REPORT TO THE 109TH LEGISLATURE

AS REQUESTED IN CHAPTER 75 OF THE RESOLVES OF 1978

January, 1979

Alfred W. Perkins
Commissioner of Business Regulation

TO GOVERNOR JOSEPH E. BRENNAN AND MEMBERS OF THE ONE HUNDRED AND NINTH LEGISLATURE

Gentlemen:

It is with pleasure that as Commissioner of the Department of Business Regulation I transmit the following report pertaining to a study of the costs and benefits accruing to the State if a self-insurance plan were instituted for state employees and their dependents. This action has been taken to fulfill the Joint Resolution contained in Chapter 75 of the Resolves of 1978.

At this time I wish to thank the members of the committee who assisted in making this report possible.

Respectfully submitted,

Alfred W. Perkins
Commissioner of Business Regulation

AWP/jc

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This Resolve was presented to the Governor by the Senate on MAR 9 1978 and has become law without his signature. (Constitution, Article IV, Part Third)

Received in the office of the Secretary of State MAR 22 1978

MAR 22'78

CHAPTER 75 RESOLVES

STATE OF MAINE

S. P. 637 — L. D. 1996

RESOLVE, Requiring the Commissioner of Business Regulation to Study the Costs and Benefits accruing to the State as a result of Self-insurance of all or Part of Group Health Insurance Coverage.

Whereas, there may be substantial savings to the State by providing that the State may self-insure part or all of the group health insurance benefits provided by the State; and

Whereas, there are many factors to be considered in determining whether such a plan would result in a cost saving while ensuring that members of the group have comparable coverage and other benefits; now, therefore, be it

Study by the Commissioner of Business Regulation. Resolved: That the Commissioner of Business Regulation shall direct a study with the assistance of a committee which shall include the State Controller, the board of trustees who administer the state group accident and sickness or health insurance and 2 state employees who shall be appointed by the commissioner. The commissioner shall provide assistance to the committee from bureaus within the Department of Business Regulation, consultants or actuaries as necessary, and be it further

Factors to be studied. Resolved: That the study shall include a consideration of at least the following factors:

1. Cost. The cost to the State and state employees;

2. Quality. The quality of service;

3. Funding. The funding of service;

4. Claims. The reporting and handling of claims; and

5. Location. Location of administrative functions, number, type and cost of personnel;

and such other matters as the commissioner may deem necessary, and be it further

Report of Findings. Resolved: That the commissioner report his findings to the First Regular Session of the 109th Legislature with all recommended legislation in final draft form.

CHAPTER 2

RECOMMENDATIONS AND COMMENTS

The following recommendations are made by the committee:

A. Tranfer the present state health law to the Retirement System.

Comment. This would locate in one place all personal benefits provided through the State for its employees. A management staff is presently available.

B. Set up a health board within the Retirement System.

Comment. The majority of the committee felt that the administration of these benefits needs more personal attention. The Board of Trustees of the Retirement System represent other interests such as teachers and municipal employees not covered by the State health plan.

C. Provide for self-insurance on an optional basis.

Comment. The practical aspects of self-insurance should be further considered by the health board through the bidding process against insurance. It was also the consensus of opinion (borne out by the actuarial report) that the so-called companion plan which provides benefits for those retirees eligible for medicare should remain on an insured basis.

D. Set up a Health Benefit Fund.

Comment. In the event of self-insurance, this fund would receive all income and make all disbursements for health benefits. It would be allowed to build to at least the projected amount of outstanding claims and corresponding administration costs of claim handling in the event of termination. Amounts in excess of this minimum could be used to reduce both the state and employees monthly cost for benefits.

E. Provide for Consulting Actuarial Services

Comment. A consulting actuary will be needed to design, recommend, review and evaluate original specifications to determine whether to self-insure any part of the health benefit plan. To the extent self-insurance is approved by the board, continuing actuarial services will be needed on a consulting basis to review experience and suggest forthcoming costs to the board.

F. Appropriations. As developed in the actuarial report, start-up costs of $68,000 should be appropriated.

Comment. To the extent any part of the health benefit plan is self-insured this amount shall be an obligation to be repaid from the Health Benefit Fund.

CHAPTER 3

INTRODUCTION

At the Second Regular Session of the One Hundred and Eighth Legislature, Senate Paper 637 "An Act Relating to the Maine State Employees Accident and Sickness or Health Insurance Plan" was considered by the Committee on Business Legislation. This Act would have allowed for the self-insuring by the State of any part of its group health plan.

After due consideration, the Committee on Business Legislation decided that a feasibility study should be made of this subject. Pursuant thereto they required that the Commissioner of the Department of Business Regulation, through Chapter 75 Resolves of 1978, conduct such a study and report back his findings to the One Hundred and Ninth Legislature.

The Commissioner was given the assistance of the present Board of Trustees of the State Group Accident and Sickness or Health Committee, the State Controller and two members to be appointed by the Commissioner.

The following members made up this committee:

James Banks
Dr. Howard Bowen
Colburn Jackson
Conrad Lausier
Richard Dieffenbach
William Blodgett
Robert Maxwell
John P. O'Sullivan

This committee held its first meeting on April 25, 1978. At this meeting it was decided to employ consulting actuarial service to aid the committee in the development of the study. A set of specifications were adopted and on May 16, 1978 (see Exhibit A) sent to eight consulting actuarial firms for bidding consideration.

Bids were to be received by June 8, 1978. As a result of these replies, the firm of Tillinghast, Nelson and Warren, Inc. was declared the successful bidder. Their final report was submitted to the committee on September 29, 1978.

In addition to the report by the consulting actuaries, a public hearing was held on November 29, 1978. A copy of the notice for this hearing is shown as Exhibit B.

CHAPTER 4

ACTUARIAL STUDY REPORT

This report was an indepth study of self-insurance with particular reference to the State of Maine Health Plan. The major features of the report are shown below:

A. Advantages and Disadvantages of Self-Insurance.

A savings in the total cost of the medical program is usually cited as the major advantage. In realistically evaluating such a savings, the policyholder must include all its direct cost, indirect cost, and the price for the acceptance of risk before comparing his former retention with the new administrative cost.

