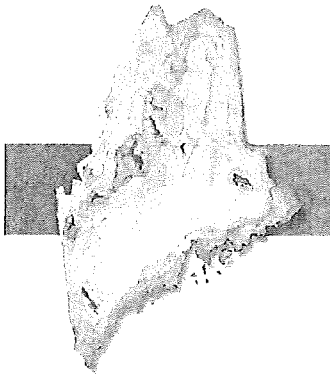

MAINE DEPARTMENT OF
**Professional & Financial Regulation**

# WHITE PAPER:

# MAINE'S INDIVIDUAL HEALTH INSURANCE MARKET


PREPARED BY THE STAFF OF
THE MAINE BUREAU OF INSURANCE



JANUARY 11, 2000
*Updated January 22, 2001*



ANGUS S. KING, JR.
GOVERNOR

S. CATHERINE LONGLEY
COMMISSIONER

ALESSANDRO A. IUPPA
SUPERINTENDENT

## Table of Contents



### Tables

## Executive Summary

Individual health insurance, also called "non-group" health insurance, is generally purchased by those not eligible for employer-sponsored plans. An estimated 38,000 Mainers are covered by individual health insurance. However, the future viability of the individual health insurance market in Maine is uncertain. Rates have risen steeply in the past two years, making coverage unaffordable for many. This not only results in more people becoming uninsured, it also can cause a deterioration of the average health of the remaining pool of risks. This is because those who have health problems and utilize their insurance benefits are much less likely to drop coverage than are healthy individuals. In turn, deterioration of the risk pool could lead to further rate increases, causing more people to drop coverage. If this cycle were to continue, it could lead to a collapse of the individual health insurance market. This phenomenon of a shrinking pool of risks and higher insurance rates is sometimes referred to as a "death spiral."

While affordability is the immediate problem, availability is also a concern. Since HMOs are required by law to offer individual coverage, HMO coverage is readily available to those who can afford it. However, for those wanting indemnity coverage, the choice of carriers is currently limited to two, down from five in 1994.

*January 2001 update: In the year since this white paper was originally prepared, another carrier has ceased offering individual indemnity coverage, leaving Anthem Health Plans of Maine (formerly Blue Cross Blue Shield of Maine) as the only carrier offering indemnity coverage.*

This paper examines some of the possible causes of these problems in Maine's individual health insurance market, some possible solutions, and the advantages and disadvantages of each possible solution. Measures to address the broader problems of the overall costs of health insurance and health care are beyond the scope of this paper. This paper is not intended to endorse any of the proposed solutions, but rather to provide a framework for discussion.

## I. Background

Health care in Maine and throughout the United States is financed through a variety of private and public mechanisms. Public programs, including Medicare, Medicaid, and others, cover approximately 25% of Maine's population. Approximately 61% of Maine's population is covered privately, while 14% are uninsured.[1] Most private coverage is employer-based. Employer-based coverage falls into two categories – insured plans and self-funded plans. Insured plans are issued by insurers and health maintenance organizations (HMOs). Self-funded plans may be administered by an insurer or an HMO, but the risk is borne by the employer.[2] While insurers and HMOs are licensed and regulated by the state, states are pre-empted from regulating self-funded plans.[3]

*January 2001 update: Public programs now cover approximately 28% of Maine's population; private insurance covers approximately 59%; and 13% are uninsured.*[4]

In 1998, 62,000 Maine residents had health insurance coverage that was not paid for by their employer[5]. Those covered by individual health insurance are a subset of this number. Other subsets include self-employed individuals covered by group plans[6] and those covered by other types of group plans, such as association groups.

Individual health insurance is generally purchased by individuals and families who are ineligible for public programs or employer-based health plans. These include employees whose employers do not offer health benefits, employees such as part-time or seasonal workers who do not qualify for their employer's plan, self-employed individuals, and the unemployed, including retirees. Since Medicare covers most of those over age 65 and those who have been disabled for two years, these individuals are generally not covered in the individual health insurance market.[7, 8] Approximately 38,000 Mainers were covered by individual health insurance as of September 30, 1999[9], of which approximately 3,500 were covered by HMOs.[10] However, the future viability of the individual health insurance market in Maine is uncertain. The purpose of this paper is to explore options to improve the viability of this market.

---

[1] 1998 Current Population Survey, U.S. Census Bureau.
[2] Some of the risk may be passed on to an insurer through an "excess loss" or "stop-loss" policy.
[3] Employee Retirement Income Security Act of 1974 (ERISA).
[4] *Report of the Year 2000 Blue Ribbon Commission on Health Care.*
[5] 1998 Current Population Survey, U.S. Census Bureau.
[6] Self-employed individuals can purchase "one-life group" plans from small group insurers that do not offer individual coverage. Carriers that do offer individual coverage generally are not required to issue group coverage to a one-life group [Title 24-A M.R.S.A. § 2808-B(6)(I)], although some do.
[7] The Medicare supplement market is a separate insurance market.
[8] Due to guaranteed renewability requirements, those who purchase individual health insurance prior to Medicare eligibility can keep it even after they are on Medicare. Those with substantial prescription drug needs are particularly likely to do so because of the limited pharmaceutical benefits available in Medicare supplement plans. These individuals tend to have high claim costs and therefore the effect is to increase rates for other individuals due to modified community rating. The law was amended in 1997 to permit carriers to rate Medicare-eligible individuals separately, but in 1999, the effective date of this amendment was delayed until July 1, 2000.
[9] Survey of carriers by the Bureau of Insurance.
[10] Annual Statement data.

*January 2001 update: A year later, the number covered by individual HMO plans had dropped to 1,500.*[11] *Since 1994, the number of carriers offering individual indemnity coverage has dropped from five to one. It is now clear that the future viability of the individual health insurance market in Maine is at serious risk.*

[11] *Quarterly Statement data.*

## II. The Problems

### 1. Affordability

Rates for individual health insurance in Maine have risen steeply in recent years, particularly in 1998 and 1999. For indemnity coverage,[12] Blue Cross Blue Shield of Maine (BCBSME), the dominant carrier in this market, has doubled its rates since individual health insurance reforms took effect in December of 1993, and has increased rates 39% in the last two years. Individual HMO rates have increased even faster than indemnity with some rates more than doubling over the last two years.[13] As a result of these increases, fewer people are able to afford individual coverage. Many have switched to "catastrophic" health insurance plans with very high annual deductibles. BCBSME's $5,000 annual deductible plan is currently its most popular plan. However, recent rate increases on this plan have caused some individuals to drop coverage entirely. This not only results in more people becoming uninsured, it also causes a deterioration of the average health of the remaining pool of risks. This is because those who have health problems and utilize their insurance benefits are much less likely to drop insurance coverage than are healthy individuals. The deterioration of the pool causes further rate increases, leading to more people dropping coverage, etc. This can result in a collapse of the individual health insurance market, sometimes called a "death spiral."

*January 2001 update: Blue Cross Blue Shield of Maine, now Anthem Health Plans of Maine increased rates again on January 1 by an average of 23.5% for indemnity plans and 32.6% for HMO plans.*

It is difficult to say whether Maine's individual health insurance market is currently in a death spiral. A death spiral is easier to recognize after it has occurred than when it is in its early stages. The market for individual HMO coverage is of particular concern due to both the high level of rates and the steep rate of increase. In the larger indemnity market, rate increases have been less dramatic, but a death spiral is at least a potential problem, and even if the market were to stabilize, it would be at a level that many individuals would be unable to afford.

*January 2001 update: The market for individual HMO coverage does now appear to be in a death spiral. Despite the high level of rates and the steep rate of increase, all HMOs are experiencing claims expense in excess of premiums for this product.*

### 2. Availability

While affordability is the immediate problem, availability is also a concern. Since HMOs are required by state law to offer individual coverage,[14] HMO coverage is readily available to those

---

[12] For purposes of this paper, indemnity coverage means medical coverage other than an HMO plan. Indemnity plans generally allow choice of provider and do not require referrals from a primary care provider in order to access specialty care. Indemnity plans typically have an annual deductible and percentage coinsurance.

[13] See Table A on page 5.

