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insurance plans to include certain types of services or to insure them adequately; (3) the inadequacy of some insurance plans in covering high expenses (an estimated 37 million Americans have plans that do not adequately cover high expenses or long hospital stays); and (4) the ineffectiveness of tax subsidies in assisting low-income families.[6/]

The lack of adequate basic insurance coverage for almost one-third of the families whose incomes are below the national median and the failure of both public and private health insurance programs to cover certain types of services have resulted in two kinds of catastrophic out-of-pocket expenses: the cost of long-term care for the aged; and average or normal expenses that consume an unreasonable proportion of a low-income family's resources.[7/] Although 103 million persons have major medical insurance, and programs such as Medicare and Medicaid cover part of the costs incurred by the elderly and the medically indigent, both groups still experience high out-of-pocket expenses for non-hospital services, as well as for those aspects of their hospitalization not covered by private insurance or public medical care programs.[8/]

These are some of the issues, along with the failure of the federal government to enact thus far a national health insurance plan, which have prompted states to enact their own insurance plans. This paper will now examine the experiences of the five states that have enacted such programs.

CHARACTERISTICS OF STATE HEALTH PLANS

In deciding to adopt a state health insurance plan for its residents, a state government must consider many questions. First, how does it initially determine the need for a state health insurance program? What kinds of criteria should be used to decide whether a plan should be limited to catastrophic illness costs or be more comprehensive in scope? How does it decide whether a plan should be mandatory or voluntary for its citizens? And if the plan is voluntary, how does the state proceed in marketing it to the public?

Another question that arises deals with the relationship of the state plan to private insurance carriers such as Blue Cross, Blue Shield, and commercial insurers, as well as to HMOs and Medicaid and Medicare beneficiaries. In addition, what effect will any potential national health insurance program have upon the state plan? What if the state plan is broader in scope than the initial national health insurance program? Will the state plan just supplement those benefits not covered by the national health insurance plan? What if the state plan is narrower than any initial national health insurance program? Will the state dissolve its own plan in favor of the national health insurance program? And what kind of legislative obstacles must be overcome to get such a plan enacted in the first instance?

Thus far, it would appear that at least five states have answered some of these questions to their own satisfaction. They

Plan	National Assn. of Insurance Commissioners	Council of Insurance Legislators (COIL)	Connecticut	Hawaii	Maine	Rhode Island	Minnesota
Coverage	Comprehensive	Comprehensive	Same as COIL plan, with one substantive difference: Instead of flat $200 deductible, individuals given choice of three: $250, $500, and $750.	Comprehensive	Catastrophic	Essentially catastrophic	Comprehensive/ catastrophic
Availability	All employers and private health insurers must offer state plan as alternative; firms must insure those who can't get or aren't eligible for private insurance.	All insurers required to offer state plan as an option, through state insurance pool if necessary.		All employers must make health insurance available to meet basic minimum coverage standards.	All state residents covered.	All state residents covered; extent of coverage based on whether individual has private insurance policy.	State association of private insurers must make coverage available to anyone rejected by two private firms; state-funded catastrophic plan also. All employers with more than 10 employes must make coverage available.
Deductible	Option 1: $200 per person. Option 2: Choice of $200, $400, or $750 per person.	$200 per person.		According to private policies.	When individual's out-of-pocket health expenses exceed 20% of gross adjusted income, state pays rest.	From $500 to $5,000, depending on whether or not individual has private insurance.	Three "levels" of deductibles to be phased in gradually.
Funding	Premiums	Premiums		Premiums	State cigaret tax; no premium	State revenues	Comprehensive coverage paid by premiums; catastrophic by state
Co-payment	Option 1: 20% co-payment. Option 2: No co-payment. Both options provide that when policyholder's out-of-pocket expenses equal 10% of gross adjusted income, insurance will pay all additional health expenses.	20% of costs over deductible, up to maximum of $1,000 out-of-pocket expenses per person.		According to private policies.	None	None	Private carriers will determine, with approval of state.
Structure	Insurance conducted by private sector, under guidelines of "state health care commission" with broad representation. Commission required to review hospital costs; insurance commissioner has option of enacting review rules for physician costs.	Coverage for uninsurables handled by state association of private insurers to pool reinsurance costs. Some mechanism established to review hospital costs; peer review, as currently exists, required for physicians.		Not really state health insurance, but a set of legal requirements to expand the private insurance market to all employed persons.	Run by state government.	Run by state government.	Private insurers must handle comprehensive plan; state will handle catastrophic umbrella coverage.

Source: "State Health Insurance Plans: Tiptoeing in Back Door," American Medical News, November 8, 1976, p. 8.

include Maine, Rhode Island and Minnesota which have enacted catastrophic health insurance programs, and Hawaii and Connecticut which have enacted plans that are more comprehensive than the catastrophic illness approach.

RHODE ISLAND

The state of Rhode Island decided in April 1974 that a catastrophic health insurance plan was needed for the average working person whose income was about $10,000 per year. Under the program, effective January, 1975, Rhode Island pays the costs of eligible health services after a person has incurred a specified amount of medical expenses. The program encourages the purchase of private health insurance including that of major medical whether it be from Blue Cross and Blue Shield, commercial insurers or through Health Maintenance Organizations. This encouragement is fostered by varying the amount of the deductible that the individual must meet prior to the state plan becoming effective. The amount of the deductible is tied to the kind of private health insurance that an individual purchases. Thus, the deductible would be smallest for an individual or family with qualified health insurance coverage that also includes major medical, larger for the individual or family which has qualified health insurance coverage without major medical and largest for an individual who does not have qualified health insurance coverage at all. The same incentives apply to Medicare beneficiaries who purchase private health insurance as supplementary coverage to Medicare benefits. The program requires

all insurance carriers to offer a qualified policy that meets minimum standards and minimum benefits as specified by the state. The rates for such insurance must be approved by the state as well. The program provides for the establishment of a reinsurance pool and all carriers writing qualified health insurance policies may participate in the pool. There is also mandatory participation in the pool if the insurance commissioner deems such participation to be necessary. 9/

MAINE

In distinct contrast to Rhode Island, the state of Maine in 1974 merely established a catastrophic medical expense fund that was partially financed through a cigarette tax to aid all persons who were experiencing catastrophic medical expenses and who were not otherwise eligible for aid through federal programs. The plan has a very high deductible that must be met prior to its assisting those in need and opposition to the state program has been small on the theory that the eligibility standards are very high and that only those truly in trouble will be aided. The program covers major [illegible] less than one-year long disabilities and prevents the total wipe out of families with small assets. The plan terminates when any similar program on the federal governmental level becomes effective. 10/

CONNECTICUT

Connecticut, on the other hand, has enacted a more comprehensive health insurance program than either Maine or Rhode Island and the plan became effective on April 1, 1976. The plan requires private

insurers to offer Connecticut residents a wide range of benefits, including protection for catastrophic illness with a lifetime maximum of $1 million per individual. A choice of three deductibles--$200, $500, and $750--is available to individuals and groups. A Health Reinsurance Association insurance pool for hign risk insureds is included. The plan guarantees that no one in the state has to pay more than $1,000 per year in out-of-pocket medical expenses as a covered individual or $2,000 per year as a covered family.[11/]

HAWAII

Like Connecticut, the state of Hawaii also enacted a comprehensive health insurance plan but back in 1974. Unlike Connecticut, the Hawaii plan only pertains to those who are employed in the state rather than to all of the state residents. The law requires that companies offer workers acceptable prepaid health care plans similar to Kaiser or Blue Shield programs. Employers must pay at least 50 percent of the costs; employee contributions are limited to a percentage of their wages. The Hawaii Department of Labor and Industrial Relations administers the program. A seven man advisory council--appointed by the Director of the Department--assists in determining whether a prepaid health care plan qualifies. The council members represent the medical and public health professions, consumer interests and the prepaid health care field. The law specifies that the new program will terminate upon the passage of a federal voluntary health insurance program that provides for health care on a basis that is at least as favorable as that provided by the state program.[12/]

MINNESOTA

The latest state health insurance plan to have become operational is that of Minnesota, effective January 1, 1977. Employers in this state must include qualified catastrophic protection in the health insurance programs which their companies offer. Following a $150 deductible, the qualified basic plan pays 80 percent of the first $3,000 per year and 100 percent thereafter, to a lifetime maximum of $250,000. Starting March 1, 1977 the state welfare department will pay 90 percent of yearly medical costs for any person whose incurred expenses exceed 40 percent of household income up to $15,000, plus 50 percent of that between $15,000 and $25,000, plus 60 percent of that over $25,000 or $2,500, whichever is greater.[13/]

BENEFIT COVERAGE AND ELIGIBILITY

In considering the scope of benefit coverage and program eligibility, a state must examine various alternatives and options in terms of the financing available and the capability of administering the program as well as the goals it seeks to attain through the program's establishment. For example, one important question relates to the scope of benefit coverage. Should such coverage be limited to specific age groups, be univeral for all state residents, or be delimited by income range or personal asset valuation? Should the benefit coverage include categorical welfare groups, the unemployed, uninsurables, employer groups, Medicaid and Medicare recipients or beneficiaries of other federal health

programs such as military personnel and their dependents. What about benefit coverage for state residents who work outside the state and out-of-state residents who work within the state? After eligibility determination, the state must decide if it wishes to limit its program to those benefits that embrace the cost of catastrophic illness or establish a program that is much broader in scope than that kind of insurance, as already noted. In the latter case, how does the state determine the kind, priority and extent of benefit coverage?

