NAMES OF SPEAKERS

HEARINGS, 10 DECEMBER 1968

SUBJECT: PROPOSED CHAPTER 57, MAINE INSURANCE CODE

(HOSPITAL AND MEDICAL SERVICE CORPORATIONS)

Chairman Kenneth P. MacLeod

Vice-Chairman Douglas F. Thornsjo

Roger F. Woodman, member of the Commission

John J. Connor, Jr., member of the Commission

Robert Williams, General Counsel for the Commission

Mr. John Mitchell, Counsel for Associated Hospital Service of Maine

Mr. David Whorf, representing Maine Association of Life Underwriters

Mr. Richard Nellson, Executive Director, Associated Hospital Service of Maine

Mr. Paul Webb, retired, (from) Associated Hospital Service of Maine

Mr. Robert R. Roberts, Union Mutual Life Insurance Company

Mr. Fred Schreiber, Asst Vice President, Life Insurance Association of America

Drafted from tape, 10 December 68

MITCHELL: My name is John Mitchell, representing the Associated Hospital Service of Maine, I believe the only corporation at least presently in existence that would fall within the provisions of this Chapter. I had prepared certain suggested changes in this section, and with your permission, I will pass out copies of this to the Commission so that you can follow my various suggestions as we go through...

The first point that I would like to make which will be under line 5 of the Code as presently written is to raise a question as to the reference to Chapter 91, of Title 13. This Chapter refers to Tenants and Common of Lands and Whorfs, and I frankly can't find any reason why it should be under the Insurance Code. It did occur to me that possibly it was intended to make reference to Chapter 89 of Title 13, which is the Fraternal Benefits Societies, which you have, in fact, already pulled over and made a separate chapter here. And if that was the purpose, then you may be getting into inconsistencies between the type of contracts authorized under Chapter 57 and those which are already provided for as Health Insurance Certificates under Fraternal Benefits Societies, and I'd like some clarification on that if I could have it.

WILLIAMS: This is the present law; that's the way it reads. Refers to Title 13, Chapters 81 and 91.

MITCHELL: I'm sorry, you must have looked at a different section of the statute than I did, I only saw the reference to Title 13, I have not seen the Chapter 81 and 91; but in any event, if it is in the present law, I still suggest that it may be a mistake. I don't see what the incorporation of Tenants and Commons of

MITCHELL, CONTINUING:

Wildlands and Whorfs has to do with the Insurance Code. In any event, I raise it for the Commission's consideration.

The next point that I would like to make, is to request the addition of some language at the end of line 7 of Section 4251. Where there is now a colon, we would request that there be a semi-colon, and this additional language "except that where such corporation was heretofore organized by special act of the legislature, this chapter shall not apply where inconsistent with such act as heretofore amended, colon." Now the reason we've asked for that was that I was interested to find in Section 3301 on, I believe, page 375 of the present draft, similar language with respect to insurance companies which have been previously organized under private laws. I anticipate that what this really means is an effort to avoid the impact of the case of AHS versus Mahoney which said that "where a special act of incorporation is inconsistent with the general law, the general law will apply." Therefore, at least with respect to insurance companies previously organized in this State, this potential conflict has been eliminated by saying that if they are inconsistent, the general law doesn't apply at all; therefore, the special act of incorporation shall remain paramount. We would suggest the same treatment for Associated Hospital Service of Maine, to whatever extent it may benefit us. I'm not sure that it will benefit us at all, I'm not sure that it's necessarily any benefit to the private insurance companies or the domestic insurance companies of the State of Maine. We do ask equal treatment in this respect.

The next point which I would like to make, and, Mr. Chairman, if you prefer,

MITCHELL, CONTINUING:

I'll wait for other comments on each one of these points as I go through, or make my entire presentation with respect to 4251, if you prefer.

MAC LEOD: I think it would be easier if you went right through, John.

MITCHELL: Thank you. The next point is a more major point. The rest of this section is basically a recodification of the existing law. As we visualize one of the purposes of a revision of the insurance laws, it is to make the laws more nearly conform to the facts of present-day life. The entire area of health care has been an almost explosive field in the last 20 years. Not only in the financial sense, but also in the sense of the comprehensiveness of the care which is now being provided to the American public. I think this was very drastically and dramatically pointed out when the Congress of the United States passed Medicare and Medicaid. One of the most important provisions for changes in this area has been with the crush of the population in the hospitals, there has arisen the well-recognized necessity on the part of health care people that some incentive must be provided to patients who are beyond the acute care stage to be moved out of the acute care hospital and into the so-called "extended care facilities." One of the problems was that both AHS and the commercial insurance companies for years provided no benefits to the person who moved out of the hospital and into the nursing home; therefore, we found a reluctance for the people to leave the acute care hospital. Now, Gentlemen, as this statute points out, the Board of Directors of Associated Hospital Service of Maine is dominated and controlled by the basic purveyors of health care in the State of Maine, that is, the hospitals and the doctors. For years, the hospitals have recognized the need for some form of coverage to induce people to leave the hospital, the acute care hospital room, that cost

MITCHELL, CONTINUING:

$50,000. to build, and costs maybe $50. per day to occupy, and to move these people for whom it is not medically necessary, into the extended care facilities where a room costs $10,000. to build and perhaps $12. or $15. a day to occupy.

There have been other changes in the health care area, in terms of drug programs, dental programs, prosthetic appliances, and for years AHS has been prevented by the narrowness of its charter and the general law from moving out into a more comprehensive health care area. At the insistence of the hospitals, who, as I say, dominate our Board, back in 1963, we went to the legislature, and the legislature expanded the scope of the power of AHS to, in fact, provide some sort of comprehensive health care to the people of Maine. And, in passing, I'd like to point out that this corporation covers approximately 1/3 of the population of the State of Maine; some 380,000 people are covered under our contracts; a very substantial proportion here. The law court in Maine said that the route that we requested in 1963 was improper because the route which we requested at that time was an amendment in our special act of incorporation, and called for expense indemnity contracts, essentially insurance contracts. They said we can't do that and remain the unique creature which we, in fact, are, because to do so would constitute unequal protection of the laws with the insurance companies.