[14] Title 24-A M.R.S.A. § 4204(2-A)(N).

who can afford it. However, for those wanting indemnity coverage, the choice of carriers is limited to only two.[15]

*January 2001 update: As noted above, the choice is now limited to one. Table C on page 8 shows the history of carrier participation in Maine's individual health insurance market since enactment of health insurance reforms in 1993. While the number of carriers offering individual health insurance has decreased nationwide, the decline has been most marked in states adopting reforms similar to Maine's.*

Affordability and availability problems in individual health insurance are not unique to Maine. Other states have had similar problems. For example, New Hampshire was nearly left with no carriers in the market when Blue Cross Blue Shield of New Hampshire announced it was withdrawing from the individual market. The New Hampshire Insurance Department took emergency measures to preserve the market. Under the system adopted through emergency rule-making, and later by statute, all group health insurance and excess loss carriers in New Hampshire are assessed an amount (36 cents monthly in 2000) per covered person. Funds are distributed to individual carriers according to a formula designed to compensate those with large losses.

The state of Washington has faced similar availability problems. In that state, commercial insurers have left and indemnity coverage has disappeared. In some counties, no private individual coverage at all is available. Kentucky has also experienced limited availability of individual health insurance. The situations in both of these states and their causes are described in Appendix C.

[15] Conseco Medical Insurance Company and Pioneer Life Insurance Company are affiliated companies offering identical products and rates. Under the Maine Insurance Code, Title 24-A M.R.S.A. § 2736-C(1)(A), these two carriers are treated as one. The only other carrier is Blue Cross Blue Shield of Maine.

Table A

## Increases in Maine Individual Health Insurance Rates

This table shows the increase for each carrier since the coverage was first offered, and also the increase over the last two years. Current rates for each plan are also shown, as is the number of members covered. It should be noted that those with the largest rate increases do not necessarily have the highest rates.

Rates shown are community rates for the Standard and Basic plans, which all carriers in the individual and small group markets are required to offer.[16] These plans are outlined in Appendix D.

| Carrier | Date of initial rates | Increase to date | Increase since 1/1/98 | Monthly Community Rates as of 11/1/99 | | | | Number of Non-Group Members 9/30/99 |
|---|---|---|---|---|---|---|---|---|
| | | | | Individual | | Family | | |
| | | | | Standard | Basic | Standard | Basic | |
| **HMOs** | | | | | | | | |
| HMO Maine (BCBS) | 7/1/95 | 101% | 88% | $424 | $349 | $1,146 | $942 | 848 |
| Healthsource Maine (CIGNA) | 7/1/95 | 87% | 47% | $387 | $309 | $1,076 | $859 | 118 |
| Harvard Pilgrim | 7/1/95 | 112% | 109% | $359 | $287 | $1,042 | $834 | 694 |
| Aetna U.S. Healthcare (formerly NYLCare) | 1/1/96 | 43% | 19% | $415 | $327 | $1,133 | $894 | 0 |
| Tufts | 8/26/96 | N/A | 103% | $381 | $304 | $1,347 | $1,077 | 1791 |
| Maine Partners | 1/1/98 | 88% | 88% | $403 | $331 | $1,089 | $895 | 42 |
| Central Maine Partners | 1/1/98 | 88% | 88% | $403 | $331 | $1,089 | $895 | 6 |
| **Indemnity** | | | | | | | | |
| Blue Cross Blue Shield | 6/1/95 | 66% | 35% | $392* | $332* | $941* | $797* | 19,704 |
| Conseco** | 10/1/97 | 42% | 38% | $520* | $456* | $1,321* | $1,132* | 10,757 |

* Indemnity rates shown are for $500 deductible. $250, $1,000 and $1,500 deductibles are also available.

** Conseco includes Conseco Medical, Pioneer Life, and Washington National Life.

[16] Title 24-A M.R.S.A. § 2736-C(8), Title 24-A M.R.S.A. § 2808-B(8), and Bureau of Insurance Rule 750.

*Table A: January 2001 Update*

## *Increases in Maine Individual Health Insurance Rates*

*This table shows the increase since the coverage was first offered, and also the increase over the last three years, for each carrier currently offering coverage. Current rates for each plan are also shown, as is the number of members covered. It should be noted that those with the largest rate increases do not necessarily have the highest rates.*

*Rates shown are community rates for the Standard and Basic plans, which all carriers in the individual and small group markets are required to offer.*[17] *These plans are outlined in Appendix D.*

| Carrier | Date of initial rates | Increase to date | Increase since 1/1/98 | Monthly Community Rates as of 1/1/01 | | | | Number of Non-Group Members 9/30/00 |
|---|---|---|---|---|---|---|---|---|
| | | | | Individual | | Family | | |
| | | | | Standard | Basic | Standard | Basic | |
| **HMOs** | | | | | | | | |
| HMO Maine (Anthem) | 7/1/95 | 167% | 149% | $566 | $463 | $1,499 | $1,226 | 607 |
| CIGNA (formerly Healthsource) | 7/1/95 | 146% | 94% | $511 | $408 | $1,418 | $1,133 | 199 |
| Aetna U.S. Healthcare (formerly NYLCare) | 1/1/96 | 99% | 65% | $573 | $462 | $1,566 | $1,261 | 71 |
| Maine Partners | 1/1/98 | 149% | 149% | $537 | $439 | $1,424 | $1,165 | 122 |
| **Indemnity** | | | | | | | | |
| Anthem Health Plans of Me. | 6/1/95 | 105% | 67% | $458* | $388* | $1,192* | $1,010* | 22,400 |

* *Indemnity rates shown are for $500 deductible. $250, $1,000 and $1,500 deductibles are also available.*

[17] *Title 24-A M.R.S.A. § 2736-C(8), Title 24-A M.R.S.A. § 2808-B(8), and Bureau of Insurance Rule 750.*

## *Table C*

## *History of Carrier Participation in Maine's Individual Health Insurance Market*

| ***Indemnity*** | ***Entered the Market*** | ***Stopped New Business*** | ***Stopped Renewing*** |
|---|---|---|---|
| *American Republic* | *Prior to 1993 Reforms* | *1993* | *Still Renewing* |
| *Golden Rule* | *Prior to 1993 Reforms* | *1993* | *Still Renewing* |
| *Bankers Life & Casualty* | *Prior to 1993 Reforms* | *1995* | *Still Renewing* |
| *Mutual of Omaha* | *Prior to 1993 Reforms* | *1995* | *2001* |
| *Principal* | *Prior to 1993 Reforms* | *1996* | *1997* |
| *Washington National* | *Prior to 1993 Reforms* | *1996* | *Still Renewing*[18] |
| *Trustmark* | *Prior to 1993 Reforms* | *1997* | *Still Renewing* |
| *Time/Fortis* | *Prior to 1993 Reforms* | *1999* | *1999* |
| *Pioneer Life* | *1995* | *2000* | *2001* |
| *Conseco Medical (formerly Connecticut National)* | *1996* | *2000* | *2001* |
| *Anthem Health Plans of Maine (formerly BCBS of ME)* | *Prior to 1993 Reforms* | *Still Writing* | *Still Renewing* |
| ***HMO*** | | | |
| *Tufts* | *1997* | *1999* | *2000* |
| *Harvard Pilgrim* | *1996* | *2000* | *Still Renewing* |
| *Aetna U.S. Healthcare (formerly NYLCare)* | *1995* | *Still Writing* | *Still Renewing* |
| *Central Maine Partners** | *1998* | *2000* | *2000* |
| *CIGNA Healthcare (formerly Healthsource Maine)* | *1995* | *Still Writing* | *Still Renewing* |
| *HMO Maine (Anthem)* | *1995* | *Still Writing* | *Still Renewing* |
| *Maine Partners* | *1998* | *Still Writing* | *Still Renewing* |

* *Central Maine Partners merged into Anthem Health Plans of Maine as of December 31, 2000*

[18] *Washington National notified the Bureau of Insurance and its policyholders that it would stop renewing policies as of December 31, 2000. However, the Superintendent issued an order requiring the company to continue renewing these policies based on the policy language. The company has appealed the order, but is complying pending resolution of the matter.*

## III. Possible Contributing Factors

There are several factors that may be contributing to the problems in Maine's individual health insurance market. However, it is not clear to what extent, if any, each factor is causing the problems.