In answering some of these questions several states adopted the following regulations. The state of Rhode Island's catastrophic health insurance plan covers persons who have resided in the state for at least three months but excludes anyone who moved to the state primarily to obtain benefits. In addition, state benefits to otherwise eligible persons are payable, generally, only if services are not available under other programs. Applicants for benefits are screened to determine possible eligibility for other benefits. The law specifically gives precedence to benefits provided under federal programs such as those for military personnel and for the aged, poor and indigent. The state Medicaid program also takes precedence. The law does not specify the types of services that are reimbursable under the catastrophic program but does note that some services will be excluded or covered only under given conditions or to a limited extent. The restrictions cover such services and items as prescription drugs, chiropractic care, psychological therapy and social

counseling only if they are prescribed as being medically necessary; and cover only up to 50 percent of the costs for outpatient psychiatry care; covers dental care and optometry only if they are required because of an injury or serious illness; covers eyeglasses, hearing aids and related aids only if they are medically necessary for rehabilitation; covers cosmetic surgery only if it is needed to repair an injury; and excludes custodial and domiciliary care and non-prescription drugs.[14/]

In view of the recent advent of state health insurance plans, Rhode Island is one of the very few states to obtain any utilization experience. During 1976, the state paid $858,565 in benefits to 150 families. Emotional disorders led the list of disabilities. Claimants also received state aid for cerebrovascular disorders, cancers and cardiac and kidney conditions. The state health department notes that 65 of the families (43 percent) aided by the state plan were Medicare recipients. The department also stated that 57 families who received state aid in 1976 had Blue Cross, 14 had commercial insurance and 14 had no insurance. Under the Rhode Island plan, a family qualifies as a unit and the catastrophic definition is determined by financial loss rather than by type of illness. Once a family has qualified for the state plan more than one person can get state assistance benefits. Benefits are only available after the claimant has exhausted all health insurance coverage and met certain levels of out-of-pocket expenditures. After qualifying, a claimant can maintain eligibility by incurring out-of-pocket

medical expenses that equal or exceed 25 percent of the first year deductible. In 1976 the plan paid benefits to 189 individuals. The average expenditure was $4,544, about 16 percent above the 1975 expenditure when 114 persons received benefits.[15/]

In order to qualify for the Rhode Island Catastrophic Health Insurance Plan, a person who has private health coverage which has been certified as a qualified program must have accumulated out-of-pocket expenses totaling either $500 or 10 percent of their allowable income, whichever is greater. Medicare beneficiaries with a qualified plan must meet a flat $500 deductible. Persons with less coverage than provided by a qualified program will have to make a larger out-of-pocket expenditure in order to receive state financial coverage. For example, a person with no health insurance must spend either $5,000 or 50 percent of his allowable income, whichever is greater, before becoming eligible. Any benefit that is covered under a qualified program, as defined in the CHIP Act, would be covered under the state financial coverage in full. Thus, it would appear, as in the case of Rhode Island, that those who might not be able to afford the purchase of health insurance must meet the highest form of deductible in order to qualify for the state's health insurance program and in this sense deductibles are regressive since individuals who may need to be protected the most against health care costs through insurance must also bear the greatest personal cost burden before the state's plan becomes effective for them.

On the other hand, a person in Maine must incur medical bills in excess of the following deductibles in order to qualify for benefits through the state's catastrophic illness program:

(1) $1,000

(2) 20 percent of annual income before taxes

(3) 10 percent of net worth over $20,000 if the excess over $20,000 is in the form of cashable assets

The individual is responsible for bills up to the previous amount. Costs in excess of this amount are payable by the Maine Department of Human Services. Eligibility for the Catastrophic Illness program is for a period of a year and can be retroactive for up to 12 months. Out-of-state providers of medical care within 15 miles of the Maine/New Hampshire border and within five miles of the Maine/Canada border are routinely reimbursed. This helps people living in these areas to maintain their usual pattern of health care services. Persons visiting Maine or temporarily from out-of-state are covered for emergency services. All other out-of-state medical services require prior authorization. The Catastrophic Illness program will pay for the following services when medically necessary. These include ambulance services, durable medical equipment, inhalation services, inpatient hospital services, laboratory and x-ray services, outpatient hospital services, ophthalmologist services, physical therapy, physician services, prescription drugs, and skilled nursing services.[16/]

In Hawaii the state mandated health insurance plan is compulsory and workers cannot waive the protection provided by the law. A worker is covered as soon as he has had four or more consecutive weeks of employment. If an employee is not able to work because he is sick, protection continues for three months following the month in which he became ill. All employers with one or more regular employees are covered by the law except the following: government employees, agricultural seasonal employees, employees who work less than 20 hours a week or whose monthly wages are less than 86.67 times the prevailing state minimum hourly wage, employees covered by a federal program or receiving public assistance, individuals who depend on prayer or spiritual means for healing, individuals in family employment, and insurance and real estate salesmen or brokers paid solely on commission.

If an individual works concurrently for more than one employer, the one who pays the most wages will be the principal employer and will be responsible for providing health care coverage. The employee, however, may select a different principal employer if he works at least 35 hours weekly for an employer who does not pay the most wages. If he works for a government agency and a private employer, the former will be deemed the principal employer. If an employee's dependents are themselves employed, they may choose to be covered under the plan at their own place of employment. As far as benefits are concerned, the employer's prepaid group health plan meets the requirements of the law if it provides health care benefits equal to, or medically

reasonably substitutable for, the benefits offered by prepaid health plans of the basic types, such as the Kaiser Foundation Health Plan, commercial insurers or non-profit plans such as the Hawaii Medical Services Association--plans that have the largest number of subscribers in the state, as already has been noted.

The Director of the Department of Labor and Industrial Relations, with the advice of an advisory group, determines whether a plan complies with these standards. Exceptions are permitted when the plan is deemed to provide sound health benefits at a premium commensurate with the benefits after taking into account coinsurance features, deductibles, limitations on reimbursability, and dependents' benefits.

The plan's protection must include hospital benefits of at least 120 days confinement in each calendar year; outpatient hospital care; surgical and diagnostic benefits; home, office, and hospital visits by a physician; and maternity benefits (applicable to employees with at least nine months' coverage before delivery).

Employees are free to bargain collectively for different prepaid health care coverage or for a different allocation of the costs. Employers are in compliance with the law if they provide health care services under a collective bargaining agreement and if the services are provided for employees not covered by such an agreement.[17/]

As far as the state of Connecticut is concerned, its comprehensive health care plan requires insurers to make available to all persons under 65 a standardized health insurance policy covering specified minimum benefits. Included benefits are hospital services, physician services, prescription drugs, partial payment for treatment of mental conditions, skilled nursing home facility care, home health agency visits such as ambulance services, physical therapy, oxygen, anesthetics, diagnostic x-rays and laboratory tests and other lesser benefits. Three deductible levels are available--$200, $500 and $750 as already has been noted--and a 20 percent co-payment provision will be in all the plans. However, a ceiling on cost sharing per year is set at $1,000 per individual and $2,000 per family. However, although a person is eligible for the various benefits under the state health plan, benefits for pre-existing conditions that exist within six months of effective date of the plan coverage and pregnancies that exist on the effective date of the plan are not covered.[18/]

The state of Minnesota has four plans available under its comprehensive state health insurance program and three of the plans are tied to variable out-of-pocket expenses and the fourth plan is concerned with Medicare beneficiaries. In addition, Health Maintenance Organizations may be used in those areas of the state where an HMO has agreed to make coverage available and has been selected as a writing carrier. A plan is certified as a number one plan if it meets the requirements established by the laws of the

state and provides for payment of 80 percent of the covered expense in excess of a deductible which does not exceed $1,000 per person. A health coverage plan shall be certified as a number two plan if it meets the requirements of the state of Minnesota and provides payment of 80 percent of the covered expenses in excess of a deductible which does not exceed $500 per person. Any plan which provides benefits to persons age 65 years or more may be certified as qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deductible and co-payment required under Medicare and 50 percent of the charges for services covered under the state plan which are not covered by Medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000. A number three plan is certified as such when the minimum benefits are equal at least to 80 percent of the cost of covered services in excess of an annual deductible which does not exceed $150 per person. The coverage shall include a limitation of $3,000 per person on total annual out-of-pocket expenses for services covered under this plan. The coverage may be subject to a maximum lifetime benefit of not less than $250,000. Covered expenses as in the case of number one and two plans shall be the usual and customary charges for the following services and articles when prescribed by a physician. These include such benefits as hospital services, prescription

drugs, limited nursing homes services, home health agency services of 180 visits per year, oxygen, anesthetics, protheses, rental or purchase of durable medical equipment, diagnostic x-rays and laboratory tests, physical therapy services, oral surgery, physician services, other than outpatient mental or dental, for diagnosis and treatment of injuries or illnesses, and beginning in 1980, subject to appropriate deductibles, coinsurance and maximum lifetime limitation provisions, services for well-baby care, physician services for routine checks and annual physicals, and multiphasic screening and other diagnostic testing.[19/]

ADMINISTRATION AND FINANCING OF STATE HEALTH INSURANCE PLANS

In considering the administration and financing of any state health insurance plan, state government must consider many questions. First, does the government have the ability and capacity in terms of finances and manpower to operate such a program, as already noted? What kind of cost and quality controls should be incorporated into the program to make it economically feasible and manageable? What kind of audit and accountability procedures should be included in the program so as to avoid the kind of fraud and abuse problems that presently plague Medicaid and Medicare? Should the financing of benefit coverage be phased in by legislative schedule or by the executive branch's administrative decision, if the program is initially limited in its benefit scope? What are the advantages and disadvantages of each of the latter choices? What kind of reimbursement methods are most equitable under the program and how is the method equitably

determined for the providers of health care services who are participating in the program? These are some of the important questions that arise when considering the establishment, administration and financing of a state health insurance program.

In answering some of these questions, the state of Maine, as already noted, established a catastrophic medical expense plan that was partially funded through a one mill cigarette tax increase. An annual minimum amount of $800,000 per year was appropriated for the program by the state government. All participating providers of medical service and supplies agree to accept the payment received from the Maine Catastrophic Illness Program as full reimbursement for services rendered according to state program requirements. No additional charge is to be demanded from the program's beneficiaries for a service or supply covered by the program.[20]

As far as the state of Rhode Island is concerned, catastrophic illness payments are made out of general revenues. The Rhode Island Department of Health Administration administers the program with private health insurers serving as fiscal intermediaries for the payment of benefits. However, despite the use of general revenues to fund the program, it is still up to employers/employees to pay for most of the insurance coverage. The State Department of Business Reuglation establishes the minimum standards--applicable to all health insurance contracts in the state--that are designed to standardize and simplify benefits; eliminate misleading or confusing provisions and limited coverages of little value; eliminate deceptive selling

practices; add coverages in the public interest; promote efficient management of health service; and make qualified plans available to all persons regardless of age, sex, occupational status or medical condition. After the standards are issued, each carrier files a sample contract with the Department. The contract is available to the Rhode Island Consumer Council. If the Council requests a hearing, it will be held to review the contract provisions. The Department may approve, disapprove or modify a contract and, as necessary, all other carrier contracts will be modified to conform with the decision. Insurers must offer the same plan to all persons. Also, they must offer the same coverage to all employers regardless of the characteristics and the number of their employees. The carriers are required to promote efficient management and reimburse only those which are certified by the Department of Health. Insurers operating for profit and self-insured organizations may enter into arrangements to form a reinsurance pool. The pool will spread the losses among the insurers in proportion to the number of persons covered under qualified policies. These agreements must be approved by the State Department of Business Regulation and the Department which, after a hearing, may require all insurers to participate in the pool. In addition, carriers must submit to the State Department of Business Regulation their proposed rates or rating formulas for health insurance. The Department will provide hearings for the public and for representatives of the carrier and the Rhode Island Consumer Council. At the hearings the carriers will be required to prove that the

proposed rates are appropriate for the coverage provided, consistent with the proper conduct of the carrier's business and in the public interest. The Department is authorized to approve, disapprove, or modify proposed rates. Providers of health services must be certified by the Department of Health as a condition of participation in the program. They must meet existing laws and regulations and agree to provide services without regard to race, religion, sex, age or occupational status. Service providers must also offer services at costs, charges or rates that are equitable, non-discriminatory and in the public interest. The State Department of Business Regulation (after a hearing) will be able to disallow payments made by a carrier to a non-certified provider or one engaging in discriminatory practices against insurers. This, in summary, is the essence of the Rhode Island Catastrophic Health Insurance Plan.[21/]

