

# Issue Brief

## Myths and Realities of Health Insurance Reform in Maine

The high and rising cost of medical care reflects principally the cost of providing care. Insurance programs are supposed to distribute costs across a large number of people in order to promote affordability. The current insurance system does not effectively do this, leading to significant disparities in affordability among different populations. Reasons for this deficiency include fragmentation of the risk pool caused by differential purchasing practices, the preemptive authority of federal law and the costs associated with various policy initiatives that are, ironically, intended to promote access and affordability. While reform in Maine's health insurance market may be needed, it cannot substitute for measures to address the underlying cost of medical care.

### Who has Health Insurance Coverage?<sup>1</sup>

When it comes to paying medical bills, nearly all Mainers fall into one of five categories:

- Employee-sponsored. For more than half of us (680,000), health insurance is provided through a place of work. This coverage varies widely from employer to employer and often depends on the size of the company, whether it is unionized, pressures on the company's bottom line and competitive pressures to retain a workforce.<sup>2</sup>
- Private. About 3% of Maine's population (41,000) purchases a private health insurance plan directly. These individuals pay the entire premium cost directly. In order to reduce these

premium costs, the coverage arrangements for these health plans are increasingly characterized by a very significant front end deductible.

- Medicare. Medicare is a federal insurance system for people over age 65 or disabled. Over 17% of Maine's population (231,000) has Medicare coverage. Medicare premiums are collected through payroll taxes and individuals covered by the program.
- Medicaid. About 21% of Maine's population (278,000) is covered by Medicaid. This program is generally available to low and lower income individuals and families. Medicaid is jointly funded by both the state and the federal governments; for every dollar that Maine pays for health care services, the federal government "matches" approximately two dollars.
- No coverage. Approximately 10% of the population (132,000) does not have any insurance and pays directly for health services. This population is the greatest source of bad debt and charity care for health care providers.

### The Cost of Health Care Drives Insurance Costs

Health care in Maine (and elsewhere) is very expensive. Insurance costs reflect these costs (plus administration and profit or surplus, which are usually modest compared to the cost of care). Advanced technology; provider and consumer driven demand for services, i.e., utilization;

### Fast Facts

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- Over 17% of Maine's population (231,000) has Medicare coverage.
- About 21% of Maine's population (278,000) is covered by Medicaid.
- Approximately 10% of the population (132,000) does not have any insurance and pays directly for health services.
- 80% of the costs of care for a large population of people will be incurred by about 20% of the individuals in that population.

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malpractice expenses; the aging of the population; unhealthy lifestyles and other factors are major contributing factors that would still drive the high cost of health care even if Maine established a perfectly efficient and effective insurance program.

Except for the very wealthy, few people can afford to directly purchase a comprehensive medical insurance plan. Consequently, the cost of health insurance is nearly always subsidized, by the government in the case of Medicare and Medicaid, and by private companies, as part of the benefit plan. Notwithstanding the underlying factors that drive the high cost of health care, there are inefficiencies in the State's overall health insurance system that exacerbate these costs. Some of these inefficiencies reflect conscious policy decisions, others reflect unintended consequences.

## How Insurance is Supposed to Work, and Doesn't

The underlying principle behind insurance is simple: everyone pays a little in order to have funds on hand to pay the medical bills incurred by a few. This principle is dramatically illustrated by the fact that 80% of the costs of care for a large population of people will be incurred by about 20% of the individuals in that population. This principle is described as "pooling" risk for health care expenses and it works best when the risk is distributed across a large population. By doing so, the average insurance cost for an individual can be best predicted and is less likely to change dramatically from year to year.

This basic concept starts to break down when there is "fragmentation" in the risk pool. Imagine 100,000 people each pay \$50 for insurance. This creates a total pool of \$5,000,000. Now assume that 100 people get very sick and have expenses of \$50,000 each, or \$5,000,000 in total. In this simple example, total premiums cover the expenses. Let's break our group into two subgroups: one with 25,000 people and a second with 75,000 people. In the smaller group, a disproportionate number of people get sick, say 40, and only 60 get sick in the larger group. Look what happens:

	Total Premium	Expenses	Surplus/(Shortfall)
<b>Group 1</b>	\$1,250,000	\$2,000,000	(\$250,000)
<b>Group 2</b>	\$3,750,000	\$3,000,000	\$750,000
<b>Total</b>	\$5,000,000	\$5,000,000	\$0

In the following year, Group 2's premiums will not increase; in fact they may go down. In contrast, Group 1's premiums would need to increase at least 20%.

While simplistic, this example illustrates the potential impact of fragmenting the insurance pool. How likely is it that there would be a disproportionate distribution of sick people? Depending

on how the subgroups are constructed, very likely. In the above, hypothetical example, if the smaller group is everyone over age 55 (who are likely to need more services than people less than age 55), medical expenses are likely to be distributed disproportionately.