Self-insurance encourages more competitors who can offer services to the policyholder. For very large groups who have been with a single carrier for many years there often is minimum competition at the time of renewal or when specifications are distributed. The reason for this is that quoting a low guaranteed rate with a low retention in order to win the competition puts an insurance company in a high risk situation with little potential reward. Only the largest companies have the financial strength to accept large risks, which eliminates companies with lesser amounts of capital and surplus. When self-insurance is involved, however, many companies can supply an administrative staff ranging from 10 to 50 people without straining their manpower or financial resources. The competition normally produces a more favorable administrative offer to the policyholder even when the company awarded the administrative services only contract is the same company who formerly provided the underwritten insurance.

The policyholder has more flexibility in revising benefits, revising administrative renewals, and financing the program. Changes can be made in the middle of a policy year and premium revisions can be made during a policy year.

In some underwritten situations the committee representing the policyholder engages in acrimonious debates with a carrier about each premium revision, the amount of claim liabilities held, the retention, the use of surplus and other matters. Often the committee is required to have periodic formal bidding which causes a certain amount of policyholder expense and expenses to the carriers which they must include eventually in the retentions charged policyholders. It is asserted that having a cost-plus or stop-loss program avoids some of the inefficiencies relating to the debates and the bidding process.

The major disadvantage usually cited for self-insurance is that the policyholder is subject to the risk of excess claim costs which he has not anticipated in his budget and for which he has not provided in the premiums to be paid by the employee.

Another disadvantage is the risk of unwise benefit increases without consistent premium rate increases. In the early stages of a self-insurance program, the cash claims compared to the premiums or compared to the budgeted allowance appear very favorable. Therefore, there could be pressure by unions or politicians representing employees' interests to expand the benefits. Proper accrual accounting should minimize this problem.

Another disadvantage asserted is that there could be political pressure to budget the State's share of the medical program cost at an unrealistically low level for fiscal reasons.

There is a fear that political or bureaucratical interference in the settlement of individual claims can take place. The method of avoiding this problem is to have very clear documents describing benefits and conditions of eligibility and to have those responsible for administrating claims insulated from outside pressures.

It is asserted that a claim paying organization who itself has no risk of excess claims and therefore no financial incentive may be lax in enforcing coordination of benefits and preexisting conditions provisions, denying excessive claims or denying claims for services outside the scope of the contract.

There may be supplementary benefits which can be lost in transferring from an underwritten to a self-insured program. These could include the right of an individual to convert his insurance to an individual policy and certain cost savings that a carrier has with medical providers, such as hospital discounts.

B. Experience of Other Self-Insured State Plans.

The states where information was obtained are Arkansas, Georgia, Louisiana, Missouri, Oklahoma and West Virginia. Each state cited as the major advantage and prime reason for adopting a self-insured plan the savings in administrative costs. Some of the other potential advantages were mentioned or discussed briefly, but without the expectation of a substantial cost savings, none of the states would have adopted self-insurance.

We believe there is evidence of cost savings in all states except for Louisiana. The Louisiana administrators are convinced the program is in a favorable administrative cost position. Our difficulty in verifying this conclusion for the Louisiana plan is the inability to track the internal state cost through the financial statements covering the Louisiana medical plan.

The other potential advantages are not necessarily absent but are not perceived to be of major importance.

The potential disadvantages relating to financial fluctuations and consequent budget problems have not caused any practical problems to date. None of the states purchased a stop-loss or a CAP and none seems inclined to request proposals for such a partial insurance feature.

The modification in benefits without regards to financial implications has not been perceived to be a problem. In most cases the premium rates or state contributions have followed the consultant's advice or advice of the staff.

Each state has elected to use an outside claim administrator to adjudicate claims and several have given as reasons the desire to avoid direct requests by a politician or another state employee for special claim administration consideration. In all cases except for Louisiana, the states report no problems as to the claim administration party being able to operate impartially in accordance with the written documents describing the benefits, eligibility, effective date, etc.

Each state has made some arrangement for conversion and the loss, if any, of any supplementary benefits is not perceived by the administrators to be a problem.

The question of whether the claim administrator is doing all it should to properly investigate claims involving coordination of benefits (COB), pre-existing conditions, etc., is unanswered. No serious concern has been raised about this subject. In the case of Arkansas, there are no statistical records of claims by incurred date or type of service and no audits or reviews of claim payment procedures so that there is no positive assurance of rigor and accuracy in claim handling.

The question was raised about the payments of claims incurred out of state. No problems were mentioned by anyone and the perception of the staff is that these claims are handled routinely without any serious inconvenience to the covered person. Identification cards listing the benefits and giving the address and telephone number to call for claim administration appear to be sufficient to satisfy providers.

C. Administrative Functions.

Below is a list of administrative functions with some comments about certain aspects of these functions. The comments are not exhaustive but are intended to support the logic of the balance of our report.

1. Functions Which Should be Performed by a Policyholder Such as the State of Maine.

(i) Enrollment, Changes, Terminations

On large cases the policyholder usually performs these functions whether the program is conventionally insured, underwritten on a cost-plus basis, or self-insured.

(ii) Premium Billing, Collection Accounting

On large cases the policyholder usually performs most of these functions, although the carrier in an insured arrangement would be involved to some extent.

(iii) Benefit Eligibility

There can be several approaches to this function. One approach is to have the policyholder certify an employee or his dependent as eligible at the time a claim is submitted. Another approach is for the carrier or claim administrator to have sufficient premium billing records to certify directly without checking with the employer. A third approach is for the carrier or claim administrator to be supplied with an eligible list from which it is expected to pay claims. We favor the third approach with the eligibility record being available either in hard copy or on computer which can be extracted by a request through a computer terminal.

2. Functions Which Should be Performed by Outside Contractors.

(i) Claim Adjudication and Processing of Benefit Checks

The carrier generally performs this function under insured plans and many cost-plus plans and self-insured plans use an outside agency such as an insurance company. This is the major administrative responsibility of a medical plan and it should be performed by knowledgeable, experienced persons.

(ii) Preparation and Maintenance of Accounting and Statistical Information Regarding Claims

This function is a by-product of the preparation claim drafts. It should be and generally is performed by the same unit that adjudicates claims.

3. Functions Which Might be Performed by the Policyholder, Consultant, or the Claim Administrator, or the Underwriter in the Case of an Insured Plan.