We are now asking this Commission to consider, however, the need for this 1/3 of the population of Maine, to have offered to them more comprehensive contracts for health care which will be restrained to the traditional role of Associated Hospital Service which is essentially a three-party contract. The Corporation contracts with the hospital, whereby the hospital agrees to give certain services to our subscribers in returnfor a formula reimbursement from AHS

MITCHELL, CONTINUING:

whereby the hospital keeps the basic underwriting risk of the contracts we write. If our underwriting is wrong, it is the hospitals that lose, not AHS. We have no underwriting capacity as such.

We are now asking, and there have been various provisions made in here, but if I can direct your attention essentially to new subsection 3; what we are asking for is the ability to write health care plans, whereby again we will have contracted with the purveyors or the providers of the health care, so that we ask the opportunity to expand our coverage within the traditional scope of the Associated Hospital Service or traditional Blue Cross/Blue Shield plans in the country. The only other change we have made with respect to 4251, is in order to avoid redundancies, we have taken the language with respect to the ability of the corporation to act as principal or agent for insurance companies, and moved it into a separate section, or subsection under this section, and the right to contract with municipalities, state,county, governmental units, put that under a separate subsection. Now, in addition, there is one more thing we have asked for, which will be under new subsection 6, which would have been old subsection 4. This is the provision in our charter, which authorizes us on a non-profit basis to utilize our services for the United States or the State of Maine governments or the units or agencies of either. This is the basic corporate authority which we had to administer Medicare, Medicaid, federal programs such as Champas, aid to military dependents, etcetera. We have asked for an expansion of our ability to render service in this area, to include charitable or non-profit organizations involved in health care, and basically, the reason for that is that we have invested in some fairly extensive electronic data processing machinery. Due to the fact that we have participating hospital contracts with every acute-care general hospital in the State of Maine,

MITCHELL, CONTINUING:

and because at least 1/3 of the population of the State of Maine, their medical histories in one form or another flow through our data processing. We are continually being asked by regional health planning groups to run off data studies to aid them in this regional health planning concept, which is a rapidly-expanding concept. The old days of a hospital for a single town is rapidly disappearing, and everything is being done on a regional or state-wide basis, and because we have the data already locked into our IBM machines, so to speak, they come to us and ask us to run these surveys to aid them in their area-wide planning. We obviously cannot do it for nothing. We have to pay our employees. We request simply that this Commission recognize that this is one additional area where Associated Hospital Service can aid in health planning, and while it had been my opinion in the past that to do so was an incidental purpose, and therefore perfectly proper, we thought we'd better have it clarified since we are, in fact, revising this section of the statute.

Are there any questions from the Commission?

THORNSJO: Do you have additional comments with respect to other sections? In other words, is this hammed up only for 4251?

MITCHELL: Only for 4251; the same changes with respect to the ability to write health care plans, we have noted throughout with the various sections, and I'll pass them out to you at this time if you wish.

THORNSJO: Well, I think I'm curious, Mr. Chairman, on how all these changes fit together. I find it hard to ask questions if I ... well to be quite specific, the concept of expanding the powers strikes me essentially as being reasonable; but if the

THORNSJO, CONTINUING:

concept of expanding the powers is to be inserted, then I'm curious as to how you've reacted to the provision relative to taxation, are you suggesting that you be taxed, then, in the same way that insurance companies are taxed?

MITCHELL: No sir, we do not. For the very reason that we are not asking for the ability to write what is essentially an insurance contract. The law court of Maine said if we go out and write the expense-indemnity type of contract, then we should be taxed like an insurance company. The extension of powers, and I agree with you, Mr. Thornsjo, if you look at my amendments to the other sections, you will see that we have kept the traditional method of operation which has by and large kept Blue Cross/Blue Shield a tax-exempt organization because of the three-party contract system rather than the two-party between the insurer and the insured. And, if you prefer, Mr. Chairman, I'll hand out those other sections now.

MAC LEOD: You have something to hand out that amends some other sections?

MITCHELL: Of this Chapter, yes sir.

MAC LEOD: I think it would be very appropriate.

WOODMAN: I have a question on this section.

MAC LEOD: Go ahead, Roger.

WOODMAN: In this extension of service, in contracting with institutions, would these contracts be with charitable institutions, such as the present hospital arrangement, or with 'for profit' institutions?

MITCHELL: Some of them would necessarily be with profit institutions and some would not, just as at the present time we write contracts with doctors who guarantee medical services, and they are not charitable; and we write contracts with hospitals

MITCHELL, CONTINUING:

which by and large are charitable institutions for the hospital service guarantee. Now, if we extend out and say we start writing a drug program, I'm not aware of any charitable drug stores in the State of Maine; there may, in fact, be, but I would presume that by and large that they would not be. On the other hand, one of our primary urgencies here is to handle something on an extended-care facility basis, and talking off the top of my head, I would venture to say that probably close to 50% of the newly qualified extended care facilities will, in fact, be charitable, non-profit corporations. The older nursing homes which may be qualifying by and large are proprietory. So that might be a 50/50 split, and that may change as time goes on, I don't know.

MAC LEOD: Why don't you pass those out, John, please.

WILLIAMS: Anything further on section 4251?

MAC LEOD: Elimination of the last half of subsection 1 in 4251, you're taking care of under new subsection 7?

WILLIAMS: This appears to be just a reorganization of material.

MITCHELL: It is a reorganization, because now you see, we have one subsection for hospital services, one for medical service, and one for health care, and rather than repeat the same language three times, we made it a separate section.

WILLIAMS: Are we ready for section 4252?

WHORF: Needless to say, those of us sitting "below the salt" are at somewhat of a disadvantage because we have no idea of what the cross references, and so forth, are, and we are in no position to debate any of the merits, if they are, indeed, merits, of what's been suggested, so may I request a deviation from normal procedure, perhaps at this point, so that if it suits Mr. Mitchell's purposes,

WHORF, CONTINUING:

and obviously those of the Commission, to go through this material, section by section, we'll just sit back and be quiet, but we'd like to have an opportunity to perhaps give a few constructive thoughts in retrospect after he's completed his going through of the various sections.

MAC LEOD: Some of us sitting above the salt are not quite sure of the implications of these.....

MITCHELL: I have prepared, I believe, 15 copies of these, it's possible there may be enough around so that those of both sides of the salt can at least get a look at one copy.

general conversation by members of Commission relating to number of copies available, suggesting extras be passed on to Mr. Whorf. Tape turned off while copies are distributed.

