October 10, 1988

To: The Special Select Commission on Access to Health Care

From: Mike Vadas, Administrator Government and Industry Relations
Mercy Hospital Mike Vadas

Re: Written Comments on Commission's September 29, 1988 Symposium

I must begin by complementing the Special Select Commission on Access to Health Care and your consultant, Lewin/ICF, for the thoroughness of your work and the manner in which the meetings are conducted. Allowing, and sometimes soliciting, the involvement of interested parties throughout the process is refreshing and greatly appreciated. It is evident that this approach has encouraged public and private sector understanding and cooperation, made effective use of available resources and is well on its way to producing outcomes that will be constructive, fair and have broad based support.

The outline presented on September 29, 1988 was quite thorough. My following comments do not uncover subjects or goals not already addressed but emphasize and/or offer alternative approaches to meeting the Commission's objectives on a few select items; promoting access; marketing to the easy-to-reach uninsured employed, and reducing the cost of malpractice insurance.

Promoting Access

The demand for health care and insurance far exceeds the supply of physicians and the types of insurance plans now available.

Without sounding redundant, I would again reflect upon the comments of my peers and caution that a new system that increases the supply to meet the demand may still not achieve ultimate "access" without the proper information and referral networks. Once programs are in place a vehicle to reach out to eligible participants and assist them in signing up is essential. Because the program participants may need continued assistance in accessing the system and scheduling preventive exams and tests, a toll free number they can call for information regarding their plan and how to use it (i.e. the special assistance programs such as the Pennsylvania Mercy Health Plan "TLC" program explained in the attached brochure) should be considered.

The same issues exist for employers or individuals seeking new insurance products offered through commercial carriers or the state. Getting the buyer and seller together is a necessity. Access involves not only the creation of services but an awareness of them and clear directions on how to obtain them.

Many times the physician is blamed for outcomes that were not the result of their diagnosis and plan of treatment, but rather the patient's actions or lack of action to follow the physician's advice.

Legislation that would hold physicians harmless for uncontrollable health set backs, if that physician practiced to a "standard" approved by the AMA as appropriate treatment, would reduce the amount of unnecessary suits filed, return more favorable decisions on the side of the physician, ultimately reduce the high cost of malpractice insurance that shows up in hospital and physician charges, and make physicians more willing to accept Medicaid patients.

However, whatever efforts are undertaken in Maine to redress the malpractice issue should build on the concepts of peer review, and the Maine Medical Assessment program which have demonstrated effectiveness in improving patient outcome. Improve patient outcome, and the reduction in interventions which are unlikely to improve outcome are important strategies in reducing the opportunity for malpractice claims.

Not only could this provider cost pass through be lowered in our individual bills, but the number and cost of excessive testing, x-rays and other unnecessary services would be eliminated. Physicians would certainly appreciate support on this issue.

In Closing

Thank you again for the opportunity to provide input to the process. If I can be of any further assistance, please consider me a willing and reliable resource.

Marketing to the Easy-to-Reach Uninsured Employed

An employer's decision not to provide health care benefits to employees not only makes access to primary care more difficult, especially for the low income employee and their family, but also contributes to health care system bad debt if these uninsured individuals have an accident or acquire an illness that demands expensive medical treatment. Bad debt burden subsequently gets passed on to employers that provide insurance and, along with other inflationary factors, resulting in more employers dropping their insurance and moving more individuals to the uninsured ranks...a continuing cycle.

Many small employers face an "all or nothing" decision when it comes to providing health insurance benefits. Plans offered in the market are rich, covering everything from $10 prescriptions to $100,000 accident claims involving expensive surgeries and long hospital stays. The cost of these rich plans exceed $1,000 per covered individual annually, a financial burden too great for many small employers.

Forcing employers to purchase these rich plans or "pay" the consequences such as in Massachusetts, may address cost shifts but does little to provide access for the uninsured employee and their family.

I would recommend a balanced employer-state health insurance program in which employers and the state share responsibility for extending access to this easy-to-reach uninsured employee group. An innovative approach the Committee should consider in that regard is a system of tax credits and vouchers. This option is outlined as "Option 2", page 8, of the attached article entitled "Covering the Uninsured: How Much Would It Cost?".

The state's potential financial burden would also be reduced beyond the level that it would have incurred if sponsoring the entire insurance program.

Reducing the Cost of Malpractice Insurance

You do not solve the malpractice insurance problem by merely subsidizing the cost of malpractice insurance. You cannot encourage primary care physicians or obstetricians to treat any or all patients unless you support them clinically, as well as financially, for even an unjustified malpractice suit causes damange to the physician's practice. Physicians will tell you they perform additional diagnostic testing that may not significantly add to the accuracy of the diagnosis but do provide legal protection for the physician if a malpractice suit is ever filed. It has become too easy and convenient to sue physicians.

John R. McKernan, Jr.
Governor

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE

Rollin Ives
Commissioner

ADDRESS REPLY TO

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October 13, 1988

TO: Bonnie Post, Chair
Special Select Commission on Access to Health Care

FROM: Neill Miner, Director
Office of Alcoholism and Drug Abuse Prevention

SUBJECT: Comments on the Commission's Indigent Care Plan

I've had the opportunity to review some initial work of the Special Select Commission and to discuss the Commission's work with staff, Deborah Curtis. Based on this, I'd like to offer some thoughts concerning the connection between substance abuse treatment and other health care services for Maine's indigent people.

First, I believe it is essential for the Commission to recognize substance abuse treatment services as a core health service that must be made available to patients across the state, along with other basic health care services. This position is based on research that has been done nationally that documents the cost effectiveness of treatment. In particular, Jerome Hallan from Oregon State University and other researchers have documented a consistent pattern among substance abusers of greater and greater use of health care services (emergency room visits for accidents caused by substance abuse, diagnostic tests for symptoms created by substance abuse, etc.) up until the point of intervention and treatment. Following treatment, use of health care resources drops off dramatically, because the primary health problem -- chemical dependency -- has been treated. These same studies have shown that, when substance abuse treatment is part of a covered service package, the end result is a savings in benefits paid out. In short, based on this research, I don't think we can afford not to include substance abuse services in a core package of services.

Second, given this, it's important to assure universal access to substance abuse treatment. A substantial amount of money is currently spent by the Office of Alcoholism and Drug Abuse Prevention and the Bureau of Medical Services through Medicaid on access to care specifically for indigent people. As a result, many people do have access to treatment on demand. The problem is that there are insufficient resources to respond to the demand for some groups and in some geographical areas. It's my recommendation that the Commission call for equal access to substance abuse treatment (including outpatient, nonresidential rehabilition, and residential rehabilitation) for all low income people.

Relating these comments to the language the Commission is using regarding populations, some portion of each of the three groups is currently experiencing access problems in relation to substance abuse treatment. Insured low income people with special needs - e.g., elderly, adolescents - experience problems when the treatment providers in the local area are not trained or skilled to treat the individual with his special needs. Easier-to-reach low income uninsured people may simply not have the funds to pay for the required services. This is particularly true of more expensive services such as 28-day residential rehabilitation or nonresidential rehabilitation. The difficult-to-reach low income uninsured may experience either or both of the problems mentioned above (inability to pay for the service; lack of access to the service geared to their needs), depending on the specific characteristics of the individual.

The Department of Human Services is currently considering service expansion requests in several areas for the consideration of the Legislature in either this or future sessions. New resources will be carefully targeted. Allocation will be done according to established standards regarding the amount of service that should be available in any geographic area, and according to current availability of the services across the state, compared to the desired levels.