In contrast to Rhode Island, the program in Hawaii only mandates coverage for almost all employed persons, as already noted, while not covering dependents. While deductibles, coinsurance and other cost-saving devices are permissible, the law requires thorough and near total coverage of basic and catastrophic health costs. The program is employment-based with costs to be paid by the employer or shared with the employee. The employee portion of the cost is limited to half the premium costs, not to exceed 1.5 percent of his wages. Provisions are made for state subsidization of those small employers who would be heavily burdened by the costs of this program. The state uses funds from general revenues and penalty

fines to subsidize the premiums of an employer with less than eight employees if the employer's share exceeds 1.5 percent of total wages payable to employees and the amount of the excess is greater than 5.0 percent of the employer's income before taxes that are directly attributable to the business. A formula in the law determines income for this purpose. A special premium supplementation fund is used to pay the subsidy for an employer's share of a premium that exceeds the limits specified above. Employer's penalty fines for failure to comply with the law are deposited in the special fund.[22/]

As already noted, Connecticut's state health insurance plan became effective on April 1, 1976. The program has incorporated several mechanisms in order to control its costs. One is three sets of deductible options--low, middle and high--that are available for individual choice and which already have been discussed. The amount of deductible that is chosen may not be greater when a service is rendered on an outpatient basis than when the service is offered on an inpatient basis. The plan also contains a coinsurance mechanism of 20 percent for charges for all kinds of health care in excess of the deductible chosen and 50 percent for specific kinds of health services listed in the act that creates the program. However, the sum of the deductible and co-payments required in any calendar year under any option may not exceed a maximum limit of $1,000 per covered individual, or $2,000 per covered family. Both the deductible thresholds and the $1,000 and $2,000 annual limits may be adjusted on an annual basis by the State Insurance Commissioner to correspond

with the change in the medical component of the Consumer Price Index. The law that creates the state health insurance program also authorizes the State Commission on Hospitals and Health Care, within one year of April 1, 1976, to adopt regulations designed to require state Professional Standards Review Organizations established under P.L. 92-403 to extend their review of certain inpatient services to services received by all patients. The State Insurance Commissioner also shall adopt regulations to establish minimum standards for benefits under each of the following categories of coverage in individual policies: basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage and specified accident coverage. Specified disease policies, riders and benefits shall be prohibited whether they are issued on a group or individual basis. The state program also creates a Health Reinsurance Association for high risk insured. Any plan that is not insured by or through the Health Reinsurance Association or any other medical market association may not exceed the premium which would be applicable through participation in such associations. Finally, each self-insurer whose plan covers three or more employees shall make an individual comprehensive health care plan available under a conversion privilege to every person covered by the plan who is a resident of the state, who is not eligible for Medicare and whose coverage under the self-insured plan ceases as a result of a layoff, death

or termination of employment. The individual has his choice of low, middle and high option deductibles under this situation as well.[23/]

THE FUTURE

The future of the state health insurance movement cannot be viewed with precise clarity for national health insurance is still a viable possibility for enactment in the 95th Session of the U. S. Congress. Although several states have enacted health insurance programs and several other jurisdictions are presently contemplating the introduction of health insurance bills in their 1977 legislative sessions, the experience that has been gained thus far from these plans is still too minimal to make any decisive statement as to whether or not they are achieving the goals for which they have been or are being enacted. But, the fact that state government has chosen to create such vehicles to assist its residents in paying for the costs of medical care only underlines how serious a problem the financing of such costs has become for many of our citizens. The enactment of state health insurance programs may now be considered an appropriate role and extension of state activity in the health care area but until recently the provision of health insurance protection has been the province of private industry--not the responsibility of state government. However, as already noted, the problem of individual state health insurance programs is that they are individual creations and not uniformly designed among the states in terms of benefit coverage and other areas of legislative intent.

Even though model health insurance bills have been adopted by the Congress of Insurance Legislators (COIL) and the National Association of Insurance Commissioners (NAIC), it is still the decision of state government as to whether or not it wishes to adopt a model bill for its own jurisdiction or enact a bill of its own formulation. The following is one problem that can result from these activities. Should states enact health insurance programs that are diverse in content as well as in intent, then it would be possible that without a national health insurance program this country could be faced with another type of Medicaid situation of having 50 diverse and separate state health insurance plans rather than a uniform 50-state plan with all the possible problems that have attended Medicaid's enactment and operation. If nothing else has been learned from the Medicaid experience after a decade of operation, it should be that the path and experiences incurred under Medicaid should be avoided under diverse state health insurance plans as well so that all involved in such programs--the purchasers, the providers and the payers--will be treated equitably at costs that are reasonable to all.

FOOTNOTES

1. "States Mandating Health Insurance Benefits," Perspective, Fall, 1976, p. 29.

2. Ibid.

3. Ibid.

4. Susanne A. Stoiber, "Catastrophic Health Insurance," Congressional Budget Office, Congress of the United States, Washington, D. C., January, 1977.

5. Casey Crawford, "CBO Releases Definitive Study on Catastrophic Health Insurance," Health Services Information, January 31, 1977, p. 6.

6. Ibid.

7. Susanne A. Stoiber, op. cit., p. xv.

8. Ibid., pp. xv and xvi.

9. Saul Waldman, "Rhode Island Catastrophic Health Insurance Plan," Social Security Bulletin, February, 1975, pp. 41-43.

10. American Medical Association, "Catastrophic Health Insurance," State Health Insurance Report, October 3, 1975, pp. 8 and 9.

11. "States Mandating Health Insurance Benefits," op. cit.

12. Alfred M. Skolnik, "Compulsory Health Insurance in Hawaii," Social Security Bulletin, December, 1975, pp. 23 and 24.

13. "States Mandating Health Insurance Benefits," op. cit.

14. Saul Waldman, op. cit., pp. 41-43.

15. "Benefit Payments Reported Up 16 Percent in Rhode Island's State Health Insurance Plan," National Health Insurance Reports, March 14, 1977, pp. 8 and 9.

16. "Catastrophic Illness Program," State of Maine Department of Human Resources, March, 1976.

17. Alfred M. Skolnik, op. cit., pp. 23-24.

FOOTNOTES (CONTINUED)

18. "Comprehensive Health Care Plans," State of Connecticut, Chapter 692, Hartford, Conn., April 1, 1976, p. 283.

19. "Comprehensive Health Insurance," State of Minnesota, Health Care (62E.02), 1976, pp. 1003-1005 and 1007.

20. "Catastrophic Illness Program," State of Maine, op. cit.

21. Saul Waldman, op. cit., pp. 42 and 43.

22. Alfred M. Skolnik, op. cit., p. 24.

23. "Comprehensive Health Care Plans," State of Connecticut, op. cit., pp. 3, 280-294.

ELIGIBILITY AND BENEFITS UNDER MINNESOTA
CATASTROPHIC HEALTH EXPENSE PROTECTION ACT OF 1976

By Larry R. Fredrickson

I. Historical Background:

The first significant Legislative interest in a state catastrophic health insurance plan was in 1973 when two state senators asked Legislative staff to start working on legislation for a state catastrophic health insurance program. They were prompted by complaints from constituents who had suffered major economic reverses due to health care expenses.

In 1974 two bills were introduced in the State Senate. One bill emphasized catastrophic protection for middle-income people who exhausted their insurance coverage. The other bill emphasized protection for low-income working people who were not eligible for medical assistance (Minnesota's medicaid program). Several hearings were held in a Senate subcommittee, but no action was taken. There was serious concern as to who would benefit under a catastrophic health insurance program and how much it would cost. Little concrete information and data were available then (or later).

A special Senate subcommittee was appointed to study health care costs during the interim between the 1974 and 1975 Legislative sessions. Its membership included five senators and five public members including an insurance company executive, a registered nurse, a union official, a housewife and a Native American. The subcommittee recommended an alternative to a

state catastrophic health insurance program which would include establishing minimum benefits (including catastrophic protection) for health insurance policies and a mechanism to enable uninsured people to obtain health insurance. They recommended that the state:

> Encourage further work and study in mandating minimum benefits provided under health insurance policies sold in the State, including minimum benefits for catastrophic coverage, and development of a plan of health insurance providing catastrophic coverage to the handicapped, uninsurable and others not having health insurance available. Both of these acts should provide coverage for ambulatory services. Minimum benefits in group health insurance plans should cover services including but not limited to periodic screening, immunization and non-communicable disease control . . . .

At the start of the 1975 session, the Governor recommended a $17 million state catastrophic health insurance program patterned after the then newly-enacted Rhode Island program. A group of Minnesota Senators, Representatives and staff made a site visit to Rhode Island to study their program. During the same site visit, meetings were held in New York with representatives of the Health Insurance Association of America. The officials and insurers working on the Rhode Island program were very enthusiastic about their law. The national insurance industry representatives supported the alternative recommendation of the Senate subcommittee - an approach which was later enacted in Connecticut. During the 1975 session, the Senate supported the recommendation of their subcommittee, while the House supported the Governor's recommendation. There was some committee action, but because of the conflict between the House and the Senate, no final action was taken.

At the start of the 1976 session, a new bill was introduced in the House which combined the basic features of the House and the Senate bills from the year before into one omnibus bill. The new bill became the basis for the law which was enacted in 1976.

II. Basic Content of Law:

The 1976 law contained three articles and is codified in Chapter 62E of the Minnesota Statutes. The first article dealt with health insurance standards and availability. Minimum standards were established for qualified health insurance policies. Insurers could continue to sell unqualified insurance but were required to offer qualified policies to all applicants for health insurance. Employers were generally required to make health insurance available to their employees. A state-mandated risk pool was established, using a private insurer as the writing carrier, to allow uninsurable or under-insurable people to purchase health insurance.

Because of a fear of inflation in health costs due to increased third party coverage, a second article was included. It increased the powers of the state insurance commissioner to regulate health insurance rates and established a hospital rate review system.

