REPORT ON L.D. 1444

TO THE

COMMITTEE ON BANKING AND INSURANCE

SUBMITTED BY:

STATE EMPLOYEE HEALTH COMMISSION

DATE: JANUARY 6, 1994

William McPeck
Co-Chair

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STATE EMPLOYEE HEALTH COMMISSION

(207) 287-6780

January 6, 1994

Senator Dale McCormick, Chair
Representative Edward Pineau, Chair
Joint Standing Committee on Banking & Insurance
State House Station #2
Augusta, Maine 04333

Dear Senator McCormick and Representative Pineau:

Please find the enclosed report on L.D. 1444, An Act to Provide Choice Within the Maine State Employee Health Insurance Program.

The State Employee Health Commission prepared the report as requested by the Joint Standing Committee on Banking and Insurance. The report is based on information gathered by the Commission from Healthsource Maine, Inc., Blue Cross and Blue Shield of Maine, the Maine State Employees Association, and the Maine Medical Association. An analysis of L.D. 1444 by the Commission's consultant, Harvey Sobel of William M. Mercer, served as the foundation for comments and observations by interested parties.

On behalf of the State Employee Health Commission, we would like to extend our appreciation to the Committee on Banking and Insurance for deferring judgment on L.D. 1444 until we had the opportunity to fully examine its merits.

We look forward to meeting with the Committee to discuss this report and any other relevant issues.

Sincerely,

Frank Johnson

Frank Johnson, Co-Chair

William McPeck

William McPeck, Co-Chair

Enc.

September, 1993

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Executive Summary

At the request of the Committee on Banking and Insurance, the State Employee Health Commission (SEHC) completed a study of L.D. 1444, An Act to Provide Choice Within the Maine State Employee Health Insurance Program. To facilitate the study, the SEHC directed its consultant firm, William M. Mercer, to analyze L.D. 1444 while numerous parties were invited to participate in a series of public hearings.

Using the Mercer report and analysis as a benchmark, the SEHC received comments and observations from Healthsource Maine, Inc,; Blue Cross and Blue Shield of Maine; the Maine State Employees Association; and the Maine Medical Association.

The Mercer report identified five major issues to consider in examining proposals for multiple vendors and multiple plans. Those five issues and a brief summary of the SEHC's findings follows:

- Lack of Incentive to be Lowest Bidder - While the "competitive negotiated procurement" process outlined in L.D. 1444 may have merit, the SEHC found no convincing evidence to refute the compelling argument that the proposed bid process would significantly alter the current incentive for vendors to submit the lowest bid.
- Adverse Selection - Healthsource presented a persuasive

argument that risk adjustments, primarily age/sex, may be developed to effectively deal with the problems of risk selection. Blue Cross/Blue Shield testimony and the SEHC's own research revealed that age/sex factors alone have not proven to be accurate predictors. The SEHC found no record of a plan where risk adjustments were introduced in an environment with two networks offering one benefit plan, the concept proposed by L.D. 1444. This is unchartered territory and the SEHC is reluctant to embrace a concept with no proven, effective track record.

- Administrative Costs - While there is the potential for increased administrative costs in a multi-vendor plan, the critical issue is how much of these added costs would be absorbed by the vendors rather than passed onto the State Employee Health Insurance Program (SEHIP). Tillinghast's analysis offered tangible techniques that may enable the SEHC to manage administrative costs. Under any scenario, these techniques should be given consideration in future negotiations with vendors.
- Cost to Employees and Retirees - The cross-subsidy between active and retired subscribers has been a feature of the SEHIP's premium rates for many years. Both Mercer and Blue Cross/Blue Shield comment that it would be difficult to maintain the current subsidy without adverse impact to the contribution rates of retirees. Tillinghast observes that the arrangement could be maintained with the implementation of

risk adjustment factors. While the introduction of multiple vendors does not preclude continuing the subsidy, the need to implement risk adjustment factors causes concern.

- Availability of Providers - All parties acknowledge that more restrictive provider networks can lead to more favorable fee arrangements. Initially, however, the SEHC has decided to introduce the broadest network of providers possible to limit adverse impact on plan members. The issue of network design remains in the forefront as the SEHC begins to evaluate our experience with a managed care program.

Additionally, there were issues not addressed by the Mercer report which were considered in the examination of L.D. 1444. The Maine State Employees Association (MSEA) expressed its genuine concern over the potential disruption of introducing a multi-vendor proposal so soon after employees made the transition from years of a fee-for-service plan to the current point-of-service plan. The prospects for disruption are magnified with national health care reform on the horizon. A consensus developed that the SEHC should not endorse any significant changes to the SEHIP until the parameters of national reform have become more clearly defined. Therefore, it is the Commission's recommendation that L.D. 1444 not be approved.

As the debate on national and state health care reform evolves, the SEHC expects to expand its dialogue with Blue Cross/Blue Shield,

Healthsource, the provider community, and the Legislature on matters of network development, health care delivery, and the issue of having multiple plans.

REPORT ON L.D. 1444

An Act to Provide Choice Within

the Maine State Employee Health Insurance Program

Background

Responding to the directives of the Legislature to significantly reduce health plan expenditures, the State Employee Health Commission (SEHC) introduced Maine State Select, a point-of-service managed health plan, effective April 1, 1993. The Commission's action was challenged in Kennebec County Superior Court resulting in a ruling that instructed the SEHC to issue a Request for Proposals (RFP) according to the following schedule:

- Publication of RFP - April 1, 1993;
- Deadline for bidders' proposals - April 30, 1993;
- Analyses of proposals, interview of finalists, and site visits - May 3 to June 4, 1993;
- Contract award - June 15, 1993.

In response to the RFP, two organizations, Blue Cross/Blue Shield of Maine and Healthsource Maine, submitted proposals for consideration. Following the Commission's analysis and evaluation of the competing proposals, Blue Cross/Blue Shield of Maine was selected as the successful vendor. The selection of Blue Cross/Blue Shield was based at least partly on a quote for retention which was approximately $4 million less than the

Healthsource proposal.

Coinciding with the Commission's deliberations, the Joint Standing Committee on Banking and Insurance was considering L.D. 1444, An Act to Provide Choice Within the Maine State Employee Health Insurance Program. After several work sessions, the Committee decided to hold L.D. 1444 over with the request that the SEHC conduct a study of the bill with the findings reported to the next session of the Legislature.

In the judgment of the Commission, the most effective way to gather facts, opinions, and observations regarding L.D. 1444 was to solicit comments from a wide range of potentially interested parties. With this objective in mind, the SEHC wrote to thirty-five individuals and organizations on September 1, 1993 extending an invitation to participate in public hearings on multiple health plans. Concurrently, the SEHC directed its consultant, Harvey Sobel of William M. Mercer, to conduct an analysis of L.D. 1444. The Mercer report was submitted to the SEHC on September 13, 1993.

At its meeting of October 20, 1993, the SEHC heard testimony from Richard White, Chief Executive Officer of Healthsource Maine; Nancy Nelson, Consulting Actuary from Tillinghast (retained by Healthsource); Karen Foster, Chief Marketing Executive for Blue Cross/Blue Shield of Maine; and Carl Leinonen, Executive Director for the Maine State Employees Association. Following the hearing,

these individuals agreed to respond to specific questions posed by the SEHC.

A significant portion of the SEHC's meeting of November 15, 1993 was devoted to a panel discussion with Richard White of Healthsource Maine; Robert Stevens of the Public Affairs Group; Karen Foster and Ken Giaquinto of Blue Cross/Blue Shield of Maine; and Gordon Smith, Executive Vice President of the Maine Medical Association. Panel members addressed a variety of questions from SEHC members.