It is my recommendation that the Commission will recognize the critical importance of access to treatment on demand, and endorse the Department's initiatives to establish expanded access to substance abuse treatment for low income people on an equal basis with the people who can afford to pay for the services.

Please let me know if I can provide any additional, detailed information to the Commission regarding this issue.

MPA

Maine People's Alliance

Capital Office: 8 Crosby Street, P.O. Box 2490, Augusta, Maine 04330 (207) 622-4740

COMMENTS OF THE MAINE PEOPLE'S ALLIANCE ON THE PROPOSALS BY THE LEWIN/ICF BEFORE THE SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE

I. NEED FOR A PUBLICLY ADMINISTERED PROGRAM COVERING ALL PERSONS UP TO 150% OF POVERTY

The materials set out several approaches to reaching a segment of the Maine population not currently receiving health care. For the reasons that follow, the Maine People's Alliance, as a member of the Consumers for Affordable Health Care coalition, as well as a membership organization with 15,000 members statewide, propose that the primary program for insuring the majority of those presently without health care insurance be through the following publicly administered program to ensure access and low costs.

We propose that all Maine residents, regardless of age, sex, employment status or family composition, whose household income does not exceed 150% of poverty, be covered by a comprehensive health insurance program administered by the State and funded primarily through general revenues of the State. Depending on household income, a sliding scale premium could be set for those participating in the plan. The sliding scale premiums developed for the ASPIRE program could be used as a model.

The program should not be through an expansion of the current Medicaid program or through a private insurance product for the following reasons. With regard to Medicaid expansion, this draws down on federal funds. It also may carry the present access barriers that the Medicaid program has raised for Medicaid recipients. With regard to a private insurance product, many problems are presented. The primary problem is that of costs. Because of the high administrative costs, high marketing costs, high legal costs, and profit incentives inherent in the private insurance market, it is clear that the most economical and efficient method of insuring, without restrictions or high premiums, a large segment of the population is only through a publicly administered program. The above problems with private insurance can be no more strongly advanced than through the fact that there is no private insurance product in existence now covering this segment of the population.

This proposal to insure those persons without coverage up to 150% of the federal poverty level will serve to reduce the present level of uncompensated care now being passed onto those with insurance or to those paying for their health care out-of-pocket.

II. STATEWIDE EMPLOYER-SPONSORED GROUP COVERAGE

It is necessary that those persons who are in the Maine work force, have adequate health coverage. Insuring persons in Maine through their place of employment is a stream-lined, efficient and effective way

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to provide access to health care for a large segment of the population. It also provides an equitable and progressive method for funding as it spreads the costs of such program back over thsose employers who are not presently contributing to the costs of health care for their employees.

Our proposal is to modify the MaineCare program so that any insuror licensed in Maine who offers small group coverage to apply to be a MaineCare carrier. Eligibility would require compliance with state standards for: minimum program benefits, program eligibility, and medical underwriting crtieria.

The program would allow businesses of 20 or less employees to enroll in any of the designated MaineCare carriers. Applications would be made through either the state office of economic development or DHS or other designee. Employers who enroll their business in a MaineCare program would be required to pay a specified protion of the premium for their employees and their dependents. A "Marginal Business Assistance Fund" could provide grants for a maximum of two years to those businesses qualifying as marginal and that had been previously uninsured.

This program would be funded through a payroll tax of 2%, with a forgiveness of the tax for those businesses that provide an adequate level of health insurance coverage. The tax would be based on all employees down to 10 hours a week.

Because this program should result in reduction of hospital bad debt, a contribution from hospital revenues toward a reinsurance pool should be required.

III. EXPANSION OF HIGH RISK INSURANCE PROGRAM

The High-Risk Insurance program should be expanded to increase access for those Mainers with pre-existing conditions. The enrollment cap of 300 should be removed, the subsidy fund should be substantially increased, deductibles as well as premiums should be subsidized, subsidies should lower the enrollees costs below standard commercial rates, and some prescription drugs should be covered.

The hospital assessment, which is currently capped at .015 percent, should be significantly increased.

IV. UNDERSERVED COMMUNITY GRANTS PROGRAM AND EDUCATIONAL LOAN FORGIVENESS

An underserved community grants program would make grants available based on review and approval of proposals submitted by community groups for the purpose of assisting these communities in building their service delivery capacities. These grants could be used for planning purposes, e.g., for coordinating and regionalizing services between contiguous health service areas or for developing "circuit rider" systems. Such grants could also be used for funding capital development projects to attract and retain an appropriate range of providers to the communities.

A state funded educational loan forgiveness program for primary care physicians, public health nurses, midwives, and other specified providers who agree to practice a specified time in underserved areas and who agree to provide services on a sliding scale basis.

Nelson, Desmond & Payne Insurance

A DIVISION OF DESMOND & PAYNE INSURANCE, INCORPORATED

TO : Deborah Curtis, Staff, Special Select Commission on Access to Health Care

FROM: Sally I. Nelson

DATE: October 5, 1988

RE : Commission's Indigent Care Plan

I am writing to offer comments regarding the eligibility requirements and pre-existing condition clauses of insurance contracts.

90% of commercial insurance carriers require that employees work a minimum of 30 hours per week in order to be eligible for insurance benefits (see attached). This is especially true in contracts for groups with less than 10 employees. BlueCross/ Blue Shield has the same requirements for groups with 3-9 employees. These programs will not cover part-time or seasonal employees.

Usually there is a pre-existing condition clause that states, ie; if the employee or other dependents have a medical condition that has required treatment, this condition will not be covered for a period of time. The time limit is normally 12 months but can be as long as 18 months. I see this as a situation where you may mandate that an employer provide benefits but the employee may still not have coverage for certain medical conditions for a specific period of time. There needs to be consideration given to those employees who have pre-existing conditions and where they can get coverage during their exclusion period.

In my opinion, as a life and health agent specializing in the group and health market, the major issues are cost, eligibility and pre-existing conditions. If an employee earns $12,000 per year and is required to pay $200 per month to cover his dependents under a group health plan, he'll probably drop the coverage because it's too expensive. One the other hand, if an employer cuts benefits to keep the costs down eveyone is up in arms. There needs to be a subsidy for these people according to income.

I'd be happy to provide the Commission with any further information they may need or answer any questions they may have.

GENERAL INFORMATION

Durham Life

COVERAGE AND ADMINISTRATION OF THE TRUST

A fully insured Multiple Employer Trust, such as the Small Business Group Insurance Trust, enables many employers, each with a small number of employees, to unite in joint purchasing power. The Small Business Group Insurance Trust was formed in 1976. Coverage in the Trust is provided under a group master policy issued by Durham Life Insurance Company.

The Rhode Island Hospital Trust National Bank serves as trustee for the Small Business Group Insurance Trust, and each Participating Employer joins by separate agreement. The Trust and the insurance are administered by United Plans. The group policy is issued in Rhode Island; however the coverage is available to employers in many states.

ELIGIBILITY OF EMPLOYERS

Most businesses with one or more employees are eligible. However, some are not acceptable, including, but not limited to:

- Attorneys
- Automobile Dealers
- Aviation Crews
- Bars
- Garages
- Gasoline Stations
- Governmental Units (City, County and State)
- Hospitals and Clinics
- Junk Dealers
- Parking Lots
- Religious Organizations
- Stockyards
- Welfare Funds

Note: Some of those businesses that are unacceptable may be considered for the owners and salaried employees with special underwriting approval.