MAC LEOD: The suggestion has been made that since a lot of this is quite new material, is new material, and there are some people interested in looking at it, if there is no objection, would it be all right if we went on with Chapter 63 to give these people who have just seen this for the first time a chance to prepare some comments?

MITCHELL: If I could spend about five minutes more just going through to outline generally the thread of my thoughts in making these revisions, it might make it a lot more understandable for people who look for possible hidden meanings that are not intended. Accepting for the moment that basically what we are asking for is the ability to expand into legitimate health care field contracts, the next section which we attempted to change is 5254. And all we had done in that is to re-write it by substituting as you will see, where we have referred to

MITCHELL, CONTINUING:

either hospitals or physicians we have used the more encompassing phrase of "providers of health care", and simply put in there the limitation as to who was a proper provider of health care: those who were licensed by the appropriate department or board of the State, and that's the only essential change that has been made in 5254, (Excuse me, 4254). (In) 4256, the only changes that have been made there, again, are to change the language so as to comprehend providers of health care rather than individually naming either hospitals or physicians. The same thing is true under 4260, having to do with disputes. I will address myself to the question 4262 at a later time, the matter of taxation, and the final change we've made of 4263 again serves simply the same purpose of expanding from hospital and medical service to actual health care. At this time I'll retire and give people a chance to study it.

...Chapter 63 taken up...
... Mr. Williams reads the new provisions suggested by Mr. Mitchell

MAC LEOD: I have a question, Mr. Mitchell. Eliminating Section 3 of 4254, John, and the substitution of this so-called "provider of health care" where we used to have physician in the current law, does this do anything to the personal liability in relationship to the liability of the doctor that used to exist between the patient and the doctor?

MITCHELL: We feel that it does not, Mr. Chairman, for the reason that we have included that under paragraph 2, where we call for the private (what was formerly the private)physician/patient relationship, now becomes the private provider/ patient relationship. So that we do not feel that we have infringed in any way upon the traditional role between the physician and the patient.

MAC LEOD: Do you have a definition of "provider"?

MITCHELL: Yes, the definition of "provider" will be "providers of health care who have been licensed under the appropriate department or board." Now, institutional providers are licensed under the Department of Health and Welfare in the State of Maine, but when you get into the professional providers such as dentists, doctors, MD's, osteopaths, etc, these each come under separate boards. For that reason we have had to make the change providers licensed under the appropriate department or board. And that, I believe...

MAC LEOD: That's in 1.

MITCHELL: Is in 1, right. And by handling it under 1, it was not necessary to repeat it again. For instance, in the second sentence of sub 1, where we provide that all contracts shall constitute direct obligations, formerly just of hospitals. And that was what was repeated under 3 with respect to physicians. By just talking about health care, you see, we've covered it all under 1, and that's why we felt we could eliminate the first sentence of subsection 3, because it has now been covered under section 1. The remaining sentence under section 3 has been moved up into section 2; namely, any such physician or optometrist shall be free to refuse service for appropriate professional reasons, we now give the same power to any provider. Because, once again, we do not want to interfere with the historical or traditional relationship between the provider and the private patient.

MAC LEOD: Well, why do you eliminate the first part of 3?

MITCHELL: Because it is now covered under the second sentence of section 1, whereas formerly, that second sentence simply provided all contracts for hospital service shall constitute direct obligations, we've now covered the entire health/field care by saying all contracts, instead of for hospital service, for the

MITCHELL, CONTINUING:

provision of health care shall constitute direct obligations between the provider and the subscriber.

CONNOR: What's your purpose in making it a direct obligation between the provider and the insurer, corporation, or what word you want to use? (this question not completely clear from tape, spoken very low.)

MITCHELL: Because this has been the traditional role of Blue Cross plans and Blue Shield plans since they were first organized some 30 years ago. This is the way in which we say we differ from the normal commercial insurance company which agrees to pay, in effect, a cash indemnity directly to the subscriber upon their sustaining a loss. Our traditional role has been to go to the hospital and get the hospital to agree to provide service to our subscribers, and we then enter into a contract with the subscriber saying "these hospitals will render this service to you for the payment of a certain price." This casts the underwriting risk upon the providers of hospital service rather than upon the corporation Associated Hospital Service itself. We have no underwriting capacity, in effect. That is the reason why we have tried to keep the three-party contract system which has been traditional.

CONNOR: That contract is at a reduced rate, is that right? Between the hospital and the insurer?

MITCHELL: Not necessarily. When you say between the hospital and the insurer, I assume you're talking about the participating hospital agreement which we now have with our hospitals, and which we would contemplate having with our other providers of health care. This operates on an initial payment which is at a reduced rate, with then supplemental payments of any moneys we have left over going to the hospitals. Now this results under our formula basis of some hospitals getting

MITCHELL, CONTINUING:

more than they normally would bill to the patient, some getting less, because with the varying hospitals in the State of Maine, to take a typical example of Bar Harbor, where that hospital has large amounts of endowment funds, they actually bill their patients something on the order of $5. or $6. a day less than the actual cost of running that hospital. On the other hand, your larger medical centers, such as Maine Medical Center, and I think Roger can bear me out on this, their cost is actually a little bit less than what they bill to the private patient, because they're having to make up for the charitable patient and the no-pay patient. Our reimbursement formula which is provided in our agreement with the hospitals provides in effect an evening out between these hospitals so as I say, some end up with more than they would bill to the patients, some end up with simply more than their cost but less than their bill, and it varies from hospital to hospital. But the ultimate risk of whether or not they are going to be paid is upon the hospitals not upon us. This is the way we react to the health care demands imposed upon us by the hospitals that dominate our board.

CONNOR: Let's assume for the moment that your contract to the hospital is for an amount, a percentage of the average .....

MITCHELL: Billing charge?

CONNOR: Going rate.....yes. Say it's 80% of $45 or whatever.

MITCHELL: 80% of the normal bill charge.....

CONNOR: I don't know whether that is your contract or not, I'm just using this. All right, now, what happens to the other 20% of that money?

MITCHELL: That...after the payment of administrative expenses, which approximate 5% in the case of Associated Hospital Service of total premiums or subscription charges.

