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REPORT OF THE JOINT SELECT COMMITTEE TO STUDY INSURANCE POOLS FOR HIGH RISK GROUPS SEEKING HEALTH AND LIFE INSURANCE

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MEMBERSHIP OF THE JOINT SELECT COMMITTEE

Member	Committee
Representative Merle Nelson (chair)	Human Resources
Senator Beverly M. Bustin	Business & Commerce
Representative Laurence E. Connolly, Jr.	Appropriations and Financial Affairs
Senator Barbara A. Gill	Human Resources
Representative Peter J. Manning	Human Resources
Representative Charlene B. Rydell	Business & Commerce
Senator Charlotte Z. Sewall	Business & Commerce

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

I. INTRODUCTION

This study examines the feasibility of establishing a state health insurance pool to help provide health insurance for individuals who, for medical reasons, are categorized as being in a high risk group and who are often unable to obtain insurance or may only obtain insurance with significant exclusions.

A. Background of the study

During the Second Regular Session of the 112th Legislature, legislation was introduced concerning the public health issues involved in Acquired Immune Deficiency Syndrome (AIDS). This legislation, LD 2063: AN ACT to Protect the Public Health in Relation to Acquired Immune Deficiency Syndrome, was referred to the Joint Standing Committee on Human Resources. One of the issues raised by this legislation concerned the use of the test which reveals the presence of antibodies to the HTLV-III virus, the virus suspected of causing AIDS. This test is designed to determine if the antibodies to HTLV-III are present. There is currently no test available to determine the presence of AIDS. The most recent statistics indicate that only about 20-30% of those individuals who test positive for the antibody will contract AIDS.

This legislation sought to prohibit the use of those test results, or the fact that a test was taken by an individual, from being used in connection with issuance or renewal of health or life insurance policies or in determining rates for those policies. That provision of the legislation was opposed by representatives of several insurance carriers in the state. They indicated a strong need to retain the ability to inquire whether an individual had taken the test and the results of the test. That information was considered an important factor in assessing the risk that the insurers were being asked to take in regard to health and life insurance.

On the other hand, public health officials were extremely concerned that if such a question were allowed to be asked as a precondition to obtaining insurance, many individuals who were "at risk" would simply not take the test. Use of the test results to deny an individual insurance coverage acts as a strong incentive for those individuals not to take the test.

The only proven method of decreasing the spread of AIDS at the present time is through education. By decreasing the number of people taking the test, the public health officials felt that they would have lost their only method of identifying individuals who are "at risk" and of educating them in ways to decrease the spread of the disease.

The committee proposed a one year moritorium, prohibiting insurers from asking whether someone had taken the test or

for the results of that test. The committee hoped that some other solution would be found to resolve that issue during the moritorium.

As the committee deliberated on this bill, they realized that there were many other individuals who were, for health reasons, considered a "high risk" and, who found themselves unable to obtain health insurance, even though they would be willing to purchase such insurance at a cost above the norm.

The Human Services Development Institute (HSDI), a public policy research organization affiliated with the University of Southern Maine, had been commissioned by the Legislature to study health insurance coverage in Maine. Their report estimated that a large number of Maine citizens (13-16% of the adults under age 65) were basically without any type of health insurance coverage. Approximately 1.6% (1,491) of those individuals had been refused insurance for health reasons.*

One of the possible solutions identified by the HSDI to help provide health coverage to Maine citizens who are "uninsurable" is to create an insurance pool for those who are in the "high risk" group. Ten states have currently enacted "high risk" insurance pools and several other states are considering such action.

B. Establishment of the Joint Select Committee

In order to evaluate the implications of establishing a "high risk" insurance pool in Maine, the Legislative Council created this Joint Select Committee. This committee is composed of members of the Joint Standing Committees on Appropriations and Financial Affairs, Business and Commerce, and Human Resources.

This study will look at the methods and feasibility of establishing a state insurance pool for individuals whose medical condition identifies them as a "high risk" to insurance companies. It will focus on the types of coverage, the benefits, the premium rates, and funding alternatives, including state subsidies. Although the committee initially was established to look at health and life insurance coverage, the complexity of the issues concerning health insurance did not leave sufficient time to consider life insurance.

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*Health Insurance Coverage in Maine: An Analysis of the Problem, Its Effects and Potential Solutions; Volume II: Preliminary Report, Human Services Development Institute, March 1986.

II. THE COMPONENTS OF A HEALTH INSURANCE POOL FOR HIGH RISKS

A. General discussion: Insurance

Insurance is designed to provide a means whereby the risk of economic loss for an individual is distributed among as many as possible of those who are subject to the same kind of risk. Each member of the group pays a premium (a pre-determined amount) into a common fund. This fund is used to pay economic losses that are suffered by any member of the group. "The member has no way of knowing in advance whether he will receive in compensation more than he contributes or whether he will merely be paying for the losses of others in the group...". His primary goal is to exchange the gamble of going it alone (in which he would either escape all loss or suffer catastrophic losses) for the financial and economic security of knowing that his maximum losses are limited to his premiums. This is known as risk distribution.*

Although there are traces of insurance practices dating as far back as the Babylonians, the first recorded instances of insurance contracts as we know them today came from the medieval Italian merchants who insured their commercial shipping ventures. Toward the end of the 17th century the practice had spread as far away as London, England. There on Lombard street (named in honor of the enterprising merchants of northern Italy) the famed Lloyd's Coffee House became the meeting place for insurers and maritime shippers. The shippers would present papers containing information about the commercial shipping venture. Anyone wishing to insure that cargo and ship would sign the bottom of the paper indicating how much of the risk they wished to assume. The term "underwriting" developed from this practice.

Insurance expanded slowly into non-marine applications. Life insurance was the first non-marine insurance. The major philosophical impediment to the development of life insurance was the public's perception that life insurance was an immoral wager on human life and an encouragement to murder for profit.

Fire insurance, although established after life insurance, actually developed faster. The tragic Great Fire of London in 1666 increased the demand for fire insurance tremendously. Even so, it suffered, like life insurance, from a bad public image. People thought (not entirely without empirical substantiation) that fire insurance would encourage arson. By the early part of the 19th century business and commerce were expanding so rapidly that perceptions quickly fell before necessity. Growth in the insurance industry kept pace with the growth of business and commerce.

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*Insurance Law, John F. Dobbyn, p 3., West Publishing Co. 1981

State legislation regulating the insurance industry came of age in 1905 as a result of investigations by a legislative committee in New York. Fraudulent practices, financial instability, political lobbying, and favoritism were among the abuses which brought about the vigorous legislative study and resulting regulation.*

Health insurance, a relatively new concept, gots its major beginings in the 1930's. Prior to that time private health insurance was a rarity and public health insurance was virtually non-existent.**

B. General discussion: Health Insurance Pooling for High Risk

The Human Services Development Institute identified a segment of the Maine population that is without health insurance. Part of that uninsured population are the uninsurables. These are the hard core uninsured who, for health reasons, cannot obtain health insurance at any price or can only obtain health insurance which excludes coverage for the chronic medical condition(s) which makes them a high risk.

Ten states have felt a need to address this problem and created state health insurance pools. They established an artificial "group" composed entirely of individuals who are high health risks. Theoretically, risk pooling is designed to provide otherwise unobtainable health coverage for the group while capturing the economic benefits of risk pooling.

The uninsurables provide a public policy challenge. They are often seen as willing to buy health insurance coverage, even at prices above the prevailing market rates; but, the willing buyer cannot find an equally willing seller. The philosophy for making this coverage availabile is that they deserve the opportunity to have access to reasonably priced health insurance. To a certain extent they are victims of circumstances beyond their control. Medical diagnosis has improved to the point where more people can be identified as having a high risk health condition. Advances in medical treatment have created a larger number of people who survive once fatal accidents and illnesses, but who then become uninsurable because of their continuing adverse medical condition requiring chronic care. The increase in life expectancy has increased the number of high-risk elderly who are not eligible for Medicare (1.5% of those over age 65).

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*The Law of Insurance, Irwin M. Taylor, pp. 1-3, Oceana Publications, Inc. 1983.