Additionally, the prime sponsor of L.D. 1444, Representative Charlene Rydell, reviewed the first draft of the Commission's report and offered several suggestions which have been incorporated into the body of this report.

Lack of Incentives to be Lowest Bidder

The Mercer report identified the major issues to be considered in evaluating proposals for multiple health plans. Several of these items focused on the issue of cost to the plan. First of all, the Mercer report argued that the "competitive negotiation" provision of L.D. 1444 drastically reduces the vendor's incentive to submit their lowest bid. According to the Mercer analysis, "the single biggest obstacle to the State Employee Health Insurance Program (SEHIP) achieving its objective of lowering its costs is the lack of incentives."

It was noted that the SEHIP maintains a limited guaranteed deficit recovery provision which puts the plan at almost full risk for its own claims experience. Therefore, premium rates are not as relevant as actual plan costs. However, the charges for administrative expenses become a significant variable and L.D. 1444 provides no incentives to submit the lowest bid for retention.

Using the most recent competitive bid as an example, the Mercer report recalls that of the $8 million cost difference between Blue Cross/Blue Shield and Healthsource proposals, approximately $4 million was attributable to the vendors' administrative expenses and profit margin. Healthsource bid $10 million, or almost $4 million more than Blue Cross/Blue Shield's $6 million. The Mercer report argues that had L.D. 1444 been in effect, Blue Cross/Blue Shield could have bid $9 million and still have been the lowest bidder - at an added cost to the SEHIP of $3 million.

The Tillinghast report concurs with Mercer's assessment that administrative expenses are more critical than medical expenses in determining the lowest bidder. Tillinghast also acknowledges that there generally would be less incentive to submit a low bid for the administrative component of the premium in the one plan/two vendor model. The Tillinghast report also notes that there are techniques which the SEHIP could use to manage administrative costs.

Blue Cross/Blue Shield argues that the present competitive bid

process produces a powerful incentive for vendors to bid the lowest possible rate with the reward being the entire membership of the SEHIP. The provisions of L.D. 1444 would eliminate this incentive, therefore, vendors would be inclined to submit higher bids.

Healthsource maintains that "competitive negotiated procurement" would enable the SEHC to negotiate with the lowest bidder for claims and administrative costs. Healthsource envisions substantive negotiations with the lowest bidder resulting in much more attractive administrative rates for the SEHIP.

While there may very well be merit to the "competitive negotiated procurement" process provided for in L.D. 1444, the SEHC would conclude that no convincing evidence was presented to refute the compelling argument that the proposed bid process would significantly alter the incentive for vendors to submit the lowest bid. The most recent bid award illustrates the distinct financial advantage to the SEHIP of the current competitive bid process. It would be highly speculative to contend that the bid procedures outlined in L.D. 1444 would have produced the results of the recent bid award.

It should be noted that the statute governing the SEHIP permits the selection of more than one health plan or more than one vendor. Should the SEHC decide to introduce multiple plans or vendors, that option would not require additional legislation. It would,

however, require considerable forethought as to how to modify the bid process to accommodate an award to two or more vendors. This is a scenario which warrants further review in order to facilitate the introduction of plan choice in the future.

Adverse Selection

The issue which generated the most discussion but produced little clarity is that of adverse selection. When multiple plans are offered, the SEHIP membership is no longer one large measurable risk pool. Vendors cannot be assured of insuring a broad cross section of the SEHIP population as employees will choose the plan they believe best meets their needs. Both the SEHIP and the vendors will seek to protect themselves from the potential impact of adverse selection with one vendor enrolling a greater proportion of higher risks. Vendors seeking to protect themselves against insuring a disproportionate share of less healthy subscribers may establish prospective surcharges on premium rates.

The Mercer report offers that if all vendors were to agree to the limited guaranteed deficit recovery rider or a similar financial arrangement, adverse selection is less of an issue. The reason for this is that the SEHIP would assume a significant portion of the underwriting risk thus being in the position to ultimately pay for its own actual claims and excess prospective surcharges could be returned through refund accounting.

Blue Cross/Blue Shield's response concurs with the Mercer report on risk selection issues but also argues that smaller risk pools create greater potential for claims expenses to exceed "stop-loss." Under the present limited guaranteed deficit recovery arrangement, the SEHIP is at risk for the difference between premium paid and actual claims expenses up to 110 percent of the premium. Blue Cross/Blue Shield maintains that with smaller risk pools there is a greater probability that claims expenses would exceed "stop-loss" since the larger pool (i.e. the entire SEHIP population) can better absorb large claims. Obviously, the greater the likelihood that claims expenses will exceed the "stop-loss" amount, the greater the risk to the insurer and the greater charge for the stop-loss protection.

Tillinghast acknowledges the potential for adverse selection in a choice environment, however, the problem is minimized by having two or more statewide networks offering identical benefit plans with identical employer/employee contribution requirements. Tillinghast proposes that risk adjustment strategies can be introduced to address the potential for risk selection. Risk adjustment enables the SEHIP to modify the working premium rates for each vendor by utilizing demographic data such as age, sex, and contract status. In the judgment of Tillinghast, risk assessment and risk adjustment remove risk selection as an obstacle to the introduction of multiple networks.

It is clear to the SEHC that risk selection is a formidable but not an insurmountable issue. We share Tillinghast's contention that risk adjustments can effectively deal with risk selection as a barrier to multiple plans. That is not to say that the SEHC accepts that principle without reservation. Blue Cross/Blue Shield maintains that age/sex demographics are not adequate to establish risk adjustment factors. The SEHC's own research has revealed several studies which conclude that age/sex variables alone have not proved to be accurate predictors of health care expenditures. Further, the SEHC is reluctant to embrace a concept with no track record whatsoever. None of the parties to this study were able to identify another situation where risk adjustments were introduced in an environment with two networks offering one benefit plan with no variation in price to employees. This is a unique structure and one can only speculate how risk selection issues would evolve.

Finally, there was one selection issue which was not addressed by any of the interested parties. The SEHC maintains that even if benefits and employee contributions are identical, there are other techniques which the networks may employ in order to attract a more favorable risk population. It may be extremely difficult to prevent or discourage subtle marketing strategies which can determine employee choice.

Administrative Costs

The issue of added administrative expenses is nearly as elusive as

risk selection. The Mercer report notes that there are relatively fixed expenses such as billing, premium collection, and rerating the group which do not vary significantly with fluctuation in group size. Each vendor would develop and distribute its own marketing materials for subscriber recruitment. Mercer argues that with multiple vendors total administrative expenses would be expected to increase (in terms of both total dollars and a percentage of premiums) in order to reflect the duplication of these services.

Blue Cross/Blue Shield also cites the need for both vendors to prepare and distribute marketing materials, and Blue Cross/Blue Shield contends that some economies of scale may be lost with smaller risk pools. Tillinghast argues that any vendor enrolling one-third or more of the SEHIP population would be large enough to be considered a large employer. In Tillinghast's opinion, there would be little, if any, difference in the target administrative expense margin as a percentage of premium.

Tillinghast's analysis offers suggestions for the SEHC to manage administrative costs. Among the techniques outlined were: requiring vendors to agree to trend guarantees for administrative expenses, limiting administrative expenses as a percentage of premium to the level in place when the point-of-service plan was introduced, or requiring administrative expenses to be expressed on a fixed cost per employee/retiree basis. There is obvious merit to Tillinghast's position that the SEHC should be able to exercise

sufficient leverage to manage administrative expenses charged by vendors.