### 1. Health care costs

After a brief hiatus, health care costs are on the rise. Prescription drug costs in particular are increasing rapidly. This is resulting in rate increases on group coverage as well as individual coverage, although the group increases are not nearly as large. A Hewitt Associates survey shows an average 1999 increase of 7.8% for employer plans compared to annual increases averaging only 2.1% in the previous four years.[19]

*January 2001 update: These higher trends have continued with an average 2000 increase of 9.4% and projected 2001 increases of 10% to 13%.*[20]

As a percentage of Gross Domestic Product, national health care expenditures rose steadily from 5.1% in 1960 to 13.7% in 1995. They then decreased slightly to 13.5% in 1997, but have increased again to an estimated 13.9% in 1999 and are projected to reach 16.2% by 2008.[21]

*January 2001 update: In Maine, the Year 2000 Blue Ribbon Commission on Health Care found that per capita health care costs rose from $2,773 in 1994 to $3,438 in 1999, and will increase to $4,590 in 2004 and $5,934 in 2009. The per capita cost of prescription drugs rose 59% from 1994 to 1999.*[22]

### 2. Cost shifting

Different payors pay different prices to hospitals and other health care providers. Government programs such as Medicare and Medicaid pay according to formulas established by law. Managed care plans pay based on contracts entered into with providers. Since in the aggregate, the provider needs a certain amount of revenue, lower payments by some payors can result in costs being shifted to other payors. In particular, recent changes in Medicare reduced the amounts that would otherwise have been payable to hospitals and other providers for services to Medicare beneficiaries.[23] This may have resulted in providers being less willing to accept contracts with managed care plans without higher reimbursement levels, and in higher charges to those who are not subject to contracted fees.

### 3. Underpricing

HMOs were required to begin offering individual coverage on a guaranteed issue basis in 1995. Some HMOs underestimated the extent to which health care costs for this population would

---

[19] Hewitt Associates, LLC Company Press Release, November 9, 1999.
[20] *Hewitt Associates, LLC Company Press Release, October 23, 2000.*
[21] U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary.
[22] *Report of the Year 2000 Blue Ribbon Commission on Health Care.*
[23] Balanced Budget Act of 1997.

exceed costs in the group market. It took some time before HMOs had sufficiently credible experience to determine that their rates were inadequate. As a result, six of the seven HMOs had at least one rate increase of 25% or more in 1998 or 1999.

*January 2001 update: All HMOs have had further rate increases ranging from 30% to 64%.*

**4. Deteriorating risk pool**

As noted in Section II, as rates rise, healthier individuals are more likely to drop coverage than are those with health problems, leaving a higher average level of risk in the remaining insured pool. One indication of a deteriorating risk pool in Maine's individual health insurance market is that rates in the individual market are significantly higher than in the group market and, at least for HMOs, the disparity is growing. While the difference is partly attributable to administrative efficiencies in the group market, the major cause appears to be the difference in the risk pool (see Table B).

**5. Guaranteed issue**

Since December 1993, carriers offering individual coverage have been required to accept all applicants, regardless of health status.[24] As a result, healthy individuals who are uninsured and develop a health problem can buy coverage at any time. For those who have had no coverage in the prior three months, the carrier can exclude pre-existing conditions for the first year, but after that, full coverage must be provided. For those who have had prior coverage within the prior three months, full coverage is immediate.[25] According to a study by Towers Perrin, guaranteed issue is the primary reason for the limited availability of individual indemnity coverage.[26]

**6. Modified community rating**

The 1993 market reforms also restricted the extent to which carriers can vary rates based on age and other factors. While claim costs for a 60-year-old are about four times those for a 25-year-old, the rates charged can only be 50% higher. As a result, coverage is a "good deal" for older individuals, while younger individuals must pay more than would be justified based on their own claim costs.[27] This results in the risk pool having a higher average age and therefore higher costs.[28]

---

[24] Title 24-A M.R.S.A. § 2736-C.
[25] Title 24-A M.R.S.A. § 2849-B.
[26] Towers Perrin Integrated HealthSystems Consulting, "The Effects of Maine's Health Insurance Reform: A Retrospective Evaluation of Small Group and Individual Health Insurance Reform Legislation," page 33.
[27] This statement applies to younger and older insureds in the aggregate. It may not be true for a given individual. A young individual with a serious health problem may pay far less than his or her expected claim cost, while an older individual in very good health may pay more than his or her expected claim cost.
[28] Towers Perrin Integrated HealthSystems Consulting, "The Effects of Maine's Health Insurance Reform: A Retrospective Evaluation of Small Group and Individual Health Insurance Reform Legislation," page 22.

Table B

## Comparison of Maine Individual Rates to Group as of 11/1/99

| Carrier | Individual | Group | Ratio of Individual to Group | Adjusted Group | Ratio of Individual to Adjusted Group |
|---|---|---|---|---|---|
| **HMOs** | | | | | |
| HMO Maine (BCBS) | $424 | $228 | 186% | $258 | 164% |
| Healthsource Maine (CIGNA) | $387 | $223 | 174% | $253 | 153% |
| Harvard Pilgrim | $359 | $239 | 150% | $271 | 133% |
| Aetna U.S. Healthcare (formerly NYLCare) | $415 | $281 | 148% | $318 | 130% |
| | | | | | |
| **Indemnity** | | | | | |
| BCBSME: | | | | | |
| $250 Deductible | $406 | $278 | 146% | $316 | 129% |
| $500 Deductible | $392 | $256 | 153% | $290 | 135% |
| $1000 Deductible | $364 | $224 | 163% | $253 | 144% |
| $1500 Deductible | $331 | $210 | 158% | $238 | 139% |

***January 2001 update:***

## *Comparison of Maine Individual Rates to Group as of 11/1/00*

| *Carrier* | *Individual* | *Group* | *Ratio of Individual to Group* | *Adjusted Group* | *Ratio of Individual to Adjusted Group* |
|---|---|---|---|---|---|
| ***HMOs*** | | | | | |
| *HMO Maine (Anthem)* | *$424* | *$287* | *148%* | *$325* | *130%* |
| *CIGNA (formerly Healthsource)* | *$445* | *$287* | *155%* | *$325* | *137%* |
| *Aetna U.S. Healthcare (formerly NYLCare)* | *$503* | *$220* | *229%* | *$249* | *202%* |
| ***Indemnity*** | | | | | |
| *Anthem Health Plans of Maine:* | | | | | |
| *$250 Deductible* | *$406* | *$308* | *132%* | *$349* | *116%* |
| *$500 Deductible* | *$392* | *$282* | *139%* | *$320* | *123%* |
| *$1000 Deductible* | *$364* | *$246* | *148%* | *$279* | *131%* |
| *$1500 Deductible* | *$331* | *$230* | *144%* | *$261* | *127%* |

Rates are community rates for Standard plan for one person. Adjusted group rates are intended to reflect group claim costs but individual administrative expenses, which are higher than group. The adjustment assumes individual rates are priced at a 75% loss ratio and group rates are priced at an 85% loss ratio.

### 7. Marketing issues

It is possible that the individual health insurance market would attract more good risks if carriers marketed the products more actively. This could be accomplished through advertising, through increased commission scales, or by other means. Some carriers do not pay commissions to producers for selling individual coverage. Bureau of Insurance Rule 750 was amended in 1998 to require carriers to pay at least as high a percentage commission on individual coverage as on group coverage unless they have an approved alternative marketing mechanism. However, not all carriers are complying with this requirement.

*January 2001 update: All carriers are now in compliance.*

Increased marketing efforts could attract poor risks as well as good risks. However, poor risks are more likely to seek out coverage in the absence of marketing than are good risks. On the other hand, to the extent increased marketing costs result in increased rates, there could be a disincentive for good risks to purchase coverage.

### 8. Plan design

Some plan designs are particularly attractive to high-risk individuals, while others are more attractive to healthy individuals. Generally, high-risk individuals will choose more comprehensive benefits. Healthy individuals place more emphasis on cost and are therefore more attracted to policies with high deductibles and/or benefit limitations. This affects the market in two ways. First, there is a tendency for the market to become segmented, with high-risk individuals in richer plans. If each plan is priced based on its own experience, the difference in rates will be greater than would be actuarially justified based only on the difference in benefits and the rates for the richer plans can become unaffordable. Second, the range of plans available in the market may affect the overall risk level in the market. For example, if only very comprehensive plans are available, healthy individuals are less likely to purchase coverage.