** The Certificate of Need Study of the Human Resources Committee of the 112th Legislature, April, 1986, Augusta.

Experience from the existing pools in other states has shown that, although enrollment has increased steadily, only a small portion of the uninsurables enroll in the pool. In addition, risk pools have not proven to be self-sufficient. Only one pool, Florida, has not experienced losses; but it anticipates losses during the current year.

The design of all existing "high risk" pools is similar:

> "Under instructions from the state legislature, a board of trustees for a state comprehensive health insurance association is organized. The association develops a standard insurance policy defining benefits, eligibility, and premiums. All health insurance companies in the state are required to offer eligible customers a 'qualified plan,' namely, one that provides benefits at or above the levels of the associations's plan. Alternatively, insurance companies may refer eligible customers to a statewide "lead carrier" that sells policies and administers under contract with the board.
>
> "In practice, virtually all insurers refer to the central pool....All underwriting losses (i.e.,total costs less income) from independently sold qualified plans as well as those for the lead carrier are assessed to all health insurers in the state, usually based on their respective market shares."*

The Federal government is considering legislation that would require the states to establish risk pools for medically uninsurable people by January 1, 1988. The federal legislation would establish certain guidelines which the state legislation must follow. Employers would be assessed to pay for the pool's losses. Both the House and the Senate have bills before them mandating state-run pools for high-risk health insurance.

The components of a standard policy as well as the proposed federal guidelines and the proposal of the National Association of Insurance Commissioners (NAIC) are described in the following sections. A synopsis of the components of existing state risk pools is contained in Appendix A.

C. Maximum Lifetime Benefit

The maximum lifetime benefit is the total health insurance benefit that a policyholder can receive throughout his or her life. Pending Federal legislation would require state risk pools to establish a maximum lifetime benefit that was not less than $500,000. The NAIC model bill proposes a $1,000,000 limit.

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* "State Health Insurance Pools:Current Performance, Future Prospects", Randall R. Bovbjerg and Christopher F. Koller, Inquiry 23: 111-121, (Summer 1986), Blue Cross and Blue Shield Association, p. 111-113 (quote at 113.)

D. Deductibles.

Deductibles are the amounts that the policyholder pays before receiving any insurance benefit. Inclusion of a deductible eliminates some of the smaller medical expenses, reserving the policy payments for more major medical expenses. In several risk pools, the policyholder is offered a choice of deductibles. Pending federal legislation would require that the deductible not exceed $1,000 per individual. The NAIC model act provides optional deductibles of $500 or $1,500 per annum per individual.

The lowest practicable deductible appears to be $500. A deductible lower than that will require the policy to pay for items such as office visits and laboratory costs, increasing the cost of the policy excessively.

Some insurers speculate that it may be meaningless to set a limit higher than $500. The feeling is that if an individual in a high risk pool incurs medical expenses beyond the $500 deductible, those expenses will quickly exceed any maximum out-of-pocket expenses during that year. The $500 covers routine medical expenses. When an individul in a high risk group incurs medical expenses beyond the routine, those expenses will be costly and will quickly exceed the out-of-pocket limit. This makes the out-of-pocket expenses (see item F.) the real limit and it makes no difference whether the deductible threshold was $500 or $1,000 if the individual has already exceeded out-of-pocket expenses.

E. Co-Payments

Co-payments refers to the provision in a policy that requires the policyholder to pay a certain percentage of all medical expenses incurred beyond the deductible amount. The total amount of co-payment is limited by the maximum out-of-pocket expense. Pending federal legislation does not address co-insurance, but merely establishes an overall maximum out of pocket expense limitation. (See F. below.) The NAIC model act provides for 20% coinsurance.

F. Maximum out-of-pocket expenses.

The maximum out-of-pocket expenses refer to the maximum amount of money (through deductibles and co-insurance) an individual or family will pay for medical care covered by the policy. The calculation of out-of-pocket expenses excludes premium costs. After that amount is paid, the insurer pays 100% of all eligible medical costs. The proposed federal legislation provides for a maximum out-of-pocket expense for an individual of $1,500 and $3,000 for a family. The NAIC model act provisions establish a maximum out-of-pocket expense of $3,500 per individual and $5,000 per family per annum.

G. Premium cap.

The premium cap is the maximum amount which can be charged for premiums by the risk pool. It is expressed as the highest percentage above a comparable standard policy offered in the state. The federal proposal sets a premium cap of 150% of the average premium rates for individual standard risks in the State for comparable coverage. The NAIC model act requires the premium to be not less than 150% nor more than 200% of rates applicable to individual standard risks.

H. Waiting period for pre-existing conditions.

The waiting period for pre-existing conditions refers to the length of time a policyholder must wait after the effective date of the policy before he or she can receive insurance benefits for treatment of a pre-existing condition. A pre-existing condition is a medical condition for which medical advice, care, or treatment was recommended or received during a specific time period (usually 6 months) prior to application for the policy. The federal legislation would permit the state plan to deny coverage for pre-existing conditions for a period of up to 6 months.

The NAIC model act excludes coverage for 12 months following the effective date of coverage for "any condition which, during the 6 month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care, or treatment was recommended or recieved." The model act also provides for a waiver of the pre-exisiting condition exclusion for an applicant who had already satisfied a waiting period under a previous policy that was involuntarily terminated, provided the applicant applies within 31 days of the termination.

I. Eligibility

Eligibility refers to the criteria which is established for defining who is eligible to purchase health insurance coverage in the pool. The proposed federal legislation requires that all residents be eligible except those who are eligible for Medicaid. The NAIC model act requires that all residents be eligible except the following:

(i) those who have coverage,
(ii) those eligible for Medicaid,
(iii) those who terminated coverage in the pool less than 12 months prior to application,
(iv) those who have already received the maximum lifetime benefit under this pool, and

(v) those eligible for public programs or those who are inmates in public institutions.

J. Benefits

The benefit component of the plan describes the benefits which may be available under the plan including any mandated benefits. The benefit component may include such requirements as managed care. The proposed federal legislation requires a level of benefit typical of the group coverage available in the state. The NAIC model offers two options for benefits. The first option describes in detail the benefits that are available. The second option requires the benefits to be established by the board and to be "generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state."

K. Governing Board

States establishing a risk pool have created a governing board to administer it. The most significant aspect of the provisions of those states concerning the governing board are the composition of the board and the duties and authority of the board.

L. Financial Aspects

The financial aspects of the risk pool are discussed in the following two sections.

III. PREMIUM RATES

A. Cost to Insureds

Each state with a pool has set a premium cap. This "premium cap" is the highest percentage above the average health policy premium offered in the State that a risk pool is allowed to charge. This average is based on prices of comparable individual policies sold to standard risks in the State. Some states use only the average premium of a comparable individual policy of the five largest insurers. These caps in the various states that have "risk pools" range from 125% to 400%. The federal proposal sets the "premium cap" at a maximum of 150%. The NAIC model sets the cap at a minimum of 150% and a maximum of 200% calculated on the average individual standard rate charged by the five largest insurers.

Separate schedules of premium rates based on age, sex, and geographical location are permitted in the NAIC model. All states with existing pools have schedules based at least on age. Two states (Florida and North Dakota) use age only and three states (Connecticut, Indiana, and Wisconsin) use all three criteria in setting up separate schedules. Differences by geographical location are referred to as "zip code ratings" and are set to reflect differences in medical costs in different areas. The federal proposal only states that premium rates should be self-supporting and based upon an actuarial determination.

Premium rates are also affected by the amount of the deductible. Some states have only one deductible amount and others have either 2 or 3 different amounts. All existing plans have a $1,000 deductible category. The NAIC model specifies that pool coverage must provide optional deductibles of $500 and $1,500. The federal proposal allows the plan to have a choice of deductibles as long as no deductible exceeds $1,000.

The actual cost of premiums in the states with pools ranges from a low of $97/quarter in Indiana for the youngest male covered to a high of $1,095/quarter in Florida for the oldest covered male or female (See Table III-a). Florida has the highest premium cost of any state and Minnesota and North Dakota have the lowest premium costs (See Table III-b).

Table III-a

Ranges of Quarterly Premium Rates (Ranges in states with pools that have operated more than one year.)