The Mercer report also expresses some concern that multiple vendors may increase the SEHIP's internal administrative costs. The introduction of multiple vendors will result in limited one-time costs to implement adjustments to the payroll system and to establish membership records. The extent of these cost increases is difficult to determine without a clearer idea of how the two network plans would be designed. There's no question that the SEHIP will assume additional administrative tasks managing multiple vendors, however, it should not be suggested that the costs associated with these administrative functions would be prohibitive.

While all parties agree that administrative expenses for the vendors may increase somewhat, the critical point for the SEHC is defining how much of those added costs would be absorbed by the vendors rather than passed on to the SEHIP. The SEHC would conclude that the potential for increased administrative costs is real but that a much more thorough evaluation of this issue is required before judgment is passed.

Cost to Employees and Retirees

The Mercer report accurately points out that the Health Insurance Trust Fund of the Maine State Retirement System is currently being

subsidized by the funds budgeted for active employees. Under the present single vendor arrangement, the cross-subsidy is not critical since rates are established to collect the total amount of funds required. It is argued that the multiple vendor scenario may ultimately result in any vendor wishing to insure retirees to establish premium rates which are self-supporting. Consequently, it would be expected that premium rates for retirees would increase rather significantly while the rates for active employees would decline slightly. The magnitude of these rate changes would be reflected in the contribution rates of retirees and active employees.

Commenting on the current subsidy of retirees, Blue Cross/Blue Shield advises that discontinuing the subsidy would add $7.4 million to the premiums of non-Medicare eligible retirees. Blue Cross/Blue Shield maintains that in the absence of the entire SEHIP population or proportionate share of non-Medicare eligible retirees and active employees, no insurer could offer a rate which would continue the current subsidy practice. Further, Blue Cross/Blue Shield argues that should the subsidy continue, every insurer would be compelled to adjust rates to compensate for the adverse risks associated with enrolling a disproportionate share of retirees.

The Tillinghast analysis observes that the SEHC may choose to determine that the current subsidy structure is intended. Since the current structure has been such an integral feature of the

SEHIP's premium rates, it is unlikely that the SEHC would consider altering the subsidy in the immediate future. In her follow-up letter, Nancy Nelson of Tillinghast argues that the subsidy could be maintained under a multiple vendor arrangement. Ms. Nelson comments that the differences between active and retiree costs may be recognized by either permitting the vendors to propose separate rates or through age/sex factors used to recognize differences in enrollment mix between vendors. Ms. Nelson notes that the relationship between the rates that the SEHIP chooses to charge retirees and actives are not required to match the relationship in the rates (or risk adjustment factors) used to determine the working rate paid to each vendor.

The SEHC may be persuaded by Tillinghast and Healthsource that the current cross-subsidy arrangement can be continued under a multiple vendor plan, however, in order to accomplish this the SEHC would have to be reliant on the efficacy of uncertain risk adjustment techniques. While the implementation of multiple vendors does not preclude the continuance of the subsidy, the need to introduce risk adjustment factors causes some legitimate concern.

Availability of Providers

The Mercer report notes that more restrictive provider networks can produce more favorable fee arrangements with providers, thus lowering program costs. The Tillinghast analysis acknowledges this principle and asserts that more effective management of care in a

tightly controlled network also contributes to lower costs.

As Blue Cross/Blue Shield reports the current point-of-service (POS)plan includes two-thirds of Maine's primary care physicians as Select Physicians. Presently, the only areas where access to primary care physicians is limited are several remote rural locations with a shortage of physicians. For the SEHC, the issue of availability of providers is as much a matter of access to care as reduced provider fees. The SEHC has made a conscious decision to expand provider networks to ensure access to both the POS and prescription drug plans.

The transition from the fee-for-service indemnity plan to the current point-of-service plan constituted a significant change for subscribers to the SEHIP. In order to make this transition as smooth and palatable as possible, the SEHC determined that the broadest network of providers be a requisite feature. Ultimately, the SEHC may choose to restrict provider networks to further reduce costs but that decision won't be made until and unless the SEHC is satisfied that subscribers will continue to have reasonable access to quality primary care physicians.

Other Selection Criteria

There was unanimity that L.D. 1444 should include selection criteria in addition to cost and provider availability. Nobody would dispute that other selection criteria should include the

vendors' financial solvency, experience in administering managed care services, and demonstrated ability to service an account of the size and diversity of the SEHIP.

Other Comments and Observations

Generally, the Maine State Employees Association (MSEA) concurs with the reservations over costs identified by the Mercer report. Additionally, MSEA expressed concern about the issue of plan disruption for subscribers by introducing the multiple vendor approach advocated by L.D. 1444. Carl Leinonen noted the significant transformation experienced by the SEHIP and he accurately depicted the considerable time and energy that was required to educate employees on the point-of-service plan. Mr. Leinonen candidly noted that a great deal of fear, anxiety, and confusion had to be overcome on the part of plan participants. MSEA was emphatic that it could not endorse a proposal for further changes to the health plan based on speculative savings. A persuasive argument was made that disrupting the plan again at this time would be extremely untimely. With some form of national health care reform expected to be enacted in 1994, it would not be prudent to alter the plan in the next several months only to have to revise the structure to conform to new national mandates.

At the SEHC's invitation, Gordon Smith presented the Maine Medical Association's (MMA) position on L.D. 1444. In his remarks, Mr. Smith expressed the opinion that plan choice would be beneficial to

both patients and physicians as multiple networks would provide for greater participation by physicians and improve geographic distribution of primary care physicians. The MMA acknowledges the potential short-term obstacles and expenses associated with L.D. 1444, but encourages the SEHC to balance the advantages and disadvantages of the multi-vendor approach. From his observation of the national health care reform debate, Mr. Smith commented that it is apparent that a choice of plans will be a cornerstone to the eventual reform package.

L.D. 1444 and National Health Care Reform

Like many other organizations, the SEHC has been monitoring the development of various national health care reform initiatives. Obviously, many questions have emerged and will remain unresolved until a comprehensive package is enacted. In examining President Clinton's plan, the SEHC is particularly interested in the status of large public sector plans such as the SEHIP and their relationship with regional alliances. In its present form, the President's proposal prohibits the SEHIP from establishing a corporate alliance. This will certainly be a determining factor in assessing the SEHIP's role and responsibility in a much larger risk pool which in turn, may affect the SEHC's anxiety over a federal risk adjustment system.

It is apparent from reviewing the various health care proposals that consumer choice will be a fundamental principle in whatever

reform plan finally emerges. Choice is likely to be a point-of-service plan in concert with a fee-for-service plan and an HMO. Clearly, the SEHC must be prepared to introduce plan options consistent with federal and state requirements. Fortunately, sufficient time will lapse between now and the introduction of a national health care plan to allow for a well executed transition.

In the interim, it would be beneficial for the SEHC to continue its dialogue with Healthsource, Blue Cross/Blue Shield, the provider community, and key legislators to assess the impact of national reform initiatives.

Commission Findings and Conclusions

The SEHC is grateful to Healthsource, Blue Cross/Blue Shield, the Maine State Employees Association, and the Maine Medical Association for offering their insights and observations on L.D. 1444. The conduct of public hearings was an exercise that provided the SEHC with differing perspectives on the provisions of L.D. 1444 in particular, and multiple vendors more generally. Virtually all parties to this dialogue would agree that L.D. 1444 contains some flaws. There was considerable debate, however, as to whether these deficiencies were significant enough to dismiss this proposal.

Of the issues outlined in the Mercer report, the SEHC found each produced a different level of concern or unease. The problems surrounding administrative costs and the availability of providers

are relatively straightforward and manageable. The questions concerning the competitive bid process and risk selection are far more complex and wrenching. These were the issues generating a wide disparity of opinions, often based on theory rather than practical experience. Perhaps, no other factor contributed to the SEHC's reservations over L.D. 1444 more than the uncertainty of its provisions. The lack of a proven record or anecdotal history to support selected parts of the proposal caused considerable anxiety.

