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HB 409

(FILE NO. 3)

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

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

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

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

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

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

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

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

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

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

chapter.

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 107

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

\* Sec. 2. AS 47.25.255 is repealed.

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



# LAWS OF ALASKA

1978

Source

Chapter No.

CSSSB 59(Rules) am H

108

## AN ACT

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

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

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

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

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

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

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

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

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

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



**THE COUNCIL OF STATE GOVERNMENTS**

36 WEST 44TH STREET  
NEW YORK, NEW YORK 10036

TABLE OF CONTENTS

	Page
Introduction . . . . .	i
Analysis of the Law . . . . .	
Eligibility . . . . .	iii
Exclusions . . . . .	iii
Duties of the State . . . . .	iv
Qualified Health Program . . . . .	iv
Duties of Providers . . . . .	iv
Minimum Standards . . . . .	v
Facilities Reinsurance Pool . . . . .	v
Health Resources Development Fund . . . . .	vi
Filing a Claim . . . . .	vi
Conclusion . . . . .	vii
Appendix A (Catastrophic Health Insurance Program Law). . . . .	1
Chart I Eligibility Requirements . . . . .	18
Chart II Claim Processing . . . . .	19

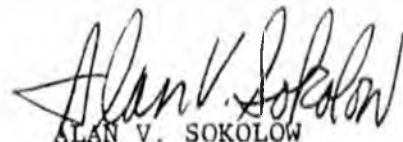
## I N T R O D U C T I O N

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

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

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

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



ALAN V. SOKOLOW

Director, Eastern Office  
COUNCIL OF STATE GOVERNMENTS

*Projections:*

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

CHEPP-2

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

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

*Projections:*

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

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

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

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

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

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

#### EXCLUSIONS

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

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

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

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

## MINIMUM STANDARDS

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

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

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

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

## RATES CHANGED

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

## FACILITIES REINSURANCE POOL

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

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



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

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

### REACTIONS TO THE BILL

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

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

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

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

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

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

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

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

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

74-S 2259 Substitute "A"

State of Rhode Island and Providence Plantations

JANUARY SESSION, A.D. 1974

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

It is enacted by the General Assembly as follows:

PREAMBLE

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

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

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

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

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

It is enacted by the General Assembly as follows:

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

CHAPTER 62  
Catastrophic Health Insurance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) An eligible person

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

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

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

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

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

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

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

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

h) Drugs and medication not legally requiring prescription;

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

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

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

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

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

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

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

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

i) It meets the minimum standards of this act,

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

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

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

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

Providers Utilized by CHEPP-1 Patients

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

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

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

CHEPP-1 Caseload

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

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

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

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

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

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

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

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

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

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

#### iii) Major Medical Coverage

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

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

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

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

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

Current CHEPP-1 Costs

Costs to Patients - July, 1977 to August, 1978

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

Costs to State - July, 1977 to August, 1978

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

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

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

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

## ARTICLE II

### Minimum Standards Protection

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### ARTICLE III

#### Health Resources Development Fund

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

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

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

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

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

Income ranges and number of cases in each range were:

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

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

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

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

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

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

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

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

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

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

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

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

### CHEPP-2 Caseload

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

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

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

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

### Current CHEPP-2 Costs

#### Costs to Patients

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

EXPLANATION

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

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

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

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

Article IV provides for administration of the act.