CONNECTICUT	under 30	60-64	Child (all ages)
(1) $400 deductible			
Male	$225	$798	306
Female	336	921	
(2) $1000 deductible			
Male	$151	$635	197
Female	245	735	
(3) $1500 deductible			
Male	$118	$498	145
Female	190	584	

FLORIDA	under 19	64
$1000 deductible	$300	$1095
$1500 deductible	255	931
$2000 deductible	225	822

Florida is at the 150% level now and will be asking for a higher amount this fall. Their statutory maximum is 200%.

INDIANA

Indiana has four different plans, divided by age and by zip code. There are five different zip code areas.

$1000 deductible	lowest zip Age 0-18	highest zip Age 65
Male	$97	$694
Female	110	754

MINNESOTA

	Age 15	Age 64	to add Family
(1) $1000 deductible	$108	$312	$135
(2) $500 deductible	155	411	177

The low cost of the Minnesota premium is a function of the low standard rate in the state.

WISCONSIN

$1000 deductible	Age 0	Age 64
Male	$160	529
Female	160	594

Wisconsin has only the $1000 deductible and has 2 area ratings similar to Indiana.

NORTH DAKOTA

	under 18	18-39	44-54	55-64
(1) $150 deduct. (most popular Plan)	$129	228	390	444
(2) $1000 deduct.	$99	180	234	346

North Dakota also has a $500 deductible plan, a chiropractic plan, and a Medicare Supplement plan. The Medicare Supplement plan ranges from $201/quarter to $264/quarter depending upon age.

Table III-b
Quarterly premium range - $1,000 deductible

CT	FL	IN	MN	WI	ND
$151-635 (M)	$300-1095	$97-694 (M)	$108-312	$160-529 (M)	$99-346
245-735 (F)		110-754 (F)		160-594 (F)	

Table III-C

ANNUAL PREMIUMS FOR TYPICAL INDIVIDUAL COMPREHENSIVE MAJOR MEDICAL POLICIES IN MAINE

Company:		New York Life	Bankers Life & Casualty	Mutual of of Omaha (Non-Smoker)	Time Ins. Co. (Non-Smoker)	Annual Average	Quarterly Average	150% of Quarterly Average	Blue Cross Blue Shield & Blue Alliance *
Deductible:		500	500	500	500	500			
*Out-of-Pocket Limit:		1500	2500	2500	3000				
Sex	Age								
M	25	484	400	355	313	388	97	$146	877
	45	810	653	527	591	645	161	242	916
	64	1881	1005	1039	1239	1291	323	485	949
F	25	734	568	541	385	557	139	209	877
	45	1095	838	788	694	854	214	321	916
	64	1407	965	858	1122	1088	272	408	949

* Blue Cross and Blue Shield of Maine does not offer comprehensive major medical coverage on a non-group basis. The rates shown are for an individual Blue Cross contract with a $180 daily room and board limit, a Blue Shield "H" contract, and a Blue Alliance supplemental major medical policy. The variations in rates by age are entirely due to the supplemental major medical since Blue Cross and Blue Shield of Maine does not rate by age. (Data submitted by Bureau of Insurance, August 26, 1986).

In Maine the estimated quarterly average of a typical individual comprehensive major medical plan ranges from a low of $97 for a 25 year old male to a high of $323 for a 64 year old male. If the high risk pool premium is set at 150% of this average then the premium rates would probably range from $146-485 per quarter for members of the pool (See Table III-c).

B. Affordability

Even in states where there is an established insurance pool for high risk individuals, many people still have no health insurance because they cannot afford it. Wisconsin is the only state that has addressed this problem to date.

In 1985 Wisconsin appropriated $277,000 for the first year to subsidize premiums for low income policy holders. Those individuals with an income of $16,500 or less are eligible for some help from the state. As of August, 1986, more than 600 of 1,964 pool members, or approximately 30%, were receiving premium reductions ranging from 6% to 30% (See Table III-d). Four hundred pool members or 21% were receiving help in September, 1985, but the rate appears to have stabilized now at 30-31%. Benefits with this subsidy in the lowest range cost $112-150 per quarter and in the highest range cost $416-558 per quarter. The unsubsidized range is $160-594 per quarter.

The plan in Wisconsin is guaranteed to receive $433,000 each year from the State. During the first year the plan was given $277,000 since the subsidy program would be operating only part of the year. The plan used only $128,000 in the first year (9 months) for subsidies. Therefore, the Bureau of Insurance is proposing to increase all subsidy categories by 11% so that the reductions would range from 17-41% and to institute a subsidy to reduce the deductible from $1,000 to $500-900, depending upon the income category.

The Legislature in Wisconsin used the income level of $16,500 or below as the threshold for the subsidy because this amount is used in their tax code for a homestead credit. The Wisconsin Bureau of Insurance thought the formula used by the tax department to arrive at this amount was appropriate to use for the high risk pool also. This may or may not be a realistic subsidy level for Maine.

If a subsidy program is instituted in Maine, either an appropriation from the Legislature would be necessary or increased costs for the pool should be anticipated. Using Wisconsin's experience an approximate amount can be calculated (See Table III-e). However, these amounts would be affected by the income level used, the deductible amount (Wisconsin has only one $1,000 deductible category), Maine's usage rate (Wisconsin's usage rate for the subsidy program is 30%), population trends, and inflation.

TABLE III-d

Percentage reductions in premiums are figured from the following table:

Annual Household Income	Reduction Percentage
$ 0,000 To $ 5,999	30%
$ 6,000 To $ 8,999	24%
$ 9,000 To $11,999	18%
$12,000 To $14,999	12%
$15,000 To $16,499	6%

The number and percent of policyholders receiving the premium reduction and the percentage of that reduction is as follows:

	6%	12%	18%	24%	30%	Total
Number of Policyholders Receiving Reduction as of March 31, 1986	40	142	129	127	159	597
Percent of Total Policyholders in Plan	2%	7%	6%	6%	8%	30%
Total Number of Policy-holders in Plan as of March 31, 1986						1,963

TABLE III-e

These projections are based on Wisconsin's experience and projected enrollments furnished by the Bureau of Insurance.
Assume: 30% usage rate for the subsidy with a graduated scale of 6%-30%.

Year	Projected No. enrolled in plan	No. of those using Subsidy (30%)	Projected cost of the Subsidy
1987	100	30	$ 8,535
1988	300	90	25,605
1989	600	180	51,210
1990	900	270	76,815
1991	1200	360	102,420
1992 & thereafter	1500	450	128,025

IV. FINANCING POOLS

A. Introduction

In each existing pool, rates have climbed quickly to the maximum allowed, or close to it, but have still failed to cover operating expenses. Only Florida, which has the highest premiums, has not lost any money to date. In general, claims experience is slow to develop during the first few years of a pool's operation because of the initial limitation in coverage for preexisting conditions and normal lags in payment of expenses. Then after the start-up period and as enrollment increases, the expenses exceed the income from premiums. This pattern is inevitable considering that these pools are insuring those people who are "high risks" and are almost certain to incur high medical expenses. Although the losses are and have been very difficult to predict, Maine could expect yearly losses of about $400,000-800,000 by 1990, depending on whether a "buy out" plan is adopted. (See Table IV-a).

Connecticut has been the one exception to this pattern. Since Connecticut does not restrict eligibility, the pool initially enrolled many good risks. However, as more and more high risk individuals enrolled, claims increased, and costs of premiums rose higher than the "good risk" individuals wanted to pay. So even in Connecticut, the current pool is now losing money. Current losses there are around $1.5 million.

In all existing pools, commercial insurance companies that sell health insurance policies are required to be members of the pool or "association". Blue Cross/Blue Shield is included in the pool, regardless of their tax exempt status, in all states except Minnesota. The "Blue's" have tax exempt status in Minnesota, Florida, and North Dakota (See Table IV-b). Some states and also the NAIC model include HMO's (Health Maintenance Organizations), as well. At the end of a year, the losses incurred by the pool are divided on a pro rata basis by the members of the pool. In all but two states (Conn. and Wis.) the insurers are permitted to take a dollar-for-dollar credit against state taxes on premiums. This method results in an indirect state subsidy that pays the losses incurred by the pool. The effect in Connecticut and Wisconsin is that insurers selling health insurance must absorb the losses of the "high risk" insurance pool, which probably results in higher premiums for all other insureds in the state.