(i) Plan Design and Rules of the Medical Program

Some joint responsibility about benefits, effective dates, and eligibility dates is usually shared by the underwriter and the policyholder. Under cost-plus or self-insurance the responsibility shifts very substantially to the policyholder.

(ii) Documents, Booklets, Forms

An insured program usually has a master contract and employee certificates or plan booklets prepared by the insurance carrier. On a self-insured plan the policyholder might arrange for the carrier to prepare communication material or it might use a consultant and its own staff. Forms for enrollment, termination, status changes, claim forms, etc. are usually developed by the carrier in insured plans and cost-plus plans. On a self-insured plan, it could be the responsibility of either party.

(iii) Design of Statistical and Accounting Information and Reports

For insured plans, this is usually performed by the carrier. For self-insured plans, the carrier or a consultant or the policyholder's staff could do this. In any case, those who are to use data and reports should review the information to be sure it includes all that is needed.

(iv) Analysis of Experience for Purposes of Budget Projections, Premium Setting, Determination of Financial Status and Results

For an insured program, the carrier would perform these functions because it has the financial responsibility for setting premiums and determining any experience refunds. For a cost-plus or self-insurance plan, the policyholder might request an insurance company to perform these functions. It would nevertheless review this independently and in most cases would use the services of an outside consultant.

(v) Audit of Various Aspects of Operation Including Premium Billing, Benefit Eligibility, Claim Administration, Handling of Funds

Under an insured plan, the carrier usually performs internal audits. A large policyholder may have some audits of its area of responsibility, i.e., premium billing, benefit eligibility. Under self-insurance, the policyholder should have audits of each portion of the operation performed by its internal staff or by outside auditors.

(vi) Investment of Funds

Under an insured plan, the insurance company manages and invests all funds. Under a self-insured plan, a policyholder would have one of its financial officers charged with the responsibility for cash management and investment of all funds to obtain the greatest investment income.

4. Rationale for Recommending Division of Responsibilities.

We believe there are valid reasons for contracting with an insurance company or with a Blue Cross plan for the payment of claims and the con-current collection, compiliation, and reporting of claim data. We do not believe the State could hire and train a staff with the necessary expertise to do the type of claim service that is necessary to maintain the present quality of service. It could be done at a price but not at a price which is more economical than is likely to be offered by a qualified carrier with a proven record of experience. In addition, the association with such a carrier gives the State of Maine access to some of the other services it may not wish to perform itself.

The other functions which should be contracted out are those which involve technical skills which are not readily available within the ranks of the State employees and are needed only occasionally. For example, the design of statistical and accounting information and reports, and the analysis of experience for purpose of budget projections, and the setting of premiums are not done regularly. Therefore, it may be more economical to have these done on a consulting basis. There are other functions, such as writing of documents

and employee booklets, where State employees in the personnel department may do similar work and could perform this function effectively.

D. Expressions of Interest by Carriers.

We have contacted various companies who are active in medical insurance and who are known to be interested in receiving consideration as claim administrators under self-insured plans. The companies' responses were tentative since it appears likely that with the requirement for legislative action needed as a prerequisite to adopting a self-insured plan the inception date might be as late as July, 1980. Insurance companies cannot commit that far in advance, and they also are reluctant to reveal exactly the quotation they are prepared to make. Nevertheless, the data received did indicate the availability of services and the approximate cost and in some cases the restrictions attached to any offer.

The companies contacted were CNA, Employers Reinsurance, Equitable Assurance Society, Hartford Life, Maine Blue Cross, Metropolitan Life, Northwestern National, and Union Mutual. They were asked to estimate the fee basis for claim administrative service and production of statistical reports on claim activities. A summary of the responses is shown below. The companies identified as A, B, C, D, E for each comparison are not the same companies.

Company	
A*	2.9% of claims paid
B	3.35% of claims paid
C	3.5% to 3.7% of claims paid
D	3.75% to 4.10% of claims paid
E	4% to 5% of claims paid

* Cost-plus with initial deposit required.

We conclude that a cost-plus fee of 3% of claims paid is a realistic expectation and an ASO fee of 3.5% of claims paid is realistic.

E. Consequences for the State of Maine if it Adopts Self-Insurance.

1. The State should make a decision prior to the change from insurance to self-insurance on exactly which functions it would handle and which functions it would contract to others. Our recommendation is that the claim administration aspects should be contracted out but certain services now performed by Blue Cross such as direct billing to individuals or units not within the State payroll system should be handled by the State.
2. The distribution of specifications, receipt of proposals, and inception of the self-insurance program should be coordinated with the hiring or assigning of staff to perform the additional State functions determined in (1). Assume that the program is intended to commence January 1, 1980. Assume that the additional functions will require 4 staff people and consulting assistance with an annual cost of approximately $136,000. The staff should be added during the period July, 1979 through

December, 1979 and begin planning procedures, form preparation, drafting benefit booklets, etc., and duplicating any billing or eligibility work currently being done by Blue Cross. The staff and consultants should be working on the specifications, analysis of proposals, and negotiations and coordination with the selected claim administrator to put the program into effect January 1, 1980. In addition, there are several close-out items relating to the insured program which should be pre-arranged and which will be discussed later. In summary, the State should expect to spend about 6 months lead time and about 50% of the annual $136,000 budget for the proper preparation for a self-insured plan. Not every required employee will be on duty the entire 6 months, but the consulting services will be more substantial than for a period when the plan is operating normally

3. The probable cost savings we would anticipate is about 3% of claims if no stop-loss protection is purchased and if a realistic expectation of future retention is 7% of claims for an insured program. Of course, the claim amounts in any one year may vary and a carrier may underprice in any one year, but over a 3-year period we would expect the carrier to recover his retention and all the incurred claims.

4. The State under its current insured contracts has certain arrangements with regards to terminal liabilities and dividends and rate stabilization funds. The Union Mutual has certain claims for which it is responsible and it holds a claim reserve to pay such claims. After

the final runout, it would make a final dividend payment, if any surplus is generated on a cumulative basis by the State of Maine for major medical insurance. This will operate automatically without any further action by the State. However, the State might consider a special arrangement with Union Mutual to release them from liability from unpaid claims and for the claims reserves to be transferred to the claim administrator (which might be Union Mutual or its CSI affiliate) with a final dividend calculation made as soon as possible. The claim reserve transfer might be less than 100% depending on Union Mutual's cumulative financial position. This subject can be investigated at the proper time.