PARTICIPATION REQUIREMENTS

If an employer has less than 5 employees, all eligible employees must be enrolled. From 5 to 9 employees, all but one must enroll. An employer may pay all of the employee costs or at least 25% of both employee and dependent costs.

ELIGIBILITY OF EMPLOYEES

To be considered an eligible employee, a person must be working regularly on a full-time basis for the employer and for compensation. "Full-time" requires a minimum of 30 hours per week by the employee. Individuals who are on retainer, such as attorneys or accountants and persons who are members of boards of directors, but not employees, are not eligible.

In determining participation, the ineligible employees are not included in the calculation of the eligible employees who are participating.

Dependents of insured employees are eligible for Dependent Life Insurance and health care coverages only. The spouse of the employee and each unmarried child less than 19 years of age, or 25, if a full-time student, are eligible. Handicapped children enrolled continuously under this plan prior to 19 may be continued without regard to age as long as they are unmarried and incapable of self-support.

EVIDENCE OF INSURABILITY

If the employer has fewer than 10 eligible employees, each employee must submit Evidence of Insurability satisfactory to the Administrator on him/herself and his/her dependents.

TERMINATION OF COVERAGE

The employee and dependent coverages cease on the first of the month following termination of the employee's employment, unless terminated sooner for reasons specified in the group policy.

Coverage may be terminated retroactively to the first date of coverage if an employee or dependent knowingly provides incorrect or incomplete information to United Plans.

U. S. Life

Eligibility

An eligible employee must work on a full-time basis, at least 30 hours per week, at the employer's place of business or at any other location his employer requires him to travel.

Eligible dependents include:

— a spouse

— an unmarried child who is under 19 years of age or, under 25 years of age if a full-time student, dependent upon the employee for support. Dependent children must be over 14 days of age to be eligible for dependents' life insurance.

Minimum Life Schedule

All groups must take the minimum life schedule required by United States Life. Higher schedules are available subject to underwriting approval.

The minimum life schedule is $10,000 for all lives. For one life groups, $100,000 is the minimum schedule if the employee is under 50 years of age at the time of application, and $50,000 if the employee is age 50 or over at the time of application.

Participation

- All employees and if applicable, all eligible dependents, must be insured if the employer pays the entire premium.
- In contributory programs, required participation is 75 percent of eligible employees and dependents.

Premium Payment Schedules

Annualized Premium:	Available Payment Schedule
$300 to $600	Annual (A), Semi-Annual (SA)
$600 to $1200	A, SA, or Quarterly (Q)
$1200 or more	A, SA, Q, Monthly

- Minimum annualized premium which may be written is $300.
- A $20 administration charge will be made for each premium statement.

from Phoenix Mutual

COVERED SERVICES

Dental benefits are paid on a Usual, Customary and Reasonable basis for covered services. This coverage includes four types of services:

Type 1 (Preventive) Services—Oral exams, X-rays, sedative fillings, prophylaxis. The deductible is waived for Type 1 services. Phoenix Mutual pays 100% of UCR charges for these services.

Type 2 (Basic) Services—Root canal therapy, simple extractions, and fillings. After you pay a $50 deductible, Phoenix Mutual pays 80% of UCR charges for these services.

Type 3 (Major) Services—Crowns, dentures, periodontics. After you pay a $50 deductible, Phoenix Mutual pays 50% of UCR charges.

Type 4 (Orthodontic) Services—These benefits are available only to dependent children to age 19. The deductible is waived for Type 4 services. Phoenix Mutual pays 50% of the UCR charges for these services up to a lifetime maximum of $1,000 for each covered person.

LIMITATIONS

1. The first year of coverage for each covered person is limited to Type 1 and Type 2 services.
2. The second year of coverage for each covered person is limited to Type 1, Type 2, and Type 3 services.
3. Type 4 services are not available until the third year of coverage.
4. Type 1, Type 2, and Type 3 services have a combined maximum benefit of $1,000 per calendar year per person.
5. Coverage for Type 1, Type 2, and Type 3 services is provided for dependent children aged 19-25 if they are full-time students.
6. When the cost of dental treatment is more than $200, the treatment plan must be submitted in advance for pre-determination of benefits. We will review the plan and notify you and your dentist of the reimbursement expected for the services.

EXCLUSIONS

1. Replacement of bridges, partial or full dentures, inlays, onlays, or crowns:
   a) if they can be repaired or restored; or
   b) if they have been inserted within 60 months.

   Exceptions to this exclusion will be made if the replacement is necessary because of:
   a) the extraction of functioning, natural teeth while you are insured with Phoenix Mutual;
   b) accidental bodily injury. (Chewing injuries are not accidental bodily injury.)
2. Cosmetic procedures.
3. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, or bite analysis.

Blue Cross / Blue Shield

REQUIREMENTS

ELIGIBILITY

In order to qualify for this program, you must employ three to nine employees under the age of 65. These employees must be actively at work thirty (30) hours or more per week to be eligible for this program.

People who are not bona fide employees (i.e., firm's accountant or attorney, directors, stockholders) are not eligible. No part-time employees are eligible for this program. Also, a group composed of three family members only is not eligible.

Active employees over age 65 and eligible for Medicare may not be counted to qualify your group for this program. However, if your group qualifies, they will be eligible to enroll in Blue Cross and Blue Shield of Maine's Companion Plan and will be eligible for the Phoenix Mutual benefits of this program.

Example: Your group has two employees under age 65 (yourself and another person) and two employees 65 or over. You cannot count the two people over age 65 to satisfy the three-person minimum requirement.
However, if you had three employees under age 65 and two employees age 65 or over, your group would meet the minimum three-person requirement and qualify for this program.

(cont'd.)

3. At least 50% of all employees who take medical coverage, with the maternity option and have a dependent must take a family-type coverage regardless of other coverage.
4. Applicants who are in the last trimester of pregnancy will not be considered eligible for coverage until after delivery of the newborn. Pregnancies in the first and second trimester will be underwritten according to group size.

Eligibility

Employee: Any employee, including the proprietor or partners, who works for the participating employer at least 30 hours per week on a regular full-time basis is eligible. Applicants must be U.S. citizens. Part-time and temporary employees are not eligible. Sub-contractors are not eligible employees.

Employees are eligible for coverage on the original effective date if they are employed at the time the application is made. An employee must be actively at work on the effective date of coverage. Employees not on active, full-time duty will be eligible upon their return to active work.

Dependents: Dependents are eligible for medical and dental coverage only. Eligible dependents include the lawful spouse and unmarried, legally dependent children to age 19. Full-time students are considered eligible dependents to age 25.

If a dependent is confined to a hospital on the effective date of coverage, that dependent is not covered until final discharge from the hospital.

Husband and Wife Employment: The spouse, if also an eligible employee, ***must be covered under a Family Type Medical and a Family Dental Plan, and not under separate Single Plans.*** Separate Life and AD&D coverage is still required for each one. If husband and wife are both employees, the Major Medical and Dental premium is based on the attained age of the employee with the earlier date of employment.

New Employees: New employees will be eligible for coverage on the first of the month following the waiting period chosen by the employer. Waiting periods of 0, 30, 60, 90, 120, and 180 days are available.

Evidence of Insurability

Underwriting is done on a case basis taking into consideration the number of employees covered, the number of minor or major health problems and the amount of benefits applied for. If the full coverage cannot be issued as applied for, you will be contacted regarding what coverage can be issued. This may include a special medical exclusion rider. If questions arise during underwriting, telephone contact will be made for clarification.