This is not to suggest that the basic principles of L.D. 1444, choice and competition, are not worthy concepts. The SEHC is firmly committed to choice and the Commission fully recognizes that national health care reform will demand choice in plans and providers. Questions remain as to how choice can be expanded without disrupting the plan and inadvertently increasing plan costs. Competition is obviously in the best interests of the SEHIP as the most recent bid process clearly demonstrates.

As the SEHC struggles with these issues, the Commission is looking over its shoulder at the uncertain figure of national health care reform. While we can't identify what changes the SEHC will have to adapt to, we can be certain that there will be some major changes. During the Commission's discussions with the interested parties, a consensus developed that it would be prudent to monitor the national reform debate and delay any action on multiple vendors until national health care reform is more clearly defined.

Hopefully, some of the more weighty questions posed by L.D. 1444 will be addressed in a national reform package. This posture enables the SEHC and all parties to continue their dialogue on choice and competition while we await clearer direction from the federal level.

It should be noted that the stated objectives of L.D. 1444 are not inconsistent with the goals of the SEHC to provide access to high quality, affordable health care to subscribers of the SEHIP. The SEHC's objections to L.D. 1444 are not based on issues of fundamental policy but rather on sincere reservations over the practical consequences.

Recommendation to the Committee on Banking and Insurance

All parties to this process are in agreement that the SEHC should await enactment of national reform before embarking on a multiple vendor plan. Healthsource has acknowledged that its own interests will shift from L.D. 1444 to the broader issue of adequate health care of all Maine citizens. Clearly, the focus of the Committee on Banking and Insurance will be on proposals such as L.D. 1285, The Family Security Act. In light of that, the Commission would recommend that L.D. 1444 not be approved.

The SEHC wants to express its desire to continue discussions with the Committee and other interested parties on state and national reform measures. The Commission would like to exert a greater role

in this debate and welcomes an opportunity to work with Blue Cross/Blue Shield, Healthsource, and the provider community as the SEHC refines its networks, evaluates quality of care, and strives to improve the delivery of health services to its subscribers. Further, the Commission will continue to examine other states which offer multiple options as the SEHC proceeds with plan development.

APPENDICES

A. Mercer Report - Providing State Employees With a Choice of Health Plans: Issues to be Considered

B. Tillinghast Report - Report to Healthsource Maine Regarding L.D. 1444

C. Testimony of Richard White, Healthsource Maine, Inc. before State Employee Health Commission on October 20, 1993

D. Testimony of Karen Foster, Blue Cross and Blue Shield of Maine before the State Employee Health Commission on October 20, 1993

E. Testimony of Carl Leinonen, Maine State Employees Association before the State Employee Health Commission on October 20, 1993

F. Response of Nancy Nelson of Tillinghast, to questions from the State Employee Health Commission dated November 10, 1993

G. Response of Richard White of Healthsource Maine, to questions from the State Employee Health Commission dated Nov. 12, 1993

H. Testimony of Richard White of Healthsource Maine, before the State Employee Health Commission on November 15, 1993

APPENDIX A

Mercer Report

WILLIAM M.
MERCER
INCORPORATED

MAINE STATE EMPLOYEE HEALTH INSURANCE PROGRAM

PROVIDING STATE EMPLOYEES WITH A CHOICE OF HEALTH PLANS: ISSUES TO BE CONSIDERED

September 13, 1993

Contents of Report

SECTION 1: BACKGROUND

On May 5, 1993, Legislative Document No. 1444 (L.D. 1444) — An Act to Provide Choice within the Maine State Employee Health Insurance Program (SEHIP) — was introduced into the Maine Legislature. The purpose of the act is to reduce the costs of the SEHIP through the introduction of multiple health insurance vendors. In essence, the State Employee Health Commission (SEHC) would be required to offer employees a choice of any insurance vendor who is able to provide Maine State Select point-of-service plan benefits for the same premium rates as is bid by the lowest-cost vendor.

L.D. 1444 is not the first time that the SEHIP considered multiple vendors; in January, 1990, the SEHIP requested bids from health maintenance organizations (HMOs) to satisfy the requirement that two or more health insurance options be offered. This requirement was the result of negotiations between the State of Maine and the unions representing State of Maine employees' bargaining units, which included MSEA and AFSCME. While multiple vendors were ultimately not offered in 1990, the results of the bidding process conducted at the time provide an insight as to what might be expected under L.D. 1444 — or a successor act.

add MSTA

L.D. 1444 was not enacted by the 116th Legislature, but was held over to the next session. The Legislature directed that the SEHC examine the bill in detail and report back to the Legislature by January, 1994 as to the effects the bill will have on the SEHIP.

William M. Mercer was asked by the SEHIP to provide the SEHC with analysis of issues to be considered under any bill that requires SEHIP offer health insurance through more than one organization or insurer. This report analyzes the major issues the SEHC should consider.

SECTION 2: ISSUES TO BE ADDRESSED UNDER L.D. 1444

2.1 COST TO THE SEHIP

The purpose of L.D. 1444 "is to reduce the costs of the SEHIP so as to avoid serious detrimental impact on the financial position of the State." L.D. 1444 envisions doing so by directing that the SEHC go out to bid. In the process, the SEHC must:

- Negotiate initially with the lowest responsible bidder to refine the benefit design and establish the lowest set of premium rates; and then
- Allow any other organization or insurer that can provide statewide coverage[1] and that has submitted a timely bid to offer its point-of-service plan at the same rates as the lowest bidder.

This is in contrast to the current bid process, in which bidders submit their "best-and-final" price, and the SEHC selects the single, lowest-cost bidder.

There are three major obstacles to the process proposed by L.D. 1444 yielding cost savings. These obstacles can be summarized as follows:

- There's no incentive to be the lowest bidder;
- Choice introduces adverse selection, which raises plan costs; and
- There's added administrative costs — both for the vendors and to the SEHIP — of having multiple vendors insure the SEHIP.

[1] or has the ability to arrange for services on a statewide basis.

These items are described in further detail in the rest of this subsection.

Lack of Incentives To Be The Lowest Bidder

The single biggest obstacle to the SEHIP achieving its objective of lowering its costs is the lack of incentives; the vendors have no incentive to offer the lowest price. All they need do is be prepared, after the all the bids are in, to match the price of the vendor who happens to be the lowest. This is unlike the current arrangement in which the vendor with the lowest price scores the highest in the cost category of the bid scoring and enhances its chance of being awarded the contract.

For example, the SEHC recently bid its medical plans, for a July 1, 1993 effective date. Two vendors submitted bids — Blue Cross/Blue Shield of Maine (BCBSME) bid $76 million while Healthsource bid $84 million, a difference of $8 million. The medical plan was ultimately awarded to BCBSME, in part because of the favorable financial terms relative to Healthsource.

Had L.D. 1444 been in effect, BCBSME would not have had the same incentive to bid so low. It could have bid $82 million with the knowledge that even if another vendor bid less than $82 million, BCBSME could match it (presumably down to as low as $76 million). Of course, with the benefit of hindsight, we see that a bid of $82 million would still have made BCBSME the lowest bidder — but at a cost to the SEHIP of $6 million more than might have otherwise paid absent L.D. 1444.

The SEHIP currently has signed a Limited Guaranteed Deficit Recovery Rider which puts the SEHIP at almost full risk for its own claim experience.[2] Therefore, premium rates do not matter as much as actual plan costs — the sum of actual claims, capitation payments, and the insurer's charges for administrative expenses and profit. However, even assuming that claims and capitation payments are the same for all vendors, the vendors would still have no incentive to furnish the lowest bid for their administrative expense and profit charges.