The final article established a state-funded catastrophic health expense protection program (hereafter "state program") to pay health care expenses of people who exceeded the specified threshold level of out-of-pocket expenses. There was not a great deal of legislative discussion of eligibility and benefits

under the article. In order to enable the health insurance availability programs of Article I to begin to function first and potentially save the state money, the third article was given a delayed effective date of July 1, 1977. The state program was originally to be administered by the State Insurance Department to avoid the appearance of it being a welfare program. At the last minute it was changed to have the Department of Public Welfare do the administration primarily because of their prior experience with the medical assistance program.

III. Eligibility Standards:

A. Legislative Considerations:

Initially there were attempts to devise a statutory formula which utilized three factors in determining eligibility: income level, expense level, and insurance protection level. This was the approach used in Rhode Island and seemed to be working there. It was decided to focus on people who were not eligible for existing categorical programs. (In fact, there was some sentiment [illegible] excluding people who were already eligible for categorical programs since they already had some protection.)

There was little objection to including the income and expense level factors in the formula. It was generally agreed that expenses in excess of a specified percentage of income should be the major factor. The state Tax Study Commission prepared a computer analysis of a sampling of itemized state tax returns. With this information, it was possible to obtain a rough approximation of the number of people at various income levels who had medical expense deductions in excess of specified dollar amounts.

The computer data did not differentiate between tax deductions for expenses which would be covered under the state program and tax deductions for expenses which would not be covered. This required the use of "guess" factors to estimate the actual numbers of people who would qualify under various threshold factors and the cost to the state of paying the qualified expenses of those people. This was especially true, for example, with senior citizens where it was assumed that many of them with high expenses had been paying for nursing home care which was not expected to be fully covered under the state program. With the Tax Study Commission data, the Legislature was able to select income and expense level thresholds which matched their policy and fiscal concerns.

The question of utilizing levels of insurance coverage as a qualification factor quickly became the major focus of the debate over eligibility standards.

Some legislators strongly felt that insurance coverage should be a major factor. (It is a significant part of the Rhode Island formula.) They were concerned that a failure to do so would, in effect, penalize those people who took the initiative in obtaining their own health insurance and reward those people who neglected or refused to obtain their own insurance protection. They argued that people would simply "gamble" on remaining healthy and not buy insurance if they knew that the state back-up protection would save them from total economic devastation if they guessed wrong.

On the other hand, other legislators felt that using existing insurance

coverage as an eligibility factor would penalize those people who could not obtain health insurance because of economic or health problems. They also argued that:

(1) The state protection program would require a significant enough out-of-pocket expense level to deter any "gambling";

(2) The day-to-day expenses of health care (as opposed to catastrophic expenses) are high enough to create a stronger incentive to buy insurance than any incentives not to buy insurance;

(3) The person who makes the decision not to buy the insurance may not be the one to need the health services - it could be a spouse or dependent child who became sick;

(4) It would be harder to draft a tripartite formula; and

(5) It would be harder to administer a tripartite formula.

The opponents of an insurance-related eligibility formula ultimately prevailed.

Four other factors did receive some scrutiny during the Legislative deliberations:

First, there was a concern that nonresident people with serious health problems would move into Minnesota to avail themselves of the state program. Various residency tests were considered and eventually rejected. The main arguments against them were court decisions which have rejected most types of residency tests imposed on beneficiaries of public assistance programs and a

contention that the proposed benefits were not lucrative enough to entice any significant number of people into the state.

Second, there was discussion over whether the primary purpose of the program should be (i) protection from non-recurring high cost episodes of illness or injury, (ii) protection from high-cost chronic diseases, or (iii) both. It was decided that the emphasis should be on non-recurring expenses. This enabled the legislature to set an income and expense level threshold which was not particularly generous. The required out-of-pocket expenditures were set high enough so that most households could not afford to make them year after year and continue to qualify for the state program. Instead, they would eventually qualify for another assistance program such as medical assistance. In light of the decision on the thrust of the program, it was decided to not emulate the Rhode Island approach which established a lower threshold for the second year's eligibility. To provide more assistance to the victims of a single high-cost episode, it was decided to provide for a flexible year of eligibility. The potential recipient can, in effect, pick the twelve month period in which to receive the benefits in a way to maximize benefits. This differs from the usual approach of using a calendar year as the basis for benefits.

Third, it was decided to go with a very broad definition of household income. All income of all members of the household was to be included. There was some discussion of providing limited exceptions in some cases such as where a dependent child was working to earn money for college. None of the suggested exceptions were adopted. On the other hand, proposals to factor

in assets such as real property, savings, or investments were also rejected primarily to avoid complicating the administration of the state program.

Finally, there was consideration of making special provisions for unemployed people and low income people without health insurance. Amendments were drafted to establish a mechanism for purchasing health insurance for these groups in the state risk pool for uninsurables. It was eventually decided to delay a decision on these provisions until the state program had been in operation for two or three years.

B. Standards in the Law:

The law has a graduated schedule for determining eligibility. As originally passed, it read:

> 62E.53. [APPLICATION FOR ASSISTANCE.] Subdivision 1. Any person who believes that they are or will become an eligible person may submit an application for state assistance to the commissioner. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the 12 month period for computing expenses began.
>
> Subd. 2. If the commissioner determines that an applicant is an eligible person, he shall pay 90 percent of all qualified expenses of the eligible person and his dependents in excess of:
>
> (a) 40 percent of his household income under $15,000, plus 50 percent of his household income between $15,000 and $25,000, plus 60 percent of his household income in excess of $25,000; or
>
> (b) $2,500;
>
> whichever is greater for the 12 month period in which the applicant becomes an eligible person. If the commissioner determines that the charge for a health service is excessive, he may limit his

payment to the usual and customary charge for that service. If the commissioner determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determinations as to whether or not a charge is excessive. To the extent feasible, the commissioner shall contract with a review organization as defined in section 145.61, in making any determination as to whether or not a service was medically necessary. If the commissioner in accordance with this section refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

The bill which originally passed the House did not contain a graduated formula or the copayment requirement. The Senate, whose bill did not contain the state program, suggested in conference committee that some changes be made to control costs and make eligibility standards high at higher income levels. The conferees then developed the graduated income formula and the copayment feature primarily as cost and utilization control features.

Under the income and expense formula as adopted, the following out-of-pocket expenses would have to be incurred by a household to qualify:

Household Income	Out-of-pocket Expenses Incurred	Incurred Expenses as a Percentage of Income
$ 5,000	$ 2,500	50%
10,000	4,000	40
15,000	6,000	40
20,000	8,500	42.5
25,000	11,000	44
40,000	20,000	50
75,000	41,000	54.7
100,000	56,000	56

By and large, higher income households must pay a higher percentage of household income as out-of-pocket expenses before qualifying. The exception comes for households with very low incomes. It was assumed that these households would easily qualify for other assistance programs - hopefully ones where the Federal Government would participate in the costs of the program. Once it qualifies a household must still pay 10 percent of the costs of services provided. A second cost control mechanism was the provision in the law allowing the Commissioner of Public Welfare to establish mechanisms to review provider charges and prohibiting providers from attempting to collect excess charges from consumers.

IV. Benefits Schedule:

A. Legislative Considerations:

The question of benefits under the state program was not a major part of the deliberations in the Legislature once the bills were introduced. This was surprising - especially since the benefits were identical to those required to be covered by qualified health insurance policies sold by insurers and made available to employees by employers. This triple purpose for the schedule of benefits resulted in most of the little discussion that occurred focusing on the health insurance standards aspect rather than on the state program aspect. (In fact, the part of the law which created the state-funded catastrophic program does not list the benefits. It merely cross-references the benefits in the Insurance Standards Act.)

The triple purpose of the benefits schedule provided some consistency in achieving the three purposes of the schedule. However, it also meant that some of the standards were different from those that would have been established if each had been done separately.

The initial schedule of benefits was drafted by an insurance company's head actuary. It was then revised by the authors and Legislative staff after comparing it with similar laws and bills in other states, the National Association of Insurance Commissioner's Model Act, and the Conference of Insurance Legislators' Model Act.

Since the same benefits were being used for the state program, the minimum standards for qualified health insurance and the required offering by employers, the proposed benefits schedule was then reexamined in light of its effects on the health insurance industry and on employer-sponsored benefit plans.

Legislative staff obtained access to an insurance industry sponsored study of employee benefit plans. This study found that about 70 percent of the existing employer plans did not provide the required medical coverage, 40 percent did not provide the required hospital coverage, 25 percent did not provide the diagnostic x-ray and laboratory coverage, 85 percent did not provide the required major medical coverage, and 85 percent did not provide the required maternity coverage. Generally, larger employers were more likely to be in compliance. The relatively low level of coverages was something of a

surprise to legislators and a cause of some concern. However, it was felt that a dramatic rise in health insurance coverage would impose a serious burden on some employers and could cause serious inflation in health care costs. At this point there was consideration of having separate benefit standards for health insurance and for the state program. In the end, the decision was made to keep the benefits consistent and lower them somewhat to lessen the disruption in existing programs. The benefits schedule was therefore re-written again. Also, insurers and employers were allowed to substitute actuarially equivalent benefits for those set forth in the act. The state program would not make substitutions.

Once it was revised the second time and the bills were introduced, there were few changes.

There were five areas where conflicts did arise:

1. Coverage of Blood and Blood Derivatives:

The bill originally covered blood and blood derivatives. There was objection from some insurers and blood donor groups that this coverage under insurance policies would diminish the public incentives for voluntary blood donations. Because of this, the provision was deleted. This was done despite the counter-argument that the deletion would, in effect, disqualify most hemophiliacs from the state program.

2. Coverage of Preventive Services:

There was little input into the benefits schedule by consumer groups. Efforts were made to get comments from various consumer groups, but they

generally lacked the time and the expertise to participate. A consumer task force which was working with the Foundation for Health Care Evaluation (a joint insurer-physician peer review organization) did do some lobbying for the inclusion of more preventive services. As a result of efforts, and despite some mild opposition from insurers, the law was amended so that benefits will be expanded to cover well baby care, check-ups, annual physicals and diagnostic testing beginning in 1980.

3. Nursing Home Coverage:

The authors of the bills wanted to limit nursing home coverage in the benefits provisions of these bills. There was a concern about mandating it as a health insurance benefit and about the estimated cost of including it under the state program. It was predicted that coverage of nursing home expenses would lead to a state takeover of most of the nursing home expenses not already paid by the state under the medical assistance program - an additional $56 to $64 million per year. (Minnesota's medical assistance program already pays about two-thirds of the costs of nursing home care in the state.) As a result, the bills limited nursing home coverage in the same way that it is limited under Medicare - a maximum of 120 days per year with the stay commencing within 14 days after a hospital stay of at least three days. There was also an exclusion of domiciliary and custodial care. Objections raised by representatives of senior citizens organizations led to the removal of the exclusion. However, they were unsuccessful in their efforts to increase the coverage for nursing home care.