MITCHELL, CONTINUING:

The balance goes back to the hospital in the form of the supplemental payments. In other words, we don't make a profit, if we have what otherwise might be called an underwriting profit, it goes back to the people who take the ultimate risk who are the providers. By virtue of this supplemental payment, excuse me just a moment ... (speaking to someone sitting in the back of the room) ... Dick, what's that run to $5 or $6 million a year we ..... (somewhat garbled here, speaking off mike) As I say, these supplemental payments, whatever is left over under the contractural payments, more than is necessary to operate this corporation goes back and I was wrong, its $1,600,000 was returned to the hospitals. In other words, they get the underwriting profits under our operation.

CONNOR: There still could be a deficit, right?

MITCHELL: Yes, sir, and in that case we don't make supplemental payments to the hospitals because we don't have the cash to give it back.

CONNOR: I mean, there still could be a deficit to the hospital between what their bill was and what they finally obtained from you.

MITCHELL: Very possibly, but then you have to be very careful....

CONNOR: My question was, what happens to that deficit? Does it revert to the non-subscriber? In the rate that's figured in here? An individual goes into the hospital, he's not a member of the Blue Cross, he has hospitalization with some other company. His company, nor he, doesn't get the advantage of this discount that you get?

MITCHELL: To the extent that there is a discount, but then we must determine whether or not you are talking about a discount from the cost of operating the hospital or the billing out charge of the hospital.

CONNOR: We're talking about the cost to the patient.

MITCHELL: The cost to the patient under billing charges, that is correct, that to the extent that a hospital gets only 90% of its bill charges back with respect to Blue Cross patients, they have nevertheless billed out to other patients 100% of cost. Some people are in a position, and in fact, pay 100% of billing. Some people are not in a condition to pay, and they pay 50%, 10%, or in some cases, nothing. They still get the same service from the hospital, Mr. Connor.

CONNOR: Yes, I understand that.

MAC LEOD: And the deficit, isn't the deficit really made up by the other patients who pay the full board and room costs and who may have an insurance plan with a commercial company?

MITCHELL: I'm afraid that's not capable of such easy generalization, these deficits may be made up from many sources, from the hospital endowment funds, from public funds, through welfare payments, through those people whether they have commercial insurance or not who pay 100% of their charges. It comes from many different sources, I don't think you can pin it down to any one source.

MAC LEOD: Okay, the 50 dollars a day, 52 dollars a day that the regular patient that has no plan at all goes into the Eastern Maine General and pays for his board and room care; he's paying maybe ten dollars a day because of these various deficits coming out of many sources, one of which may be Blue Cross/Blue Shield discounts offered to the subscribers, offered to the hospital for accepting their subscribers. That's one source of the ten bucks extra a day he's paying, isn't this possible?

MITCHELL: One possible source, yes sir. To the extent that particular hospital is getting less than 100% back on its billing. Many hospitals, of course, get in excess of 100% back, in which case we're giving money back to the other patients.

MAC LEOD: Again, why did you leave out any mention of the subscriber in your changing or omitting this 3 and bringing it up into 1, about the contracts for the provision of health care issued by such a corporation shall constitute direct obligation, and so forth. Why did you leave out any mention of the subscriber?

MITCHELL: I'm sorry, in section 1 of 5242, the subscriber is in the second line, so I'm not sure that I understand your question. The rendering of health care to the subscribers only with institutions licensed. Am I addressing myself to your question?

MAC LEOD: Yes, they mention it up there, but does that take care of the second sentence where you say all contracts for the provision of health care issued by such a corporation shall constitute direct obligation of the provider of health care and so forth; down in 3, which you eliminated, that section had, to the subscriber accepted for service, you have this direct obligation.

MITCHELL: We believe it does, for the reason that the prior subsection 3, was, in effect, a parallel language of subsection 1 with reference to medical service, whereas old subsection 1 had reference to hospitals. We have attempted to combine the two and just talk about health care.

THORNSJO: Following the line of questioning that Mr. Connors has opened, do I understand you to say that any excess that you have over and above claims and expenses, is always returned to your participating hospitals.

MITCHELL: If you and I understand the words claims and expenses in the same sense, I would say, yes. Included within expenses, however, are certain amounts retained for reserves, which are on the basis of a national standard set by the National Blue Cross Association, which I believe the national standard calls for three months.

THORNSJO: So that you are never, then, in the posture where you're servicing a group of employers, for example, and that some portion of the excess over reserves, expenses, and claims, is returned to the employers.

MITCHELL: I'll ask permission to turn to my principals, I'm not aware of any such thing. No, that would never happen. Any profits, so to speak, are returned to the underwriting capacity, which is the hospitals or the physicians, or in the case now, any of the providers of health care.

THORNSJO: Do the "Blues" in the State of Maine handle the Bankers Association at all? Sir? A Blue Cross/Blue Shield plan for the Bankers?

MITCHELL: Excuse me, this is Mr. Nellson, Executive Director of Associated Hospital Service.

NELLSON: Yes, we had a group, and as far as I know, unless something has changed in the last week or two, we still have a banker group.

THORNSJO: I seem to have a vague recollection that the bankers informed me that they received some kind of a dividend from their plan with the "Blues".

NELLSON: If they received a dividend, it wouldn't be from Associated Hospital Service, it would be from maybe somebody that was insuring with them, giving them additional coverage that we were not able to give them. This happens in many instances, it happens with the State group where we insure with Union Mutual, they have the Major Medical, we have the base plan. On three different occasions that I know of, I think I'm right and Bob can correct me if I'm wrong, they have been able to issue a dividend back on the Major Medical because the base plan has been comprehensive enough so that they haven't had to get into that; but we have not issued any kick-backs or any dividends because if we have turned it back in either in benefits or lowering of rates.

THORNSJO: The lowering of rates; is this a prospective? In other words, if you've got

THORNSJO, CONTINUING:

something excess... I'm trying to get back to this question of all the moneys that are in excess of expenses, reserves, and claims ... we've been told that it always goes back to the hospitals, but now you apparently indicate that there are instances in which you reduce rates, do you do this in the way of having established some kind of excess and instead of giving it back to the hospital, you say to the Association or whoever it might be, "next year you don't have to pay us as much money"?