Most of the states with existing pools would also like to have those employers who self-insure included in the pool. However, the federal Employee Retirement Income Security Act (ERISA) preempts direct state regulation of employee benefit plans. Therefore, unless the federal law is changed, self-insurers cannot be required to join the pool or share in the pool's losses. Representatives of Blue Cross Blue Shield reported that 5% of employees in Maine, approximately 18,150, are in self-insured plans.

There is some movement by Congress to change the law, but at this time change is not likely to happen this year. The federal proposal as written now would require all employers with 20 or more employees who offer a health benefit plan or the entity through which the employer's health benefits are offered to be members of a qualified pool.

Even though "high risk" pools are generally losing money, there are certain savings in administrative expenses that result for a variety of reasons. Since uninsurables cannot obtain other coverage, pools generally avoid "in and out" costs. If the lead carrier approach is used and all pool operations are under one administration, then the savings are greater than those pools with decentralized operations. A major administrative savings is that the pools do not pay agents' commissions. Instead a one-time fixed referral fee of $35-$50 is paid. Since the standard agent fee is 10% of premium, this is a considerable savings.

Administrative expenses are capped statutorily as a percentage of premiums collected in three states: Minnesota, 12 1/2%; Montana, 12%; and North Dakota, 12 1/2%. Actual costs for existing pools have ranged from a low of 4.0% in Indiana to a high of 13.1% in Florida. North Dakota, which has a similar population to Maine's, has kept administrative costs at 7.9%.

TABLE IV-a
Projected Losses in Maine Using Other States' Experience

Year	Projected Enrollment	Projected loss using $500/ person[1]	Projected loss using $289/ person[2]	Projected loss using $666/ person[3]
1987	100	$ 50,000	$ 28,900	$ 66,600
1988	300	150,000	86,700	199,800
1989	600	300,000	173,400	399,600
1990	900	450,000	260,100	599,400
1991	1200	600,000	346,800	799,200
1992	1500	750,000	433,500	999,000

1. Average current loss of the 5 existing pools reporting losses
2. From Wisconsin, the lowest reported current loss
3. From N.D., the highest reported current loss

This table does not take into account the fact that in the early years the losses are usually much less. The Wisconsin and North Dakota figures are current and both plans have been operating around 5 years.

ROUGH PROJECTION SUBMITTED BY BUREAU OF INSURANCE

	Enrollment (Dec.31)	Premiums(000)	Claims (000)	Admin Costs	Gain (Loss)
1987	100	25	12.5	50	(37,500)
1988	300	200	137.5	24	38,500
1989	600	450	525	54	(129,000)
1990	900	750	1050	90	(390,000)
1991	1200	1050	1650	126	(726,000)
1992	1500	1350	2250	162	(1,062,000)
1993	1500	1500	2775	180	(1,455,000)
1994	1500	1500	2775	180	(1,455,000)

These projections are based on the assumptions listed below. These assumptions are ballpark estimates based on the experience of other states. Actual results may differ greatly from these assumptions.

Assumptions

Start-up - 7/1/87
Enrollment: Growing to 1,500 in 5 years; level thereafter
Average Premium: $1,000 per year per person
Claims: 50% of first-year premiums plus 200% of renewal premiums
Administrative Costs: $50,000 first year; 12% of premium thereafter
Inflation: Ignored
Interest: Ignored
Lapsation: 10% per year beginning in 1994

TABLE IV-a continued

BUY-OUT OF PRE-EXISTING CONDITION EXCLUSION AT 25% ADDITIONAL PREMIUM

Year	Enrollment Dec. 31	Premiums (000)	Claims (000)	Admin. Costs (000)	Gain(Loss) (000)
1987	100	28.1	49.2	50.0	71,100
1988	300	221.9	394.5	24.0	(196,700)
1989	600	481.3	892.2	54.0	(464,900)
1990	900	787.5	1,490.6	90.0	(793,100)
1991	1200	1,087.5	2,090.6	126.0	(1,129,100)
1992	1500	1,387.5	2,690.6	162.0	(1,465,100)
1993	1500	1,518.8	2,995.3	180.0	(1,656,600)
1994 plus	1500	1,518.8	2,995.3	180.0	(1,656,600)

Assumptions

Start-up: 7/1/87
Enrollment: Growing to 1,500 in 5 years; level thereafter
Buy-out: 50% will opt to buy out the pre-existing condition exclusion.
Average Premium: $1,000 per year per enrollee plus $250 for each who opts to buy out the pre-existing condition exclusion
Claims: 50% of first-year premiums plus 200% of renewal premiums plus 250% of first-year premiums for those who elect buy-out
Administrative Costs: $50,000 first year; 12% of base premium thereafter
Inflation: Ignored
Interest: Ignored
Lapsation: 10% per year beginning in 1994

TABLE IV-b

State	# of People Currently in Program	Quarterly Prem. Range (1,000 deduct.)	Tax credit	Current Losses	Type of Plan	Waiver of Pre-Existing condition	BC/BS tax exempt	BC/BS included pool
Conn (1975)	3,388	$151-$635 (M) 245-735 (F) (125%-150% cap)	no	$1.5 million $443/person	lead carrier and other insurers may sell plans	yes - credit for time covered in a Conn group policy	no	yes
Fla (1982)	900	$300-$1095 (150%-200% cap)	yes 100%	none to date	lead carrier	none	yes	yes
Indiana (1981)	3,229	$97-694 (M) $110-$754 (F) lowest to highest (150% cap)	yes 100%	$2 million $620/person	lead carrier	no credit but can buy out at 25% of premium	no	yes
Iowa (1986)	expect 225 in year 1 and 8,600 at end of 10th year	not set yet (150% cap)	yes 100%	NA	not set yet	will get credit for time if involuntarily terminated	no	yes
Minn (1976)	10,439	$108-$312 (125% cap)	yes 100%	$5 million $479/person	lead carrier	one narrow group gets waiver - those whose medicare supplement coverage is involuntarily dropped	yes	no
Wis (1980)	1,964	$160-529 M $160-594 F (150% cap)	no	$567,000 $289]person	lead carrier	none	no	yes
N. Dakota (1981)	1,300	$99-$346* (135% cap)	yes 100%	$866,000 $666/person	lead carrier and other insurers may sell plans	yes - credit if had insurance in last 12 mo. or a buy-out at 18Xmo. premium(50% of prem)	yes (income tax only; must pay prem tax)	yes

B. Alternative Financing Methods for Pool Losses

(1) Assessment of Insurers; Tax Credit

This is the most popular method of financing "high risk pools" of the states that have pools at this time. This seems to be a popular method because there is a limited initial government role, yet there is an indirect government subsidy through the tax credit. All taxpayers pay because the premium income lost must be made up by other taxes. Other reasons for using this method are: that a program can be put into place without having to seek an appropriation each year; that this approach is easy and fair; and that insurers won't dump their "bad risks" into the high risk pool since they all share in the pool's losses.

Some states tax insurance companies both by a corporate tax and by a premium tax. No insurance companies in Maine pay corporate taxes. All insurance companies in Maine without tax exempt status pay premium taxes.

Blue Cross/Blue Shield does 40-50% of the health insurance business in Maine and is tax exempt. If Maine assesses insurers and allows a tax credit and if Blue Cross/Blue Shield is a member of the pool, the state will indirectly subsidize 50-60% of any losses because of the tax credit given to the commercial insurers. Blue Cross/Blue Shield would have to absorb its share of the losses and would probably pass these losses on to its policy holders.

(2) Assessment of Insurers; no Tax Credit

The reasons behind this method are very similar to the ones for assessment with a tax credit. The big difference is in who ultimately pays for the program. Under this method, the insurers bear the initial cost as a function of the distribution of risk aspect of insurance. All insurance companies would probably pass along their share of losses to all their policy holders to the extent they are able. Under this method ultimately then all individuals who buy health insurance pay for the losses through higher premiums. If insurance companies can't pass it all along, then they must absorb the rest of the losses.