The contractual agreement with the Maine Blue Cross regarding the rate stabilization fund is different. In the event of a termination with Blue Cross, any funds will be retained by the Maine Blue Cross. However, if the Maine Blue Cross were continued as the carrier under a cost-plus arrangement the rate stabilization funds would be transferred to the State of Maine. The exact rate stabilization fund amount would not be known on the last day of the insured contract year. Under normal circumstances, it would take 6 months or longer to run out a sufficient amount of claims incurred in the policy year, and therefore, allow for exact accounting. However, if the State would release the Blue Cross from the financial obligation to pay for claims outstanding as of the end of the policy year and make such claims

part of the new cost-plus arrangement, then a rate stabilization fund accounting could be done almost immediately. A modification of this would be to limit prior claims to those paid through the month following the contract year and to charge all claims thereafter to the cost-plus account. The purpose is to free funds that would serve as the initial deposit if the Maine Blue Cross was selected to serve as the carrier under a cost-plus contract.

F. Recommendations.

On the basis of our studies which included a review of the experience of other States who adopted self-insured plans, the specific facts that pertain to the State of Maine, and the probable offers we expect to receive for services beginning July, 1979, we have the following recommendations:

1. Request legislative authority to adopt a cost-plus or self-insured medical program. Request legislative appropriation of approximately $68,000 for the six-month period preceeding the implementation of a self-insured plan to hire the key staff personnel and to provide for consulting assistance in implementing the program including writing specifications and selecting a claim administrator.
2. After the legislative authority is obtained to begin the preparatory work to implement a cost-plus or self-insured medical program using an experienced medical underwriter as the claim administrator. Secure proposals for such an arrangement for an inception date which is convenient with respect to either the benefit design or the State's fiscal year. The specifications should

be distributed 5 months prior to the inception date with proposals to be received 3 months prior to the inception date and the contract awarded 2 months prior to the inception date.

The specifications should request a stop-loss quotation, but only as an option. If there are any questions about which services the State might wish an organization to furnish, obtain the proposal with the fee basis for optional additional services.

3. The purchase of stop-loss insurance should be made only if the price is reasonable in relation to its intrinsic value. Considering all the other risks of contingent events having costs which exceed budget, such as building bridges, roads, office buildings, airports, etc., the medical insurance program is probably relatively stable and of less financial consequence even with a rather unusual deviation.
4. The initial rates for budgeting and the payroll deductions from employee salaries should be set at approximately the same level as if the program were insured. This would produce a fund with a modest margin over the liability for incurred but unpaid claims. It would also protect against small adverse deviations in the experience.
5. The preliminary study and decision making with regards to the plan excluding benefit design questions should involve the functions the State should contract out and the functions it should retain. It should also consider the protection of the conversion rights of employees. It should consider any restriction on

delivery of administrative services such as location of the claims office. It should consider the statistical and accounting requirements and the contractor's duties with respect to such data.

Some of the recommendations we made in Section C-Administrative Function and some of the comments of the staffs from states which have adopted a self-insured medical program are:

(i) Claim administration should be contracted out to a qualified organization who has procedures, trained staff, computer facilities and programs, and technical advice available about all aspects of claim adjudication including legal and medical.

(ii) The premium billing should be performed by State employees.

(iii) State employees should perform the benefit eligibility functions but not on a per claim basis. Rather a periodic list prepared once or twice a month should be submitted to the claim administrator.

(iv) The claim office should be in either Augusta, Maine (first choice) or Portland, Maine.

G. Miscellaneous.

Among other things this report shows the various costs which go to make up an insured or self-insured medical program. It also sets forth the various types of self-insurance plans which would be available and the remote probability of excess losses. It also shows the power of compound interest and the value to the account which owns it.

CHAPTER 5

COMMENTS ON ACTUARIAL STUDY

The full study report is available at the following places: the offices of the Commissioner of Business Regulation and Commissioner of Finance and Administration, the Maine State Library, the Maine Law and Research Library and in the office of the Business Legislation Committee.

It was thought too voluminous to be reproduced intoto in this report.

The study backs up its recommendation with several examples as applied to the Maine plan. For purposes of illustration, the actuaries selected two different 3-year periods, i.e., 1975-78 and 1979-82.

There has been some criticism that the illustrations in the report should have covered a longer period of time. In order to satisfy such criticism, the actual data which we know, that is, paid premiums and claims for the past 8 years, was projected on the assumption that the State decided on October 30, 1970 to become a self-insurer using a 5% per annum interest rate and an administrative cost of 6% of paid claims. On a cash flow basis, the following State fund would have been developed by September 30, 1978:

Basic Medical Benefits	$1,673,823
Major Medical Benefits	982,031
TOTAL	$2,655,854

Thus, the State would have in hand earning interest a fund of approximately $2,656,000 on September 30, 1978. (In accordance with present monthly experience, it can be assumed that this fund would be increased by at least $500,000 by July 1, 1979.) The development of this amount is shown in Exhibit C. This amount should also prove to be more than sufficient to meet the outstanding claim liabilities on the assumption that the plan should be terminated on September 30, 1978.

It was the feeling of the committee that self-insurance of health benefits should be optional rather than mandatory and this is provided for in the suggested legislation.

CHAPTER 6

FACTORS STUDIED

Chapter 75 of the Resolves of 1978 asked that certain specific factors be studied. This has been done and the results are as follows:

A. Cost. The immediate charges to both the State and its employees would be similar under either an insured or self-insured plan. Future changes in cost would be more flexible, more efficiently timed and nearer to actual true costs on a self-insured basis.

B. Quality of Service. It is perceived that the quality of service under self-insurance would be at least as good as that now being experienced with more local control than at present.

C. Funding. Under self-insurance funding would primarily be through contributions on behalf of the State and by its employees for dependent coverage similar to what is being done now. At the start there could be a rather sizable return from one of the insurance carriers. This amount would have been $379,010 as of October 1, 1978 and since the present experience is excellent, it can be assumed that this figure will be greatly increased by July 1, 1979.

D. Claims. All parties unanimously agree that the reporting and handling of claims under self-insurance should be contracted out to a qualified organization.

E. Location. It is the consensus of opinion that the administrative functions should be located with the State Retirement System. This will place all personal benefits for state employees in one place with a permanent management staff.