NELLSON: I'll give you an example, after the advent of Medicare, as most insurance companies, we found ourselves in very good financial condition (position). As a result of that, we took the money that had been charged to premiums, we took it and advanced the coverage under our companion plan, we cut the rate back from $4.50 per individual to $4.00. Yet we still had enough money to pay the level that we normally pay with basic payments and with supplemental payments to the hospital.

THORNSJO: I think my confusion, sir, is that I find it difficult to distinguish between a dividend and a rate reduction; and I find it difficult therefore, to square with the statement that whenever there's any excess it goes back to the hospitals to help reduce their costs. Do you see my problem?

NELLSON: I think I see your problem, yes.

MITCHELL: If I may address myself to that, I think that the difference is between giving a rate reduction to a particular group based upon a basic underwriting study, or experience rating basis, which AHS traditionally does not do, it operates on a uniform community-wide rating basis. If we find that we have more than enough money to pay the hospitals 100 cents on the dollar to cover all their billing, then we will adjust the contract which we have out to expand benefits or reduce future rates to an entire group of people such as the State of Maine, or those

MITCHELL, CONTINUING:

people who hold a Blue Cross "B" or Blue Cross "C" contract, as opposed to giving a rate reduction to a particular group such as the Bankers or the Maine State Employees, this practice we do not do.

THORNSJO: So, then, you aren't distinguishing between dividends and rate reductions, you're saying that your rate reduction is applied on a wider basis than that which would be used by a commercial company.

MITCHELL: I believe that would be a correct statement. Since we do not operate on an experience-rating basis, but rather on a uniform community-wide rating basis.

THORNSJO: Then I want to get this straight. There are instances, then, where not all moneys go back to the hospitals because they, in a sense, then would be making some kind of a profit or something, and instead, you give rate reductions, much like a commercial company gives, but you're saying the distinction is that you don't give it to an individual policy holder, you give it to some kind of a community rating basis.

MITCHELL: We give it to all the customers in the community, Mr. Thornsjo.

THORNSJO: All right, now, are there no instances in which this rate reduction has been given to an individual association, or an individual policy holder such as a trust.

MITCHELL: I will say, not to my knowledge. It is conceivable, but it certainly would be not our normal practice. I am not aware of any such. To my knowledge, when on your reference to the bankers group or to the State of Maine group, that dividend comes I think, from the overriding Major Medical plan which is written by the commercial insurance company which we don't get into.

Remarks off mike, unidentified speaker.

THORNSJO: Well, I assume that anybody, Mr. Chairman, anybody can make comments when they think they have something to contribute ... apparently Mr. Connors has got one.

CONNOR: Mr. Mitchell, I would like, if possible, a definition of these two words: "health care", would you give me an all-encompassing definition of those words? Frankly, they confuse me.

MITCHELL: I can try, sir; it's rather difficult, but health care as has been, I understand, defined by the American Hospital Association, American Associated Hospital Service, "health care, as used herein, means care of or attention to a patient for the purpose of maintaining or restoring to normal activity, any and all functions of body and mind, limited however to such care when rendered by one licensed to give such care or attention in accordance with the laws of the jurisdiction where the care is rendered and acting within the scope of said license." This is apparently as short as it could be boiled down. If you feel that such a definition is necessary within the scope of the statute, I'll be happy to submit this to the commission.

CONNOR: I was interested in it for my own enlightenment. And, also, "provider" of health care.

MITCHELL: I believe that "provider" would be covered within Section 4254, Sub 1, where we refer to institutions or persons licensed by the appropriate departments or boards to provide health care.

CONNOR: Well, under this, provider of health care, this could include a cobbler shop that provided orthopedic shoes, is that right?

MITCHELL: I am not frankly familiar whether or not a cobbler shop making orthopedic shoes would be licensed by the appropriate department or board of the State of Maine, therefore, I cannot answer your question.

CONNOR: It still could be health care.

MITCHELL: It could, in fact, be health care, but I doubt that it would be by a licensed institution.

CONNOR: I wonder if "provider of health care" could that include the State hospitals?

MITCHELL: I would say that it could if the State hospitals saw fit to become participating hospitals with the Associated Hospital Services of Maine. Frankly, I doubt that the circumstances would come to pass that this would be a material point, but it might.

CONNOR: Well, then this would only apply to those health care services who are participating in the Associated Hospital plan.

MITCHELL: Absolutely, sir, because if not, then you see, by contract, we would not have passed the underwriting risk on to the provider.

CONNOR: Thank you very kindly.

MAC LEOD: Mr. Roberts, do you have something you want to say?

ROBERTS: We did not plan any specific comments on this section, but because of the extensive changes, I think it is appropriate that particularly after hearing Mr. Mitchell's discussion of the lack of underwriting capacity in the Blue Cross/Blue Shield and the turning over basically of the excess funds to the providers of services on hospitals, I believe that I am aware of at least one case where in spite of what Dick Nellson commented on the dividend payments coming from the Union Mutual, that a rather sizeable portion of the dividend payment came from Blue Cross. I believe this is what it was called, and this is the bank case, which as I understand is written on an arrangement where the excess of expenses, claims and reserves, is returned directly to the trustees of the Association. There also, is no question that in day-to-day competition

ROBERTS, CONTINUING:

with the Blue Cross, I think this is certainly understandable that the community rating concept in full seems to be shifting to some extent, because those group cases which seem to have a higher risk, they do seem to be paying more premiums than the companies that have the lower risk. This is a competitive observation I would make. But I certainly believe there are some cases in the State, and I'm sure the records are quite clear, where excess funds are returned to the policy holder.

MAC LEOD: Thank you. I guess I have a question again, Mr. Mitchell. Do you, in writing group plans, for large employers, are the rates based on the census that's provided by the employer, do you have a standard rate that applies to all groups of employers, or do you rate each group separately and have different premiums that you charge.

MITCHELL: I think this would depend upon the level of independent items of coverage which have been offered to the group, Mr. Chairman.

MAC LEOD: Let's say the coverages are equal, comparable coverages ... two groups, A and B, both with 500 employees, will the rates always be exactly the same?

MITCHELL: I can't answer that.