All carriers are required to offer certain standardized plans, as described in Appendix D. They may offer additional plans if desired. In the indemnity market, the design of these plans does not seem to be a factor contributing to increasing rates. However, some HMOs have asserted in the past that the Standard plan required to be offered in that market had unusually rich benefits, particularly for prescription drugs, and was a magnet for high-risk individuals. In response to these concerns, the Bureau of Insurance increased the drug deductibles from $3 for generic drugs and $6 for brand name drugs to $10 for generic drugs and $20 for brand name drugs when Rule 750 was amended in 1998. Nonetheless, the prior levels may have contributed to past rate increases and if the plan did attract high risks into the pool, residual effects may last several years. Also, some HMOs believe that the current plan design is still too comprehensive.

*January 2001 update: Data for Blue Cross Blue Shield of Maine show that the cost of health care services for individual HMO members is more than two-and-one-half times the cost for those covered by individual indemnity plans.*

Some insurance producers have also argued that both of the standardized plans are too expensive for many individuals and a third option is needed. Unlike the indemnity market, where carriers

have offered high-deductible plans in addition to the Standard and Basic plans, HMOs have offered only the two standardized plans. In recent years, this may be in part due to a provision of Rule 850 requiring all HMO plans to be at least as comprehensive as the Basic plan. However, even before Rule 850 was adopted, HMOs did not offer alternative plans in the individual market. Pursuant to legislation enacted in 1999,[29] the Bureau is currently working on a new rule that will supersede this provision of Rule 850 and set a lower minimum standard for HMO benefits.

*January 2001 update: The Bureau proposed amendments to Rule 750 to establish a new minimum standard for HMO benefits. Revisions are being made to the proposal in response to comments received through the rulemaking process and a final rule is anticipated soon.*

**9. Mandated benefits**

Mandated benefits are often mentioned as a cause of high health insurance rates. It is important to point out that individual plans are currently exempt from the most costly mandates – mental health and substance abuse. The mandates that do apply to individual plans are estimated to constitute at most 2.9% of premium. The largest components of this figure are chiropractic care (1.0%), contraceptives (0.8%), and prostate cancer screening (0.7%). A full list of existing mandates and approximate costs are set forth in Appendix A.

*January 2001 update: The estimate of the maximum impact of mandated benefits on premiums for individual coverage has increased from 2.9% to 3.33% due to the enactment of a mandate for access to clinical trials in 2000 as part of the Patents' Bill of Rights. See Appendix A.*

**10. Medicaid**

In conformance with federal law,[30] Maine's Bureau of Medical Services operates a Private Health Insurance Premium Program[31] under which it pays health insurance premiums for some Medicaid enrollees when it is cost-effective to do so. The requirement that it be cost-effective means that Medicaid enrollees are only placed in this program if their claims are expected to exceed their premiums. Generally, these are enrollees with serious medical conditions. The result is more high-risk individuals in the individual health insurance market.

The Bureau of Medical Services indicates that it does not actively seek private insurance coverage for Medicaid enrollees, but will evaluate this option when the enrollee requests it. As of December 1999, there were 74 enrollees in this program of which 12 had individual coverage, with the remaining 62 under group plans.

---

[29] 1999 Public Law Chapter 223, "An Act to Clarify Basic Health Care Services to be Offered by Maine Health Maintenance Organizations."

[30] 42 United States Code, Section 1396a(a)(25)(G) and 1396e.

[31] Title 22 M.R.S.A. § 18.

*January 2001 update: Anthem Health Plans of Maine found that for 11 of these individuals enrolled in their individual plans in 1999, they paid $338,210 in claims while collecting only $42,847 in premiums. They estimate that without these individuals, the January 1, 2001, rate increase for HealthChoice would have been 22% rather than 23.5%.*

## IV. Possible Solutions

The following are some possible measures to address Maine's individual health insurance market, with corresponding advantages and disadvantages. These proposed solutions are aimed at reducing the disparity between the costs of group and individual health insurance coverage, at increasing the range of coverage available in the individual market, or both. Measures to address the broader problems of the overall costs of health insurance and health care are beyond the scope of this paper.

### 1. Partial integration of the group and individual health insurance markets

As discussed above in Section III, Part 4, rates in Maine's individual health insurance market are significantly higher than in the group market and, for HMOs, the disparity is growing. Because employers heavily subsidize group coverage, low-risk employees are much more likely to participate in employer-sponsored plans than are low-risk individuals in the individual market. Also, employees in group plans are generally at least healthy enough to be working, although their dependents may not be. This may not be true in the individual market where retirees or unemployed individuals may purchase coverage regardless of health status.

As a result, low-risk purchasers of individual coverage bear a proportionately greater burden in subsidizing high risks than do purchasers of group coverage. Therefore it may be more equitable to spread the risk evenly over the entire health insurance market rather than segmenting the market into group and individual. This could be achieved through a risk adjustment mechanism in which carriers with lower-than-average risk are assessed in order to fund the "excess" costs of carriers with higher-than-average risk.

Full integration of the market in this manner does not appear feasible. First, employers would likely view this approach as a subsidy from them to the individual market. Philosophical and political considerations aside, any system that significantly increased the cost of coverage for employers would be (i) an incentive for employers to reduce or drop coverage, (ii) an incentive to relocate to another state, and (iii) a disincentive to new employers locating in Maine.

Partial integration, with a cap on the increment to group premiums, might mitigate these drawbacks. By setting the cap at a relatively low level, it would not be a significant incentive for employers to drop coverage or leave the state. As an example, if the group market is 16 times larger than the individual market,[32] then an assessment on group premiums capped at 1% would enable a 16% rate reduction in the individual market. Also, capping the transfer of funds from the group market to the individual market at a level far below the level that would be needed to fully equalize the risk pools would make it unnecessary to determine the actual differences in the risk pools for each carrier, thereby simplifying the mechanics of the system.

[32] This is an estimate based on limited available information and may be inaccurate.

*January 2001 update: Recent data indicate that premium volume in the group market is about 17 times larger than that in the individual market.[33] Including self-insured plans would increase the 17-to-1 ratio.*

While the above example uses an assessment based on premium, this would not be the best method because an assessment on group premiums would not affect self-insured employers. This would be inequitable and would provide additional incentive for employers to self-insure. A system recently adopted in New Hampshire avoids this problem by basing the assessment on the number of covered lives and applying it to stop-loss carriers as well as group carriers.[34] New Jersey and New York also have systems that partially integrate the group and individual markets. Massachusetts requires all group carriers to offer individual coverage (similar to Maine's HMO law) but does not require any merging of the risk pools. Appendix B provides further information about the systems in all four of these states.

*January 2001 update: A new law in the state of Washington also assesses stop-loss carriers to fund a high-risk pool. See Appendix C.*

Advantages

- The reduction in individual rates resulting from an assessment on group plans could attract more low-risk individuals into the individual market, thereby further reducing rates.

- A subsidy from a lower-risk segment of the market to a higher-risk segment would be consistent with the risk-pooling principles inherent in our small group and individual health laws. For example, the small group laws require low-risk small employers to pay more to cover the costs of high-risk small employers.

- It has long been recognized that employers have some ongoing responsibility for the health care costs of employees who are covered under their health plan and then become unable to work due to serious medical problems:

  - Before 1996, group carriers were required to provide for conversion coverage for those who left the group. Conversion plans typically had very high costs because those with health problems were much more likely to exercise their conversion rights. However, rates were not permitted to fully reflect these costs[35] and an explicit charge was generally added to employers' rates to cover the excess cost. The conversion requirement was repealed when it became unnecessary due to guaranteed issue in the individual market. This resulted in cost savings to employers with the cost passed on to individual ratepayers. An assessment on employer plans would in effect restore an obligation employers had in the past.

---

[33] *1999 Supplemental Health Insurance Premium Reports.*

[34] Although at least one federal circuit court has upheld a similar law, it remains an open question whether such an assessment mechanism would be preempted by ERISA.

[35] Bureau of Insurance Rule 281.