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Indeed, there are many examples in Maine (and elsewhere) where fragmentation of the risk pool occurs. Employers that choose to self-insure their employees and dependents effectively fragment the commercial insurance pool.<sup>3</sup> Employers

choose to self-insure for two principal reasons. First, they believe (usually correctly) that the medical expenses of their employees and dependents will be less, on average, than the general population. While an insurance company may still administer the benefit program, the medical expenses associated with a self-insured group are not blended with other groups. Secondly, self-insurance provides greater flexibility for companies to design their medical benefit plans (see discussion below, The Role of Regulation).

Insurance companies also establish separate risk pools for different segments of the market, usually in response to competitive pressures. For example, small businesses may be grouped together with a premium rate that reflects the expected medical expenses of this market segment. Similarly, insurance premiums for persons who wish to directly purchase individual coverage (often because coverage is not available through a place of employment) are often grouped together and the premium is based on the expected medical expenses that these individuals will incur.

In Maine, Anthem provides a good illustration of this fragmentation and its impact. Nearly 285,000 people were covered by Anthem in 2006.<sup>4</sup> On the face of it, Anthem's population represents a very large insurance pool. However on closer examination:

<i>Anthem Book of Business in Maine, 2006</i>		
	Number of Covered Lives	Average Increase (2006)
<b>Large Companies, insured and self-insured</b>	168,363	9-10% <sup>5</sup>
<b>Small Companies, insured</b>	80,741	8% <sup>6</sup>
<b>Insured individuals</b>	35,590	16%

As the cost of insurance becomes disproportionately more expensive for certain groups, individual units within the group may leave the pool. For example, a small employer with a relatively young and healthy workforce may discontinue coverage, providing additional cash compensation instead. Similarly, a healthy

person may decide to discontinue his or her individual insurance plan. As this migration occurs, the residual population is increasingly less healthy and the costs will increase even faster. This phenomenon is known as adverse selection and more likely to occur among insured individuals and small groups. Among large employers, there is more stability in the group and virtually no migration due to health insurance costs.

Taken to its logical conclusion, adverse selection will result in a risk pool that contains only very sick people who pay exorbitant premiums. Many argue that adverse selection is happening in Maine today for individuals who purchase Anthem's individual policies and that this will lead to the eventual demise of this product.

One final word on fragmentation: Medicare and Medicaid represent subsets of the general population that have been segregated for purposes of providing health insurance. On one level, this fragmentation of the risk pool has had a positive impact on the cost of private health insurance. Medicare and Medicaid provide coverage to populations who are sicker and consequently more costly. These public programs effectively remove these populations from the general risk pool. However both programs reimburse providers at levels below what providers believe are adequate. In order to recover this shortfall, providers charge commercial insurance programs more than would otherwise be the case. This is referred to as "cost shifting" and is a separate consequence of fragmentation of the State's insurance pools.

## The Role of Regulation

Maine, like all states, regulates health insurance sold within its borders. This regulation does not extend to self-insured companies that are regulated by the Department of Labor and the federal Employee Retirement Income Security Act or ERISA. In Maine, the Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates health insurance companies selling policies within the state. The chief regulatory authority is the Superintendent of Insurance.

There are two major components of Maine's regulatory activity. The first is to assure that a company will be able to pay claims to individuals for whom premiums have been collected, either directly or through an employer. Insurance is a form of promise. A premium is paid today in exchange for the promise that medical expenses, if incurred, will be paid at some future date. The regulators' job is to assure that the insurance company will be in business to fulfill this promise.

Secondly, the Bureau of Insurance is required to implement various legislative requirements. Many states, including Maine,

have identified certain benefits and services that are required to be included in any medical insurance plan that is operating in the state. Examples of "mandated benefits" include a minimum number of chiropractic exams, certain annual preventive services and the like. In Maine, there are over 40 such mandated benefits. If a company is self-insured, it is not required to provide mandated benefits because, again, federal ERISA laws preempt the state.

Another example of the Bureau's regulatory authority is around rules governing how insurance companies can provide coverage to individuals and small groups. For example, Maine has a "guarantee issuance" law which requires an insurance company, if it provides individual coverage, to enroll anyone who applies, regardless of prior medical condition. Similarly, there are regulations around the price that can be charged to an individual. Someone who is at higher risk to be sick cannot be charged an excessively higher premium than someone who is at lower risk. These provisions represent attempts to assure available and affordable health insurance for individuals. According to the insurance industry, however, these provisions make it very difficult to insure individuals profitably and, consequently, only a few companies offer individual coverage in Maine.

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A final example is the Bureau's authority around provider contracting by an insurance company. Rule 850 requires an insurance company to reimburse for services provided by a hospital or doctor in a patient's geographic location, regardless of whether the insurance company has established a mutually acceptable contract with the provider. The purpose of this rule was to assure consumers that they would not be required to travel unreasonable distances for health care, simply because an insurance company could, or would, not contract with a local provider.

## Strategies and Limitations on Fixing the Insurance System

Earlier, the point was made that health care is very expensive. There are two broad policy perspectives that underscore efforts to reduce these costs through Maine's insurance system.