NELLSON: (garbled, speaking off mike) We have three different kinds, two basic, two kinds of groups. Standard group. That standard group has standard coverage, the same coverage as our direct enrollees have, that group is to be charged exactly the same all over the state, regardless of the size of the group, or whatever. I won't say size, if it is of a certain size, it can get a size-discount. Now, we also have special groups with special coverage. They have the basic master contract and the group has the opportunity to pick up special endorsements on part of that. Now those groups are rated, but they're rated

NELLSON, CONTINUING:

by area and by industry. This is the large area rating and industry rating. Now, the reason we've had to do that is because, to be perfectly frank, is because our brothers have taken a good deal of the cream, and you can't operate entirely on skim milk. So, in order to be competitive, we have had to do some rating. We, it is not rated by individual groups. It is rated by an area and it is rated by industry within the area. That's one segment, the other segment is the standard group, and the only discount they will get is size discount. The coverage is the same, the cost is just the same unless they reach a certain size.

MAC LEOD: Now, you say there is a third category?

NELLSON: The third category is the direct coverage to the individual.

MAC LEOD: Which is the same, state-wide?

NELLSON: The same, state-wide.

MAC LEOD: For any given plan.

NELLSON: For any same plan, its the same rate all over the state.

MAC LEOD: Thank you

CONNOR: John, does Blue Cross/Blue Shield maintain a surplus fund, as distinguished from reserve?

MITCHELL: I'm sorry, at this time you're getting into the details of internal administration which I'm not that familiar with, I'd like to ask either Mr.Nellson or Mr. Webb to answer that particular question. I'm aware of the reserve fund, that's all. Paul?

WEBB: I'm hesitant to speak for the Association because I've long since retired from

WEBB, CONTINUING:

the administration, but the American Hospital Association has certain standards for approval. They recommend that Plans develop reserves equal to claims and administrative expense for three months. Associated Hospital Service does have reserves aimed at that standard.

CONNOR: Not a surplus?

WEBB: No.

MITCHELL: Is there any fund other than the reserve that you hold back and accumulate?

WEBB: No, there are reserves for unearned premiums for instance which are distinguished from earnings that you've made over and beyond expenses, but there's a limit of how far we can attempt to go on that.

MITCHELL: I believe the correct answer would be that we have the reserves set by the American Hospital Association, and that's all, no surplus as such.

THORNSJO: Mr Mitchell, there are two areas that you might help to clarify my thinking on. One is the concept of non-profit corporation, which is, I think implied throughout this Chapter, and the other is the concept that if we grant for the sake of reasoning that the Blues are non-profit corporations, and hence should be tax exempt, what is the consequence of non-profit tax exempt organizations doing large shares or large parts of the business of insurance in the state vis-a-vis, paying the revenue that the state needs to function, which currently is carried by the commercial companies. Now, let me explore a little bit with you both these points. On the non-profit concept you, if I understand you correctly, have indicated that you maintain your reserves, you pay your expenses, you pay your claims, and then the excess over and above these sums are either returned to the hospitals to help their expenses, or in the alternative used as rate reductions on some kind of a area and industry basis. A mutual

THORNSJO, CONTINUING:

insurance company of the commercial brand, after provision for claims, expenses, and reserves, makes contributions to hospitals of a charitable nature, in theory, and then returns the excess to the providers of the health care, that is, those who pay for the health care in the form of rate reductions. Now, do you understand my problem, on distinguishing between these two types of corporations. Then, before you answer that, let's concede, however, for the sake of reason, that this is a non-profit area, it would appear from what's been said that with the benefit of a lower cost from the hospital, and with the benefit of having to pay no premium tax, that you should, in all good conscience, be able to write all of the health business in the state. Now, I don't know what currently the commercial companies are paying/the way of premium tax, presumeably, that revenue would be lost to the state. Now, there's many theories that are posed to solve this problem. If the churches own all the property in a city, they voluntarily may make payments to the city for the expenses of the city. Do you have any proposal at all that would meet this potential, that I think is a real potential, for what would happen to us if all this business were written by the "Blues" and no premium tax were paid?

MITCHELL: Mr. Thornsjo, if you'll excuse me just a moment, I think your question has several factors and I want to make a note so I'll get them all. First of all, I'll address myself to your problem of the distinction between the two companies; if I understand your basic hypothesis, it is that the mutual company returns the dividend, so to speak,to providers whom you've described as the subscribers or the insureds. In our set-up, the providers are people like the hospitals and the nursing homes who provide the health care to our subscribers. And, I submit, that that is the very essential difference between the two types of companies. We pass dividends, if you will, supplemental

MITCHELL, CONTINUING:

allowances, or whatever nametag you want to hang on it, back to the hospitals and the nursing homes, rather than the providers, as I understood you to say it, being the individual insureds who have paid you the money.

THORNSJO: We have a distinction here in degree, though, John. Because, you're saying you give most of your money to the hospital, and a little bit of it in rate reductions to the industries and areas. I'm saying that the mutual company gives a little of it in the form of contributions to the hospital and most of it to the people who are paying the cost in the form of rate reductions. Now, is this a sufficient distinction? A difference of degree, purely, is this a sufficient distinction to base our whole structure on?

MITCHELL: We submit that it is, for several reasons. First of all, the people to whom we are returning our supplemental allowances, essentially the hospitals, are in fact, non-profit and non-taxably entities. I submit to you that if there is one area of our economy that doesn't need more taxes, it's the cost of health care. It's bad enough as it is. Now you presupposed a loss in premium taxes because the "Blues" may write all the insurance in the State of Maine. There are several reasons why this will never happen. One of them, Mr. Nellson has already alluded to. By individual rating of groups, in effect, the commercial companies are in a position to skim off the cream, that segment of the population who are the working people and who therefore will have a far better experience, loss-wise, than the aged, the infirm, and the young. This is the skim-milk that Blue Cross is left with. We can't, with a community-wide or essentially community-wide rating system, attract the low-risk group, that will go with the commercial carriers. Plus, possibly we should change our practice in one respect, we don't pay commissions to our salesmen. Maybe they don't have as much incentive to go out and sell insurance that the commercial insurers provide. But, basically, I still submit that the fact that we are controlled by, we

MITCHELL, CONTINUING:

were essentially created by, the hospitals, to serve a need. We are controlled by the hospitals. And it is the hospitals that are the non-profit organizations that receive any dividends, rather than the individuals of the State of Maine. And they, unfortunately, pay taxes. Now, it may very well be, as you say, that there will come a time, when the hospitals or the church or other people may be forced to pay taxes, at which point probably we should pay taxes, too. But as long as we exist as an instrumentality of the hospitals in the State of Maine, we submit that we should not, thereby, be taxed. We seem to have gotten off the rest of this onto the question of taxation. I wonder if you wish me to move to this?