Returning to our example of the most recent bid, of the $8 million cost difference, about $4 million was attributable to the vendors' administrative expenses and profit margin: Healthsource bid $10 million, or almost $4 million more than BCBSME's $6 million. Had L.D. 1444 been in effect, BCBSME could have bid $9 million and still been the lowest bidder — at an added cost to the SEHIP of $3 million.

[2]The rider obligates the SEHIP to reimburse BCBSME for claims and administrative expenses to the extent it exceeds premium. However, the State is not liable for any shortfall above 10% of premium. If experience is favorable, the SEHIP is entitled to the entire surplus.

Adverse Selection

When vendors prepare their bids, they are assuming that they will be insuring the entire SEHIP, and their rates reflect the experience of a broad cross-section of State employees — healthy as well as unhealthy employees. When multiple vendors are offered, an individual vendor can not be assured of obtaining this broad cross-section, since employees will generally choose the plan that best meets their needs. This process is known as *adverse selection*, and insurers will seek to protect themselves against insuring a disproportionate share of less healthy, more costly employees by surcharging their premium rates. In some cases, the surcharge is a function of what percentage of the group the vendor enrolls.

For example, in early 1990, the SEHIP was in the process of selecting one of three HMOs to be offered as an alternative to the then-current BCBSME traditional indemnity plan. To protect itself from adverse selection, BCBSME added 5½% to its indemnity plan premium rates. At today's premium volume, this translates to about $4 million.

If all vendors were to agree either to the Limited Guaranteed Deficit Recovery Rider, in which the SEHIP bears most of the underwriting risk, or to another financial arrangement that permit the SEHIP to assume some of the underwriting risk, adverse selection is less of an issue, since the SEHIP will ultimately pay for its own actual claims, and any "unneeded" surcharges will presumably be returned. However, adverse selection can still occur — albeit at a lesser level — since employees will still be able to select against the SEHIP.

Added Administrative Costs

Under its current medical plan, the SEHIP is paying BCBSME approximately $6 million — or 8% of premium — to cover BCBSME's administrative expenses and profit charge. The $6 million covers BCBSME's cost of processing claims, billing and collecting premium; servicing the account and rerating the group each year. In addition, the $6 million covers the SEHIP's share of BCBSME's expenses for developing its provider networks and for other corporate overhead items, such as new computer systems. Many of these expenses are related to the size of the SEHIP — either in terms of number of employees or number of claims. To the extent there are multiple vendors, administrative expenses would be shifted from BCBSME to these other vendors.

However, there are many administrative expenses that are relatively fixed. For example, the expenses of billing and collecting premium or rerating the group does not vary significantly with changes in the size of the group. Furthermore, each vendor would need to develop its own marketing material describing its plan and its provider network. Therefore, in the event multiple vendors are offered, total administrative expenses would be expected to increase — both in absolute dollars and as a percentage of premium — to reflect the cost of these redundancies.

In addition to external costs, there are added internal costs as well. The SEHIP would now have to administer multiple medical plans. To do so, the State might have to purchase new software to keep track of employee elections and notify each vendor of their covered participants. At a minimum, the SEHIP would have the added administrative cost of negotiating with multiple vendors and communicating the multiple plans to its employees.

2.2 Cost to Employees and Retirees

Section 2.1 describes how L.D. 1444 will tend to add rather than reduce costs to the SEHIP. Because employees and retirees pay for dependent coverage, any increase in costs, by definition, will raise contribution rates. However, there's one additional consideration.

In the past, BCBSME developed premium rates without separately charging for the higher costs associated with insuring retirees. Retirees, to a large extent, are being subsidized by active employees. For example, for the current fiscal year (the year ending June 30, 1994), the rates were developed as follows:

- Maine State Select rates *for other than prescription drug coverage* do not vary between active employees and non-Medicare eligible retirees;
- Prescription drug rates do not vary between active employees and retirees (both non-Medicare and Medicare eligibles); and
- Medicare-eligible retirees have separate rates for all but prescription drug coverage: Companion Plan community rates for Medicare supplement coverage and experience rates for major medical coverage.

As a result of this rate structure, the Health Insurance Trust Fund of the Maine State Retirement System is currently being subsidized by the funds budgeted for active employees. Furthermore, retiree contribution rates are understated, while active employee contribution rates and COBRA rates are slightly overstated.

When one health insurer is underwriting the entire SEHIP, these cross-subsidies are not that critical, since the insurer is able to set rates to collect the needed amount of funds in total, even if the amounts by status (active employee vs. retiree) are incorrect.

In the event the SEHIP offers multiple health insurance vendors, BCBSME — or any vendor wishing to insure retirees — will have a greater need to establish premium rates that are self-supporting. Consequently, we would expect premium rates for retirees to increase. At a minimum, vendors would establish a separate class of prescription drug rates for Medicare eligible retirees. These rates could be two or three times the current set of rates (vs. the current composite rates). It is also possible that, over time, vendors would request a different, higher set of rates for non-Medicare eligible retirees.

Should retiree rates be increased, the following can be expected to occur (all other things being equal):

- Plan costs will go up for the Health Insurance Trust Fund;
- Plan costs will decline slightly for the funds budgeted for active employees:
- Contribution rates for retirees will increase significantly; and
- Contribution rates for active employees and COBRA qualified beneficiaries will decrease slightly;

2.3 Availability of Providers

L.D. 1444 seeks to lower costs while, at the same time, increasing the availability of providers. The past experience of the SEHP has shown that to lower costs, the Program should consider *restricting* the availability of providers, whether it's physicians, hospitals or pharmacists. That's because vendors are able to negotiate lower fees with providers if they are able to be exclusive. A provider will accept lower fees if they feel threatened with the loss of patients. However, if the provider can retain his (or her) SEHP patients by "holding out" for another vendor with more favorable financial terms, he'll do so — at an added cost to the SEHP.

For example, when the SEHC last bid the medical plan, effective July 1, 1993, BCBSME indicated that they could lower physician fees by 5-10% if the SEHP were willing to limit the number of specialists in the Maine State Select network. In the prior bidding of the prescription drug plan, effective July 1, 1992, all of the drug vendors, including the incumbent, MEDCO, indicated that they could lower fees paid to pharmacists by about 10% by limiting the size of the pharmacy network.

Maine State Select program currently has a very high percentage of participating Maine providers; over 60% of the primary care physicians, 97% of the specialty care physicians and all 42 hospitals participate. While there are some areas of the State with limited access to primary care physicians, this is more a result of a shortage of physicians rather than a shortage of medical insurers.

2.4 Other Selection Criteria

In selecting a medical vendor, the SEHC applied selection standards that gave weight to criteria other than cost and provider availability. Some of these criteria were the financial solvency of the vendor, their claims paying ability and their ability to service the SEHIP in a timely manner.

L.D. 1444 is silent as to all selection criteria other than cost and provider availability. Any vendor who is willing to match the price of the lowest cost bidder must be allowed to offer its plan to employees, provided it has statewide access. For example, it doesn't matter whether the vendor is unable to process a simple claim; the SEHC must offer the vendor as a choice.

Of particular concern is financial solvency, which constituted 15% of the scoring in the last bidding. With the failure of Executive Life and Mutual Benefit Life, employers and the general public are increasingly concerned about the viability of their insurers. Most employers will not place their health insurance business with undercapitalized insurers and/or insurers who are not highly rated by the major insurance company rating services.

Should the SEHC be required to offer multiple medical vendors, it should not be at the expense of its selection standards. The SEHC should have the right to reject vendors that are inadequately capitalized or do not meet its service or other administrative criteria.

