties have been provided general information about the program in various bulletins. A manual and an administrative rule for the CHEP Program have both been developed and are in effect. The majority of these training and publicity activities occurred in 1977.

In view of the fact that CHEPP is a new program and has been less utilized than expected; perhaps the public, the potential eligibles, the potential referral sources and the county welfare personnel have not been as well-informed as they could be or should be. Publicity and training activity results can also be useful in determining whether or not need for CHEPP is being met in view of application activity following active, organized training and publicity on the program.

Because it is not known whether CHEPP is meeting the need for such a program, ongoing examination of who is using the program and their characteristics, in addition to follow-up on cases which are closed or denied, is important for purposes of obtaining information on additional factors which may be impeding the usage of CHEPP.

## CHEPP RECOMMENDATIONS

The CHEP Program has been operational just over one year. In view of maximum annual eligibility for the program of twelve months, minus the time period in which the deductible is being met, there is not, as yet, enough program experience upon which to base sound predictions for future costs and usage.

Prior to development of CHEPP legislation, legislative staff collected information and data over a three-year period for purposes of projecting need, utilization, and costs for catastrophic health care coverage. During, and since that time, no data has been discovered upon which to comfortably and firmly base cost and utilization projections for the CHEP Program.

Trends can be noted and some projections based on them, although a minimum of one more year of CHEPP experience is desirable for development of projections based on actual experience.

At this time, the four basic options available regarding the CHEP Program are:

1. Continue to operate the program as in the past.
2. Continue to operate the program as in the past with minor modifications and add publicity, training and need determination activities.
3. Propose legislative changes to modify CHEPP eligibility requirements.
4. Combination of numbers 2 and 3.

After review of the proposed and current functioning of the CHEP Program, the fourth option is the one recommended. The basic unanswered questions at this time are whether the CHEP Program is meeting the need (in view of the eligibility requirements) or whether the utilization is low because potential eligibles or their referral sources do not know about the program. Until there is more information available on these two issues, major modifications of CHEPP legislation are not recommended. It appears most new health care coverage

programs start out slowly but soon expand beyond all projections, as in the General Assistance Medical Care and Medicaid Programs.

Specific CHEPP recommendations, based on the necessity of determining whether or not the need for the program is being met, are the following:

1. Contact county financial workers on a county-by-county basis to obtain information on the following issues for purposes of assessing unmet need for CHEPP:
  - a. determine their knowledge of CHEPP;
  - b. determine if need is being met regarding catastrophic health expenses from county agency's viewpoint;
  - c. determine why some counties have never referred cases;
  - d. determine why some counties have referred one case long ago and none since;
  - e. determine why there are few, if any, applications;
  - f. follow up on cases;
  - g. determine from these contacts the method and type of CHEPP information that is required at the county level.
2. Provide or arrange for training of county financial workers regarding the CHEP Program on an ongoing basis. This training should be available on a scheduled basis as well as on an "as requested" basis.
3. Provide for education of providers and their billing personnel regarding the CHEP Program on a regular basis. Providers, especially hospitals and physicians, and their billing personnel, are likely to be among the best program referral sources. Inclusion of CHEPP information in the programs presented by the provider education unit of the medical assistance program is suggested.

Other methods of educating providers about the CHEP Program include:

- a. making presentations; i.e. at association meetings;
- b. sending out additional provider bulletins;
- c. placing messages on provider remittance report.

4. Add to the CHEP Program application information that would be useful in the program administration including:
  - a. referral source
  - b. patient's diagnosis, per physician
  - c. identification of the "patient"
  - d. occupation
  - e. total expenses for the episode of illness
  - f. additional information on health insurance status
5. Develop a CHEP Program report which summarizes CHEPP activities, utilization, need and costs so that program effectiveness can be measured on a regular ongoing basis. A program summary should be developed annually and contain recommendations for future program changes based on actual experience.
6. Conduct a telephone survey on a sample of the skilled nursing facilities and intermediate care I facilities to determine the unmet need for CHEPP-2.
7. Utilize health education techniques in publicizing the CHEP Program. Public health students in health education may suggest or aid in this for purposes of determining effectiveness of health education alternatives.
8. Collect information on the health insurance status of the patient and family so that problems in this area can be delineated, as in relation to coverage available for certain groups, and knowledge about the Minnesota Comprehensive Health Association health insurance plans.
9. Followup on past activity initiated to determine if a federal contribution to the cost of CHEPP could be received during the time that the eligibility for medical assistance or general assistance medical care was forestalled.

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THE PRECEDING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.

Georgetown University Health Policy Center  
Seminar on State Health Insurance Plans  
Mayflower Hotel, Washington, D.C.

September, 1977

THE POLITICAL PLANNING OF A STATE  
HEALTH INSURANCE PROGRAM

By Senator Donald D. H. Ching  
Majority Leader  
Hawaii State Senate

The concept of prepaid health care based on mandatory employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. It became law three years later as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature, and for many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in our statutes since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

To be sure, there was resistance and opposition from the traditional opponents of so-called "social legislation." But there was not the hue and cry that one might expect, considering the novelty of the concept.

This is not to say that the spectrum of political thought in Hawaii does not cover any ground to the right of center. Let me assure you we do have traditional conservative views held by many in our State, and I, for one, believe this is a healthy condition. But to the credit of those who did not adhere to the concept, their opposition was not based on the emotionalism that too often attends and distorts vital public issues of the day.