There are additional reasons for choosing this method. One is that there is very little government involvement and thus less administrative cost to the State. Another is the belief that insurance company practices that deny health insurance to individuals are partially to blame for the problem.

(3) General Fund Subsidy

This approach to pay for pool losses would require either an appropriation from the general fund or a surtax on income or a special dedicated tax. One reason given at the work sessions for using this approach is that society as a whole is responsible for all its citizens and a direct subsidy by the State is a "more honest" way of making this statement. Some individuals also argue that there would be less administrative expense.

Arguments against this approach given by contacts in other states and others at the work session range from "too much government involvement" to "too difficult to start or to continue the program year to year when money must be appropriated annually." Others suggested that the administrative expense is essentially the same as using a tax credit approach and the results are essentially the same, since all taxpayers end up paying for losses using either method.

(4) Reserve Fund Approach

A reserve fund from taxes or state contributions could be set aside to fund "risk pools." In Iowa a tax has been imposed on insurers for a year. This will result in a $10 million reserve fund by July 1, 1987 when the pool is expected to start operating. This is a one time tax and assessment of insurers (with a tax credit) will pay for additional losses. In Utah a one-time only state contribution of $3 million has been proposed as an alternate plan. Proponents in Utah argue that this amount, together with interest, will be enough to pay claims for several years, especially since claims usually come in slowly in the early years. A variation of this method would be to appropriate a fixed amount from the general fund each year with any additional losses to be paid by assessing insurers.

(5) Employee Tax

California is the only state so far that is proposing to put a tax on workers beginning in January, 1987. This tax of three-tenths of one percent ($51 annual maximum) will accumulate in a reserve fund and draw interest until December 31, 1991 and will result in an accumulation of over $4 billion. This reserve fund cannot be used until December 31, 1991, although the plan will begin operating January 1, 1988. From 1989 through 1991 the tax can be increased up to a maximum of 1% to cover any deficit. After January 1, 1992 any proposed increase in tax can be reduced in half by withdrawing an equal monetary amount from the reserve. Also, reserve funds can be used to reduce premiums beginning in 1992.

Proponents there believe the financing mechanism provides for the smallest possible burden on taxpayers while building a large reserve. However, there is some lag time before citizens can be served by a pool and the premium cap will be set at 300%.

The California plan has a provision that requires all insurance carriers, insured employers and self-insurers to pay an annual assessment to the association if specified federal legislation is enacted to provide state jurisdiction over self-insurance and employer-provided insurance plans. A tax credit will also be allowed if the State Constitution is amended. These provisions show that an assessment of insurers with a tax credit is preferable to California legislators as long as self-insurers can also be assessed.

(6) Tax on All Employers

One reason suggested as to why employers should be taxed is that employers have certain interests in the health of their employees and in the work force. However, many employers may disagree with this position and say this is overburdensome.

A tax imposed on all employers, regardless of whether the employer offers health insurance, may not technically violate the ERISA preemption. However, there is a danger that a court may see this method as a way to circumvent ERISA and invalidate the funding method.

(7) Tax on Health Care Providers

Another method of financing pool losses would be to tax all health care providers. Utah is proposing this method as an alternative to fund a "high risk pool". Because, ultimately, this plan would draw from all health care consumers, self-insureds and noninsureds would also pay. This is also referred to as a "sick tax".

V. RECOMMENDATIONS

1. Maximum Lifetime Benefit

The amount will be set by the Board but will not be less than $500,000.

2. Deductibles and Co-payments

The Board will set the deductible amount or amounts using the following guideline: Minimum $500 - Maximum $1,000 per individual. There shall also be a 20% Co-payment by the insured of all expenses after the deductible, up to the out-of-pocket expense limit.

3. Maximum Out-of-pocket Expense

$1,500 individual
$3,000 family.

4. Premium Cap

Not to exceed 150% of the standard individual rate for the defined benefit package.

5. Waiting Period For Pre-existing Condition

6 months for conditions that were diagnosed, treated, or had been the subject of a consultation within 6 months period prior to application.

Some coverage for the pre-existing condition for maintenance only, up to $1,000 will be allowed. The Board shall determine the type of maintenance.

Credit for time in another plan shall be given toward the waiting period if coverage is terminated unless the person is eligible for a conversion plan at a cost equal to or less than the pool premium. Application must be made within 31 days of termination of coverage.

The Board shall provide for a "buy out" plan for the waiting period at an additional cost to the insured of 25% of the premium. The criteria, which shall include residency requirements, shall be set by the Board.

6. Eligibility

1. Must be a resident of the state, however, the following shall not be eligible for the pool:

a. persons eligible for health care under Titles 18, 19, and 5 (Medicaid, Medicare, Maternal-Child);

b. persons who have terminated coverage in the pool (unless 12 months have elapsed);

c. persons who have been paid $500,000 in benefits by the pool;

d. inmates of public institutions;

e. persons terminated for coverage of any insurance plan because of nonpayment of premium; or

f. persons eligible for conversion at a cost less than the cost of the pool premium.

2. Any person who ceases to meet eligibility requirements may be terminated at end of policy period.

7. Benefits

Mandated benefits PLUS benefits in standard group plan (as determined by board), including alternative care. Managed care is required and shall be defined by the Board.

8. Referral Fee

None.

If an agent tells an individual that he or she is not eligible for health insurance, the agent must give that individual written notice of the "high risk pool". Rules concerning this notification and penalties for violation shall be adopted by the Bureau of Insurance.

The Board shall furnish agents with a written brochure or leaflet explaining the "high risk pool".

9. Administrative Costs

No statutory cap shall be set at this time. The Board shall make recommendations regarding whether a cap should be set and in what amount in the annual report.

10. Board

A. Composition:

The board shall consist of 7 members to be appointed by the Governor and shall be composed of at least the following:

a. Two public members that represent consumer interests

b. The Superintendent of Insurance or his designee

c. One domestic commercial insurer; and

d. One non profit insurer.

The Chairman of the Board shall be appointed by the governor.

The Board shall report to the Joint Standing Committee on Business and Commerce and the Joint Standing Committee on Human Resources by February 1st of each year. The report shall include the following:

(a) experience under the funding plan and recommendations for further funding;

(b) experience regarding administrative costs and recommendations regarding the need for a statutory cap; and

(c) experience regarding the subsidy program and recommendations for future aspects of the subsidy program.

11. Funding Pool Losses

A majority of the Committee voted to ask the Legislature for an appropriation from the general fund to pay for start-up costs, anticipated losses, and the costs of the "buy out" plan and the subsidy program. After the pool has been in operation for 2 years, the Board will make recommendations regarding future funding of the pool.

There was discussion of the possibility that insurance companies might "dump" their bad risks into the State funded pool. The Committee agreed to watch closely for this problem if it arises.

12. Affordability Issue

The Board shall make available a plan to subsidize premiums for those individuals who have been denied health insurance because of a health condition and who meet income eligibility requirements set by the Board. The subsidy plan shall not exceed $25,000 in costs to the State during the first two years of operation.

No subsidy may be given to a person if the premium amount, after deducting the subsidy, is less than the premium of any individual policy currently available to that person in the State.

The Board shall relate the experience of the subsidy plan to the Legislature in the annual report and shall make recommendations regarding the plan.

13. Support of Robert Wood Johnson Foundation Grant Proposal

The Committee again voted to support the proposal as a very important part of the whole issue of health care for Maine citizens who are unable to obtain health insurance.

VI. MINORITY REPORT

The minority committee members concur with the recommendations of the full committee except with respect to the methods of funding the proposed high risk insurance pool.