2.5 Legal Considerations

L.D. 1444 requires that the SEHC offer any vendor meets all five of the following conditions:

1. The vendor must be a licensed HMO, insurer or nonprofit service organization;
2. The vendor submits a timely bid;
3. The vendor agrees to match the point-of-service plan benefit design of the lowest bidder;
4. The vendor agrees to match the schedule of rates of the lowest bidder; and
5. The vendor has either statewide coverage or the ability to arrange for services on a statewide basis.

On the surface, these requirements seem clear. However, upon careful examination, the last two requirement could cause any bidding process to go into litigation, for the following reasons:

Schedule of Rates

As discussed in greater detail in Section 2.1, the SEHIP, by signing the Limited Guaranteed Deficit Recovery Agreement, has agreed to be at almost complete risk for its own claim experience. Therefore, any schedule of rates only represents the vendors' upfront estimate of the costs of the Program for the upcoming year and is not a schedule of premium rates in the normal sense of the word, since the SEHIP's cost is not guaranteed. Vendors could deliberately bid low, recognizing that the SEHIP will be liable for any shortfall.

For example, in the last bidding, BCBSME bid $76 million to insure the SEHIP, which was $8 million less than Healthsource's bids. Of the difference, about $4 million was attributable to Healthsource being more conservative in projecting claim experience than BCBSME. While some differences may be valid, since each vendor reimburses providers under different fee or capitation schedules, many Commission members believed that the $4 million was not a real cost difference. It was felt that a comparison of each vendor's administrative expenses and profit margin (i.e., retention) was a more valid basis for judging the costs of the two vendors rather than premium rates.

Therefore, absent an elimination of the Limited Guaranteed Deficit Recovery Agreement, any vendor could claim to be able to match the lowest schedule of rates, since any shortfall is recoverable. The SEHC does not appear to have the needed authority under L.D. 1444 to base the award on the true cost differences between bidders.

Statewide Coverage

The language used to require that the vendor has either statewide coverage or the ability to arrange for services on a statewide basis could also generate litigation. The language does not give the SEHC the needed authority to judge the viability of a vendor's provider network, since the criteria is not specific. For example, a vendor whose provider network includes one doctor in each county could claim that they have statewide coverage, but clearly their network would be inadequate. Yet the SEHC does not have the clear authority under L.D. 1444 to rule out that vendor.

Furthermore, since virtually any vendor awarded a contract with the SEHP will have the potential "patient clout" to negotiate with providers in areas of Maine where they are currently weak, any vendor could claim that they have "the ability" to arrange for services on a statewide basis, even if their current network is limited.

Given the history of past litigation over prior SEHC awards, it is critical that L.D. 1444 be clear as to how awards must be made. As it stands now, any vendor ruled out for the two major reasons — cost or network coverage — has the grounds to litigate the award.

SECTION 3: CONCLUSION

Maine State Select currently provides employees with considerable choice of providers. Employees are covered if they seek medically necessary care at any provider, but receive enhanced benefits if care is rendered by a Maine State Select participating provider. With participation in Maine State Select so high, one can argue that multiple health vendors are not necessary and, in fact, counterproductive.

However, should the Legislature still wish to require that the SEHC offer additional vendors, it needs to consider and address the issues raised in this report. Otherwise, the costs to the SEHIP, as well as to its participants, will probably increase rather than decrease.

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APPENDIX B

Tillinghast Report

REPORT TO HEALTHSOURCE MAINE REGARDING

LEGISLATIVE DOCUMENT NO. 1444

"AN ACT TO PROVIDE EMPLOYEE CHOICE WITHIN THE STATE EMPLOYEE HEALTH INSURANCE PROGRAM"

OCTOBER 14, 1993

Tillinghast
A Towers Perrin Company

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I. INTRODUCTION

Legislative Document No. 1444 was introduced into the Maine Legislature in May, 1993. The legislation, which is referenced as L.D. 1444, is titled "An Act to Provide Choice within the Maine State Employee Health Insurance Program." If enacted, the legislation would require that a choice of vendors be offered to Maine Employees covered under the Maine State Employee Health Insurance Program (SEHIP). The lowest bid submitted to the SEHIP would be used to establish working premium rates, and any vendor wishing to be offered would be limited to these rates.

L.D. 1444 was carried over to the next session for further consideration by the Banking and Insurance Committee. The Committee also directed the State Employee Health Commission (SEHC) to examine the bill and report on its potential effect on the SEHIP by January 1994.

Tillinghast provides actuarial consulting services to Healthsource Maine, Inc. Healthsource Maine has asked Tillinghast to prepare a report commenting on issues relevant to L.D. 1444, and responding to a report prepared for the SEHC by its consulting firm, William M. Mercer, Inc.

This report includes comments on the following items:

- The advantages of choice in employer plans,
- Approaches that may be used to address risk selection issues, and
- The Mercer Report.

II. ADVANTAGES OF CHOICE IN AN EMPLOYER HEALTH PLAN

The SEHIP has adopted a point-of-service benefit plan structure featuring more generous benefits for services that are received from a network of participating providers. With a network benefit program, employee choice of providers is necessarily somewhat more limited than under a traditional open access fee-for-service type of benefit program, given that there are higher in-network benefit levels when network providers are used. We believe that, over the long term, offering a choice of point-of-service plan sponsors will help to ensure that the SEHIP provides state employees with a benefit plan that is both cost effective and high quality.

Offering a choice of point-of-service plan sponsors should increase employee satisfaction with the program by providing greater choice of providers. Unless the competing networks are identical, offering a choice will increase the number of employees who are able to continue existing relationships with their current medical providers. The broader overall choice of providers allowed by a choice of plan sponsors should also improve the geographic distribution of providers.

The level of service provided to both employees and their families and to the employer should be improved with a choice of programs. With the existence of two programs, there will be a need for each vendor to compete for membership. Since L.D. 1444 requires that the same benefit plan and rates will be used for all vendors, employees will perceive no difference between the plans from benefits or contribution rates. As a result, competition between plans will be largely on the basis of the quality of the services provided.

A choice of vendors also creates a basis for comparison. In managed care programs, such as the SEHIP's point-of-service program, utilization and cost statistics

are usually monitored more closely than has historically been common under unmanaged fee-for-service plans. Measurement and comparison of utilization and cost patterns will help the SEHIP to evaluate the effectiveness of its managed care programs. If a significant difference were to be found that could not be explained through an evaluation of risk selection, the SEHIP would be able to justify goals for improvement for the plan(s) with less favorable results.

Innovation is more likely to occur in a competitive situation. An example of innovation in benefit delivery might include new programs designed to encourage employee fitness, or to promote health education. Innovation in service might include expansion of information provided to the SEHC. For example, data on the utilization of well child and well adult services, such as immunization rates and cancer screening tests could be provided.

III. RISK ADJUSTMENT

Health risk assessment and health risk adjustment are two concepts that are receiving considerable attention in the context of the current health care reform discussions occurring at both the Federal and State levels.

Risk assessment and risk adjustment are also important concepts in the discussion of L.D. 1444 because they are the means of dealing with the potential for risk selection in a choice situation. If risk selection occurs and the working premium rates are not risk adjusted to reflect this selection, the working premium will be overstated for one (or more) vendors while being understated for the remaining vendors. This result can be avoided through an appropriate risk adjustment mechanism. Therefore, risk selection should not be an obstacle to the introduction of a choice of plan sponsors to the SEHIP.

Health risk assessment is a means of determining how the expected medical expense of a particular person or group relates to expected average medical expenses. The assessment of an individual or group should be made in an objective way. Risk assessment can be simple, involving only readily available information such as age, sex, contract status (e.g., single/family or active/retiree) or geographic location.