F. Excess Losses. This subject was addressed in the actuarial report. Statistics were developed to show that such a probability was remote. On a practical basis, assuming that the State should self-insure its health benefits, then during the first year it would need pay the actual bills arising from new claims only in the case of basic medical benefits. This amount should not be in excess of 85.6% of total basic medical benefits payments. The balance would have to be paid by the present carrier by reason of termination and not charged to the State. Thus, the contributions at the full rates being made by the State and its employees should be in excess of the cost for new claims during the first year. This excess plus the return from the major medical carrier indicated in (C) above should provide a relatively large positive fund at the end of the first year and careful projections should keep this fund positive thereafter.

STATE OF MAINE

IN THE YEAR OF OUR LORD NINETEEN HUNDRED SEVENTY-NINE

AN ACT Relating to a Health Benefits Program for State Employees

Be it enacted by the People of the State of Maine, as follows:

Sec. 1. 5 MRSA Chapter 13, Subchapter II is repealed.

Sec. 2 5 MRSA Chapter 101, Subchapter VIII is enacted to read:

SUBCHAPTER VIII

GROUP HEALTH BENEFITS PROGRAM

§1185. Group health benefits for state employees and their dependents.

Group health benefits shall be made available to state employees and their dependents subject to the following provisions:

1. Group health benefits defined. As used in this subchapter, group health benefits shall mean group hospital, medical and major medical benefits as provided by the insurance laws of this state.

2. Eligibility. Each appointed or elective officer or employee of the State of Maine who is eligible for membership in the Maine State Retirement System or the State Police Retirement System or a member of the judiciary or an employee of the Maine State Credit Union or of the Maine State Employees Association or of Council 74 of the American Federation of State, County and Municipal Employees or the Maine Turnpike Authority, including those employees in any of said categories who have retired and any such employees in any of said categories who retire and who on the date of their retirement are currently enrolled in this health benefit plan shall be eligible for the group health benefits program. Program eligibility shall not be extended to include members of the Maine State Municipal Association or the Maine Teachers Association or employees of counties and municipalities and instrumentalities thereof including quasi-municipal corporations. Dependents of eligible employees in any of the above categories may be included within the health benefits program.

3. Enrollment. Any employee eligible under this section may join within the first 60 days of his employment or during a declared open enrollment period. The filing of necessary applications shall be the responsibility of his employer. Effective dates under this section shall be at the discretion of the health benefit board.

4. Coverage. Each state employee to whom this subchapter applies shall be eligible for group health benefits determined by any of the methods listed in this subsection.

(a) Insured. Any part of the coverage may be provided from one or more insurance companies or nonprofit organizations.

(b) Self-Insured. Any part of the coverage may be self-insured by the State.

§1186. Administration.

1. Health Benefits Board. The responsibility for the proper operation of the group health program and for making this subchapter effective are vested in a health benefits board consisting of 5 members. The board shall formulate policies and exercise general supervision under this subchapter. Administrative responsibility under this subchapter shall be vested in the executive director of the State Retirement System. The board shall determine through competitive bidding the best method or methods of providing group health benefits taking into consideration the cost to the State and state employees, the quality of the service, the funding of the service, the reporting and handling of claims and the number, type and cost of personnel to administer these benefits.

2. Health Benefits Board membership. The Health Benefits Board shall consist of 5 members, 2 of whom shall be appointed by the Maine State Employees Association; one of whom shall be a retired state employee selected by a majority vote of the Presidents of the Chapters of the Retired State Employees Association; and 2 members who shall be appointed by the Governor, one of whom shall be a state employee. The board shall hold office for 3 years with initial appointments to be made as follows: one member appointed by the Governor for 3 years and one member appointed by the Governor for 2 years; one member appointed by the Maine State Employees Association for 3 years and one member appointed by the Maine State Employees Association for 2 years; and one member appointed by the Retired State Employees Association for one year.

3. Expenses. The board shall be reimbursed from the Health Benefits Fund for all necessary expenses that they may incur through service on the board and shall be entitled to a payment of $50 per diem in addition to expenses when engaged in the performance of authorized board duties. No payments shall be made under this subsection until sums are available in the Health Benefits Fund.

4. Oath. Each board member shall, within 10 days after his appointment, take an oath of office to faithfully discharge the duties of a board member, in the form prescribed by the Constitution. Such oath shall be subscribed to by the board member making it and certified by the officer before whom it is taken and immediately filed in the Office of the Secretary of State.

5. Quorum. Each board member shall be entitled to one vote in the Health Benefits Board. Three board members shall constitute a quorum for the transaction of any business. Three votes shall be necessary for any resolution or action by the board at any meeting of the board.

6. Chairperson, employees. The board shall elect from its membership a chairperson. The executive director of the Maine State Retirement System with the consent of a majority of the board shall engage such services as shall be required to transact the business of the board. All such employees shall be considered as employees of the State and subject to all the provisions of state law regarding state employees and shall be employed under the rules and regulations established by the Personnel Board and shall receive such compensation as is provided by the rules and regulations of the Personnel Board for state employees in similar capacities.

7. Insured health benefits. To the extent health benefits are to be insured, other than through self-insurance, the board shall purchase through competitive bidding from one or more insurance companies or nonprofit organizations group policies of health benefits as defined in this subchapter. Such company or companies or nonprofit organizations must be licensed under the laws of the State of Maine. The policy provisions shall be subject to and as provided by the insurance laws of this state.

The insurance company or companies or nonprofit organizations shall furnish the usual master policy, certificates or certificate booklets. The executive director of the Maine State Retirement System shall be the holder of the master policy or policies.

8. Changes of coverage. The board is authorized to change health benefits coverage, in whole or in part, from insured to self-insured coverage and vice-versa. For the purpose of making such changes, the board may enter into any necessary contracts, and the board is specifically authorized to include in such contracts provisions to hold harmless an existing health benefits provider in order to receive any funds due the State which are held by the provider.

9. Rules and regulations. The board shall from time to time establish the rules and regulations for the administration of the Health Benefits Fund and for the transaction of its business.

10. Data. The executive director shall keep in convenient form such data as shall be deemed necessary by the board for review of the experience of the group health benefits program.