The expected losses of the high risk health insurance pool should be funded by an assessment upon the profit and non-profit health insurors and not by a general fund appropriation. The minority committee believes there are several good reasons to support this method of funding. High risk health insurance pools are funded by assessments in every one of the existing seven states. The pool is as much a service to the insurance industry to collectively finance policies that would be too expensive for any one carrier as it is a service to individuals who might otherwise be denied insurance. The pool certainly protects the public appearance and good will of the insurance industry, which otherwise is in the awkward position of denying insurance to the people who are most in need. Insurance company policies are at least partially to blame for creating the situation which requires a high risk pool. Accordingly, it is not inappropriate to ask those companies to bear financial responsibility for the solution to the problem. The actual losses of the pool will be very difficult to anticipate and therefore difficult to appropriate the correct sum of money for in advance. The Legislature, naturally, has been reluctant in the past to approve a program with such an uncertain demand for funds, which might escalate steeply in later years. Based on the experience of other states, the losses could increase rapidly enough to present a significant problem for the appropriations committee; however, these losses would not be a significant proportion of total health insurance revenues. If the insurance industry itself shares the cost of the pool, there needs to be little governmental involvement and accompanying administrative expense.

Finally, the economics of any publicly funded high risk pool will inevitably encourage insurors to place more policies in the high risk pool. This practice, often referred to as "dumping," does not occur because the insurance industry is "bad" but because they are businesses which respond to economic incentives. Only if the industry is assessed to pay for the pool losses will the economic incentive to "dump" be eliminated.

The most common argument raised against insurance industry funding is, in our view, a compelling argument in favor of this method. The industry complained that they did not wish to be selected out exclusively for a "tax" other businesses don't have to pay. In fact, at present, the insurance industry has very favorable tax treatment. The non-profit insuror pays no taxes, and the for-profit insurors pay no corporate income tax. Instead, the for-profit insurors pay a premium tax of 2%, which is similar to, but less than, a sales tax. Sellers of other products collect a 5% sales tax.

The expected costs of the high risk insurance pool are a very modest step in the direction of taxation truly equivalent to those paid by other Maine businesses.

The only other argument against an assessment on insurers is that businesses who self-insure cannot presently be assessed under current Federal law. It is widely expected that Congress will address this problem in the next session, and at least one other state, California, is considering legislation to tax self-insuring businesses that would be contingent on the expected change in Federal law. We recommend that contingent legislation for this purpose be included as well in the proposed legislation for Maine.

In summary, we recommend that the proposed high risk health insurance pool be created in Maine with an annual assessment of all sellers of health insurance to cover pool losses and administration as in every existing high risk health insurance pool.

The minority committee believes that there are legitimate arguments for the general fund to pay for subsidizing the cost of high risk insurance premiums for low-income people whose health impairments qualify them for the high risk pool but have insufficient income to pay the full cost of premiums. We recommend that a general fund appropriation be sought only to subsidize the cost of premiums for high risk individuals who could otherwise not afford to enter the pool but who cannot purchase regular insurance because of their health conditions.

VII. ADDENDUM

Subsequent to the deadline for committee action on this report, but prior to the publication of this final report, the Committee received additional information relating to the proposed method of funding the high risk insurance program.

The Office of Fiscal and Program Review is responsible for reviewing the proposed legislation and preparing the necessary Appropriaton and Fiscal Note data. Their analysis of the proposal indicated that if the program is funded directly by general fund appropriations,as opposed to indirectly through tax credits as other states have done, there is a danger of violating the debt limit imposed on the State by its Constitution.

Article IX, Section 14 of the Maine Constitution (Appendix B) prohibits the state from creating debts in excess of $2,000,000 without a referendum authorizing the issuance of bonds. There are some exceptions to this limit such as the supression of insurrection, to repel invasions, and for purposes of war. In addition, sections 14-A through 14-D created separate Constitutional debt limits for specific programs such as the Maine Guarantee Authority, School Buildings, and others.

The Constitutional question under the proposed funding mechanism arises as follows:

(1) Under the proposed funding mechanism, the state is obligated to pay, during the term of the policy, any and all medical claims of the policyholders, up to the lifetime maximum, which exceed premium income;

(2) The fiscal liability arising from these claims cannot be specifically determined because it is based on an unknown variable, the amount of covered medical care required during each year by the policy holders; and

(3) The medical expenses are highly likely to be extreme because the entire pool of insureds are individuals with known medical problems which automatically places them in a high risk category.*

* A recent survey conducted by the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA) shows one example of the problem. The average medical claim payment for AIDS amounted to $36,159. Forty-one AIDS patients (6%) out of a total of 657 received payments that totaled more than $100,000. Five patients (.1%) had claims that exceeded $200,000.

These factors create a distinct possibility that the valid claims against the state and the administrative expenses of the program will exceed the premiums collected and the amount appropriated for reserves and anticipated claims. When this happens, the debt limit will have been exceeded placing the State in violation of the Constitution. This committee has been advised that the State has probably already reached the $2,000,000 debt limit which is now permitted by the Constitution; therefore, any further debt will exceed that limit.

The committee feels that this Constitutional question warrants further consideration. Time constraints prohibit this committee from evaluating the issue further; but, we recommend that it be carefully examined by joint standing committee of the Legislature to which the legislation is referred prior to any action being taken.

7636

EXISTING STATE HEALTH INSURANCE 'RISK POOL' ASSOCIATIONS

Year Enacted	Connecticut 1975	Florida 1982	Indiana 1981	Iowa 1986	Minnesota 1976	Montana 1985	Nebraska 1985	North Dakota 1981	Tennessee 1986	Wisconsin 1980
Includes self-insurers	Yes	No	Includes those not exempted by federal tax law	No	Yes	No	No	No	Yes	Yes
Tax credit	No	Yes	Yes	Yes*	Yes	Yes	Yes	Yes	Yes	No
Maximum benefits	$1,000,000	$500,000	No limit	$250,000	$250,000	$100,000	$500,000	$250,000	$500,000	$250,000
Benefits Specified	Yes	Yes	Yes	Yes	Yes	Yes	No; specified by regulation	Yes	Yes	Yes
Premium rate	not less than 125% of group rate nor more than 150%	150%, but not to exceed 200%	not more than 150%	150%	125%	not less than 150% but more than 400%	135%, or maximum of 165%	not specified	150%	150%
Outpatient mental health limit	$1,000 per year 50% copay	50% copay with $4,000	the first 20 visits	first 20 visits in calendar year	not covered	not covered	not specified	not covered	35 visits for mental, alcohol, or drug	The first $500 covered expenses plus an additional $2,000 after satisfying deductibles plus coinsurance
Copays, deductibles	$200, $500 or $750	$1,000, $1,500 or $2,000	$200, 20% copay	$500, $1,000 20% copay	#2-$500 #1-$1,000	$1,000	not specified	$150, $500 or $1,000	$500 $2,000**	$1,000, 20% coinsurance
Pre-existing conditions	6 months, 12 months maximum	12 months	6 months	6 months	6 months	12 months	6 months	6 months	6 months	6 months
SNF coverage	120 days if must begin within 3 days of 14 day hospital stay	120 days if services Medicare reimbursable	180 days	SNF/ICF 180 days	120 days if Medicare reimbursable	not covered	established by regulation	not covered	100 days	30 days for non-Medicare participants; 120 days for Medicare recipients, with coinsurance and deductibles after 30 days

* up 20% of premium taxes
** and any other amount determined by the board

STATE DEBT LIMIT

§ 14. State debt limit; exceptions; financial statement in connection with bond ratification election; time limit on bond authorization; debt limit on temporary loans