More complex risk assessment methods are also available. These involve evaluation of self-reported health status, or evaluation of past medical expense history as a predictor of future consumption of services. Examples of more complex methods include Diagnostic Cost Groups or DCGs which considers inpatient claims history, Ambulatory Care Groups or ACGs which consider prior year diagnoses, and the RAND 36-Item Health Survey 1.0, which is a self-report of health status.

Risk adjustment refers to a process to recognize differences in the risk characteristics of different populations. Risk adjustment methods can be designed to reduce the effect of risk selection, which may occur either randomly or intentionally. Risk selection may be considered as the situation where a population has a risk assessment factor which is measurably different from the average.

In general, a risk assessment/adjustment method must balance accuracy with the ease of data collection and ease of administration. For the SEHIP population, the detailed historical information needed to use an approach that considers past consumption of services is not likely to be readily available, and an assessment process that requires self-evaluation would be administratively cumbersome. However, the information needed to use a demographic approach to both risk assessment and risk adjustment should be readily available to the SEHIP.

IV. COMMENTS ON MERCER REPORT

As noted in the introduction, William M. Mercer prepared a report for the SEHC commenting on issues raised by L.D. 1444. As requested by the SEHC, we have responded to the issues raised by Mercer.

A. COST TO SEHIP

The Mercer report identifies three possible obstacles to cost savings under L.D. 1444. These include: (1) there may be no incentive for any plan to be the lowest bidder, (2) there will be potential for adverse selection, and (3) administrative expenses will increase.

Incentives to be Lowest Bidder

Under L.D. 1444, each potential vendor would be required to prepare a bid based on claims history and demographic data of all persons covered by the SEHIP. The rates included in the bid would identify medical expense and administrative expense components separately. This distinction is important, as the SEHIP program is subject to a "limited guaranteed deficit recovery" rider. Under this rider, the State is at risk for the actual cost of claims incurred, until the point that claims for a given year exceed the expected cost of claims, plus 10% of the total premium (medical expenses plus administrative expense).

Because of this limited guaranteed deficit recovery provision, the SEHIP is essentially at full risk, or effectively is self-funded, for the medical portion of the program. As a result, the SEHIP will be responsible for the actual cost of claims, and the projected medical claims expense submitted by all vendors becomes less critical.

What is critical, however, is that the value projected for expected claims is reasonable -- neither too high nor too low. Given that the State is essentially at full risk for claims, what should be most important is that the low bid has been developed using reasonable assumptions, in order to provide the SEHIP with a reasonable expectation of its likely claims experience for State budgeting.

Other factors could also be considered in evaluating projected medical expenses and expected cost differences between vendors. Examples would include a comparison of average fees for a sample of service types and comparison of historical utilization statistics for comparable populations.

The Mercer report notes that administrative expenses are more critical than medical expenses in determining the lowest bidder. We would agree with this conclusion. The Mercer report also expresses concern that there will be less incentive to submit a low bid for the administrative component of premium. This may be true, but there are ways that the SEHIP could manage the administrative costs and help control overall costs for the SEHIP program. These might include: requiring vendors to agree to trend guarantees for administrative service expenses, limiting administrative expense as a percentage of premium to the level in place when a point-of-service agreement was first introduced, or requiring administrative expenses to be expressed on a fixed cost per employee/retiree rather than as a percentage of premium, or guaranteeing costs on a per transaction basis.

Potential for Adverse Selection

We agree with the Mercer report that, in a choice environment, there will be potential for selection. However, we believe that the potential for selection is minimized in a choice situation involving two or more statewide managed care networks offering identical benefit plans and subject to identical employer/employee contribution requirements.

Alternatively, if one of the networks is more tightly controlled, costs for members in that plan should be lower relative to those for comparable members in the other plan, because the more tightly controlled network should be able to manage utilization more effectively. In this case, overall costs for the State should be reduced, rather than increased, despite any bias in the enrollment between plans.

In either case, it is possible to risk adjust the working premium rates for each vendor by applying demographic adjustment factors to the rates that reflect the demographics of the employees that enroll in each plan. A simple example of how this could be accomplished is given below:

EXAMPLE OF RISK ADJUSTMENT TO RATES

Vendor	Enrollee	Mix	Rate	Age/Sex Factor	Working Rate
Initial Rate Proposal - Based on Total Group Demographics					
A	Active	80%	$100.00	1.00	$100.00
	Retiree	20%	$175.00		$175.00
	Total/Avg	100%	$115.00		$115.00
B	Active	80%	$ 95.00	1.00	$ 95.00
	Retiree	20%	$165.00		$165.00
	Total/Avg	100%	$109.00		$109.00
Negotiated Rates - Vendor B Proposal Accepted, Vendor B Rates Age/Sex Adjusted To Developing Working Rates					
A	Active	35%	$ 95.00	1.030	$ 97.85
	Retiree	15%	$165.00		$165.00
	Average	50%	$109.00		$118.00
B	Active	45%	$ 95.00	.977	$ 92.82
	Retiree	5%	$165.00		$165.00
	Total/Avg	50%	$109.00		$100.00
Total A & B		100%	$109.00		$109.00

The example summarizes the rates initially proposed by two vendors, Vendor A and Vendor B, and the working rates for the two vendors after adjustment for the age/sex mix of the enrollees actually selecting each vendor. To simplify the example, we have used only rates for single employees, and assumed that 50% of total enrollees select each plan, with a somewhat skewed active/retiree mix by plan. We have also assumed that the early retiree group primarily consists of persons in the 60 to 65 range, and that no age/sex adjustment is required for these persons. The risk assessment and adjustment method to be used to modify the negotiated premium rates could be specified as part of the bidding process.

Administrative Expenses

Large employers generally offer at least some choice in their health plan offerings. This may be accomplished through high and low benefit plans, or through offering HMO options.

In the case of offering a choice of vendors, the Mercer report indicates that administrative expenses will increase for both the vendors and the employer. The vendor's reduced ability to spread fixed costs over a larger number of persons is given as an example. We agree that costs may increase to the vendor somewhat. However, in practice, we suspect that the number of persons that would be covered by a vendor enrolling as little as a third of the total SEHIP population would be large enough that the group would be considered to be a very large employer. As a result, we believe there would be little, if any, difference in the target administrative expense margin as a percentage of premium relative to that which would be charged for the full group. With regard to preparing bids and customized marketing materials, we believe that most HMOs and carriers should be prepared to provide these services fairly routinely.

The Mercer report also expresses concern that costs will increase for the SEHIP if it is required to deal with two vendors. However, it would be appropriate to verify the real extent of the increase in costs. For example, would the State actually have to invest in new computer software, as suggested by the Mercer Report? Our experience is that most large employer's payroll systems can easily accommodate an additional benefit option, and once programmed, there should be no incremental costs. In addition, L.D. 1444 specifies that any cost associated with consulting fees required to deal with multiple vendors would be passed back to the vendors.

B. COST TO EMPLOYEES AND RETIREES

The Mercer report notes that the current program tends to subsidize retirees through the rates charged to active employees, and that this situation may change if a choice of vendors is provided.

One response to this criticism is that, while the current structure may subsidize the retiree rates at the expense of active employees, it would be appropriate for the State to formally evaluate whether this is its intent.

If it is the intent of the State to continue this type of subsidy structure, we believe it may be accomplished in a multiple choice situation by specifying the expected/ desired relationship between employee, retiree and early retiree rates in the bid specifications. As a result, we feel a conclusion that rates for retirees will necessarily rise is invalid.