Prudent field underwriting techniques must be employed at all times. The following list of medical conditions will be considered as unacceptable medical risks. Each case is evaluated on its own merits, therefore, this list is not all inclusive.

1. Arteriosclerosis
2. Aneurysm
3. Brain tumors
4. C.V.A. (Cerebral Vascular Accident; stroke victims)
   T.C.I. (Transient Cerebral Ischemia; stroke)
5. Ulcerative colitis (active or within seven years)
6. Cancers (malignant)
7. Juvenile diabetes, Brittle diabetes
8. Emphysema
9. Hodgkins disease
10. Stomach stapling (within five years)
11. Kidney anomalies (polycystic kidneys)
12. Mongolism (Down's Syndrome)
13. Multiple Sclerosis
14. Paralysis (hemi, para, or quadraplegia)
15. Hospitalization for mental or nervous disorders (within four years)
16. Hospitalization for alcohol or drugs (within five years)
17. Angina pectoris, myocardial infarction
18. Coronary artery disease
19. Congenital heart murmurs and other abnormalities
20. AID's or ARC
21. Muscular Dystrophy
22. Serious newborn abnormalities
23. Uncontrolled high blood pressure
24. Applicants in last trimester of pregnancy

SPECIAL BENEFITS, COVERED EXPENSES & EXPENSES NOT COVERED (cont.)

- The benefit will reduce if the benefit, plus any no-fault benefits for wage replacement for that week, exceeds 66⅔% of weekly earnings.

  "No-fault benefits" means the minimum level of personal injury benefits which state law requires to be offered under automobile insurance policies and which would be paid, regardless of fault, if claim had been made for such benefits.

- Short Term Disability benefits will reduce if, for any week, the benefit, plus one fourth of any primary Social Security benefit for the month that includes that week, exceeds 66⅔% of weekly earnings. It is assumed that the employee is entitled to Social Security benefits, unless proven otherwise.

New York Life

YOU SHOULD ALSO KNOW . . .

Eligibilty

Groups with 2 to 49 eligible employees may apply for coverage under CGT Spectrum Healthplan. See page 1 for those states where groups with 2-9 eligible employees may apply. Plan not available in Hawaii and Nevada.

Employees who are actively employed by the participating employer in the usual course of his or her business, work the employer's normal work week (at least 20 hours per week) or more, and are subject to Social Security reporting requirements, are eligible to request insurance coverage. Part-time, retired, temporary, and seasonal employees are not eligible.

An eligible employee's spouse and unmarried children under age 21 (under 25 for full-time students dependent on the employee for support) are also eligible for coverage.

The employer may choose to limit coverage to all full-time employees; to all full-time officers, owners, managers, and supervisors; to all full-time employees who are exempt from the Fair Labor Standards Act of 1938; or to all full-time employees not covered by a collective bargaining agreement.

Participation Requirements

If the employees pay part of the plan costs, at least 75% of all eligible employees and dependents must request insurance.

If the employer pays all the plan costs, then all eligible employees and dependents must request insurance.

Employees who do not request all of the coverages offered must complete a waiver form. Employees and dependents who waive Medical, and Dental, if included, because they are covered under some other group plan will not be considered eligible for the purpose of determining participation.

Employees must elect the same type of coverage - family or single - for both Medical and Dental, if included. For example, an employee with family Medical coverage must also elect family Dental coverage.

The trust administrator reserves the right to discontinue coverage for any firm which does not continue to satisfy the Plan's participation requirements.

Underwriting Requirements

When requesting insurance, all enrollees in the plan must submit a completed Enrollment Package. Insurance will become effective if the Employer's Request for Insurance is approved in writing by the trust administrator.

Transferred Business: Pre-existing Condition Coverage

If a company transfers to this plan from another group health plan with no lapse in coverage, we will pay for a pre-existing condition for those eligible employees and their dependents approved for coverage on this Plan's effective date as follows:

For people actively at work or non-confined:
We will pay the lesser of this Plan's or the prior plan's benefits, reduced by any extended benefits payable under the prior plan, up to $100,000. This will continue until the earlier of:

1. The day the person has received no medical care for the pre-existing condition for six consecutive months; or
2. The day the person has been covered under this Plan's Major Medical and Hospice Care insurance for twelve consecutive months.

After one of these requirements is met, CGT Spectrum Healthplan benefits will become payable for the pre-existing condition, subject to the $100,000 limit. However, this limit will not apply after the person completes twelve consecutive months without receiving any medical care for that condition.

For people not actively at work or confined:
We will pay the prior plan's benefits, reduced by any extended benefits payable under the prior plan, until the person meets either of the above requirements. At that time, we will pay the lesser of this Plan's or the prior plan's benefits up to $100,000.

"Actively at work" means the employee is actively at work at the participating employer's regular place of business or other location to which the employee is required to travel to perform the regular duties of employment, is physically able to perform all such duties, and is regularly working at least 20 hours per week. Work or duties performed at home or while confined in a hospital or other medical institution may not be used to meet this requirement.

"Non-confined" means a dependent is not confined at home, in a hospital, or other medical institution on the Plan's effective date or at any time during the preceding 6 days. A dependent so confined will be considered non-confined after six consecutive days during which the dependent has not been confined at home, in a hospital, or other medical institution, has not received any medical care or services, and has engaged in his or her normal daily activities.

Credit for Prior Plan's Deductible

Payments credited toward a prior plan's deductible for the calendar year in which CGT Spectrum Healthplan takes effect will also be applied toward this Plan's deductible.

Effective Date Of Coverage

Coverage begins when the group's request for insurance is approved in writing by the trust administrator. No agent has the power to bind coverage. An initial response will normally be mailed within 6 working days of receipt of completed materials.

Coverage can begin on any day of the month. All enrollment materials must be signed on or before the requested effective date, and the completed enrollment materials must be received by the trust administrator no later than 7 days after the requested effective date.

Coordination Of Benefits

To eliminate duplicate payments, benefits under CGT Spectrum Healthplan will be coordinated with benefits available under any other group insurance plan until the combined benefits equal 100% of the total allowable expenses. Benefits may be reduced if duplicate payments would be

Consolidated Group Trust
Hartford Insurance

Eligible Employees and Dependents

Eligible employees: In order to be eligible for coverage, an employee must be actively employed by the participating employer in the usual course of his or her business, within an eligible class, not seasonal, and must be working for earnings for a minimum of 30 hours per week.

Eligible dependents: An eligible employee's spouse and unmarried children under age 19 (under age 23 for unmarried full-time students dependent on the employee for support) are eligible for coverage.

Ineligible Industries

Certain industries are normally considered ineligible for coverage under this plan, including, but not limited to:

- Barber shops
- Bars
- Beauty salons
- Car washes
- Entertainment groups
- Fishing enterprises
- Logging or mining operations
- Government-funded non-profit organizations
- Oil and natural gas wells (drilling and exploration)
- Scrap dealers
- Taxi drivers
- Used car dealers

The Trust Administrator reserves the right to decline any firm that, in its opinion, does not meet sound underwriting requirements.

Administration Fee

The monthly administration fee charged by the Trust Administrator for plans that include medical coverage is $25. The monthly administration fee for plans without medical coverage is $10.

SACOPEE VALLEY HEALTH CENTER

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October 7, 1988

Special Select Commission on
Access to Health Care
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State House Station #11
Augusta, ME 04333

Dear Commission Members,

Having attended open meetings of the Special Select Commission on Access to Health Care, and having received and reviewed copies of the Lewin/ICF reports, I would like to take this opportunity to submit comments to the Commission.