The first advocates for a single, broad-based insurance program. This approach would eliminate the inefficiencies and disparities that exist in a fragmented insurance market. This approach advocates for a single risk pool that insures all persons at the same

premium cost (i.e., “community rating”). It is important to note that a “single” payer system is not the same as nationalized health insurance. Doctors and hospitals would continue to be private enterprises and consumers would continue to access the doctor and hospital of their choice. A single payer system currently exists in the United States: Medicare provides coverage to all eligible elderly and disabled consumers through a single insurance pool. Medicare is administered through different insurance companies and consumers can almost always access the doctor or hospital of their choice.

While a single insurance pool may be appealing, it would be nearly impossible for a state to adopt this reform. The federal government’s authority extends over Medicare, a large part of Medicaid, and self-insured groups through ERISA. While a state could require the pooling of all insured populations within its regulatory authority, a decline in one population’s premium means an increase for another. For example, it has been suggested that Maine require small groups and individuals to be pooled together. This would likely result in a lower cost to individuals but a higher cost to small groups which might cause more small groups to discontinue their health insurance program or attempt to self-insure.

The second often touted approach is one of deregulating Maine’s insurance markets. For example, it is estimated that Maine’s mandated benefits contribute from 4 to 6 percent to the annual premium for groups of 20 or fewer employees and approximately 8 percent for groups of more than 20 employees.<sup>7</sup> Many of these mandates, such as mammography, have become standardized benefits among both insured and self-insured plans. These benefits are not likely to be removed from benefit plans and therefore savings opportunities may be less than expected.

The elimination of guaranteed issuance and rating regulations in the individual market is often suggested as a means to reduce premium expenses for particularly younger and currently uninsured adults. For those currently protected by these provisions (who are likely to be sick), their costs will increase significantly or they will be denied insurance completely. While high risk insurance programs, reinsurance pools and other approaches have been suggested to address these dislocated individuals, significant subsidies would be required to successfully implement these strategies.

Additional deregulation would be gained by modifying Rule 850 and enabling insurance companies to more effectively negotiate with providers. Interestingly, self-insured employers that are not currently constrained by Rule 850 have demonstrated little interest in this type of patient steering. So it is unclear how broadly this strategy would be adopted if Rule 850 were modified.

## So What Can be Done?

Maine needs a clear vision of an efficient insurance system that can serve as a long range blueprint against which incremental reform steps can be assessed. Such a blueprint can help avoid quick or limited fixes that are often accompanied by unintended, and undesirable consequences.

No blueprint will be perfect. Where authority for change rests with the federal government, it is not likely to be ceded to a state. Still, Maine retains sufficient authority to develop a blueprint which can:

1. Assure compliance with basic insurance tenants that advance an efficient, effective and equitable distribution of costs. For example, in an effort to pool insurance risk across as large a population as possible, the recent reform in Massachusetts requires all individuals to have health insurance coverage.
2. Address the underlying health care cost drivers that directly and substantially impact the cost of health insurance. Consumer directed health plans are one such strategy that is grounded in an insurance product. Based on the conviction that if consumers were responsible for a larger portion of their health care bill, they would be more efficient shoppers of health care, these plans require consumers to shoulder a very significant portion of the cost of routine care. Insurance protection is provided for catastrophic claims due to a major illness or accident.

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## References

1. Enrollment data compiled from various sources, including “State Profiles: Reforming the Health Care System 2005,” AARP Public Policy Institute, 13th Edition; Maine Bureau of Insurance Web site: [www.state.me.us/pftr/ins](http://www.state.me.us/pftr/ins); and Kaiser Family Foundation’s [www.statehealthfacts.org](http://www.statehealthfacts.org).
2. The Dirigo Health Plan is structured like a private insurance plan. Enrollment in Dirigo as of the end of 2006 is 10,700. Current premiums are established by an insurance company (with approval by state government) and collected from employers and individuals. For lower income individuals (who earn too much to be eligible for Medicaid), a subsidy is provided to help pay their share of the monthly premium. Dirigo provides a similar, income based subsidy to help eligible individuals pay the annual deductible expenses.
3. As a self-insured entity, large companies assume direct financial responsibility for only their employees and dependents. While an “insurance” card may be provided, the insurance company is providing only administrative services. For smaller companies and individuals, the insurance company is “at risk” for assuring that premium income is sufficient to pay all medical and administrative expenses.
4. Anthem 945 filing for 2005, Bureau of Insurance and personal correspondence, Bureau of Insurance, 1/5/07. Covered lives for small companies and individuals include Dirigo.
5. Anthem, personal communication, 01/08/07.
6. Average for all carriers that write small businesses. Anthem has nearly two thirds of the small group market. Many small businesses have modified benefit plans to introduce higher deductible plans that effectively moderate premium increases, but require employees to pay a larger portion of the costs at time of service.
7. Bureau of Insurance, Estimate of Cumulative Impact of Mandates in Maine, 2005, 12/28/06.