4. Coordination of Benefits:

There was a major disagreement between insurers and the Minnesota Department of Public Welfare as to coordination of benefits between insurance coverage and various governmental programs. It was not really resolved. Medicare was made primary to insurance. Medical assistance was left as an open question subject to some unclear existing statutory language. There was also some concern that the state might end up paying 100 percent of the cost of treatment for people who would have eventually received medical assistance (56 percent Federal share in Minnesota). Vice-President (then Senator) Mondale was able to obtain an indication from HEW that a Federal contribution to the cost could still be received for people who benefitted under the state program if they would also have eventually been eligible for medical assistance.

5. Specialized Coverages:

Minnesota, like most other states, had already mandated various other coverages under existing group health insurance plans. In fact, Minnesota already mandated nine specified coverages - far more than any other state. These coverages included:

* alcoholism treatment
* conversion privileges
* chiropractic treatment
* optometric services
* maternity benefits
* outpatient surgical treatment
* newborn child coverage
* handicapped and retarded coverage
* mental illness coverage

It was felt that not all of these services were appropriate benefits for the state program. However, they were all passed earlier due to well-organized lobbying efforts. Exclusion of any or all of them might have resulted in major disputes as to their appropriateness. It was decided that another front in the fight over passage of the bill should not be opened. Numerous other conflicts had already arisen. The existing mandated services were consequently included by cross-reference.

B. Benefits Provided:

The new law passed in 1976 provided the following benefits:

> 62E.06 [MINIMUM BENEFITS OF QUALIFIED PLAN.] Subdivision 1. Number three plan. A plan of health coverage shall be certified. . . if it otherwise meets the requirements established by chapters 62A and 62C*. . . and meets or exceeds the following minimum standards:
>
> (a) The minimum benefits. . . shall be the usual and customary charges for the following services and articles when prescribed by a physician:
>
> (1) Hospital services;
>
> (2) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction;
>
> (3) Drugs requiring a physician's prescription;
>
> (4) Services of a nursing home for not more than 120 days in a year if the services commence within 14 days following confinement of at least three days in a hospital for the same condition;
>
> (5) Service of a home health agency up to a maximum of 180 visits per year;

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*This language has the effect of incorporating existing mandated benefits by reference.

(6) Use of radium or other radioactive materials;

(7) Oxygen;

(8) Anesthetics;

(9) Prostheses;

(10) Rental or purchase, as appropriate, of durable medical equipment;

(11) Diagnostic X-rays and laboratory tests;

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth; and

(13) Services of a physical therapist.

(b) Covered expenses for the services and articles specified in this subdivision do not include the following:

(1) Any charge for any care for any injury or disease either (i) arising out of an injury in the course of employment and subject to a worker's compensation or similar law, (ii) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (iii) for which benefits are payable under another policy of accident and health insurance or medicare;

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect;

(3) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury;

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician;

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided; and

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(c) Effective January 1, 1980, the minimum benefits. . . shall include, in addition to those benefits specified in clause (a), benefits for the following services. . .:

(1) Well baby care;

(2) Physicians' services for routine check-ups and annual physicals when prescribed by a physician; and

(3) Multiphasic screening and other diagnostic testing. . .

* * *

V. Estimated Program Costs and Beneficiaries:

Using the data obtained from the Tax Study Commission's computer study of tax returns, actuarial studies provided by an insurer, and from Rhode Island's actual experience with their program which was already in operation, several estimates of costs and the number of beneficiaries by income level were made.

Based on the Tax Study Commission figures, the following estimates were made:

Program Cost

	Calendar Years			
	1976	1977	1978	1979
Cost of Care*	$11.3	$12.1	$12.9	$13.8
Less 10% Copayment	1.1	1.2	1 3	1.4
Gross State Cost	10.2	10.9	11.6	12.4
Less Savings in Other Programs**	1.7	1.8	1.9	2.1
Net State Cost***	$ 8.5	$ 9.1	$ 9.7	$10.3

All figures in millions of dollars

*1975 figures inflated 15% for inflation in health care costs and deflated 8% for inflation in income each year.

**It was assumed that there would be offsetting cost savings in other state health care payment programs.

***It was assumed that the Tax Study Commission figures were too high because of the inclusion of non-covered benefits which are tax deductible.

Beneficiaries by Income Level

Household Income Level	Senior Citizens (1,250 Households)	Others (500 Households)	Total (1,750 Households)
0-$5,000	40%	33%	38%
$5,000-$10,000	40%	50%	43%
$10,000-$15,000	20%	17%	19%
Over $15,000	0%	0%	0%

Based on Rhode Island's actual experience, the following estimates were made:

Time Period	Rhode Island (Actual)		Minnesota (Estimated)	
	Cost	Recipients	Cost	Recipients
First Six Months	$200,000	58	$ 800,000	230
Second Six Months	300,000	104	1,200,000	415
Third Six Months	400,000	261	1,600,000	1,045
Fourth Six Months	540,000	N.A.	2,160,000	N.A.

It was concluded that the Rhode Island figures indicated that there would be a lower level of participation in the early phases of the state program, probably because people would not be fully aware of the program, and that the Rhode Island figures would probably be more indicative of what Minnesota's actual experience might be.

The Legislature eventually approved a biennial budget of $17 million for the program. It is expected to be more money than needed, but health expense payment programs have historically cost more than anticipated.

VI. 1977 Amendments:

Even before the law took effect, pressures to make changes in the eligibility and benefit standards started to build. Insurers, consumer groups and the state Department of Public Welfare all requested changes in the law. Bills and amendments were introduced which would:

1. Provide specific coverage for blood and blood derivatives under the state program. (This was designed to bring hemophiliacs back under the provisions of the law.)

2. Provide specific coverage for renal dialysis and related costs under the state program.

3. Provide specific coverage for nursing home care under the state program.

4. Require coverage for a second opinion on surgery under both the health insurance mandatory coverage provisions and the state program.

5. Provide an earlier effective date for the coverage of the preventive services.

6. Make minor adjustments in the overall benefit schedule.

7. Exclude the income of certain dependents from the determination of household income.

8. Delay the effective date of the state program for another year.

Bills which actually passed did the following:

1. Provided state payment of 90 percent of the household expenses for nursing home care in excess of 20 percent of household income. The coverage would only apply to the expenses of people under age 65 and only after three years of treatment in a nursing home. (1977 Session Laws, Chapter 448)

2. Excluded the income of dependents under age 23 in determining household income. (1977 Session Laws, Chapter 448)

3. Excluded custodial and domiciliary care. (1977 Session Laws, Chapter 409)

4. Included coverage of a second opinion on surgery effective in 1979. (1977 Session Laws, Chapter 409)

5. Made health insurance and tort recovery primary to any state payments. (1977 Session Laws, Chapter 409)

6. Provided that health care providers be reimbursed on the same schedule as providers under medical assistance. (1977 Session Laws, Chapter 409)

VII. Summary:

The Minnesota state program is primarily designed to provide protection to households which face major health care expenses of a non-recurring nature. Since the program has only been operative since July 1, 1977, the efficacy of its benefits and eligibility standards are not yet known.

BENEFIT COVERAGE AND ELIGIBILITY STANDARDS
OF STATE HEALTH INSURANCE PLANS
RHODE ISLAND CATASTROPHIC HEALTH INSURANCE PLAN (CHIP)

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One issue of great importance in the design of a health insurance program--be it a publicly sponsored or privately sponsored plan--is the determination of its benefit structure and eligibility standards. Questions relating to eligibility qualifications, the kind, extent and priority of benefit coverage, projected utilization rates, for example, are all issues of great importance. In this section of the seminar program, we present two papers that discuss both sides of the same issue. Larry Fredrickson of Minnesota analyzes how a state determines the benefit and eligibility standards that it wishes to incorporate into its plan design while this paper discusses the actual experiences of such determinations once the plan has become operational and has incurred several years of utilization experience.

I. ELIGIBILITY

Eligibility standards are delineated primarily through the guidelines of the Catastrophic Health Insurance Plan (CHIP) itself. Program eligibility is contingent upon essentially two elements: residency and a deductible. An applicant would normally be the head of a household and must be a permanent resident of the state for at least three months and must not have moved here

primarily to become eligible for CHIP. In addition, an applicant's out-of-pocket family medical expenses must exceed a CHIP deductible specified in the law, after all payments are made by his or her private health insurance plan. This deductible will either be a flat dollar amount or a percentage of the family's income, whichever is greater. Income is defined by Regulation as "the adjusted gross income of the taxable family unit, minus dependents allowances, as set forth by the Internal Revenue Service." Those persons who are Medicare subscribers only have to meet a dollar deductible since they are generally living as a group on fixed incomes. When found eligible, all members of a household are covered for CHIP benefits.

There are six levels of CHIP deductibles. They are applied to a particular applicant based upon the type and quality of the person's private health insurance plan. As the quality of a person's coverage goes up, the CHIP deductible goes down. The lowest deductible category is utilized when a person has what the law defines as a "qualified plan." This would be a combination of plans, provided by either Blue Cross or a commercial insurer, which includes the following:

- Semi-private hospital coverage for at least 120 days
- A medical/surgical plan providing coverage for usual and customary physician charges
- A major medical program providing at least $10,000 in supplemental coverage

CHIP DEDUCTIBLES

Health Insurance Status	Amount	% of Income
Qualified plan	$ 500	10
Semi-qualified plan (no major medical coverage)	1,250	25
Non-qualified plan		*
No health insurance plan	5,000	50
Qualified Medicare plan	500	N/A
Non-qualified Medicare plan	1,000	N/A

*The difference between a qualified and a non-qualified plan plus the deductible of a qualified plan.

Since CHIP has been designed as a "last payor" program, all other resources available to the applicant must be utilized first before CHIP would consider payment. For example, if a person was injured in an automobile accident and also has private health insurance, CHIP would not only be secondary to the health insurance plan but also to any automobile medical payments available as a result of the accident. CHIP would also be secondary to other programs such as Workmen's Compensation, Vocational Rehabilitation, Medicare and Medicaid.

The Division of Health Insurance of the Rhode Island Department of Health is responsible for the overall administraiton of the CHIP program. These duties also include eligibility services. Most applications are handled by mail but occasionally personal interviews are requested by either party. The Division also

directly refers CHIP applicants to other available programs. Outreach services of CHIP are considered to be an integral part of the program.