I am most encouraged to see the Commission give strong consideration to service components in the development of an overall plan for improving access to health care services and programs. Too often, access issues are addressed solely through insurance based alternative health care delivery plans. These proposals only deal with financial barriers, and do not factor in the actual availability of services as well as the willingness of existing services to accept participation under reimbursement levels and administrative burdens imposed by the plans.

I believe that the first step in resolving access problems is to develop a baseline level of services that everyone can agree should be available to all segments of the population. Then specific services can be developed for targeted population groups. This means the first level of support would go to service and program development.

I support the Lewin/ICF outline for Community Service Delivery Grants. This program establishes a service baseline and allows for programs to be tailored to the community. I would recommend that outreach and education aspects (essentially called marketing) be emphasized. It would be a wasted effort to develop a service or program and not have the target population utilize it because of a lack of awareness or understanding of what is available. One aspect of the Delivery Grant proposal that is of direct concern to our Health Center is the requirement that providers maintain full hospital privileges. Being 26 miles from the nearest community hospital and 36 miles from the nearest tertiary hospital, it is not practical for our physicians to maintain and round on an inpatient service. Furthermore, hospitals are not willing to grant us privileges because of our distance and the amount of time it would take for our physicians to get to the hospital in the event of a patient emergency.

In a case such as ours, an alternative to full admitting privileges could be formal contracted arrangements with hospital based physicians. These arrangements would be subject to periodic (annual?) utilization review and written verification of referrals.

I also support the suggestion that the State develop recruitment and retention plans for physicians and mid-level practitioners. It is virtually impossible for a community health center to compete with HMO's and hospital emergency rooms. Recruitment problems are compounded by the high cost of housing. Coupled with medical or graduate school loans, the financial incentives are inadequate to attract physicians and mid-level practitioners to rural areas.

As regards insurance based initiatives, two areas of concern are the Medicaid obstetrics crisis and the possibility of a State sponsored capitated health plan. In spite of comments during Commission open sessions indicating that the Medicaid obstetrics lockout is primarily a result of excessive paperwork, it is my strong impression that reimbursement is the overriding consideration in OB/GYN Medicaid participation, with paperwork distinctly second as a factor. The Medicaid global fee reimbursement for a complete prenatal and delivery package amounts to several hundred dollars less than just the delivery component of obstetricians' global fee packages. With such a low level of reimbursement for what is considered to be a high risk service, it is no small wonder that Medicaid prenatal patients have access problems. The impact on our Health Center's global fee is a net loss of $600 per package after we have reimbursed our covering obstetrician for a Medicaid delivery.

The other concerning area, that of a capitated health plan, presents considerable difficulties for community health centers. There is a question whether adequate enrollment numbers can be generated from the target populations to provide capitated revenues sufficient to offset the financial risks associated with such a plan. This is particularly true in rural settings where the proposed target populations are difficult to reach for any level of services. It is not reasonalbe to place community health centers at additional financial risk that adds to the deep revenue cuts resulting from sliding fee scales, free care, and bad debt. It is also too much to ask community health centers to absorb the cost of developing the administrative and financial tracking and reporting systems and staffing necessary to manage capitation without offering support funds.

One aspect of a health care delivery system that has not received much attention in the Levin/ICF reports is non-medical health care services such as social service programs and mental health counseling. I see the total health care service picture as a wheel with the provider at the "hub" and a variety of services such as hospital, lab, counseling, social services, WIC, family planning, etc. out at the "rim". To focus solely on the medical (need provider) component without providing the support and ancillary services is to develop an incomplete health

In order to develop effective access and move patients from the "hub" to the "rim" provisions should be made for a facilitator. Often this role is filled by a social worker. However, the vital role these individuals play in linking people to services is not recognized through the reimbursement system. I see a real need for this to change or for an alternative to be developed so that patients (and providers) are assisted in accessing services. If the burden of facilitating access is placed totally on the providers, I believe any comprehensive plan will have great difficulty in achieving its objectives.

I appreciate the Commission's willingness to accept input into their process, and thank you for the opportunity to present my views.

Sincerely,

Kenneth M. Green
Executive Director

KMG:njb

SPECIAL SELECT COMMISSION ON ACCESS TO CARE

Comments on Lewin-ICF Proposed Insurance Strategies

October 12, 1988

Beth Kilbreth
Human Services Development Institute
Project Director, Robert Wood Johnson
Foundation Program for the Uninsured
Board Member, Maine High Risk
Insurance Organization

These comments are addressed to the insurance strategies proposed by Lewin-ICF as a means of expanding access to care for the medically indigent in Maine. While I am supportive of the proposed strategy to develop a sliding scale, subsidized individual coverage program coupled with a program to maximize employer-based coverage, I think the Commission needs to consider the many implementation issues raised by such a strategy in the context of existing Maine programs and concurrent legislative initiatives such as the review of the Health Care Financing Commission. Specifically, I would like to address:

- the inclusion and expansion of the Maine High Risk Organization as a component of the strategy to maximize employer-based coverage;
- a review of the lessons learned from the development and implementation of the Robert Wood Johnson initiative to expand subsidized coverage to small and marginal businesses; and
- the consideration of possible and pending changes in hospital financing that will impact upon the financing strategies considered by this Commission.

1. High Risk Insurance Organization. The High Risk Insurance Organization, authorized by the Legislature in 1987, opened for enrollment in September of this year. Designed specifically to provide coverage to those individuals denied coverage elsewhere because of high risk medical conditions, this program is currently limited to 300 individuals. The opening of the High Risk Pool to all high risk individuals, with a premium subsidy for those with low incomes, not only would provide insurance to those most likely to generate unguaranteed hospital bills, but also would increase the ability of small groups to purchase insurance at reasonable cost for the rest of their normally healthy work-force.

This program is currently funded through a combination of premium payments and an assessment on hospital revenues. The hospital assessment was chosen as a means of distributing the excess cost of these high risk individuals across the population of insured and self-payers. Since the insurance practice of screening high risk individuals holds down the cost of coverage for normally healthy individuals, it seems appropriate to spread the cost back across the total population of insured. The hospital assessment is currently capped at .015 percent of hospital revenues (generating a little over $1 million annually). If the enrollment is significantly expanded, the assessment will need to increase, as well.

2. Expanding and Reducing the Cost of Small Group Coverage. The Robert Wood Johnson demonstration program, "MaineCare", has successfully negotiated with its service area hospitals -- and has received MHCFC approval -- for a discount of 30% off hospital charges and a forgiveness of 100% of the cost of charges that exceed $20,000, on a per discharge basis. This discount was negotiated based on studies that reviewed the participating hospitals' actual experience in collecting on uninsured accounts. These studies found that the hospitals collected about 50% of charges on these accounts and that the collection rate rapidly approached zero as the size of the account went above $3,000. The MaineCare Program payment of 70% of charges for these previously uninsured patients is thus expected to improve the hospitals' cash flow while at the same time, reduce gradually, the hospitals' bad-debt experience and the cost burden on other payors.

   This win/win strategy, which reduces the cost of coverage to the currently uninsured and consequently should introduce new revenues into the health care system through the premium payments of those who currently can't afford coverage, should be considered for applicability to a statewide program.

   Further, the use of the hospitals' bad debt/charity care "allowance", either on an individual institution or a statewide pooled basis, as a stop-loss fund for a small group program should be considered. Again, costs to such a fund should be more than off-set by reductions in bad debt, with the implementation of a statewide coverage program. The provision of stop-loss coverage through existing resources in the system should provide a reduction in premium cost of between $5.00 and $7.00 per member per month, which would otherwise be paid to an out-of-state insurance company.