- In most states, individuals can be denied individual coverage until they have exhausted their "COBRA" rights. COBRA[36] allows someone losing eligibility for a group plan to stay on the plan for 18 or 36 months. While the individual must pay the group rate, these individuals on average have much higher claim costs due to adverse selection. In Maine, they have the option to purchase individual coverage instead of going on COBRA. This may be less expensive because employer plans are usually richer in benefits and the individual may not need the extra benefits. Here again, a cost that would otherwise have fallen on the employer is passed on to the individual market.

Disadvantages

- The cost of group plans has also been increasing, though not nearly to the same extent as in the individual market. Small employers in particular have felt burdened by high health care costs. Anything that further increases their costs, even slightly, will not be well received by many employers.

  *January 2001 update: Preliminary modeling indicates that a one-dollar monthly assessment per covered life would result in a premium reduction in the individual market of approximately 8%.*

- By capping the assessment at a low level, the resulting rate reduction in the individual market may not be sufficient to address the affordability problem.

- This mechanism would add some administrative costs to the system.

- An assessment on stop-loss coverage might be subject to legal challenge under ERISA.

**2. Risk adjustment within the individual health insurance market**

A risk adjustment mechanism within the individual health insurance market alone would be possible. A risk adjustment mechanism shifts premium dollars from plans with relatively healthy or young enrollees to plans with sicker or older members. This could be based on demographic factors, on certain high-risk health conditions, or on some other factor. Risk adjustment would help ensure an even distribution of risks among carriers in the market.

Advantages

- A risk adjustment mechanism could reduce the incentive for carriers to avoid high risks, since the cost would be shared with other carriers.

- A risk adjustment mechanism could compensate for the tendency of the market to become segmented by plan design. Carriers (particularly HMOs) that have attracted high-risk individuals due to comprehensive plan designs would benefit.

---

[36] Consolidated Omnibus Budget Reconciliation Act (COBRA), U.S. Public Law 99-272, signed into law April 7, 1986.

- A risk adjustment mechanism could cause some carriers not currently in the individual market to consider re-entering by providing some comfort that guaranteed issue will not result in more than their share of high risks.

Disadvantages

- A risk adjustment mechanism would do nothing to reduce the cost of coverage.

- A risk adjustment mechanism can be cumbersome and expensive to administer, thus adding to the cost of coverage. To the extent the system is simplified to avoid this, it becomes less able to accurately reflect risk.

**3. Assigned risk pool**

Under an assigned risk pool, carriers could initially reject high-risk individuals, who would then be assigned to a carrier. Each carrier would be assigned a number of risks based on their market share. This is essentially a form of risk adjustment mechanism and subject to the same comments noted above. This would help ensure an even distribution of risks among carriers in the market, although this does not currently appear to be a problem.

Advantages

- An assigned risk pool could cause some carriers not currently in the individual market to consider re-entering by providing some comfort that guaranteed issue will not result in more than their share of high risks.

Disadvantages

- An assigned risk pool would do nothing to reduce the cost of coverage.

- An assigned risk pool would eliminate choice of carrier for the affected individuals.

**4. Changes to individual market reform laws**

As discussed in section III, the 1993 reforms may have had a role in increasing the number of high risks and reducing the number of low risks in Maine's individual health insurance market. However, there is no empirical evidence to support this or to quantify the effects, although there are studies based on the experience of other states. For example, the Wake Forest University Health Insurance Market Reform Study[37] reviewed data from several states and reached the following conclusions:

- Reforms to the small-group market are more successful than those in the individual market, and the effects of reform must be analyzed separately in each market segment.

[37] This study can be viewed at http://www.phs.wfubmc.edu/insure/.

- Enrollment in the individual market has dropped in response to reforms that impose guaranteed issue of all products and pure community rating. However, these reforms have not created an adverse selection "death spiral" nor have they caused the collapse of the individual market. Instead, these reforms tend to create an individual market that resembles a large high risk pool, one with widespread and substantial enrollment but in which it is more difficult for younger, healthier people to find affordable coverage.

- In the individual market, the stringency of rating restrictions has a dramatic effect on the willingness of insurers to remain in the market and on adverse selection effects against the market. States that have adopted pure community rating in the individual market have experienced significantly worse problems, although some states have adapted better to pure community rating than have others.

It should be noted that this study was based on experience through 1997, when reforms had been in effect only a few years. During that period, rate increases were not as substantial as those we have seen more recently.

Maine's individual market reforms have been popular with the Legislature and the public, and we would not support major changes in these laws in the absence of clear evidence that the reforms are causing major problems. However, some minor changes may be desirable. One possibility would be to relax or eliminate the restrictions on age rating. Maine is one of very few states that imposes such restrictions. Another possibility would be to allow limited rate variations based on health status. For example, allow a "good health discount," based either on a period of time with no claims or on health factors such as no smoking, no obesity, etc.

Advantages

- Such changes would reduce rates for some lower risks which could attract more of them into the market, thereby reducing the average rates for all.

- Discounts based on not smoking and/or other health habits could provide an incentive for healthy behaviors, thereby reducing overall health care costs.

- Increasing permissible age bands would make coverage more affordable for younger individuals who on average have lower incomes. If more young individuals enter the pool, there would not necessarily be any cost increase for older individuals.

Disadvantages

- Increasing permissible age bands could make coverage more expensive, at least in the short run, for early retirees who may have reduced income as a result of retirement.

- Any change in these statutes would likely be controversial.

### 5. Eliminate requirement to write one-life groups

Currently, small group carriers that do not offer individual coverage are required to offer group coverage to self-employed individuals even if they have no other employees. This is called a "one-life group." Federal small group laws[38] apply only to employers with two to fifty employees and do not require group coverage for one-life groups. Due to the potential for adverse selection, one-life groups on average have higher claim costs than larger groups. Because of this, as well as increased administrative expenses, rates are often higher than for larger groups, though not as high as rates for individual coverage. On average, these individuals are healthier than are those in the individual market. If these individuals bought individual coverage rather than group, the average risk in the individual market would be improved. Those already covered by group policies could keep that coverage as it is guaranteed renewable. However, those purchasing coverage in the future could be required to do so in the individual market.

Advantages

- Bringing these individuals into the individual market could reduce average costs in that market.

- To the extent current rates for one-life groups do not fully reflect cost differences in relation to larger groups,[39] removing them from the small group market could reduce small group rates.

- Limitations on pre-existing condition exclusions are more stringent in the group market than in the individual market. For example, pursuant to federal law,[40] Maine's law concerning pre-existing conditions on group plans was amended in 1997 to prohibit pre-existing condition exclusions with respect to pregnancy.[41] This means that a self-employed woman, or the wife of a self-insured man, who is uninsured and becomes pregnant can buy a small group plan, have her maternity costs covered, and then drop coverage. This creates the potential for severe adverse selection. Eliminating the requirement to cover one-life groups would eliminate this loophole. Alternatively, this problem could be addressed by creating an exception for one-life groups to the prohibition against treating pregnancy as a pre-existing condition under group plans.

Disadvantages

- Sole proprietors purchasing health insurance would pay higher rates and have fewer choices than currently.

---

[38] Health Insurance Portability and Accountability Act of 1996 (HIPAA), U.S. Public Law 104-191.
[39] Carriers vary considerably in the amount, if any, by which their one-life group rates exceed their rates for larger small groups.
[40] Health Insurance Portability and Accountability Act of 1996 (HIPAA), U.S. Public Law 104-191.
[41] Title 24-A M.R.S.A. § 2850(2)(A).

### 6. Increase availability of one-life group coverage

One-life group coverage is generally more affordable than individual coverage and a greater choice of carriers is available. Availability of this type of coverage could be increased by requiring all small group carriers to offer it, even if they offer individual coverage. Another way to increase availability would be to liberalize the standards for determining who is "actively engaged in a business,"[42] thereby making more individuals eligible. A related issue is the difference in premium rates between a one-life group and larger groups. Maine's small group law, unlike some other states', allows rates within the small group market to vary by group size.[43] The additional premium for one-life groups is as high as 40% for some carriers. The rationale for this is the greater adverse selection and greater administrative costs associated with one-life groups. Eliminating rate variations by group size would lower costs for sole proprietors, but at the expense of other small employers. An intermediate approach would be to allow rate variations by group size only when justified by cost variations.