THORNSJO: I have just one other question. Would you be willing to forego from your powers, the right to provide retro, prospective, or active rate reductions to the individual subscribers, the group individual subscribers, so that what you have said in the last few seconds would be truly consistent, that is, all moneys would go to hospitals, there would be no dividends in the form of rate reductions, to individual subscribers.

MITCHELL: I would like an opportunity to confer with my principals. I suspect they might very well say yes. In my knowledge of the operation of this corporation, any retrospective rate adjustments which have ever been made, I suspect, are quite minimal compared to the expansion of benefits in the future. I would like an opportunity before I commit Associated Hospital Service, to ask them and to report back to the commission on that point, however.

WOODMAN: This is the basis of my earlier question, John, in terms of contracting with "for profit" optometrists, large national chains, "for-profit" nursing homes, "for profit" pharmaceutical companies, whether you'd be dealing in terms of dividends of payments with them on the same basis that you have hospitals or

WOODMAN, CONTINUING:

it would be handled in a different manner.

MITCHELL: I do not believe we would be dealing in the area of profits, as such. I think what we would be dealing with these providers until the underwriting risks of any particular year have, in fact, been established, we probably would pay a lesser amount by contract to the provider, than the amount of benefit which he gives to the subscriber, with the understanding that once we determined what, in fact, the underwriting experience for the year has been, then we will pay over the balance of the moneys to these providers. I would anticipate, however, that the providers would never, in fact, make a profit on this. If I may make just one comment, Mr. Chairman, I realize it's getting late, with respect to the existing section 4262, I am not sure that I understand what this section is saying with respect to taxation, but if I do, it appears in the first clause up to the semi-colon, to preserve our traditional tax-exempt status, and then goes on / and says that if we write an indemnity-basis contract with non-participating providers, we should be taxed on that portion of our premium. Now, I believe that what this language contemplates is exactly the type of contract that the Supreme Judicial Court of Maine told us in AHS vs. Mahoney we could not write. So, what we really seem to be doing is simply putting a tax on illegality. And if I understand the section correctly, I'd simply like to suggest to the commission that there are other ways of enforcing the law rather than applying a premium tax to an illegal contract. I believe the insurance commissioner is capable, since he has the prior approval of both our rates and our forms, to see to it that we do not issue the type of contract which has been forbidden by the court and which apparently is called to be taxed under this section.

MAC LEOD: John, I may be wrong here, and I'm subject to challenge by members of the Commission; but this 4262 as we had intended it to be written would have been a little clearer than this as far as what we were after, and this was that the

MAC LEOD, CONTINUING:

basic service contract that you were given under the original charter to offer to the public, would be tax exempt, anything that you were doing or were going to do over and beyond that area would become subject to premium taxes, am I expressing what we had intended to have this clause read?

WILLIAMS: I didn't get that understanding.

MITCHELL: I guess we're having a problem now, I feel like a man who suited up for a football game and finds himself in a la crosse game. You mean that what we started out with as a basic contract in 1938 would be tax exempt, but anything that's happened in the last 30 years we would be subject to tax? I submit that administratively it probably would be a nightmare to ever handle, because our basic contract I believe probably started... what, Paul, at 8 or 9 dollars a day? Seven dollars a day?

Conversation off mike.

I mean, Mr. Chairman, what are we talking about, maybe $\frac{1}{2}$ of 1 percent would be tax exempt? It isn't worth the bookkeeping to figure it out.

THORNSJO: Well, this could go back, however, John, to the question I asked you, if you're willing to distinguish between the plan which is never rated, never handled on any thing other than a uniform basis, it was described as your basic plan, and the alternative options, riders, special benefits plan, and could the latter be the appropriate subject to taxation?

MITCHELL: I'll be happy to report back to the Commission once I've had a chance; first, to speak to my principals, and secondly, to contemplate all of the ramifications of that suggestion. Are there any other questions at this time?

MAC LEOD: Any questions from the Commission at this time for Mr. Mitchell?

THORNSJO: I'd like to say that I think that's one of the finest presentations I've seen, John, and I've seen a couple of the Blues represented in various states, and I think you've done an excellent job on behalf of your clients.

MITCHELL: Thank you, I'm glad my clients are here to hear that.

WILLIAMS: I think perhaps we ought to continue calling the remainder of the sections.

MAC LEOD: Where'd we leave off?

WILLIAMS: With 4254.

MAC LEOD: This is the one with the rather extensive changes.

WILLIAMS: Inasmuch as we have these, we can very briefly sketch what the memorandum suggests, in each case. 4255?

SCHREIBER: I have a very brief comment on 4254. I was confused by the statement that the hospitals take the loss. It seems to me that either the hospitals are going to go broke in Maine, or that somebody's got to make up this deficit. And it appears to me that this deficit is actually made up by the cash paying patients and the insured patients. And I wondered if the Commission might want to consider amending 4254 to put in a proviso that any element of the cost which is incorporated in charges to the public established by hospitals shall also in the same ratio be included in the reimbursement formula for the service corporation. This would prevent hospitals ... keep them liquid, and would also keep the cash paying patients and the insured patients from paying a deficit in the operation of the Blue Cross reimbursement formula.

WILLIAMS: Would you give us that in writing, please, Mr. Schreiber? In connection with 4255, the suggestion, on line

MAC LEOD: Just a moment, Mr. Williams, did you have any comment on 4254?