   Finally, with regard to program administration, Lewin-ICF has proposed for small groups, a state pool, presumably administered by a single insurance company or third party administrator. I would propose, alternatively, the competitive bidding of this program to a variety of insurors and alternative delivery systems (similar to what is done in Arizona). This strategy would allow the state to offer a variety of programs, to seek out and encourage efficient and high quality providers, and to stimulate the development of managed case systems that are just now starting to appear in the state.

3. Impact of Changes in Hospital Rate-Setting System. Concurrently with the consideration of proposals submitted by this Commission, the Legislature will be reviewing the proposals of the Blue Ribbon Commission. Maine hospitals currently provide $42 million in uncompensated care. Changes in the hospital finance system may have a significant impact on access; and conversely, major initiatives around access will significantly influence hospital costs.

Issues that have been raised by the Blue Ribbon Commission of particular importance to the strategies for improving access include: whether or not a bad debt charity care pool is formed; whether the per case payment system that has been proposed will include a mechanism to ensure coverage of uncompensated care; and whether the proposal to use tax funds to compensate hospitals for increases in bad debt/Medicare shortfalls is approved.

As I tried to indicate in the discussion above, some of the $42 million charity care funding, when coupled with new tax dollars and a new influx of premium payments from the private sector, can be used creatively to provide entitlement and to move services to appropriate settings while at the same time reducing the burden born by current payors for uncompensated care.

A rationalization of our health care system requires that the interaction between initiatives on access and hospital financing be considered together, as the Legislature contemplates major changes to the current system.

HEALEY & ASSOCIATES, INC.
INSURANCE AND EMPLOYEE BENEFITS
53 Second Street • P.O. Box 807 • Presque Isle, Maine 04769

TO : Deborah Curtis, Members of the Special Select Commission on Access to Health Care

FROM: Marcus J. Barresi, CLU, ChFC

DATE: October 11, 1988

RE : Framework for Insurance Strategies

In an effort to expedite our work on October 25th, I chose to offer some suggestions that you could think about in response to insurance strategies. When considering the current problems where insurance strategies can be used, I listed the following groups that need to be helped;

1. Small companies that cannot get health insurance for employees because of its "ineligible industry". (Logging, fishing, fast food restaurants, etc.)

2. Employees who work more than one part time job and do not qualify for benefits of the employer.

3. Self employed individuals who have limited access to individual health insurance policies.

4. Employees who can't afford the portion of the premium unpaid by the employer.

Since it is very important that we offer solutions that can be implemented as quickly as possible, I felt that we first should look at a voucher or subsidy system for individual coverage on a sliding scale. This would allow an individual to purchase health insurance from the private market, or selected carriers, at a discount with the state paying the balance of the cost to a maximum allowable level. The carrier would in turn bill the state and provide the income documentation that was submitted with the application for coverage. This could be tested for one year with Blue Cross/Blue Shield for example. Applications would be submitted and underwritten like all others. In doing this, we would be creating a solution to the problem of conversion privilege for small groups and small employers not being able to cover part time employees.

Another solution that could be implemented quickly would be to make groups under 20 employees comply with COBRA laws, which allow a terminated employee to maintain coverage for up to eighteen months while reimbursing the employer for the premiums paid. Since doing this would be an administrative burden to many companies, I would also recommend that a tax credit be offered to

employers under 20 employees for providing group insurance to their employees. The credit could be 3-5% of premiums contributed by the employer.

Without creating new bureaucracy we can solve part of the problem by implementing the suggested solutions. In conjuction with this, I would suggest the following be put in place;

A. Medicaid buy-in program.

B. Expansion of the high risk pool.

C. 800 number health insurance hotline which acts as a clearing house for people wanting information on medicaid, private insurance, medicare, medicare supplement, and long term care coverage.

Although over time this will get more people insured in some way, it still lacks the ingredients to level off the rising cost of health care. With that, the state should aggresively pursue;

A. Tort reform to address malpractice insurance premmiums and defensive medicine.

B. Incentive for providers to control costs.

I hope this has provided some help to our efforts and I look forward to your comments and suggestions.

COMMENTS TO SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE FROM CHRISTOPHER ST.JOHN, PINE TREE LEGAL ASSISTANCE ON BEHALF OF THE MAINE ASSOCIATION OF INTERDEPENDENT NEIGHBORHOODS

I appreciate the opportunity to present these brief comments to the Commission because I believe that there is now a unique confluence of events and interests which will enable Maine to make a dramatic advance in both overcoming barriers to access to health care and in controlling rising costs to those who currently have access. I believe the Commission on Access can articulate and develop the best form for this advance and lead its adoption.

PUBLIC COVERAGE FOR ALL POOR:

The most important single step that can and should be taken to address both the problem of access and the problem of cost is for the state, with general funds, to establish a program of medical coverage for people with incomes below poverty who currently are not covered by Medicaid because they don't fit into the limited categories of people eligible for the federally-shared Medicaid program. For example, poor children, the elderly, people 100% disabled for more than 12 months, and single parents are mostly covered by Medicaid, but single adults and couples who are not long-term disabled are not covered under Medicaid.

There are several reasons why a program of public coverage of these people makes sense. While many of these people are employed, they move in and out of employment frequently. They are more likely employed by low-wage, small employers who will always have a difficult time providing private insurance coverage, and their employment is likely to be seasonal and/or part-time which is typically excluded by group insurance policies. The level of income in these households is certainly insufficient to meet the deductible and co-insurance or employee share premiums typically required in private group policies.

The private insurance market, for a variety of reasons, has demonstrated that it has not and will not successfully reach the low-income population. The state has in place, in the Medicaid program,

the systems necessary to determine the eligibility of poor people; to provide them with certificates to get access; to determine reimbursement rates and negotiate with providers to make the services available; and to process, pay and review claims. These systems could and should be extended to provide the coverage in the new state program proposed here for the poor and near-poor (discussed below).

At other times, proposing such a major expansion of state-paid and administered coverage might have seemed completely unrealistic, but the present circumstances make the proposal so attractice to so many different constituencies that it should be considered favorably and adopted. The biggest obstacle is cost, and it must be pointed out that because of the current state requirement and hospital practice of providing 37 million dollars worth of "charity care and bad debt," businesses and employees and others who pay health insurance premiums are already paying the hospital costs of poor people who do not have coverage. A program of coverage for low-income people could be expected to remove at least 27 million dollars from the charity/bad debt expense of hospitals to public funds.

The current way of paying these costs is undesirable because it is regressive - placing the same burden on a low-wage individual paying their own premium as on a high profit company paying the premium for a high wage employee. The so-called cost shift of both the Medicare and charity "short fall" is the largest factor in the rapid increase in insurance premiums which is threatening the coverage of individuals who currently have insurace. Reducing the charity short fall through a publicly paid program would therefore be the most important single thing which could be done to reduce insurance premiums for everyone.

In addition to more fairly spreading the costs of such care, a program of public coverage would enable poor individuals to seek more appropriate care at an earlier stage of their illness, rather than going to an emergency room for primary care for example or going to the hospital for acute care after not receiving timely treatment.