I believe the law was generally accepted by the public because of the kind of political climate we have in Hawaii and because the law was viewed as a logical extension of the kinds of programs that were already in effect at the time.

Let me briefly describe our Prepaid Health Care Law, then attempt to present an account of its chronological place in the context of Hawaii's legislative history.

The Act requires virtually every employer in the State to provide regular employees a health insurance program and to contribute at least one-half the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under 21 working under a parental relationship.

The employee's contribution is limited to no more than 1.5 per cent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal hires in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, more liberal in coverage or employer contributions than required under the Act.

An employer can elect to provide a plan which obligates the insurer to either reimburse the expenses of health care or to directly furnish the required health care benefits. The level of benefits provided must be equal to or medically reasonably substitutable for those benefits provided by pre-paid health care plans of each type -- direct or reimbursed -- which has the largest number of subscribers in the State. In Hawaii, the standards are thus based on the Kaiser Health Foundation's Plan I, in the case of direct services, and the Hawaii Medical Service Association's (Blue Shield) Plan IV, in the case of reimbursed expenses. Both the Kaiser and HMSA plans are basic, comprehensive medical plans emphasizing ambulatory care.

Plans offered by other insurers may be provided, upon review and approval of a seven-member advisory council comprised of consumer, employer, medical profession, and health plan representatives.

What kind of coverage is required by our law? Every qualifying plan must include the following:

- 120 days of hospital benefits, plus outpatient services.
- surgical benefits, including anesthesiologist services.
- medical services, including home, office, hospital visits, and intensive medical care.
- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.
- maternity benefits, provided an employee has been covered for nine months prior to childbirth.
- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

How, then, did we come to enact what some may view as an extremely liberal mandatory health insurance program?

First, it should be noted that we have a substantial body of progressive and advanced social legislation in Hawaii. This is true of our labor laws, our educational system, our public welfare program, and in our judicial system. For instance, our minimum wage law, wage and hour law, workers' compensation, temporary disability insurance, and unemployment insurance programs all have standards comparable to the highest in the Nation. In addition, we also have a public defender program and a criminal injuries compensation law. We also have a no-fault insurance law and a medical malpractice law, the latter amended this year to remove the mandatory feature and to permit doctors the option of forming cooperative indemnity plans to protect themselves against liability judgments.

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

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

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

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

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

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

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

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

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

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

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

Data used included statistics relative to the following:

-- Population by age levels, civilian and military.

The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entitled to Medicare.

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

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 -- A political climate sympathetic to social needs.

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

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

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

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

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

Mahalo.

STATE OF ALASKA  
THE LEGISLATURE

POUCHY STATE CAPITOL  
JUNEAU ALASKA 99811  
907 452 3870

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

May 27, 1977

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

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley SH  
Research Analyst

Carter's National Health Insurance Proposal

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

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

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

- resources for the development of alternative delivery systems;
7. consumer representation in development and administration.

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

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

#### State Approaches

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

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

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

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

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

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

\* Rate for Hartford, New Haven and Fairfield region.

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

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

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

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

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

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

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

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

#### Considerations for Alaska

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

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

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

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

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

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

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

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

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

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ONE HUNDRED AND SEVENTH LEGISLATURE

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Legislative Document

No. 1161

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H. P. 1162

House of Representatives, March 25, 1975

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

EDWIN H. PERT, Clerk

Presented by Mr. Silverman of Calais.

Cosponsor: Mr. Connolly of Portland.

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STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED  
SEVENTY-FIVE

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

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

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

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

STATEMENT OF FACT

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

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

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ONE HUNDRED AND SEVENTH LEGISLATURE

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Legislative Document

No. 1601

H. P. 1287

House of Representatives, April 2, 1975

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

EDWIN H. PERT, Clerk

Presented by Mrs. Berry of Madison.

Cosponsor: Mrs. Morin of Old Orchard Beach.

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STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED  
SEVENTY-FIVE

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

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

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

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

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

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

STATEMENT OF FACT

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

# STATE OF MAINE

APPROVED

CHAS. J. F.

MAR 29 1974

768

BY GOVERNOR

PUBLIC LAWS

IN THE YEAR OF OUR LORD NINETEEN HUNDRED  
SEVENTY-FOUR

H. P. 1991 — L. D. 2535

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

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

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

§ 3454. Medical expenses for catastrophic illness

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

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

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

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

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

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

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

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

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

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

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

A tax is imposed on all cigarettes held in this State by any person for sale, said tax to be at the rate of 7 8 mills for each cigarette and the payment thereof to be evidenced by the affixing of stamps to the packages containing the cigarettes. Any increase in tax authorized under this section shall terminate when a federal program similar to that provided in section 3454 becomes effective. The Governor shall determine by proclamation when said federal program has become effective.

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

The Tax Assessor thereupon shall notify the unclassified importer of the amount of the tax due thereon, which shall be at the rate of 7 8 mills per cigarette.

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

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

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

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

To licensed distributors he shall sell such cigarette stamps at a discount of ~~2 1/4%~~ 2 1/2% of their face value.

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

1974-75

HEALTH AND WELFARE, DEPARTMENT OF

Personal Services	(8) \$ 62,245
All Other	2,770,255
Capital Expenditures	1,600
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	\$2,834,100

FINANCE AND ADMINISTRATION, DEPARTMENT OF

Bureau of Taxation	
All Other	5,900
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	\$2,840,000

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