Section 14. The credit of the State shall not be directly or indirectly loaned in any case, except as provided in sections 14-A, 14-C, 14-D and 14-E.[1] The Legislature shall not create any debt or debts, liability or liabilities, on behalf of the State, which shall singly, or in the aggregate, with previous debts and liabilities hereafter incurred at any one time, exceed $2,000,000, except to suppress insurrection, to repel invasion, or for purposes of war, and except for temporary loans to be paid out of money raised by taxation during the fiscal year in which they are made; and excepting also that whenever two thirds of both Houses shall deem it necessary, by proper enactment ratified by a majority of the electors voting thereon at a general or special election, the Legislature may authorize the issuance of bonds on behalf of the State at such times and in such amounts and for such purposes as approved by such action; but this shall not be construed to refer to any money that has been, or may be deposited with this State by the Government of the United States, or to any fund which the State shall hold in trust for any Indian tribe. Whenever ratification by the electors is essential to the validity of bonds to be issued on behalf of the State, the question submitted to the electors shall be accompanied by a statement setting forth the total amount of bonds of the State outstanding and unpaid, the total amount of bonds of the State authorized and unissued, and the total amount of bonds of the State contemplated to be issued if the enactment submitted to the electors be ratified. For any bond authorization requiring ratification of the electors pursuant to this section, if any bonds have not been issued within five years of the date of ratification, then those bonds may not be issued after that date. Within two years after expiration of that five-year period, the Legislature may extend, by a majority vote, the five-year period for an additional five years or may deauthorize the bonds. If the Legislature fails to take action within those two years, the bond issue shall be considered to be deauthorized and no further bonds may be issued. For any bond authorization in existence on November 6, 1984, and for which the five-year period following ratification has expired, no further bonds may be issued unless the Legislature, by November 6, 1986, reauthorizes those bonds, by a majority vote, for an additional five-year period, failing which all bonds unissued under those authorizations shall be considered to be deauthorized. Temporary loans to be paid out of moneys raised by taxation during any fiscal year shall not exceed in the aggregate during the fiscal year in question an amount greater than ten percent of all the moneys appropriated, authorized and allocated by the Legislature from undedicated revenues to the General Fund and dedicated revenues to the Highway Fund for that fiscal year, exclusive of proceeds or expenditures from the sale of bonds, or greater than one percent of the total valuation of the State of Maine, whichever is the lesser.

[1] Amendment CLI was approved subsequent to the recodification of 1983 but did not reflect renumbered references. These references when next recodified should read "14-A, 14-B, 14-C and 14-D".

§ 14–A. Authority to insure industrial, manufacturing, fishing and agricultural mortgage loans

Section 14–A. For the purposes of fostering, encouraging and assisting the physical location, settlement and resettlement of industrial, manufacturing, fishing, agricultural and recreational enterprises within the State, the Legislature by proper enactment may insure the payment of mortgage loans on real estate and personal property within the State of such industrial, manufacturing, fishing, agricultural and recreational enterprises not exceeding in the aggregate $90,000,000 in amount at any one time and may also appropriate moneys and authorize the issuance of bonds on behalf of the State at such times and in such amounts as it may determine to make payments insured as aforesaid. For the purposes of this section, a documented fishing vessel or a vessel registered under state law shall be construed as real estate.

§ 14–B. Authority to insure revenue bonds of the Maine School Building Authority

Section 14–B. In order to encourage and assist in the provision and construction of public school buildings in the State, the Legislature by proper enactment may insure the payment of revenue bonds of the Maine School Building Authority on school projects within the State not exceeding in the aggregate $6,000,000 in amount at any one time and may also appropriate moneys and authorize the issuance of bonds on behalf of the State at such times and in such amounts as it may determine to make payments insured as aforesaid.

§ 14–C. Authority to insure mortgage loans for Indian housing

Section 14–C. For the purpose of fostering and encouraging the acquisition, construction, repair and remodeling of houses owned or to be owned by members of the 2 tribes on the several Indian reservations, the Legislature by proper enactment may insure the payment of mortgage loans on such houses not exceeding in the aggregate $1,000,000 in amount at any one time and may also appropriate moneys and authorize the issuance of bonds on behalf of the State at such times and in such amounts as it may determine to make payments insured as aforesaid.

§ 14–D. Authority to insure Maine veterans' mortgage loans, and to appropriate moneys and issue bonds for the payment of the same

Section 14–D. For the purposes of recognizing the services and sacrifices of Maine's men and women who have served their state and country through honorable service in the Armed Forces of the United States in time of war or national emergency; enlarging the opportunities for employment of Maine's veterans; insuring the preservation and betterment of the economy of the State of Maine; and stimulating the flow of private investment funds to Maine's veterans, the Legislature by proper enactment may insure the payment of any mortgage loan to resident Maine veterans of the Armed Forces of the United States, including a business organization owned in whole or in part by a resident Maine veteran, when such loans are made in connection with such legitimate purposes and under such terms and conditions as the Legislature may determine, not exceeding in the aggregate $4,000,000 in amount at any one time and may also appropriate moneys and authorize the issuance of bonds on behalf of the State at such times and in such amounts as it may determine to make payments insured as aforesaid.

JG&JS/7379/11/24/86

FIRST REGULAR SESSION

ONE HUNDRED AND THIRTEENTH LEGISLATURE

Legislative Document No.

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND EIGHTY SEVEN

AN ACT to Establish a Maine High Risk Health Insurance Organization to Make Health Insurance Available to People Who Are Unable to Obtain Health Insurance for Health Reasons.

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

Sec. 1. 14 MRSA §8102, sub-§ 4 is amended to read:

4. State. "State" means the State of Maine or any office, department, agency, authority, commission, board, institution, hospital or other instrumentality thereof, including the Maine Turnpike Authority, the Maine Port Authority, the Maine High Risk Insurance Organization, and all such other state entities.

Sec. 2. 24 MRSA §2333 is enacted to read:

§2333.

Every nonprofit hospital service organization shall be subject to the requirements of Title 24-A, c. 71 and any rules promulgated by the Superintendent under that chapter. Any such requirements shall be in addition to requirements of this title.

Sec. 3. Title 24-A MRSA Chapter 71 is enacted to read:

CHAPTER 71

MAINE HIGH RISK INSURANCE ORGANIZATION

§6051. Definitions

As used in this Chapter, unless the context indicates otherwise, the following terms have the following meanings.

1. Benefits plan. "Benefits plan" means the coverages to be offered by the organization to eligible persons pursuant to section 6057.

2. Board. "Board" means the Board of Directors of the organization.

3. Bureau. "Bureau" means the Bureau of Insurance.

4. Health insurance. "Health insurance" means any hospital and medical expense incurred policy, nonprofit hospital and medical service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is stautorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Health maintenance organization. "Health maintenance organization" means an organization authorized in Chapter 56.

6. Insurance arrangement. "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

7. Insured. "Insured" means any individual of this state who is eligible to receive benefits from the organization.

8. Insurer. "Insurer" means any insurance company authorized to transact health insurance business in this state and any nonprofit hospital and medical service corporation.

9. Medicare. "Medicare" means coverage under both part A and part B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.

10. Organization. "Organization" means the Maine High Risk Health Insurance Organization.

11. Plan or Plan of operation. "Plan" or "plan of operation" means the plan of operation of the organization, including articles, bylaws and operating rules, adopted by the board.

12. Superintendent. "Superintendent" means the Superintendent of Insurance.

§ 6052. Creation of the Organization and Board of Directors

1. Organization established. There is hereby created a nonprofit entity to be known as the Maine High Risk Insurance Organization to provide health insurance to persons who are otherwise unable to obtain health insurance for medical reasons, as determined by this Chapter.

2. Reserve fund. A reserve fund shall be established by legislative appropriation to pay any expenses and claims above premium income.

3. Board of Directors established. The Governor shall appoint a Board of Directors for the Organization. The Board shall be composed of 7 members. 5 of those members shall represent the following interests: 2 members shall represent consumers of heatlh insurance, one member shall represent domestic commercial insurers, one member shall represent non-profit hospital and medical service corporations, and one member shall be the Superintendent of Insurance or his designee. Appointments shall be for 5-year terms, except that no more than 2 members' terms may expire in any one calendar year. Appointments for terms of less than 5 years may be made initially and to replace vacancies, if necessary to maintain the approriate staggered terms of office. The Governor shall designate the chair of the Board. The chair of the Board shall schedule an organizational meeting within 60 days of appointment.

§ 6053. Duties of the Board of Directors; Reporting Requirements

The Board of Directors shall:

1. Establish a plan of operation for the Organization to assure the fair, reasonable and equitable administration of the Organization, which may be amended as necessary;

2. Establish procedures for the handling and accounting of assets and monies of the Organization;

3. Select an administering insurer;

4. Develop and implement a program to publicize the existence of the Organization, the eligibility requirements, and procedures for enrollment and to maintain public awareness of the Organization, including furnishing all insurance agents licensed in this state with a written explanation of the Organization and its operation.