BUY-IN OR SUBSIDIZED PREMIUMS FOR NEAR-POOR:

For the same reasons discussed above we recommend that the public program be extended to individuals with incomes up to 150% of poverty, with a sliding scale of premiums between 110 and 150% of poverty as adopted by the legislature last year for the ASPIRE extension of medical benefits for AFDC recipients going to work. The Human Resources Committee and the whole legislative opted for public coverage and a sliding scale of premiums for this group recognizing that private coverage would be inadequate and too expensive.

For both the poor and near-poor the state program could require that those individuals who do have access to employer-shared health insurance take advantage of such coverage and that if the employee's premium exceeded the required contribution under the state's program, the state would pay the difference. This requirement would enable the state to reduce the cost by the extent to which any employer contribution was available.

The cost of the proposed program can be projected in the first year to be a little more than the proportion of current charity care expenses which can be attributed to poor people. Assuming that 75% of the current $37 million is hospital care for this group, the new state program might cost $27 million for hospital care. Over time the non-hospital costs could be expected as in other insurance plans, to be a greater share of the costs. In the first year, however, experience of other states' Medicaid expansions suggest that the potentially eligible population is slow to sign up and use the program. Thus 35 million might adequately fund the whole program at the outset. The Governor and legislative leadership are already discussing a potential revenue surplus of close to that amount and should be requested urgently by the Commission to set aside the alleged surplus to address the health care problem which has been acknowledged to be the most important issue facing the coming legislature.

SUBSIDY OF EMPLOYERS FACING FINANCIAL HARDSHIP TO PHASE IN HEALTH COVERAGE:

To continue to encourage private employers to expand coverage, the state should subsidize employers statewide who face financial hardship over two to five years to provide health coverage, based on the model being

developed by USM/HSDI with the Robert Wood Johnson pilot project and which they will describe in more detail. To meet the expense of this subsidy a good argument can be made in favor of a small 1-2% tax on all payrolls, against which an employer could credit any cost of health insurance purchased for employees.

GRANT PROGRAM FOR SERVICES TO UNDERSERVED AREAS:

We support a five million dollar grant program and to local entities (clinics, hospitals, physician groups) which demonstrate need and meet the criteria outlined in Lewin/ICF outline under Community Service Delivery Grants.

NEGOTIATIONS WITH PROVIDERS:

The Commission should encourage the Department of Human Services to bargain with professional associations to ensure better participation by providers in the public program in exchange for consideration of the "paperwork" and other provider concerns. Currently only about half of Maine physicians treat Medicaid patients. Experience from Massachusetts and elsewhere suggests that this rate can be improved by rigorous discussion and advocacy by the Department with provider organizations.

Maine's Business Advocate

126 Sewall Street ■ Augusta, Maine 04330 ■ (207) 623-4568

October 4, 1988

TO: Bonnie Post and the Members of the Joint Select Committee on Access to Health Care

I appreciate the opportunity to comment on the Lewin/ICF materials addressing the issue of expanded access to health care for some Maine residents. I also appreciate the opportunity that I have had to participate in the dialogue at the four commission workshops.

General Comments

As is undoubtedly clear, the business community is justifiably alarmed at the dramatic increase in health care costs which we have seen in the past year. Health insurance premium increases of 40% are commonplace at the time of policy renewal and much larger increases are not unheard of. Unless a dramatic reversal of this trend occurs, we predict $6,000 a year family insurance premiums by 1991, double the 1988 rate. Premiums of this magnitude can not be born by employers or employees and will lead to the collapse of the payment structure supporting our medical system as we have known it for years.

The primary causes of the rapid premium increases are the shifting of costs for bad debt and indigent care and the Medicaid and Medicare shortfalls on to current payors. Additional causes include high malpractice liability insurance premiums and the high cost of defensive medicine. Added to these are problems with the hospital regulatory system and the lack of a meaningful health care plan in Maine.

The Medicare, Medicaid, and bad debt and indigent care costs currently shifted to payors are estimated to be $111 million in the hospital setting alone. Others must assume some of the burden of these costs. It appears to us that the State faces a serious dilemma. If the Legislature uses available funds to expand access to health care and does not address the underlying problems of the current system, it will find itself with a growing pool of workers with restricted access as employers and employees find it impossible to afford increasing health care premiums. On the other hand, if the underlying problems are addressed adequately, where will the funds come from to expand access?

At the very least, we recommend strongly that the Joint Select Commission on Access to Health Care make it clear that its recommendations are contingent on State action to address the problems of the rest of the system in a meaningful way.

Funding

We believe that the assumption that employers are responsible for the provision of health insurance to their workers is false. Historically, most companies who could afford to provide insurance to their employees have done so. However, this has been a voluntary act and not a governmentally imposed one. Should employers presume that it is unwise to provide new benefits to their employees for fear that the government will eventually mandate that they do so? The desire to provide expanded health care is a social policy decision, not a business decision. We believe that the cost associated with this social policy should be born by the broadest possible base.

To finance the expansion from the payroll tax perpetuates the myth that businesses are responsible for the financing of this and other social programs. It also would place the burden on those businesses which can least afford it as many are barely above survival level.

To place the burden on the corporate income tax as has been suggested by some participants in the Commission's hearings would be taxing again those businesses which are already voluntarily providing coverage to their employees. This seems blatantly unfair.

A tax on hospitals or physicians would be passed on to payors, again those individuals and businesses who are already making the largest contribution to the system. This is illogical.

The State should finance any cost of expanded access as well as its contribution to relieve the burden of cost shifting and the Medicare and Medicaid shortfalls from the general fund with a mix of broad based taxes or with sintaxes.

Other Issues

We wholeheartedly support the Commission's interest in tort reform as our current tort liability system not only increases costs but decreases access. Medical malpractice insurance currently costs about $20 million per year in Maine and defensive medicine practiced by providers is estimated to cost an additional $100 million. Tort liability reform coupled with a private utilitization review system targeting defensive medicine practices could mean substantial savings for all. We believe that the Commission should be very aggressive in seeking change in this area. There will be many supporters.

The concept of community service grants is an interesting one. Through our attendance at Blue Ribbon Commission meetings, we have learned that some rural hospitals may not remain viable. It would seem appropriate to make community service grants available to help small rural hosptials plan how to transition to appropriate lower level medical facilities and to remain viable.

The report suggests the possibility of an insurance pool for smaller businesses. We would suggested to the Commission that several already exist outside of the governmental structure and more would be formed if their existance was viable. We concur with the consultant that further action in this area may be unnecessary and unproductive. Such a pool will do little to dampen the runaway cost of health care unless the underlying problems are addressed.

The concept of a subsidized insurance premium program is an interesting one and we support it as long as it is based on a broad based funding source. It would appear, however, that it should be expanded to include not only working poor in small businesses but working poor in all businesses since we presume that there are workers in larger establishments who can not afford to buy in to their employers insurance packages.

We applaud the use of incentives such as tax credits, premiums subsidies, and other methods which enable rather than coerce employers to provide health insurance coverage.

Conclusion

Unless the underlying causes of the dramatic increases in health care premiums are addressed by the Legislature, the pool of uninsured workers will increase dramatically. It seems to us to make little sense to provide new access while those who have traditionally had it lose it. Increasing the burden on the business community only hastens the loss of access.

We urge the Commission to tie its recommendations to the solving of the underlying health care problems and to a broad based funding source.

We look forward to working with you in the months ahead.