The major gaps in CHIP, as can be readily seen by reviewing the deductible structure, concerns those persons who do not have any health insurance coverage and in particular those who are earning just above the Medicaid upper income limits. Since CHIP was developed to assist the average working person, and only incidentally other income groups, no research has been initiated to ascertain the nature and extent of the financial implications resulting from any expansion of coverage to those groups falling through the gaps in the program as it is presently designed.

II. BENEFITS

The benefits provided to those persons found eligible for CHIP are essentially the same as described in the law under a "qualified plan," previously outlined. Additionally, the Department of Health has promulgated rules and regulations for the CHIP program which also carefully describe benefits and exclusions. The benefit structure of a qualified plan was extracted mainly from the best existing Blue Cross plans in the state. Blue Cross of Rhode Island covers approximately 85 percent of the state's population. If the Division of Health Insurance cannot readily determine if an applicant's plan is qualified, the policy will be referred to the Health Insurance Section of the Department of Business Regulation for review and comment according to an existing

cooperative agreement. The Department of Business Regulation may have the policy reviewed by its actuary, especially if the applicant has multiple health insurance plans, which taken singularly are not qualified, but as a composite may be an actuarial equivalent to a qualified plan.

Coverage in several specialty areas were added by regulation to those benefits provided directly by the law. For example, a qualified plan would pay for the deductibles and co-insurance for those persons on Medicare. However, neither Medicare nor a qualified plan provides coverage for prescription drugs. Since this was one of the most costly items to the consumer and largely unreimbursed by third parties, the CHIP regulations allowed for coverage of this type of expense. On the other hand, mental health benefits are currently under review since a full 20 percent of CHIP benefits in 1975 went for these services. Currently, CHIP allows for full coverage and 50 percent reimbursement for outpatient psychiatric care.

CHIP pays for 100 percent of the usual and customary costs of those eligible health expenses not otherwise payable by an insurer, state or federal agency. CHIP was designed to "top off" any existing health insurance plan a resident may have. Therefore, with only one exception (outpatient psychiatric), payment is at the rate of 100 percent. As mentioned previously, CHIP covers most of the benefits provided under a qualified health insurance plan. The only notable exception, in addition to the drug benefits

for Medicare persons, as compared with other plans offered or provided by insurers or agencies, is in the area of mental health. The Medicaid program does not provide any psychiatric benefits. Therefore, although a family may otherwise qualify for Medicaid, psychiatric benefits when required would be covered by CHIP.

Claim cost control is exercised over virtually all areas of benefit coverages, including prescription drugs and medical/surgical supplies and equipment through the use of usual and customary fee profiles. Historically, psychiatric benefits have proven to be the most difficult to control. Selected cases, especially for out-of-state private facilities, have been referred to the Psychiatric Peer Review Committee for examination. Committee results have been a disappointment as a method for substantially reducing utilization and related costs.

The expansion of CHIP coverage to those persons who may fall through the gaps in the program would have to be extended first to those who have semi-qualified plans prior to making the coverage available to others who have no coverage. Here again, this concept would be in keeping with the intent of the law which is structured to help the average working person. However, the average working person is becoming increasingly difficult to define. There are many average working persons who for various reasons are unable to afford qualified health insurance plans. These persons rather than the uninsured should perhaps be the target group of any eligibility restructuring. With the proliferation of state

catastrophic health insurance plans, several key issues must be addressed. First, with more and more states considering the adoption of health insurance plans, is this a clear signal to Washington that the states do not want national health insurance with the inherent loss of local control over the health care/financing system? We believe this to be the case in Rhode Island and suspect the same to be true in other states. Secondly, has there been any noticeable migration of individuals to states which have the CHIP coverage? There is always the potential for this problem with any public program, most noticeably involving Unemployment Compensation and Medicaid. The Rhode Island CHIP program has only a three month residency requirement. However, CHIP is patterned in such a way as to "reward" persons with better coverage by affording them a lower deductible as a threshold to eligibility. Also, the program is meant to function as a "super" major medical plan with a good base of private health insurance as a prerequisite for total catastrophic health insurance protection. With this goal in mind and considering the structure of the plan, it would not seem to be worthwhile for a family to move to Rhode Island from another state just to be able to attain coverage under CHIP. If this does occur, and we are able to confirm that this is why a family moved to the state, we would be able to deny coverage on the basis of a relevant section in the law. Specifically, it excludes persons from CHIP who were found to have moved to Rhode Island for the primary purpose of receiving CHIP benefits. The Department has found that this is not a viable issue at this time.

Finally, it is probably appropriate here to end the discussion of benefits with a few comments concerning future changes to the program. Obviously, the program is still in its developmental stage and vast coverage changes cannot be recommended at this time. However, the Department believes that the General Assembly should be the proper vehicle for amending the list of covered services provided by the CHIP program. The Department of Health has tried unsuccessfully in the past to change benefits through regulation. Since the benefits are essentially similar to the benefits which are defined by the law as constituting a qualified plan, perhaps the safer course for the Department to take would be to seek amendment to the law. It should be noted that the General Assembly has been hesitant in the past to approve any new spending programs or amend existing ones in such a way as to substantially increase the cost burden to the state. It appears that any proposed amendments liberalizing the CHIP benefit structure would encounter great opposition in the immediate future.

III. UTILIZATION

In calendar year 1976, 189 persons actually received CHIP benefits as compared to 114 in 1975. Other statistics include:

	1975	1976
Total applications	234	258
Total family units	162	150

Original projections estimated that about 200-300 persons would become eligible for the CHIP program on an annual basis. Therefore,

the program's results appears to be somewhat lower than anticipated. However, original projections by the Task Force which helped shape the legislation were only rough estimates.

Of the 150 eligible family units in 1976, 57 had Blue Cross, 65 Medicare, 14 commercial insurance and 14 were without health insurance. Those persons eligible for Medicare appear to be benefiting substantially from the CHIP program since 43 percent of the eligible family units involved this group. Another breakdown of utilization was to group the persons actually receiving benefits by age group--32 were dependent children, 97 adults under age 65 and 60 were over age 65. The Department believes that the program must mature longer before definitive conclusions are delivered.

IV. CATASTROPHIC ILLNESSES

Although "catastrophic" is defined in terms of the financial loss to the family rather than by diagnosis, a diagnosis very often signals an impending catastrophic loss. The Task Force which developed the CHIP legislation originally suggested a dread disease type of plan which eventually was replaced by the present program which focuses on the finances of a family as it is affected by the patient's illness.

Catastrophe, in a medical sense, is both an absolute and a relative concept. Any serious health problem is a catastrophe to the individual and family experiencing the affliction. Physically and psychologically, any substantive illness is, almost by definition, an extremely stressful occurrence.

The financial implications of any period of illness beyond the most minor are equally distressing and only serve to increase the seriousness of other problems. The degree of financial catastrophe is determined by such factors as the total cost of diagnosis and treatment (which relate to the duration of the illness and the sophistication of available medical modes, etc.); the adequacy of basic health insurance coverage in force; the availability of various supplemental program (both public and private); independent financial resources available to cover medical expenses (taking into account other critical needs, such as maintenance of the family unit); and the encumbrance of basic earning capacity. Clearly, the interrelationship of these factors becomes most serious when a spell of illness becomes "catastrophic." Although little formal research work has been done to define "catastrophic," it is clear that the threshold can be reached very rapidly as nonreimbursable costs are incurred. The accelerating spiral of medical costs and the related expansion of technological alternatives merely intensify the problem, both for the present and the future. The combination of medical and financial "catastrophes" must have an extraordinarily heavy social impact, particularly on the dynamics of a family structure, and the resulting effects of both the fiscal and psychological stress represent a real and significant cost to society.

Major disability statistics for 1976 experience indicates again, as in 1975, that emotional disorders lead the list of reported conditions. Although there were 189 persons receiving benefits, in

many cases more than one person in a family received payment and such persons on an average did not have catastrophic type conditions. Therefore, these relatively minor diagnoses have not been reported here.

MAJOR DISABILITIES BY FAMILY UNIT:

Disability	Count	Disability	Count
Emotional	25	Birth Defects	2
CVA	19	Epilepsy	1
Cancer	16	Paget's Syndrome	1
Cardiac	13	Cerebral Palsy	1
Kidney	12	Myasthenia Gravis	1
Orthopedic	7	G.I	1
GYN	6	Brain Damage	1
Leukemia/blood	5	Pancreatitis	1
Respiratory	5	Scleraderma	1
Arthritis	4	Syringamyelia	1
Quadraplegia	4	Appendix	1
Neurological	4	Circulatory	1
Multiple Sclerosis	4	Muscular Dystrophy	1
Amputation	3	Myeloma	1
Colitis	3	Brain Stem injury	1
Aneurysm	3	Anorexia Nervosa	1

TOTAL 150

V. SUMMARY AND EVALUATION

The CHIP program provides for mandatory yearly evaluation and health system reporting through the Annual Report on the Health

Condition of the State and Health Expenditures by the Director of the Department of Health by each January 30th to the Governor and General Assembly. In addition, the Department of Health, Division of Health Insurance implements the following monitoring programs:

1. Annual audit of fiscal intermediaries and those state agencies with whom the Department of Health has cooperative agreements
2. Preparation of a CHIP benefits annual report with statistics and demographics.
3. Contracting with private health research corporations, when required, to acquire data necessary to evaluate the program

The success of CHIP depends upon many factors: chiefly, the absolute necessity for cooperation between state government, insurers, and providers. The Law was initially conceived as a "working person's program," stressing the purchase of good private insurance as a step toward total catastrophic illness prevention. It was designed to provide an incentive for persons to purchase good basic health insurance coverage as an initial step and as an integral part of total catastrophic health insurance protection for all of the residents of Rhode Island. The State was the first nationally to implement this new approach to health insurance coverage and thereby ensure that no citizen would be forced to "spend down" or "abandon" his family to receive the kind of help which would reasonably be given to any neighbor or friend who has been struck by tragedy. The jury is still out as to a final verdict in regard to our endeavor.