NELLSON: There's just one point that I'd like to make, and it keeps coming up here, and that's the matter of somebody getting a discount or not paying all your way and people who are insured under commercial insurance are going to have to pay the difference. I don't believe that the commercial company, per se, 100% are paying the full charge of all services for all patients that are insured by them in the hospital. And I see no reason why Blue Cross should be picking up this deficit of the hospitals where the commercial people are not paying all the way. Now you take some of these, ah, I'll call them matchbox types of coverage, whereby you get, supposedly a flat $50 per day and it sounds like a big thing, cause they talk in terms of $10,000 and it may take you 50 years to get the 10,000 dollars, but those types of coverage are in Maine, I hope in not any great amount. But it's in here. But I don't think Blue Cross should be responsible for picking up the difference between that type of coverage and what the hospital's charge is. That's, I would say, far worse than what the formula would be as far as Blue Cross is concerned. Now, we will pay, under the formula, 97% of cost or 105% of charges, whichever is less. And, as John pointed out, in a hospital like the Mt. Desert hospital, this could be, that actually the charge would be less than the cost. Now, I just want to make this one point, I don't think you can take the opinion or the point of view that all commercial insurance companies pay 100% on all its insureds in every hospital.

MAC LEOD: When I raised the point in the first place, I didn't say the commercial insurance companies paid the full cost, I said that the private patient who happened to have a commercial insurance company contract may be paying $45 per day, he's charged $53 by the hospital. He pays the full amount.

NELLSON: Well, I think you will find that the Blue Cross patient also is charged that same charge, and when we figure out our supplemental payments, that enters into that. Now, here again you're getting back to your cost or your 105% of charges whichever is less. I'll say there's a differential there, but I don't think the

NELLSON, CONTINUING:

differential is quite as great as the way it had been painted.

WILLIAMS: The change on section 4255 is in subsection 3, and the essence of it is to substitute "providers of health care" for the different types of services otherwise enumerated.

4256? We have similar changes substituting the concept of health care for the hospital or physician or optometrist or other as I specified otherwise in this section.

4257?

SCHREIBER: Mr. Williams, on 4256, on checking the fees and taxes, I find that insurance companies have to pay $50 for a certificate of authority annually, and their agents are required to pay a 5 dollar fee. Contrast this with the requirement in 4256 which is $20 for a certificate of authority, and $2 per agent.

WILLIAMS: Anything further on 4256?

4257?

4258?

SCHREIBER: In 4258, there is no requirement that hospitals be examined at least once every three years, which is the case of domestic mutual insurance companies.

WILLIAMS: Thank you. Of course, there's nothing to keep him from examining as often as he wished.

4259?

4260? The same changes have been made as suggested heretofore, changing reference to hospital, physician to "health care providers", and hospital, medical, surgical service to "health care service".

4261?

WILLIAMS, CONTINUING:

4262? Inasmuch as we already had quite a discussion on that, does anyone else wish to be heard on the subject?

SCHREIBER: The section starts off by saying that the Blue Cross and Blue Shield institutions are charitable and benevolent institutions, and this is somewhat amusing, and I wonder if it isn't a myth, in fact. It would seem from this that they don't even pay property taxes and they can build themselves a beautiful home office building and not even pay property taxes. The Commission would be interested in a quotation from the Ohio Supreme Court, which very effectively shattered this myth, that they are a charitable and benevolent institution. I quote from their opinion: "Indeed, the many persons covered by such insurance would undoubtedly resent the imputation that they are objects of charity. The appelate is engaged in the insurance business for the advantage and convenience, if not the profit, of the participating hospitals, and the subscribers to said contracts; it is not engaged in dispensing charity to anyone, or furnishing any service, or carrying on any of the purposes for those who are in need, thereof, without payment. Its' property and funds are not exclusively or even in part for charitable purposes." The citation on that is 57 Northeast Second 928.

MITCHELL: I'd like to point out, as I pointed out previously, Associated Hospital Service of Maine, is, I believe, at least now the only corporation that's at all affected by this chapter, and our home office is in property that we rent from private individuals who pay taxes, we haven't built any magnificent home office. I will also go further and say that I am a little sorry that this Commission has not seen fit to ask for any guidance, help, or comments from Blue Cross or Blue Shield until this moment. The question of taxation has come up, with respect to Blue Cross/Blue Shield Plans in many states, in a great many states, I would suggest the majority, although I don't have all of the data at present, the legislature,

MITCHELL, CONTINUING:

before embarking upon such a radical course as to completely change 30 years has normally provided for a study commission by the legislature to inquire into the essential nature of the Blue Cross/Blue Shield plans, in our neighboring states, this has been true in Massachusetts, in Connecticut, I believe it's been true in New Jersey and in many other states, and almost invariably, the results of those commissions' studies, when they were reported back to the legislature was (A) that the Blue Cross/Blue Shield Plan be permitted to retain their tax exempt status, because of their unique quality, and secondly, as was specifically the case in Massachusetts, and in Connecticut, and in New Jersey, they recommended that the corporate powers of these corporations be expanded to provide more comprehensive health care. Now I am not particularly familiar by citation, with the Ohio case just cited, but there are undoubtedly a great many variations in the various plans throughout the various states. Perhaps we all ought to read that case to see whether or not it is in fact on all fours with what we're trying to do here in the State of Maine. But, as opposed to what the Ohio court said, I submit to you, that maybe this subject, by virtue of the time it has taken, that perhaps this Commission should not make this decision quite so quickly, but instead, should, in fact, have a study commission whereby all interested parties could supply additional data and expert witnesses on the issue. Thank you.

WILLIAMS: Section 4263? We have a similar suggested change in striking hospital, medical, surgical services, and insert in lieu thereof "health care"

4264?

SCHREIBER: In 4264, in reading it over, I don't find any provision for an examination of an agent selling hospitalization and medical insurance for an insurance company is required to take a written examination.

WILLIAMS: Thank you, Mr. Schreiber.

4265?

4266? Anything further on chapter 57?

SCHREIBER: The comment was made previously that the rates and the policy forms had to be filed and approved by the insurance department and I don't find any provisions in this chapter for requiring approval of these policy forms or even the approval of the rates.

WILLIAMS: I don't believe there's any such requirement in the present law. This chapter has been following the present law pretty well.

NELLSON: We do that voluntarily.

WILLIAMS: I see. That completes the schedule, Mr. Chairman.

MITCHELL: (off mike, garbled) I think the approval of both forms and rates are covered under section 4255 and the annual renewal under 4256 where it says that we continue to get a certificate of authority renewal on a yearly basis under the rates and benefits ... if the rates to be charged and the benefits provided are reasonable.

MAC LEOD: Any other comments on Chapter 57? If not, we'll declare the hearing closed until 9:30 tomorrow when we'll continue with our schedule.