11. Consulting Actuary.

A. The board shall designate an actuary on a consulting basis. The consulting actuary, if an individual, shall be a member of the Academy of Actuaries. If the actuary is a firm of actuaries, it shall designate one of its members to perform the functions required of the actuary under this chapter who shall be a member of the Academy of Actuaries. The actuary shall be the technical advisor to the board.

B. The actuary shall develop all specifications required by the board for competitive bidding and shall review all bids received and furnish the board with a written report of his findings and recommendations.

C. In the event the board decides to self-insure any part of the health benefits program, the actuary shall determine the type and form of experience reports which the board shall require.

D. The actuary shall make such investigations of the experience of the health benefits program for the purpose of determining the actuarial assumptions to be recommended to the board for adoption so that proper cost levels for the health benefits program may be obtained.

E. The actuary shall periodically review the status of the Health Benefits Fund and make such recommendations as appear appropriate.

F. The actuary shall make an annual report in writing to the board which shall include recommendations for the next fiscal year.

12. Annual Report. The board shall make an annual report to the Governor.

§1187. Financing.

1. Payment by the State. The State of Maine through the Health Board shall pay 100% of only the employee's share of the health benefits. Payment for any dependent coverage shall be paid by the employee.

2. Health Benefits Fund. If any of the group health benefits are to be self-insured, the state controller shall open on the books of the State an account to be known as the Health Benefits Fund. All contributions for health benefits by state employees or by the State on behalf of state employees together with returns of any type from financial institutions or agencies plus any investment income generated by the Health Benefits Fund shall be credited to this fund.

This fund shall be charged with the cost of all health benefit obligations assumed by the board including the cost of all claim, administrative and actuarial services and all start-up costs incurred by the board for health benefits. The minimum balance which should be developed in the health benefits fund is that amount which through actuarial projections is deemed sufficient to liquidate all outstanding claims and deferred administrative expenses for handling these claims in the event of termination.

Any unexpended balance shall not lapse but shall constitute a continuous carrying account.

Sec. 3. Any employee who retired prior to April 26, 1968, and who subsequently has continued group health benefits from the state will be continued under this health benefit program.

FISCAL NOTE

It is estimated that the cost to administer the provisions of this act prior to the determination by the board whether to insure or self-insure health benefits would be $68,000. That part of the program which may be self-insured would be self-supporting thereafter and in addition would reimburse the General Fund for the amounts previously spent in arriving at such determination.

STATEMENT OF FACT

Chapter 75 of the Resolves of 1978 required that the Commissioner of the Department of Business Regulation conduct a study of the costs and benefits accruing to the State as a result of self-insurance of all or part of the group health benefits for employees of the State of Maine.

Pursuant to this request, the Commissioner of Business Regulation employed the actuarial firm of Tillinghast, Nelson and Warren, Inc. to conduct a Feasibility Study of Self-Insurance for Medical Benefits for Employees of the State of Maine.

Their recommendations suggest, in part, that the State adopt a self-insured medical program for state employees as it was their considered opinion that such a program would be more cost efficient to the State and its employees.

This act would make it possible, on an optional basis, to self-insure any part of the health benefit program if it appears to be in the best interest of the State and its employees.

This act also would locate the board in the State Retirement System, thus, bringing together, in one place, all personnel benefits provided employees through the State.

EXHIBIT A - SPECIFICATIONS
HEALTH PLAN

1. Shall the plan provide a "cap?" (An amount above which payments for the balance of an indicated period would be made by a 3rd. party.)

   (a) How shall such "cap" be determined?
   (b) Who shall make the "cap" determination?
   (c) To whom shall the "cap" plan be sent for bidding?
   (d) What would be the estimated cost for such "cap?"
   (e) What constitutes payments above the "cap?"

2. Shall the plan be totally self insured?

   (a) What would be the safeguards?
   (b) How would they be determined?
   (c) If fund becomes totally depleted, who is responsible for remaining payments during the period?
   (d) What would the guarantee to employees be?

3. How may plan be changed?

   (a) By legislature.
   (b) By collective bargaining.
   (c) Some other way.

COST

1. Administrative.

   (a) What functions shall be handled in house?

      1. Determination of eligibility.
      2. Premium collection.
      3. Claim processing.
      4. Claim payment.
      5. Relevant statistics.
      6. Determination in advance of total costs.

         (a) Budgets.
         (b) Reports.

   (b) Location of staff and to whom responsible.
   (c) What type of staff is needed?

      1. Full time.
      2. Consultants.

   (d) Should any administrative services be contracted out?

      1. Claim processing.
      2. Claim payments.
      3. Claim reporting.
      4. Actuarial services.
      5. Other.

2. Claim payments.

   (a) What is the present true costs?
   (b) How would they be determined for the future?
   (c) Who would make such determination?
   (d) What discounts, if any, from hospitals, doctors, etc., might the State expect/require?
   (e) What initial returns, if any, may we expect from present carriers?
   (f) What is the lag in actual claim payments?

3. Premium payments.

   (a) How and by whom determined?

      1. In house.
      2. Contracted out.

         (a) Cost to do this.

   (b) For what period will they be guaranteed (if any)?
   (c) How may they be changed?

QUALITY OF SERVICE

1. What is the present quality as to:

   (a) Reporting.
   (b) Payments.
   (c) Consumer information.
   (d) Handling of consumer complaints.
   (e) Present status of service out of state.

2. How may quality of service be improved?

   (a) Outside of collective bargaining.
   (b) With collective bargaining.

3. How may we guarantee that service under any type of self insured plan will be at least equal to that at present time?

FUNDING

1. Is there a need for an advance fund?

   (a) If so, from where shall it come?
   (b) How large should it be in relation to either claim or premium payments?
   (c) How may it be replenished?
   (d) In the event of termination of carrier contracts, what additional payments will they make as to outstanding claims?

2. How will funds be made available for payments?

3. How often will state and employee deductions be made available?

4. Illustrative example (true to life) of exactly what would happen if present plan terminated on July, 1, 1979.

CLAIMS

1. Will claim payments be handled in house or contracted out?

   (a) If contracted out, who will determine eligibility?

2. What type of statistics will be collected?

   (a) To what extent shall we utilize computer?