ADMINISTRATIVE ORGANIZATION OF A STATE HEALTH INSURANCE PLAN
RHODE ISLAND CATASTROPHIC HEALTH INSURANCE PLAN (CHIP)

Prepared by
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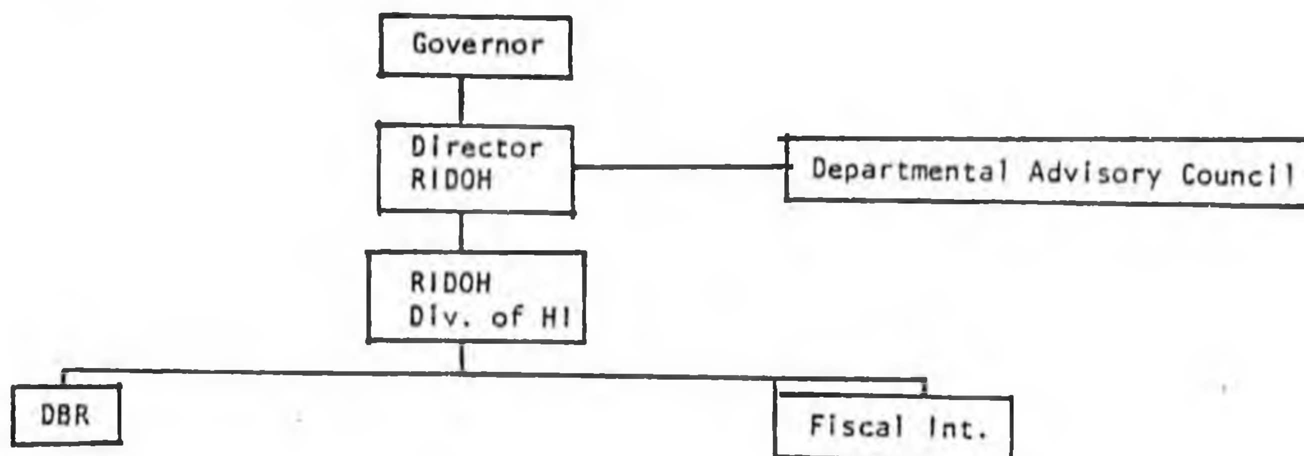
Chief, Division of Health Insurance
Rhode Island Department of Health

As of July, 1977, only five jurisdictions had enacted into law state health insurance plans whose purpose is to provide protection against the incidence of ill health above and beyond whatever other health insurance coverage may be provided to their residents either from public or private sources. Very few states have established their own health insurance department within their governmental structure to administer such a program with all the implications that ramify from such an organization. One state which has, however, is Rhode Island. This state offers a clear profile of the character of a state administered health insurance plan and the following is a discussion of this jurisdiction's program.

I. ADMINISTRATIVE ORGANIZATION AND RELATIONSHIP

Organizational Structure



The Director of the Rhode Island Department of Health is assigned the overall responsibility for the CHIP Program according to the enabling CHIP legislation and reports directly to the Governor. The Director has delegated all administrative duties to the Chief of the Division of Health Insurance. The Division of Health Insurance (DHI) has access to various Departmental advisory groups in matters relating to appeals, claims and other specific program areas, such as certification of Health Maintenance Organizations.

The DHI administers all aspects of the CHIP Program from one central location. There are no local Health Departments in Rhode Island. Duties include the following: monitors those program components assigned to other agencies (Department of Business Regulation); provides assistance and information to all applicants and general public; determines eligibility; develops and implements program policy, rules and regulations; develops, monitors and audits programs for CHIP claim administration with insurers; provides for appeal procedures and hearings; organizes program promotion and publicity; certifies and monitors Health Maintenance Organizations.

The Department of Business Regulation (DBR) is responsible to the Director of the Department of Health (DOH) for expenditures and program performance relating to the various duties assigned to it within the CHIP legislation. These include the development and

enforcement of minimum standards for health insurers, certification of qualified health insurance plans, review and approval of rates and management of a Facility Reinsurance Pool. The Director of DBR is ultimately responsible to the Governor directly on all matters relating to actual program performance. Joint decisions are made between directors on program areas which require the concurrence of both by law. The DOH reimburses the DBR for all salaries and expenses related to the performance of CHIP duties. A special Health Insurance Section has been established within the DBR to perform the tasks created by the passage of CHIP.

Prior to CHIP, health insurance regulation in the state was minimal. The primary source for contact between Departments is for requests to DBR for review of potentially qualified plans. When an applicant applies for CHIP benefits to the DOH, a review of the person's private health insurance is mandatory since eligibility is contingent upon the type of insurance plan a person may have. The law outlines what is described as a "qualified plan." The closer a person's policy comes to this qualified plan, the lower the deductible will be for them and subsequently eligible for CHIP. Therefore, the DOH utilizes the DBR to review selected policies of the applicants to determine if they are "qualified." The DOH is able to make such determinations in many cases involving only one or two basic policies held by an applicant. However, many applicants have multiple insurance poliies or complicated policies which are not readily identifiable as qualified. In several cases,

the DBR has had to utilize the services of their consulting actuary since the law allows them to qualify some of the more involved policies on the basis of actuarial equivalencies. The law indicates that "any plan or combination of plans which provide qualified plan benefits, or their actuarial equivalent, may be deemed to be a qualified program."

Fiscal intermediaries are utilized for claim administration purposes. They are appointed by the Director of the DOH and are responsible to the DHI on matters relating to claims paid, administrative costs and expenses. They are also subject to audit by the Division. Blue Cross of Rhode Island pays CHIP claims for those applicants who are Blue Cross subscribers, have no health insurance, are members of an HMO or who are on Medidare (Title XVIII). Metropolitan Life is the intermediary for those persons who have commercial health insurance. Both intermediaries have assigned one person to work on CHIP claims exclusively. In the case of Blue Cross, the person works on CHIP full time; with Metropolitan, it is a part-time function. The intermediaries both bill the DOH monthly for the costs of claims plus administrative costs, which is a percentage of the month's total paid claims. The rate is subject to review and adjustment on an annual basis. An Administrative Servcies Agreement with the DOH governs the performance of the intermediaries' duties under CHIP. The original appointment of the fiscal intermediaries was developed and concluded with the cooperative assistance of Blue Cross and the Health Insurance Association of America.

II. RELATIONSHIP TO OTHER PROGRAMS

The CHIP law was designed to be the last payer and secondary to any other health benefits available to an individual. For example, if a person has a private health insurance plan, this plan would always assume the primary position even after a person qualifies for CHIP. As long as the plan remains in force, CHIP would assume the balance of covered expenses not payable by the insurance program. In addition, if a person is or may be potentially eligible for Workman's Compensation, Medicaid (Title XIX), Maternal and Child Health Programs, medical payments on an automobile policy and so on, CHIP would be secondary to any payments made by these sources or may be totally out of the picture, particularly in the case of a person's eligibility for Medicaid.

The DHI will assist any applicant who may be unaware of the availability of such other programs. Contacts have been established with these agencies and placement is normally made by telephone with a written communication following to the agency and/or applicant.

Blue Cross and the commercial insurers have been asked to "case find" for CHIP, particularly when an insured person may be approaching their major medical maximum. Blue Cross has even gone so far as to print a computer produced note in such cases on the explanation of benefits worksheet which is sent to the subscriber detailing a particular major medical payment.

The DHI has a special relationship with Health Maintenance Organizations (HMOs) in the state. According to CHIP, they are

considered both a provider and an insurer. In the case of the latter, the DHI would consider a qualified HMO in a similar manner to an insurer if a person requests assistance from CHIP and is enrolled in an HMO. Very few CHIP applicants are in this category since HMOs normally provide a comprehensive range of prepaid services.

CHIP also requires all employers of one or more employees in the state to provide a "dual choice" to their employees if they currently participate in a group insurance program. The law now requires them to offer the choice of the insured plan or the HMO membership if a qualified HMO exists which includes the employees' place of resident in their service areas. The DHI is responsible for determining whether or not an applicant HMO is qualified. Criteria have been established within the CHIP Rules and Regulations. There are presently three HMOs in the state--all are qualified. Re-application must be made each year to the DHI. Review of applications is made by the DOH HMO Advisory Council. Qualification as a provider is different from qualification as an insurer. The DHI regulations speak to the quality of care and related administrative functions of operating an HMO and only incidentally address the issue of the specifics in the scope of benefits.

The DBR is responsible for enforcement of the dual choice option itself with employees in the state and all complaints and infractions are referred to them. Regulations have also been issued by them to cover their duties under this section of the law.

The HMO dual choice provisions of CHIP are looked upon as meeting one of the law's primary goals--that each person in the state have access to available diagnostic, curative and rehabilitative health services. Prior to CHIP, employers outwardly rejected approaches from HMOs to solicit their employees and as a result, the entire HMO movement in the state was faced with dissolution. The law has produced significant and immediate results and another HMO is being planned for organization shortly.

III. COST AND QUALITY CONTROL

Due to the projected limited scope of the CHIP program, a rate setting formula or separate reasonable fee system was not developed. It was thought that this would add another unnecessary layer of control over the existing overburdened system (e.g., Medicare, Medicaid, Blue Cross, Workmen's Compensation). Instead, the fiscal intermediaries utilize, according to the CHIP regulations, their respective reasonable fee profile systems for reimbursement of provider charges. However, they must follow the regulations completely to ascertain whether or not a particular service is covered by the program. Moreover, the intermediaries must employ their medical advisors in reaching any decisions in judgment areas such as overutilization, custodial care and medical necessity.

Applicants may appeal to the Director of the DOH any adverse decision made by an intermediary regarding all aspects of claim administration. They may also appeal any adverse decision made by the DHI concerning eligibility. A formal appeal system is

provided for by the state's Administrative Procedure Act. When an appeal is received by the Director, it is referred to the DHI. The DHI then schedules a meeting of the CHIP Appeals Review Committee, composed of a registered nurse, social worker, physician, medical advisor and CHIP coordinator of the intermediary involved and the Chief of the DHI as Chairman. Medical records and case records are carefully reviewed and the Committee has the power to overturn the decision of the DHI eligibility section and/or intermediary. If the decision sustains that of the DHI or intermediary, then the applicant may request an adjudicative hearing within the DOH before an impartial hearing officer. The officer also has the power to overturn any previously adverse decision. If the appeal is denied at this level, the applicant may file an action in the Superior Court System of Rhode Island and no further appeal is available within the DOH.

Intermediaries are required to accumulate specific demographic data from claims processed which are provided to the DHI as requested in order to monitor program performance, recommend changes to the law and regulations and to provide a base for preparation of annual reports. Application data are also used by the DHI for these purposes. Additionally, Rhode Island Health Services Research, a private non-profit locally based health research firm, is employed by the DHI to analyze such data, conduct household surveys and to provide input for the required annual CHIP report.

Medical Society Review Committees are used by the intermediary on selected cases involving custodial care, overutilization and reasonable fees. The DHI has contracted with Equifax, Inc., a private investigative firm, to conduct checks into possible duplicate coverage not reported by an applicant, residency and financial data, when none is available from the Rhode Island Division of Taxation. Since there is a percent of income requirement on certain cases in order to determine the CHIP deductible, the DHI has established a program for requesting such information from the Division of Taxation. When a return has not been filed recently, an Equifax referral may be necessary.