Advantages

- For those eligible, group coverage would be more affordable and would offer more options than individual coverage.
- If rate variations by group size were eliminated or restricted, this coverage would be even more affordable.

Disadvantages

- Bringing these individuals into the group market could increase average costs in that market, making matters even worse for those still ineligible for group coverage.
- To the extent rates for one-life groups do not fully reflect cost differences in relation to larger groups, employers of two to fifty pay more to subsidize the one-life groups. If a subsidy is needed, it may be preferable to get it from a broader base than just the small group market. Eliminating or restricting rate variations by group size would exacerbate this situation.
- As discussed above, limitations on pre-existing condition exclusions are more stringent in the group market than in the individual market, creating the potential for severe adverse selection. This problem could be addressed by creating an exception for one-life groups to the prohibition against treating pregnancy as a pre-existing condition under group plans.

### 7. "Play or pay"

One way to improve availability and increase the range of options in the individual health insurance market would be to create an incentive for group carriers to write individual coverage, similar to the New Jersey approach (see Appendix B). Group carriers in New Jersey can avoid

[42] This is part of the statutory definition of an eligible group [Title 24-A M.R.S.A. § 2808-B(1)(D)].
[43] Title 24-A M.R.S.A. § 2808-B(2)(C).

the assessment to subsidize losses in the individual market by writing their proportionate share of individual business.

Advantages

- Carriers wishing to avoid an assessment might try to attract the requisite individual market share by actively marketing individual coverage and offering attractive products and competitive rates.

Disadvantages

- If carriers avoid the assessment, it would reduce the subsidy available to the individual market. While these carriers might set rates at a competitive level, it is unlikely they would want to write the business at a loss unless the losses were fully subsidized.

**8. "Play or else"**

Another approach would be to require all group carriers (or all small group carriers) to offer individual coverage, similar to what is already required of HMOs. Massachusetts adopted this approach and only two carriers exited the small group market to avoid the requirement. However, many carriers have not actually sold any individual policies.

Advantages

- Requiring group carriers to offer individual coverage could increase the range of options in the individual indemnity market.

Disadvantages

- Carriers forced to offer individual products might find ways to avoid selling them. Active marketing requirements could be imposed, but would require significant enforcement effort.

- Requiring group carriers to offer individual coverage could reduce the range of options in the small group market if carriers leave to avoid the requirement.

**9. High risk pool**

Many states have high risk pools for those unable to obtain health insurance elsewhere. Maine had such a program from 1987 to 1994, but it was phased out when guaranteed issue laws were enacted. Creating a new pool could remove some high risks from the individual market. However, criteria would need to be established as to when a carrier could reject an individual, thus making him or her eligible for the high risk pool. To allow carriers to reject any individuals considered to be unfavorable risks and send them to the pool would represent a major retrenchment in the reform laws and would therefore be unacceptable to many.

Another concern with a high risk pool would be funding. Rates in a high risk pool are generally higher than in the commercial market, but are not self-supporting. Some states assess insurers to

make up the shortfall. However, most of these states allow a premium tax deduction equal to the assessment, so it is in effect state-funded. If no tax deduction is allowed, the burden is placed on the insured population while self-insured employers escape the assessment. As discussed above, it is possible to design an assessment that indirectly charges these employers through their stop-loss coverage. Maine's former pool was initially funded by an assessment on hospitals on the theory that the cost would be passed on to both insured and self-insured groups. Although the assessment was a small fraction of a percent of hospital revenues, the hospitals opposed the assessment and succeeded in having it replaced by general fund revenues. The number of individuals in the pool was capped at a low level[44] due to the scarcity of funding.

Advantages

- A high risk pool can provide an alternative funding mechanism for the highest risks, thereby providing rate relief to those remaining in the individual market.

Disadvantages

- Creating a high risk pool may be viewed as a step backward from the guaranteed issue requirement that was a key component of the 1993 reforms. While alternative coverage would be available, choice would be more limited and premiums would likely be higher.[45]

- Funding would be problematic. Assessments on insurers, hospitals, or any other group would meet with resistance. Public funding is not readily available and would be controversial.

**10. Purchasing alliance**

A purchasing alliance (also called a purchasing cooperative or purchasing pool) is an arrangement for purchasing health care for members. Alliances typically contract with a variety of health plans (insurers, health maintenance organizations, etc.), achieving cost savings through volume purchasing. Employees of employers participating in the alliance can choose among the available health plans. While some alliances allow only employers as members, others include individual members.

In 1995, the Maine Health Care Reform Commission (MHCRC) presented the Legislature with recommendations for incremental reform of the current health insurance system. The creation of a purchasing alliance formed the centerpiece the MHCRC proposal. One factor often cited as key to the success of a purchasing alliance is a critical mass of members. Without a large number of members, there is little incentive for health plans to negotiate favorable rates for the alliance. For this reason, MHCRC proposed that state employees form the core of the alliance. However, this feature of the proposal was not enacted. Instead, the legislation permitted formation of private purchasing alliances.[46] To date, none have been formed.

---

[44] The cap was changed from time to time, but was in the range of 300 to 600.
[45] Most high risk pools set premiums at 150% of the average standard rate in the individual market.
[46] Title 24-A M.R.S.A. Chapter 18-A.

Formation of a public purchasing alliance could result in more affordable coverage available to individuals. Alternatively, there may be ways to make formation of private purchasing alliances more attractive.

*January 2001 update: In 2000, the Maine legislature created the Joint Select Committee To Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens. Citing the problems experienced in other states, the Committee did not recommend a model for establishing a public/private purchasing alliance in the Maine.[47] The Committee did, however, recommend amending current law to reduce obstacles to the creation of private purchasing alliances.*

Advantages

- If a critical mass can be formed, an alliance may be able to negotiate with health plans to lower rates.

Disadvantages

- It is not clear how a critical mass could be achieved.
- While an alliance might result in marginally lower premiums, the rate of increase due to increasing health care costs and deterioration of the risk pool would not be likely to change.

**11. Public programs**

Creation of new programs or expansion of existing programs that provide or finance medical care could reduce the number of uninsured individuals. Such programs can be categorized as two types – those that target lower-income individuals who cannot afford health insurance, and those that target individuals with serious health problems. While programs for the low-income category are socially worthwhile, they would have little impact on the individual health insurance market and are therefore beyond the scope of this paper. Programs targeting those with serious health problems, on the other hand, could reduce the number of high risks in the individual pool.

Advantages

- Public funding spreads the cost over the entire population rather than only those who pay for health insurance.

Disadvantages

- Funding is not readily available and would be controversial.

---

[47] *Final Report of the Joint Select Committee to Study the Creation of a Public/Private Purchasing Alliance to Ensure Access to Health Care for All Maine Citizens, December 1, 2000.*

### 12. Tax incentives or other state subsidy to support the individual health insurance market

A state subsidy to help individuals purchase coverage would increase the number of low-risk individuals in the individual health insurance market, thereby potentially reducing premiums even for those who are not subsidized. It could take the form of a direct subsidy based on income, a tax deduction or tax credit, or some other form.

Currently, a partial tax deduction is available for premiums paid by self-employed individuals. Under federal law,[48] the portion of the premium that may be deducted has increased from 45% to 60% in 1999 and will further increase to 70% in 2002 and to 100% in 2003. There is federal legislation[49] that has passed the House and the Senate, but has not yet come out of conference committee, that would accelerate the 100% phase-in. Under Maine law, the deductible portion currently remains at 45% due to legislation enacted in 1999.[50] A Governor's bill that would restore conformity with federal law is currently pending.[51]

*January 2001 update: Maine law is now consistent with the federal law.*[52]

Premiums paid by individuals who are not self-employed are not tax-deductible under federal or state law unless the individual itemizes deductions and has medical expenses in excess of 7½% of income.

A Maine law enacted in 1998 provides for a limited tax credit for small employers that provide health insurance for dependents of low-income employees.[53] This would generally affect group rather than individual coverage.

Advantages

- Public funding spreads the cost over the entire population rather than only those who pay for health insurance.

Disadvantages

- Funding is not readily available and would be controversial.
- Some studies have concluded that tax deductibility of health insurance premiums does not significantly increase the number insured.