CHAPTER 8

EXHIBIT B

NOTICE OF PUBLIC HEARING

The Maine Commissioner of Business Regulation gives notice of a public hearing to consider the feasibility and adviseability of the State acting as a self-insurer of all or part of the group health insurance coverage for state employees. The Commissioner of Business Regulation is conducting this inquiry pursuant to direction of Chapter 75 of the Resolves of the 108th Legislature. A feasibility study has been submitted by an independent actuarial firm, at the Commissioner's request. Copies of the feasibility study are available for public review during normal working hours in the following locations: the offices of the Commissioner of Business Regulation and the Commissioner of Finance and Administration, the Maine State Library and the Maine Law and Research Library. The public hearing will be held at 10:00 A.M. on Wednesday, November 29, 1978 in Room 113 of the State Office Building, Augusta, Maine. Any comments on this issue or the feasibility study will be welcome at that time. Individuals who anticipate making comments are requested to notify the Commissioner of Business Regulation prior to the hearing.

This public hearing notice was published in the following newspapers:

Kennebec Journal	- 11/6 and 11/18
Bangor Daily News	- 11/6 and 11/18
Portland Press Herald	- 11/6 and 11/18

EXHIBIT C — DEVELOPMENT OF HEALTH FUND — *BASIC MEDICAL

YEAR ENDING	PREMIUMS	PAID CLAIMS	(1.06)(2)	INTEREST	FUND
1971	2,309,283	2,118,149	2,245,238	1,601	65,646
1972	2,944,919	2,763,809	2,929,638	3,664	84,591
1973	3,371,231	2,958,005	3,135,485	10,123	330,460
1974	3,909,846	3,371,805	3,574,113	24,916	691,109
1975	4,047,550	4,062,608	4,306,364	28,085	460,380
4/30/76	2,252,061	2,295,873	2,433,625	18,480	297,296
4/30/77	5,577,741	5,252,970	5,568,148	15,105	321,994
4/30/78	6,765,686	5,886,652	6,239,851	29,246	877,075
9/30/78	4,132,891	3,172,114	3,362,441	26,298	1,673,823

*BASED ON PREMIUMS AND CLAIMS PAID ON BC/BS PLAN FROM 11/1/70 TO 10/1/78.

ASSUMPTIONS.

PAID CLAIMS FOR 1ST YEAR = 85.6% OF ACTUAL PAID--SEE PAGE 14 REPORT

NEW PLAN STARTING 11/1/70

COST OF HANDLING 6% OF PAID CLAIMS

INTEREST @ 5%/ YEAR ALLOWED ON FUND AT BEGINNING OF YEAR PLUS 1/2 INCREASE OR MINUS 1/2 DECREASE FOR YEAR OF DIFFERENCE BETWEEN PREMIUMS AND 106% OF PAID CLAIMS

EXHIBIT C — DEVELOPMENT OF HEALTH FUND — *MAJOR MEDICAL

YEAR ENDING	PREMIUMS	PAID CLAIMS	(1.06)(2)	INTEREST	FUND
10/30/71	229,043	74,226	78,680	3,759	154,122
1972	288,108	198,936	210,872	9,637	240,995
1973	308,239	260,789	276,436	12,845	285,643
1974	421,445	290,828	308,278	17,111	415,921
1975	527,419	379,414	402,179	23,927	565,088
1976	696,225	621,876	659,189	29,180	631,304
1977	824,255	801,511	849,602	30,931	636,888
thru 9/30/78	1,088,331	735,337	779,457	36,269	982,031

ASSUMPTIONS

NEW CASE 11/1/70 - RUNOUTS OF OLD CASE JUST EQUALS RESERVE END OF YEAR 10/30/70 = 55,674

INTEREST @ 5%/YR ALLOWED ON FUND AT BEGINNING OF YEAR PLUS 1/2 INCREASE OR MINUS 1/2 DECREASE FOR YEAR OF DIFFERENCES BETWEEN PREMIUMS AND 106% OF PAID CLAIMS.

TOTAL COST OF PROGRAM IS 6% OF PAID CLAIMS PER YR.

FOR 1978 YEAR ASSUME 11 MONTHS PREMIUMS, CLAIMS AND INTEREST FOR SAME PERIOD.

CHAPTER 8

EXHIBIT D

BLUE CROSS/BLUE SHIELD STATEMENT AT PUBLIC HEARING

COMMENTS BY THE COMMISSIONER OF BUSINESS REGULATION,

ALFRED W. PERKINS

We appreciate the opportunity of making a few brief comments regarding this feasibility study. The decision regarding the future direction of the financing arrangements under which State employees will be provided health care benefits is, obviously, an important one to the State of Maine and its employees. As the current carrier for basic health benefits, it goes without saying that Blue Cross and Blue Shield of Maine also has more than a passing interest in the outcome of this study process.

The report itself is impressive in terms of its thoroughness and professionalism. Based upon certain assumptions, it concludes that it would be advantageous to the State to change to a self-insurance arrangement. While we do not challenge the objectivity of the report, we do feel there is room for honest difference of opinion as to the validity of these assumptions, based upon historical data. We will review that data herein toward the end of a full discussion of all factors involved in this critical decision. I would hasten to add that, regardless of the outcome of these deliberations, we feel that Blue Cross and Blue Shield of Maine can continue to provide valuable service to the State and its employees at a competitive cost, either as an underwriter or as an administrative agent.

From our perspective, the nuts and bolts of the report are contained on Pages 24 through 30. The various tables on these pages attempt to demonstrate the effects of transferring risk from the insurance carrier to the employer. In making a decision regarding the future advantages of an insured vs. self-insured program, a basic critical question which has to be answered is: "Will the total cost of claims be more or less than the amount anticipated by the carrier in establishing rates?" If the claims are less than anticipated, the carrier will generate a surplus and it would have been less expensive for an employer to be self-insured. If the claims are higher than expected, the carrier will incur a loss and the employer has saved money by being insured.

COMMENT. On a continuing basis any loss by a carrier including Blue Cross/Blue Shield will be made up in the succeeding year. If this were not true, carriers would eventually become financially bankrupt and at the very least be discriminationary between accounts.

The narrative on the bottom of Page 24 indicates that it was advantageous for the State to be insured during the three-year period ending April, 1978 due to losses incurred by the carriers in the first year of that period. Page 28 shows a projected comparison for the three-year period ending June, 1980, and the narrative on the bottom of Page 30 concludes that it would be advantageous for the State to be self-insured in the future. The projected savings are "under the assumption that an insurance carrier would not underprice an insured plan sufficiently to provide the State a windfall in excess of three percent of claims." Another way of stating this assumption is to conclude that claims will cooperate by occurring in the volume predicted--and reasonably on schedule, in accordance with the projections made by the carrier in setting rates.