5. The Board shall report to the Joint Standing Committee on Appropriations and Financial Affairs, the Joint Standing Committee on Business and Commerce, and the Joint Standing Committee on Human Resources by February 1st of each year. The report shall include the following:

A. experience under the funding plan and recommendations for further funding;

B. experience regarding administrative costs and recommendations regarding an amount of or the need for a statutory cap;

C. experience regarding the subsidy program and recommendations for future aspects of the subsidy program; and

D. an annual audited financial statement certified by an independent certified public accountant.

§6054. The Authority of the Organization

The Organization shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance business and specific authority to:

1. Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Chapter, including the authority to enter into contracts with similar agencies of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions or for technical assistance;

2. Sue or be sued;

3. Take such legal action as necessary to avoid the payment of improper claims against the Organization or the coverage provided by or through the Organization;

4. Establish appropriate rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial function appropriate to the operation of the Organization. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be

adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

5. Receive premiums and legislative appropriations; and

6. Issue policies of insurance in accordance with the requirements of this chapter.

§ 6055. Administering Insurer

1. Selection Process. The board shall select an insurer or insurers (authorized to write health insurance) through a competitive bidding process to administer the Organization. The board shall evaluate bids submitted based on criteria established by the board which shall include:

A. The insurer's proven ability to handle individual accident and health insurance;

B. The efficiency of the insurer's claim paying procedures;

C. An estimate of total charges for administering the plan;

D. The insurer's ability to administer the plan in a cost efficient manner.

2. Term and subsequent appointment.

A. The administering insurer shall serve for a period of 3 years subject to removal for cause.

B. At least 1 year prior to the expiration of the 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

3. Duties

A. The administering insurer shall perform all eligibility and administrative claims payment functions relating to the organization.

B. The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

C. The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the Organization including:

(1) Making available information relating to the proper manner of submitting a claim for benefits to the Organization and distributing forms upon which submission shall be made;

(2) Evaluating the eligibility of each claim for payment by the Organization.

D. The administering insurer shall submit regular reports to the board regarding the operation of the Organization. The frequency, content, and form of the report shall be as determined by the board.

E. Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the board on a form as prescribed by the board.

F. The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

§ 6056. Eligibility

1. Any individual person who is a resident of this state shall be eligible for Organization coverage, except the following:

A. persons eligible for health care under Titles 18, 19, and 5 (Medicaid, Medicare, Maternal-Child);

B. persons who have terminated coverage in the Organization (unless 12 months have elapsed);

C. persons who have been paid the maximum lifetime benefit established pursuant to §6057;

D. inmates of public institutions;

E. persons terminated for coverage of any insurance plan because of nonpayment of premium; or

F. persons eligible for conversion at a cost less than the cost of the Organization premium.

2. Any person who ceases to meet eligibility requirements may be terminated at end of the policy period.

§ 6057. Benefits

1. General benefits. The Organization shall offer major medical expense coverage to every eligible person. Major

medical expense coverage offered by the Organization shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized in sub-section 3 up to a life time limit of not less than $500,000 per covered individual.

The coverage offered by the Organization shall not be less than the benefits in a standard group plan and shall include:

A. All benefits required by state law with respect to group health policies subject to Chapter 35;

B. Alternative care; and

C. Managed care, as defined by the board.

2. Factors affecting benefits. In establishing the Organization coverage, the board shall take into consideration the levels of health insurance provided in the state, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.

3. Deductibles and Coinsurance. The Organization coverage shall provide a deductible or a choice of deductibles of not less than $500 nor more than $1,000 per annum per individual, and coinsurance of 20%. The coinsurance and deductibles, in the aggregate, shall not exceed $1,500 per individual nor $3,000 per family per annum.

4. Premiums

A. Premiums charged for coverages issued by the Organization may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.

B. Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.

C. The Board shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the Organization coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. In no event shall Organization rates exceed 150% of rates applicable to the standard risk rate.

D. The Board shall make available a plan to subsidize premiums for those individuals who have been denied health

insurance because of a health condition and who meet income eligibility requirements set by the Board. The subsidy plan shall not exceed $25,000 in costs to the State during the first two years of operation.

No subsidy may be given to a person if the premium amount, after deducting the subsidy, is less than the premium of any comparable individual health insurance policy currently available to that person in the State.

The Board shall relate the experience of the subsidy plan to the Legislature in the annual report and shall make recommendations regarding the subsidy plan.

5. Preexisting Conditions. Organization coverage shall exclude charges or expenses, except as allowed in ¶¶'s A, B or C, incurred during the first 6 months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to such condition.

A. The preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that

(1) application for Organization coverage is made not later than thirty-one (31) days following that involuntary termination; and

(2) the individual is not eligible for a conversion plan at a cost equal to or less than the organization premium.

Coverage in the Organization shall be effective from the date on which the prior coverage was terminated.

B. Organization coverage for pre-existing condition during the first 6 months shall include up to $1,000 for maintenance expenses as defined by the Board.

C. The Board shall provide a "buy out" plan for the waiting period at an additional first year cost to the insured of 25% of the annual premium. The criteria, which shall include residency requirements, shall be set by the board.

6. Nonduplication of Benefits.

A. Benefits otherwise payable under Organization coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by

all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.

B. The insurer or the Organization shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the Organization may be reduced or refused as a set-off against any amount recoverable under this paragraph.

§ 6058. Duty of Health Insurance Agents and Brokers or Insurers

1. Written notice. Any agent or broker licensed to sell health insurance pursuant to C. 17 shall furnish written notification of the organization to any individual:

A. who has sought health insurance through the agent; and

B. who is not eligible for adequate health insurance other than through the Organization.

Delivery to the individual of the written explanation furnished by the Board pursuant to §6053 shall satisfy this requirement. When coverage is sought other than through an agent or broker, the insurer shall provide the certification required by this section.

2. Rules; penalties.

Subject to the applicable requirements and procedures of the Maine Administrative Procedure Act, Title 5, chapter 375, subchapter II, the superintendent shall adopt rules regarding the notification process and penalties for violations of this section.

Sec. 4. Appropriation. The following funds are appropriated from the General Fund to carry out the purposes of this Act.

	1987-88	1988-89
MAINE HIGH-RISK HEALTH INSURANCE ORGANIZATION		
All Other	$1,000,000	$83,600

Provides funds to establish a $1,000,000 "reserve fund" in the first year of the biennium; and provides funds to underwrite the estimated losses experienced by the Maine High Risk Insurance. Organization. Funds not expended shall not lapse.

Sec. 5. Effective date. The Act shall take effect 90 days after adjournment.

Sale of policies under this Act shall commence July 1, 1988.

FISCAL NOTE

Enactment of this legislation requires a $1,000,000 General Fund appropriation in FY 1988 to establish a reserve fund to pay any expenses and claims above premium income. An $83,600 General Fund appropriation is needed in FY 1989 to cover estimated losses to the Maine High Risk Insurance Organization in its first year of operation. Estimated losses for the organization, to be covered by the General Fund, are as follows:

Year 1 (FY 89)	($ 83,600)
Year 2 (FY 90)	($209,200)
Year 3 (FY 91)	($464,900)
Year 4 (FY 92)	($793,100)
Year 5 (FY 93)	($1,129,100)
Year 6 (FY 94)	($1,465,100)
Year 7 (FY 95)	($1,656,600)

STATEMENT OF FACT

This bill, a result of a Legisltive Council approved study by a special Joint Select Committee, establishes the Maine High Risk Health Insurance Organization. The organization is established to make health insurance available for those individuals who are unable to obtain adequate health insurance because of existing health conditions. The bill provides for a board of directors appointed by the Governor, to select an administering insurer, establish a plan of operation, and set premium rates and schedules. The bill provides guidelines for benefits, deductibles, co-payments, maximum out-of-pocket expenses, premium rates, waiting period for pre-existing conditions, and eligibility.

The bill provides that a plan be established which will allow persons to buy out the waiting period for pre-existing conditions. Additionally, a subsidy plan is to be established by the board of directors to supplement premiums for low-income individuals.

All states that have such organizations have experienced losses. Losses for the organization will be paid from a general fund appropriation. In addition to an annual appropriation, a reserve fund is established in the amount of $1,000,000 to pay for all expected and unexpected losses.