---

[48] Tax and Trade Relief Extension Act of 1998.
[49] HR 2990.
[50] 1999 Public Law Chapter 520.
[51] L.D. 2256.
[52] *1999 Public Law Chapter 731, Part X.*
[53] 1997 Public Law 775.

## Appendix A: Cost of Mandated Individual Health Insurance Benefits

It is not possible to precisely measure the impact of mandated benefits. However, it is possible to estimate an outside limit, the maximum possible increase in health insurance premiums resulting from mandates. These estimates are based on the estimated portion of claim costs that mandated benefits represent, as detailed below. The true cost impact is less than this for two reasons:

1. Some of these services would likely be provided even in the absence of a mandate.

2. It has been asserted (and some studies confirm) that covering certain services or providers will reduce claims in other areas. For instance, covering screening mammograms may reduce claims for breast cancer treatment.

While both of these factors reduce the cost impact of the mandates, we are not able to estimate the extent of the reduction at this time. Following are the estimated claim costs for the existing mandates without the reductions:

- Dentists - This mandate requires coverage to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- Chiropractic - The amount of claims paid has been tracked since 1986 and has been approximately 1% of total health claims each year. We therefore estimate 1% going forward.

- Screening Mammography - The amount of claims paid has been tracked since 1992 and generally has been in the range of 0.2% to 0.3%. We estimate 0.3% going forward.

- Breast Reconstruction - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.20 per month per individual. We have no more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- Errors of Metabolism - At the time this mandate was being considered in 1995, Blue Cross estimated the cost at $0.10 per month per individual. We have no more recent estimate. We include 0.01% in our estimate.

- Minimum Maternity Stay - Our report stated that Blue Cross did not believe there would be any cost for them. No other carriers stated that they required shorter stays than required by the bill. We therefore estimate no impact.

- Diabetic Supplies - Our report on this mandate indicated that most of the 15 carriers surveyed said there would be no cost or an insignificant cost because they already provide coverage. One carrier said it would cost $.08 per month for an individual. Another said .5% of premium ($.50 per member per month) and a third said 2%. We include 0.2% in our estimate.

- Pap Smear Tests - No cost estimate is available. HMOs would typically cover these anyway. The mandate does not apply to individual indemnity plans.

- Breast Cancer Length of Stay - The report estimated a cost of 0.07% of premium.

- Off-Label Use of Prescription Drugs - The HMOs claimed to already cover off-label drugs, in which case there would be no additional cost. However, providers testified that claims have been denied on this basis. The report does not resolve this conflict but states a "high-end cost estimate" of about $1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. We include half this amount, or 0.3%.

- Prostate Cancer - No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. The report estimated additional claims cost for indemnity plans would approximate $0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately $0.11 per member per month, or about 0.07% of total premiums.

- Nurse Practitioners and Certified Nurse Midwives - This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- Coverage of Contraceptives – Health plans that cover prescription drugs are required to cover contraceptives. This mandate is estimated to increase premium by 0.8%.

- Registered Nurse First Assistants – Health plans that cover surgical first assisting are mandated to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

*January 2001 update:*

- *Access to Clinical Trials – The report estimated a cost of 0.46% of premium.*

- *Access to Prescription Drugs – This mandate only affects plans with closed formularies. Since no individual health plans offered in Maine have closed formularies, there is no cost impact.*

These costs are summarized in the following table:

| Year Enacted | Benefit | Type of Contract Affected | Est. Maximum Cost as % of Premium | |
|---|---|---|---|---|
| | | | Indemnity | HMO |
| 1975 | **Maternity** benefits provided to married women must also be provided to unmarried women. | All Contracts | 0[54] | 0[54] |
| 1975 | Must include benefits for **dentists'** services to the extent that the same services would be covered if performed by a physician. | All Contracts except HMOs | 0.1% | -- |
| 1975 | Family coverage must cover any **children** born while coverage is in force from the moment of birth, including treatment of congenital defects. | All Contracts except HMOs | 0[54] | -- |
| 1986<br>1994<br>1995<br>1997 | Benefits must be included for the services of **chiropractors** to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits. | All Contracts | 1.0% | 1.0% |
| 1990<br>1997 | Benefits must be made available for screening **mammography**. | All Contracts | 0.3% | 0.3% |
| 1995 | Must provide coverage for **reconstruction of both breasts** to produce symmetrical appearance according to patient and physician wishes. | All Contracts | 0.02% | 0.02% |
| 1995 | Must provide coverage for **metabolic formula** and up to $3,000 per year for prescribed modified low-protein food products. | All Contracts | 0.01% | 0.01% |
| 1996 | Benefits must be provided for **maternity (length of stay)** and newborn care, in accordance with "Guidelines for Perinatal Care." | All Contracts | 0 | 0 |
| 1996 | Benefits must be provided for medically necessary equipment and supplies used to treat **diabetes** and approved self-management and education training. | All Contracts | 0.2% | 0.2% |
| 1996 | Benefits must be provided for **screening Pap tests**. | HMOs | -- | 0 |
| 1997 | Benefits provided for **breast cancer treatment** for a medically appropriate period of time determined by the physician in consultation with the patient. | All Contracts | .07% | .07% |
| 1998 | Coverage required for **off-label use of prescription drugs** for treatment of cancer, HIV, or AIDS. | All Contracts | 0.3% | 0.3% |
| 1998 | Coverage required for **prostate cancer screening**. | All Contracts | .07% | 0 |
| 1999 | Coverage of **nurse practitioners and nurse midwives** and allows nurse practitioners to serve as primary care providers. | All Managed Care Contracts | -- | 0.16% |
| 1999 | Prescription drug must include **contraceptives.** | All Contracts | 0.8% | 0.8% |
| 1999 | Coverage for **registered nurse first assistants.** | All Contracts | 0 | 0 |
| | **Total Cost for Individual Contracts:** | | 2.87% | 2.86% |
| *January 2001 update:* | | | | |
| *2000* | *Access to clinical trials* | *All Contracts* | *0.46%* | *0.46%* |
| *2000* | *Access to prescription drugs* | *All Managed Care Contracts* | *0* | *0* |
| | ***Total Cost for Individual Contracts:*** | | ***3.33%*** | ***3.32%*** |

[54] This has become a standard benefit that would be included regardless of the mandate.

## Appendix B: Systems Adopted in Other States to Partially Integrate Individual and Group Markets

### New Hampshire

New Hampshire's system was first instituted on an emergency basis in 1997 when Blue Cross Blue Shield of New Hampshire, then the only significant writer of individual business in the state, withdrew from the market. It has since been incorporated into statute.

All group health insurance and excess loss carriers are assessed an amount (36 cents monthly in 2000) per covered person. Funds are distributed to individual carriers according to a formula designed to compensate those with large losses.

The system is administered by an association composed of all group and individual carriers.

### New Jersey

New Jersey allows only standardized plans to be offered. There are five standardized indemnity plans and one HMO plan. All group carriers must either write their proportional share of individual business or share in the individual line losses of other carriers. There is a 75% minimum loss ratio for individual health. The system is administered by a state agency.

### New York

New York has a complex risk adjustment mechanism based on high-cost medical conditions. Our understanding is that small group carriers on average pay in more than they receive while the opposite is true for individual carriers, resulting in a subsidy from small group to individual.

*January 2001 update: A new program called "Healthy New York" took effect January 1,2000. Under this program, HMOs are required to offer a "scaled down" standardized comprehensive benefit package to qualifying small employers and working individuals. Indemnity insurers may participate on a voluntary basis. The program will be subsidized through two state-funded stop-loss funds. Only small employers and individuals who have been uninsured for at least 12 months are eligible. Eligible employers must have 50 or fewer employees, 30% of whom earn $30,000 or less annually. The employer must pay at least 50% of the premium. Sole proprietors and working individuals whose employers do not offer health insurance (and have not offered it in the previous 12 months) are eligible if their household income is below 250% of the federal poverty level (approximately $41,000 for a family of four). The stop-loss funds will cover 90% of claims within a corridor of $30,000 to $100,000 per covered member. The state has allocated $219 million to fund the first two and one-half years of the program.*

**Massachusetts**

Massachusetts requires all small group carriers to offer individual coverage (similar to the Maine requirement for HMOs) but there is no subsidy from group to individual – each segment can be rated based on its own experience. While carriers are required to offer individual coverage, many carriers have not actually sold any individual policies.