COMMENT. Losses are not the only thing to be considered in determining whether self-insurance is more advantageous than insured plans. Interest on funds not spent and the administrative cost of handling are also important.

A review of the claims experience of the State Group under Blue Cross and Blue Shield since 1966 (the year in which the Medicare program began) indicates that incurred claims have exceeded expectations in eight of the twelve contract years in that period. In fact, in seven of those years claims expense alone exceeded premium, let alone administrative expenses. During this period, the State has saved a total of $1,352,109 by being insured as opposed to being self-insured for basic health care benefits.

COMMENT. Figures used in this report are not shown on a cash flow basis; i.e., what was actually paid out by Blue Cross/Blue Shield? Also this report does not assume the start of a self-insurance plan on October 31, 1966 as total claims are shown for the policy year ending in 1967 not just new claims for that year which would be somewhat less. Blue Cross/Blue Shield would be responsible for the payment of all outstanding claims on October 31, 1966 at no cost to the State. While Exhibit C only goes back to October 31, 1970, I feel certain that the approach used therein is sound and it shows, on a cash flow basis, that a rather sizable fund ($1,673,823) would have been accumulated from the basic coverage alone.

I can assure you that Blue Cross and Blue Shield of Maine did not intentionally "underprice" its product during this period of time. Having personally conducted the renewals since 1971, I am sure there are those who felt we were overpricing. However, the historical data

indicates our projections frequently turned out to be quite conservative. Our objective in approaching each renewal has been to achieve a "break even" result in the upcoming contract year. We have used the same merit rating formula applicable to all groups with five hundred or more employees, and this formula contains no factors to recover losses from prior years.

COMMENT. The formula referred to above would certainly take into consideration prior losses as it is based on the past two years' experience. Thus, a loss position in any year is automatically considered in the year following.

Regardless of the foregoing, the key to this decision will be what is expected to happen in the future rather than what has happened in the past. The past is, however, useful in developing assumptions about the future. As we have previously mentioned, we respect the quality of the study that has been completed. Nevertheless, we do feel that to the extent that the conclusions and recommendations are based upon assumptions about the future, different interpretations can be made.

We cannot guarantee that the State will continue to benefit financially from being insured. The objective of our rating formula will continue to be a "break even" one. The historical data does suggest, however, that the risk of claims exceeding expectations is not remote. We concede that the data presented so far indicates that, under certain circumstances, self-insurance could be advantageous to the State. However, in our view, the historical data by no means supports the recommendation contained in the report that the State

pursue self-insurance to the exclusion of other competing alternatives. That just is too big a leap in logic for us to grasp.

COMMENT. I again refer to Exhibit C which would seem to contradict the above paragraph.

Pages 19 through 23 of the report do a good job of reviewing the pros and cons of self-insurance. Careful consideration should be given to the fact that the current arrangement with Blue Cross and Blue Shield of Maine:

1. Provides the predictability of a premium rate which can be budgeted for with reasonable assurance of what costs will be during the contract year.
2. Allows some cash flow advantages through flexible administration of the contractual grace period.
3. Protects the State from cost overruns if claims exceed expectations.
4. Assures the State that windfalls cannot accrue to Blue Cross and Blue Shield of Maine inasmuch as any surpluses are ultimately returned to the State in the form of rate credits through the rate stabilization reserve.

There is one disadvantage of a self-insurance program not mentioned in the report. An employer would almost have to commit himself to such a program forever. If an employer finds a fully self-insured or ASO arrangement to be unsatisfactory and desires to return to a full-service traditional program the employer would then be forced to: (1) Pay premiums to the carrier; and (2) At the same time, continue to pay the lag of incurred claims under the self-insured program which had inception prior to the beginning of the new insured plan.

This resultant double payment system could be expected to last several months at least and put a tremendous drain on available funds.

COMMENT. The proposed legislation would provide that the Health Fund would be allowed to build up to at least the amounts necessary to pay outstanding claims and the administrative expenses of handling in the event of termination. Thus, if it appeared expeditious to reverse to an insured plan, it could be done without penalty.

Finally, there is one aspect of this decision with which the legislature must ultimately deal. Blue Cross and Blue Shield of Maine offers coverage and, in fact, aggressively solicits membership from all segments of the Maine population regardless of age or health status (86,000 of our members are over 65 and enrolled in our Companion Plan program--an additional 76,000 are covered by non-group programs). The percentage of the rates charged to these people which is attributable to administrative expense is but a fraction of what is included in rates for coverage available from other sources. To support this claim, we will cite figures contained in the 1978 Argus Health Chart, a publication of the National Underwriter Company. The operating results contained in this report show that the 260 companies writing health insurance in Maine had operating expense to written premium ratios of 13.70% for group business and 42.98% for non-group business, for a total of 19.48% combined. This same report shows an all lines operating expense of 6.18% for Blue Cross and Blue Shield of Maine.

Our ability to provide coverage for these "high risk" people at the lowest possible rates depends to a certain degree upon our maintaining a large "pool" of subscribers over which to spread risk and administrative expenses. If a significant number of large

employee groups opt out of this "pool," our ability in this area will be weakened. The State of Maine, above all employers, should give thought to this consideration. We are not implying that the State, or its employees, should subsidize any other segment of the population, and we think sufficient safeguards are contained in our rating formulas to preclude this. We are suggesting, however, that all segments of the Maine population can benefit from a strong "pool" of resources for protection from health care costs, and concerted rather than fragmented administrative and cost containment activities. Any commercial company can decide not to underwrite any further coverage in Maine. Our business on the other hand is doing business only in Maine.

COMMENT. I fail to buy this argument unless it can be shown that the State employees plan is presently subsidizing Blue Cross/Blue Shield. I imagine that this same argument could be used as a method to prevent competition such as for Medicare Part A now handled by Maine Blue Cross/Blue Shield.

Again, we appreciate the opportunity of expressing our views on this feasibility study. We think the discussion of these issues is healthy and we hope will contribute to a better understanding of a very complex subject. Regardless of the outcome of these deliberations, we at Blue Cross and Blue Shield of Maine are anxious to play a productive role in service to the State of Maine and its employees.