IV. PROGRAM COSTS

The following financial statistics reflect program experience during 1976:

Total claim expenditures	$858,865
Average monthly	$ 71,572
Average per applicant	$ 4,544
Difference over 1975	+$351,206
Percent change over 1975	+ 69%
Total Claims (Metropolitan)	$ 68,001
Total Claims (Blue Cross)	$790,864
Total administration (Metropolitan)	$ 13,874
Total administration (Blue Cross)	$ 55,951

Program costs are projected annually during the budget preparation time period for the following two fiscal years. Projections have

not matched costs for 1976 but are expected to do so for 1977. Program promotion efforts are now beginning to demonstrate some positive results. Slow progress was made during the first full year of operation. A contact program has been established throughout the state with various providers, special interest groups and other involved state agencies. Also, the DHI has made over two hundred appearances during the last one and one half years before different groups and organizations in the state promoting the CHIP program.

Although the total administrative costs appear to be high, many of the CHIP related duties do not pertain to claims, as was previously discussed. The actual administrative costs relating to claims, including a percentage of time from the DOH and DBR, is approximately 10%.

Officials of the State Medicaid program do not believe that the existence of CHIP has, to any measurable extent, impacted upon the administrative costs of their program. In fact, due to the nature of CHIP as a "bottomline" program, the DHI has been case finding for Medicaid. It is very difficult for the reverse to occur. As previously mentioned, Blue Cross and commercial insurers case-find for CHIP where practical when a person approaches the major medical maximum. Here again, we believe that the costs associated with these efforts are barely measurable.

Many of the CHIP cost control devices could be utilized by other states contemplating health insurance programs. For example,

most states have a variety of medical society peer review committees. Accumulation of only the specific data needed to perform an objective analysis of the program is extremely important in order to implement an effective cost control plan. If the administrative agency does not have the expertise to initiate such a program, outside professional resources should be employed. A uniform reporting system should be developed as soon as possible during the implementation phase of a new program in order to capture the required data from the outset.

V. NATIONAL HEALTH INSURANCE

CHIP has been designed to coordinate with any future National Health Insurance Program (NHI). In fact, such wording is part of the Exclusions listed in the CHIP Act--"...medical services which may be financed in the future on behalf of all citizens by the United States." This would not necessarily close down the CHIP Program but it would be altered according to the nature and extent of the NHI plan. Of course, a complete evaluation of the CHIP goals and priorities should occur immediately if and when NHI is enacted.

INFORMATION ABOUT MINNESOTA'S CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM

C PP
Minnesota Department
of Public Welfare
Box 30170
St. Paul, Minn. 5517[illegible]

What Is the Catastrophic Health Expense Protection Program?

The Catastrophic Health Expense Protection Program ("CHEPP") is a state program to help people who have had very high expenses for health care which no insurance company or other plan of health coverage will pay.

The program will pay 90 percent of the reasonable cost of covered services over and above an annual deductible that each eligible family must be responsible for itself.

When Am I Eligible?

You and your family are eligible for help from CHEPP when the sum of what you owe and what you have paid for health services received after June 30, 1977 equals your deductible. This is called satisfying the deductible. The charges used to satisfy the deductible must be for services covered by CHEPP, and they must be charges for which no one else is or has been liable. This means that anything paid or owed by an insurance company, Medicare, Worker's Compensation, or some other third party doesn't count.

How Much Would My Deductible Be?

Your "out-of-pocket" deductible is figured for your family--you and your tax dependents. It is always at least $ 2,500 per year. Often it is more.

To figure your deductible, take 40 percent of your gross family income up to $ 15,000 for the calendar year before the year in which you apply for CHEPP. To that figure, add 50 percent of your gross family income between $ 15,000 and $ 25,000 for that year. Then add in 60 percent of your gross family income in excess of $ 25,000 for that year. The sum is your deductible unless it is less than $ 2,500. In that case, your deductible is $ 2,500.

Some Examples:

A family applying for CHEPP in 1977 had gross family income in 1976 of $ 6,000. 40 percent of $ 6,000 is $ 2,400. This is less than $ 2,500, so the minimum deductible of $ 2,500 applies.

A family applying for CHEPP in 1978 had gross family income in 1977 of $ 26,000. 40 percent of $ 15,000 is $ 6,000. 50 percent of $ 10,000 (that is, $ 25,000 minus $ 15,000) is $ 5,000. 60 percent of $ 1,000 is $ 600. So the deductible is $ 6,000 plus $ 5,000 plus $ 600, which adds up to $ 11,600.

What Is Gross Household Income?

Gross household income is the sum of all the money income of all the members of a family except the children during a calendar year. It includes salaries, Social Security, pensions, welfare cash assistance, and tax-exempt interest income. It includes disability income payments, but food stamps, payments by Medicare, and payments by health insurance companies are not included. Gross household income is roughly what a family would report on its application for the Minnesota Homeowner and Renter Income-adjusted Homestead Credit or for the Senior Citizen's Special Property Tax Freeze Credit. (These applications are the goldenrod color forms that come with the Minnesota Individual Income Tax forms and instruction booklets.)

How Long Could I Be Eligible for CHEPP?

CHEPP eligibility runs for 12 calendar months, beginning on the date of the first service offered in satisfaction of the CHEPP deductible. After the 12 months, you must requalify for CHEPP by incurring a new deductible. The new deductible is based on your gross family income in the calendar year before your new application.

What Health Services Are Covered?

The following health services are covered by CHEPP (if they were prescribed by a physician) but only to the extent that nobody other than yourself and your family is or has been liable for paying for the charges. These are also the services whose costs can count towards the CHEPP deductible, to the extent that nobody else is or has been liable for them.

1. Hospital services, both inpatient and outpatient;
2. Services of a medical doctor or osteopath (but not outpatient care for mental illness);
3. Drugs which require a physician's prescription;
4. Up to 120 days of care in a skilled nursing facility which meets Medicare standards, but only if the care is for serious illness or for rehabilitation, and only if the care begins within 14 days of a hospital stay of at least 3 days and is for a condition which was treated during the hospital stay; custodial care is not covered;
5. Home health agency services from an agency which meets Medicare standards, if the services are reimbursable under the Medicare program.
6. Use of radium, deep X-rays, and other radioisotopes;
7. Oxygen;
8. Anesthetics;
9. Prostheses such as artificial legs (but not false teeth or dental bridges);
10. Rental or purchase (whichever is most appropriate) of durable medical equipment (but not eyeglasses and hearing aids);
11. Laboratory tests and diagnostic X-rays;
12. Oral surgery for partly or completely unerupted impacted teeth, tooth roots, or for the gums or mouth tissues if the surgery is not related to the simple repair or extraction of teeth;
13. Services of a qualified physical therapist;
14. Medically necessary transportation in a licensed ambulance to the nearest facility qualified to treat the patient's condition; and
15. Nursing home care for patients under age 65 who have been in a nursing home continuously for at least 36 months. (*Note: payments for this group of nursing home residents are made on the basis of a special formula, and then only at the end of each state fiscal year (June 30).*)

When Can I Apply for CHEPP?

You can apply for CHEPP when you think you owe (or have paid) enough money for covered health services to satisfy the deductible that applies to you and your family. The money you owe or that you have paid must be for services received after June 30, 1977.

Where Do I Apply for CHEPP Help?

Apply for CHEPP benefits at your county welfare or social service office.

What Should I Bring if I Apply?

1. Bills for health services you want to apply to the CHEPP deductible. Also bring bills in excess of your deductible which you would like CHEPP to pay. If you have paid some of these bills, bring proof that you paid them.
2. All of your family's health insurance and automobile insurance identification cards (or copies of the policies or certificates).
3. Tax returns from the previous year to show what your gross family income was. If you filed for the Renter's Credit, Income-adjusted Homestead Tax Credit, or Senior Citizen's Special Property Tax Freeze Credit, bring a copy of your application.
4. Medicare, Veterans' Administration, and CHAMPUS identification cards.
5. Other information about people who may be liable for health care or for buying insurance for members of your family (such as a divorced husband).

Must I List All My Property and Assets?

Owning property and having savings will not make you ineligible for CHEPP. But your county welfare department will ask you about your assets to see if you might qualify for Medical Assistance ("Medicaid") or for General Assistance Medical Care. If you are eligible for one of those programs, you are probably not eligible for CHEPP. Those programs cover more kinds of care than CHEPP. They pay 100 percent of the cost of care. Often they have a lower deductible than CHEPP. But they have restrictions on property and other assets.

What Happens if I Am Eligible for CHEPP?

When you become eligible for CHEPP, your county welfare department will give you instructions and a handbook

You will get a family CHEPP identification card. This card must be shown to all providers of health services which you want billed to CHEPP. It tells the provider what your CHEPP claim number is and alerts him to the fact that he will have to bill CHEPP instead of you. (In most cases CHEPP will not accept bills from you personally once you have become eligible.)

If you have already paid for services in excess of your deductible at the time you apply for CHEPP, copies of those bills and evidence of what part of them you paid will be collected. Then the state will pay you 90 percent of the reasonable cost of those services, minus any third party payments made to you or on your behalf.

Once a month you will get a listing from the state's computer of all the bills the state has paid for members of your family. This is called an Explanation of Medical Benefits ("EOMB"). It tells you how much copayment (the 10 percent which the state doesn't pay) you owe to the provider of each service. If the state has decided that part of a charge was too high, that part is forgiven by state law. You owe only the listed copayment amount.

Can I Substitute CHEPP for Health Insurance?

The Catastrophic Health Expense Protection Program is not intended to take the place of your own health insurance. This is why the minimum deductible is so high. (Your family's deductible may be considerably higher than the $ 2,500 minimum.) CHEPP is intended to help people whose medical bills have run way beyond what their insurance will pay or who haven't been able to buy health insurance. You don't have to have health insurance in order to qualify for CHEPP, but having some form of health insurance or prepaid health coverage is to your advantage.

How Does CHEPP Relate to the MCHA "Bad-risk" Insurance Program?

The law which set up CHEPP also set up a program of health insurance for people whose health problems have made them practically uninsurable. This other program, sometimes called "catastrophic health insurance," is run by the Minnesota Comprehensive Health Association (the "MCHA") under the supervision of the Insurance Division of the Minnesota Commerce Department. Information in this pamphlet does not apply to the programs of insurance offered by the Minnesota Comprehensive Health Association. *Information about these programs is available from:*

The Minnesota Comprehensive Health Association
Box 9309
Minneapolis, Minnesota 55440

Where Can I Get More Information About CHEPP?

To get more information about CHEPP, write to the address on the cover of this pamphlet or, after July 1, 1977, call your county welfare or social service office.

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