Sincerely,

John S. Dexter, Chairman
Coalition for Responsible
Health Care*

* The Coalition for Responsible Health Care is made up of the following concerned associations:

Associated General Contractors of Maine

Maine Auto Dealers Association

Maine Chamber of Commerce & Industry

Maine Merchants Association

Maine Motor Transport Association

Paper Industry Information Office

Savings Banks Association of Maine

JSD:mep

MPA

Maine People's Alliance

20 Danforth Street, P.O. Box 17534, Portland, Maine 04101 (207) 761-4400
Capital Office: 8 Crosby Street, P.O. Box 2490, Augusta, Maine 04330 (207) 622-4740

December 6, 1988

Special Select Commission on Access to Health Care
State House
Augusta, Maine

Dear Commission Member:

At the last meeting of the Special Select Commission on Access to Health Care, commission members discussed a recommendation to the Governor and Legislature that they consider tort "reform" as part of a legislative package to increase access to health care among Maine residents. I had hoped for the opportunity to discuss such a proposal with the commission, and to explain the objections of both the Maine People's Alliance and the Campaign for Fair Rates and Equal Justice to any such recommendations. The commission chair, however, did not feel that such input would be appropriate at that time, and suggested that such concerns be addressed in correspondence. Hence, this letter.

There are wide-ranging arguments against further tort "reform." For the sake of brevity, I will restrict my comments to the arguments offered on behalf of such a proposal during the commission discussions.

To begin with, the rationale offered for a recommendation for further tort "reform" was that it would affect medical malpractice rates, which would, in turn, expand access to health care. The connection between tort "reform" and reduced rates, however, has been refuted both by the insurance industry and by experience. In a letter to the Trafton Commission dated 10/14/87, St. Paul's, one of the largest underwriters of medical malpractice insurance in Maine and in the country, stated:

"St. Paul has not joined other insurance companies or insurance trade associations in their promotion of changes in the civil justice system. ... It simply is not possible to predict -- with any reasonable degree of accuracy -- the extent of dollar savings which might result from any given change in the tort system -- or when that savings might be realized. ... Whether or not any resulting reduction in recoveries will be sufficient to produce an actual rate reduction, over time, is uncertain."

St Paul's and Aetna reached the same conclusion in Florida in 1986 in reports to the Florida Department of Insurance. In filing their estimates of the anticipated savings from the tort "reforms" enacted in that state, Aetna estimated a 0% (yes, that is a zero) savings in 9 out of 10 areas affected by the legislation, and a change of less than 1% in the tenth area. St. Paul's concluded that the "reforms", which included a $450,000 cap on non-economic damages, limits on punitive damages, and modifications to joint and several liability, among others, " will produce little or no savings to the tort system as it pertains to medical malpractice."

The only evidence the commission discussed to support the recommendation of tort "reform" was that, in the 10 years since California instituted such changes, medical malpractice rates have stabilized. But, in 1987, California medical malpractice rates increased by 25% -- a far cry from rate stabilization. In addition, according to the Massasschusetts Joint Underwriting Association in a 1988 comparison of premiums for obstetricians/gynecologists, medical malpractice rates in California continue to exceed those in Maine despite tort "reform."

Such evidence does not support the contention of a relationship between tort "reform" and rate reduction or stabilization, and is far from sufficient justification for your recommendation to enact massive changes in our civil justice system.

The charge you have been given as a commission is to consider solutions to the lack of access to health care which exists for specific populations and which is clearly related to their economic status and/or geography. Tort "reform" does not address such inequities. It offers an across-the-board solution to very specific problems, and perpetuates the market condition which makes it hard to attract the medical personnel necessary to serve the areas and populations which suffer from the problem of access. By contrast, solutions that target subsidies, as you have discussed, or which address the inequities in the insurance classification system for different medical specialties, do address the specific access problems that exist.

Neither the Maine People's Alliance nor the Campaign for Fair Rates and Equal Justice oppose reductions in medical malpractice premiums. Where we find fault is in the attempt to achieve such reductions at the expense of victims, and in the argument that such across-the-board actions address the specific problems of access to health care.

Within the past year, both the Trafton Commission and the Legislature have considered the question of tort "reform." After much greater consideration than this commission has given the issue, both rejected the arguments put forth by tort "reform" advocates. In light of such actions and the lack of any evidence to support the contention of a relationship between tort "reform" and increased access, I would ask the commission to reject the argument that tort "reform" is germane to your mandate and make no such recommendation.

My thanks for your patience and consideration.

Sincerely,

Timothy O'Donovan
Insurance Organizer

NFIB Maine

National Federation of
Independent Business

November 29, 1988

Bonnie Post
Chair
Special Select Commission
on Access to Health Care
State House Sta. 11
Augusta, ME 04333-0011

Dear Bonnie:

I would like to provide you with some views and information regarding access to health care as the issue relates to small business.

Some sort of payroll tax has been suggested as a way to fund an access program. I can assure you that NFIB members in Maine would vigorously oppose such a proposal. Taxes on labor are among the most regressive taxes that are imposed on business, and on small business in particular. These are taxes which must be paid by a business without regard to its financial condition.

At the same time, Social Security taxes are continuing to rise and just last week insurance carriers filed for a 43 percent increase in Maine workers compensation insurance rates. The shortage of labor, and the corresponding necessity for businesses to pay higher and higher wages in order to attract and retain workers, is effectively increasing the FICA payments and WC premiums of thousands of small businesses in Maine.

A proposal to offset a payroll tax by the amount of health insurance premiums paid by a business is essentially the Massachusetts mandatory health insurance approach and would be met with equally as vigorous opposition by small business in Maine. It would likely be viewed as a backdoor attempt to mandate health insurance.

Please do not view my absence as demonstrating a lack of interest in the issue or in the Commission's work. I regret that other duties, sometimes arising unexpectedly, have prevented me from attending all of the Commission's meetings. It's my understanding that Jack Dexter of the

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Maine Chamber has eloquently expressed the common views of the business community on various aspects of the Commission's deliberations.

With regard to the access issue generally, I would like to provide you with some information from an excellent American Hospital Association report, "Promoting Health Insurance in the Workplace:"

- Of every 100 employees
  - 65 are covered by their employer
  - 13 reject coverage
  - 12 do not qualify
  - 10 work for an employer who doesn't offer coverage
- Some characteristics of businesses not offering health insurance
  - Employees have low salaries
  - Business is small (see below)
  - Firm is unincorporated
  - Firm is in an industry, such as retailing, where noncoverage is common
- The link between low wages and noncoverage exists among businesses of all sizes
- When one focuses on the number of uninsured workers instead of firms
  - 48% work in 1-24 employee firms
  - 15% in 25-99 employee firms
  - 12% in 100-499 employee firms
  - 26% in firms with more than 500 employees
- Legal status of a firm is significant
  - Only 29% of sole proprietors with 1-9 employees offers insurance, but 70% of incorporated firms
  - Only 30% of sole proprietors with 10-24 employees offer insurance, but 85% of S corporations, and 82% of C corporations
- There are a number of factors involved in noncoverage including
  - "Ineligible" industries
  - Exclusion of employees (e.g., part-time or length of employment)
  - Rejection by employees
- Medicaid coverage of the poor has declined

significantly

- 65% were covered in 1976
- 38% in 1983

- The growing number of uninsured children can be attributed to at least four developments
  - Declines in employer-sponsored dependent coverage
  - Declines in income eligibility levels for Medicaid
  - Growing number of single-parent, female-headed households
  - Expansion of jobs in industry sectors that commonly do not offer insurance

The AHA report observes that the access issue -- working uninsured -- it complex and requires multiple approaches.

Thank you for considering NFIB members views on this matter. Please let me know if you have any questions.

With best regards, I am

Sincerely,

David R. Clough
State Director