## Appendix C: Availability Problems in Other States

Some states have experienced availability problems for a variety of reasons resulting from reforms of their individual health insurance markets. New Hampshire was discussed in Appendix B. This Appendix C describes problems experienced by two other states – Washington and Kentucky.

### Washington

Even before enactment of market reforms in 1993, Washington's individual health insurance market was dominated by regional Blue Cross and Blue Shield plans, HMOs, and county medical societies. However, subsequent to reform, indemnity coverage through commercial insurers disappeared entirely. Factors likely contributing to this were guaranteed issue, a three-month limit on pre-existing condition exclusions, and a requirement that all plans issued after 1995 be HMO or point-of-service (POS) plans.[55]

More recently, a number of managed care plans have also suspended the sale of individual coverage. Reasons cited include large losses and inability to get rate increases approved by the Insurance Commissioner. Reasons cited for the large losses include the three-month limit on pre-existing condition exclusions and adverse selection due to benefit design. As a result, individual health insurance is unavailable through private insurers in several counties in the eastern part of the state. Coverage is available through two state programs: the Basic Health Plan and the Washington State Health Insurance Pool.

The Basic Health Plan was created under the 1993 reforms to provide subsidized coverage for low-income workers. It is also available at an unsubsidized rate for those who are above the income limit. The unsubsidized rate increased by 62% in 1999. This plan has been subject to adverse selection in part because it is the only plan in the state that provides maternity benefits.

The Washington State Health Insurance Pool is a high-risk pool available to those unable to get coverage elsewhere.

*January 2001 update: In response to these availability problems, Washington's legislature enacted significant changes in the individual health insurance market reform laws in 2000. As a result, the three major carriers have returned to the market and private health coverage is now available in all counties.*[56]

*The biggest change was the replacement of the guaranteed issue requirement by a health screening system intended to allow carriers to reject persons representing the highest 8% of risk in the individual market. Those rejected can only get coverage through the high-risk pool.*

---

[55] This requirement was repealed in 1995.

[56] *Washington state Insurance Commissioner web site, www.insurance.wa.gov.*

*The funding mechanism for the high-risk pool was also changed. Previously, the only source of funding to cover costs in excess of premiums was an assessment on health carriers based on each carrier's market share. The new law also assesses stop-loss carriers, at a rate about one-tenth that for health carriers. In addition, assessments on carriers were capped at 70 cents per insured person per month, with a state fund created to cover any additional costs.*

*Other changes included an increase in the pre-existing condition exclusion period from three months to nine.*

**Kentucky**

Kentucky is a rural state where managed care has not gained a significant foothold. In 1994, Kentucky enacted a health reform bill that included individual health insurance market reforms. These included guaranteed issue, modified community rating, and standardized benefit plans. The reforms were controversial and several insurers left the state.

In 1996, the laws were amended to increase the permitted pre-existing condition exclusion for six to twelve months and to increase the permitted rate variations for age, gender, occupation, and healthy lifestyles. Despite this, carriers continued to leave the market. Reasons cited, in addition to guaranteed issue, included standardized benefits and a difficult rate approval process, including mandatory hearings for increases more than three percentage points above the increase in the Consumer Price Index. By 1997, individual coverage was available only from Anthem Blue Cross Blue Shield and Kentucky Kare, the self-insured plan for state employees that sold coverage to individuals through a purchasing alliance created by the 1994 reforms.

In addition to availability concerns, the possibility of a death spiral was feared. The 1996 amendments exempted associations from the individual market reforms. This caused a segmentation of the market with the better risks turning to associations for coverage. In 1998, the market reforms were repealed and replaced by a less ambitious "Guaranteed Access Plan, " which permits rate variations based on health status within limits. There are still only two carriers in Kentucky's individual health insurance market: Anthem Blue Cross Blue Shield and Humana, which offers HMO coverage in areas of the state where it has a network and indemnity coverage elsewhere.

*January 2001 update: In 2000, the guaranteed issue requirement was repealed and a high-risk pool was created. As a result, Fortis Insurance Company returned to the individual health insurance market, along with its affiliate, John Alden Life Insurance Company.*

## Appendix D: Standard and Basic Plans

| INDEMNITY INSURERS | | |
|---|---|---|
| **BENEFIT** | **STANDARD PLAN** | **BASIC PLAN** |
| Deductible | $250, $500, $1,000, or $1,500 | $250, $500, $1,000, or $1,500 |
| Plan Coinsurance | 80% to $1,000 then 100% | 60% to $1,000 then 100% |
| Lifetime Maximum | $2,000,000 | $1,000,000 |
| Substance Abuse | $25,000 lifetime maximum. Inpatient calendar year max of 30 days. 60 day lifetime. Outpatient calendar year max of $1,000. | $7,500 lifetime maximum. Inpatient calendar year max of 15 days. 30 day lifetime. Outpatient calendar year max of $500. |
| Mental Health | $25,000 lifetime maximum. 30 day inpatient calendar year maximum. Outpatient - $1,000 calendar year maximum @ 50% coinsurance. | $7,500 lifetime maximum. 15 day inpatient calendar year maximum. Outpatient - $500 calendar year maximum @ 50% coinsurance. |
| Pre-Natal, Newborn, Well Child, and Well Adult Care | Covered expenses are payable at 100% subject to contract maximums. | Covered expenses are payable at 100% subject to contract maximums. |
| Chiropractic Care | 36 visits per calendar year. | 18 visits per calendar year. |
| Prescriptions | Subject to contract deductible and coinsurance. | No deductible or coinsurance. $20 copayment for generic drug & $30 copayment for brand names. |
| Emergency Room Care | Subject to $50 copay if not confined to the hospital. | Subject to $75 copay if not confined to the hospital. |
| Inpatient Hospital Services | No limit on number of days. | 60 days per calendar year. |
| Physician's Care | Covered expenses are subject to the medical deductible and coinsurance. | Covered expenses are subject to the medical deductible and coinsurance. |
| Skilled Nursing Care | 100 days per calendar year. | Not covered. |
| Home Health Care | 100 visits per calendar year. Max covered at 80%. | 100 visits per calendar year. Max covered at 60%. |

| HMOS | | |
|---|---|---|
| **BENEFIT** | **HMO STANDARD PLAN** | **HMO BASIC PLAN** |
| Plan Coinsurance | N/A | Inpatient only: 80% to $2,000 then 100% |
| Lifetime Maximum | N/A | N/A |
| Substance Abuse | $25,000 lifetime maximum. Inpatient calendar year max of 30 days. 60 days lifetime. Outpatient calendar year max of $1,000. $10 copayment per visit. | $7,500 lifetime maximum. Inpatient calendar year max of 15 days. 30 day lifetime. Outpatient calendar year max of $500. $25 copayment per visit. |
| Mental Health | $25,000 lifetime maximum. 30 day inpatient calendar year maximum. Outpatient - $1,000 per calendar year. $10 copayment per visit. | $7,500 lifetime maximum. 15 day inpatient calendar year maximum. Outpatient - $500 per calendar year. $25 copayment per visit. |
| Pre-Natal, Newborn, Well Child, and Well Adult Care | Covered expenses are payable at 100% subject to contract maximums. | Covered expenses are payable at 100% subject to contract maximums. |
| Chiropractic Care | Covered subject to $10 copayment per visit. | Covered subject to $15 copayment per visit. |
| Prescriptions | $10 copayment for generic drug & $20 copayment for brand names. | $20 copayment for generic drug & $30 copayment for brand names. |
| Emergency Room Care | Subject to $50 copayment if not confined to the hospital. | Subject to $150 copay if not confined to the hospital. |
| Inpatient Hospital Services | No limit on number of days. $250 copayment per day for first 5 days per year. | 60 days per calendar year. $250 copayment per day. Coinsurance (see above). |
| Physician's Care | Covered subject to $10 copayment for office visits. | Covered subject to $25 copayment for office visits. |
| Skilled Nursing Care | 100 days per calendar year. $25 copayment per day. | Not covered. |
| Home Health Care | 100 visits per calendar year. $10 copayment per visit. | 100 visits per calendar year. $25 copayment per visit. |