## PROJECTED USAGE OF CHEPP PRIOR TO IMPLEMENTATION

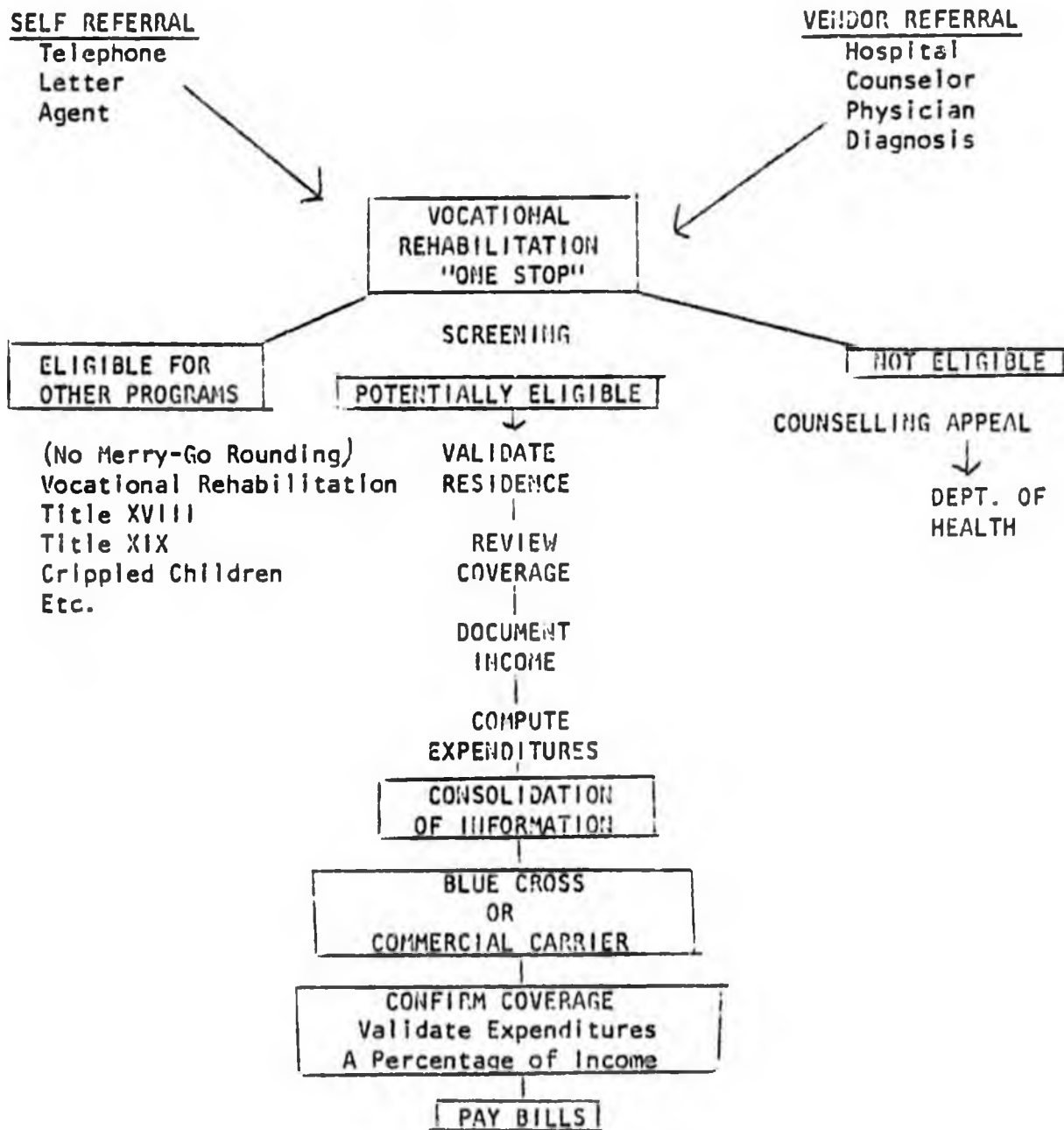
During the three-year period prior to the enactment of CHEPP legislation, legislative staff obtained information and data from numerous sources in order to attempt to project need, utilization and costs of a catastrophic health care program in Minnesota. Information and data collected included: national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

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

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

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

"THE PROCESS"



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

The following is information on Rhode Island's Program:

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

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

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

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

Objectives

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

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

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

Summary

Article I - Minnesota Comprehensive Health Insurance Act of 1976

Part A - Minimum benefits for health insurance coverage

Duties of Insurance Companies

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

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

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

Duties of Employers

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

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

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

Conversion Privileges

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

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

Part B - Comprehensive Health Insurance Plan

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

## Comprehensive Health Insurance Plan

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

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

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

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

### Public Education

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

### Referral Fee

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

### Pre-Existing Condition Clause

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

### Reinsurance

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

### Article II - Hospital Administration Act

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

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

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

Insurance Rates

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

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

Article III - Catastrophic Health Expense Protection Act

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

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

Nursing Home Provision

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

Reasonableness of Rates

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

## Experience

### Article I - Comprehensive Health Insurance Plan

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

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

### Article II - Hospital Administration Act

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

### Article III - Catastrophic Health Expense Protection Act

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

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

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

## T A B L E O F C O N T E N T S

	<u>Page</u>
Catastrophic Health Expense Protection Program Summary	1
General Description of CHEPP	3
County Referrals to CHEPP	5
CHEPP-1	
Introduction	7
Patient Characteristics	7
Providers Utilized	15
Caseload	15
Costs	18
Projections	19
CHEPP-2	
Introduction	21
Patient Characteristics	21
County Referrals	23
Caseload	24
Costs	24
Projections	25
Projected CHEPP Usage Prior to Its Implementation	26
Factors Impeding CHEPP Usage	29
Recommendations	31

CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM (CHEPP) SUMMARY

CHEPP-1 and CHEPP-2

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

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

CHEPP-1

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

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

*Projections:*

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

CHEPP-2

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

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

*Projections:*

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

## THE CATASTROPHIC HEALTH EXPENSE PROTECTION PROGRAM (CHEPP)

### General Description of CHEPP

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

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

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

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

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

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

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

or \$2500, whichever is greater.

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

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

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

## County Referrals to the CHEP Program

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

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

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

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



## CHEPP-1

### Introduction

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

### Patient Characteristics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NUMBER OF MONTHS ELIGIBLENUMBER OF CASES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Providers Utilized by CHEPP-1 Patients

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

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

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

CHEPP-1 Caseload

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

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

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

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

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

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

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

## Current CHEPP-1 Costs

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

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

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

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

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

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

## Projections - CHEPP-1

### Utilization

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

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

### Costs

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

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

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

## CHEPP-2

### Introduction

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

### Patient Characteristics

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

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

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

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

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

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

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

Income ranges and number of cases in each range were:

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

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

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

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

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

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

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

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

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

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

County Referrals to CHEP-2 Program

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

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

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

### CHEPP-2 Caseload

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

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

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

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

### Current CHEPP-2 Costs

#### Costs to Patients

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

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

#### Costs to State

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

#### Projections - CHEPP-2

##### Utilization

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

##### Costs

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

## PROJECTED USAGE OF CHEPP PRIOR TO IMPLEMENTATION

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

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

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

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

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

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

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

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

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

MINNESOTA ESTIMATES

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

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

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

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

The following is information on Rhode Island's Program:

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

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

## FACTORS IMPEDING USAGE OF CHEPP

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

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

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

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

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

## CHEPP RECOMMENDATIONS

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

Prior to development of CHEPP legislation, legislative staff collected information and data over a three-year period for purposes of projecting need, utilization, and costs for catastrophic health care coverage. During, and since that time, no data has been discovered upon which to comfortably and firmly base cost and utilization projections for the CHEP Program. Trends can be noted and some projections based on them, although a minimum of one more year of CHEPP experience is desirable for development of projections based on actual experience.

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

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

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

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

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

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

Other methods of educating providers about the CHEP Program include:

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

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

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THE PRECEDING PAGES WERE TREATED AS  
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THE POLITICAL PLANNING OF A STATE  
HEALTH INSURANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The foregoing summarizes the basic provisions of our law.

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

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