C. PROVIDER AVAILABILITY

The Mercer report notes that restricting the availability of providers will reduce costs, because vendors are able to negotiate lower fees if arrangements are exclusive. We agree that health benefit programs featuring restricted provider networks tend to be

more cost effective. However, we believe this can be attributed to more effective management of care in a more tightly controlled network, as well as to the vendor's improved ability to negotiate favorable fee arrangements.

The current SEHIP point of service program has a broad provider network. We do not believe that offering a second network option will necessarily increase costs. A second network may cause more patients to stay in network, assuming that employees who select the second network do so because of the network providers. To the extent that the network provider compensation agreements are more favorable than out-of-network fee-for-service costs, medical expenses should decrease.

The argument that more restrictive networks can be more cost effective should be of interest to SEHIP, however. It suggests that the State could potentially reduce its expenses further by offering a choice of a more restrictive network.

D. SELECTION CRITERIA

L.D. 1444 requires the SEHIP to offer a plan offered by any vendor that is able to provide a statewide network of providers and willing to accept the negotiated rates. The fact that L.D. 1444 does not explicitly allow the SEHIP to apply other vendor selection criteria is noted as a concern by Mercer.

We agree with Mercer that the SEHIP should be permitted to consider other factors. At a minimum, standards could be established for a vendor's financial solvency, experience with the administration of managed care programs, network adequacy of the vendor's network and ability to meet both employer and employee service expectations in such areas as enrollment, billing, claims payment and member services.

V. CONCLUSION

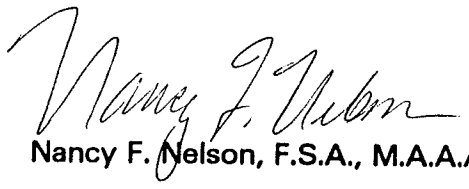
In summary, our conclusions regarding the implications of L.D. 1444 are listed below.

1. Choice in an employer health plan such as the SEHIP is attractive to employees.

2. A choice of vendors could be offered by the SEHIP without increasing costs.

3. A risk assessment/risk adjustment process based on demographic factors could be used to address issues of risk selection, if this is a problem, for purposes of establishing working premium rates for each vendor.

4. Consideration of additional selection criteria beyond cost and network dispersion in determining suitable vendors is appropriate.



Nancy F. Nelson, F.S.A., M.A.A.A.
Principal

NFN/jdl

APPENDIX C

Testimony of Richard White

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Testimony of Richard White

Healthsource Maine, Inc.

before

the State Employee Health Commission

on

Choice and Multiple Vendors

within the

State Employee Health Program

October 20, 1993

My name is Richard White, Chief Executive Officer of Healthsource Maine Inc., located in Freeport serving a state wide population. You have heard from our actuary, Nancy Nelson, who has provided an independent report on the specific technical issues suggested in your request for comments. I would like now to address some of the policy implications of these issues which I believe the Commission should consider.

The decision by the Commission to implement a point-of-service managed care program was a significant change in the health benefits offered state employees. The concepts embodied in LD 1444 would represent a further evolution of these benefits.

More importantly, I hope LD 1444 serves as a starting point for discussions among Commission members as to how the SEHC can best serve the healthcare needs of state employees in a rapidly changing environment. These hearings are an excellent example of what my company hoped would result from the introduction of the legislation: broader discussions exploring how best to meet existing and future challenges; how the SEHC can develop options in benefits design; and discussions about choice and its many benefits.

Role of the Commission

The current debate over reforming the structure of our healthcare system has placed competitive managed care on the front burner. By dealing, now, with the issues involved in administering multiple vendors and competitive negotiated procurement, the SEHC has the opportunity to define its role as a leader in the healthcare reform debate. Thus, there are long term implications of your current review in the decisions you make as a consequence.

Secondly, a system providing choice and competition will provide a greater role for the Commission in negotiating the

structure of a competitive managed care delivery system. The process of dealing with multiple vendors presents an opportunity for the Commission to be more pro-active in both benefit design and in program administration, if that is the Commission's desire. Competition will present options. Options allow the SEHC to be creative in a cost effective way.

The Mercer Report

The issues raised by Mercer Incorporated in its report are all worthy of consideration, but the Commission should make certain important distinctions as it considers their implications:

1. The Commission should distinguish between short term vs. long term cost implications. Based upon the policy decisions already established by the Commission, i.e. the of a Point-of-Service Benefit Plan choice of health plans will increase access to primary care physicians for state employees. We strongly believe that through competition, access will be increased and long term costs will be effectively controlled. The ultimate cost of the benefit

program is a combination of the medical costs and administrative costs of the program. Competing health benefit plans hold the best potential for controlling the medical costs of the benefit program which account for about 90% of the total cost of the program.

2. The Commission should distinguish between policy questions and the mechanics of program implementation. Some of the points raised by Mercer are clearly more of an implementation concern rather than a policy consideration. We firmly believe that should the Commission determine that Choice and Competition are important in the delivery of healthcare, the procedural concerns raised by Mercer can be successfully resolved. For example, assurance of financial capability is, or should be, already an established policy of the SEHC; modifying LD 1444 to assure the SEHC can implement that policy is a simple mechanical task.

The Benefits of Choice and Competition

It is my personal belief that the Commission could and should take an active role in promoting the development of competitive

managed care systems in Maine. This is the principal business of Healthsource. We see this as the wave of the future. We would welcome the Commission taking a leadership role at the State level in overseeing competitive managed care provided by multiple vendors.

We also believe strongly that choice in a healthcare delivery system will provide the following benefits:

1. Consumer satisfaction/convenience, and increased availability of primary care providers.

2. Quality assessment of the delivery of healthcare to employees.

3. Long-term cost savings from competition which would be in place with competing managed care plans.

4. Greater innovation in benefit design, service, cost control and quality.

LD 1444

LD 1444 provides a vehicle and an opportunity for the SEHC to develop a strategy to promote choice of health benefit plans for state employees.

LD 1444 in its current form, however, may not be the vehicle the SEHC determines is the most appropriate to move in the direction of choice. If so, we believe the SEHC should recommend amendments to the Banking & Insurance Committee of the 116th Legislature which would give the Commission the authority it deems necessary to create competition among health plan vendors and increase choice for state employees.

Competition and managed care are concepts that are already widely employed in the private sector. They will inevitably be key elements of whatever comes out of the national healthcare reform debate. The Commission should seize this opportunity to adopt them for the State of Maine and its employees.

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APPENDIX D

Testimony of Karen Foster

BLUE CROSS AND BLUE SHIELD OF MAINE'S
COMMENTS ON L.D. 1444
AN ACT TO PROVIDE CHOICE WITHIN THE
MAINE STATE EMPLOYEE HEALTH INSURANCE PROGRAM

Hello, my name is Karen Foster, Chief Marketing Executive for Blue Cross and Blue Shield of Maine, and I am here today to present the comments of Blue Cross and Blue Shield of Maine on L.D. 1444.

L.D. 1444's purpose, as set forth in the "Statement of Fact," is "to reduce the costs to the State Employee Health Insurance Program so as to avoid a serious detrimental impact on the financial position of the state." The bill plans to reach this goal by requiring the state to 1) undergo a competitive bidding process for the purpose of establishing rates; 2) negotiate to refine the benefit design and develop "the lowest schedule of rates"; and 3) allow any bidder to offer its point of service plan to eligible participants at the lowest schedule of rates, as long as the insurer has statewide coverage or the ability to arrange for statewide coverage. Blue Cross applauds the goal of avoiding serious detrimental impact on the state's financial position. We believe that the process for achieving that goal, as stated in the bill, will produce exactly the opposite result -- increased premium costs for the state's active and non-Medicare eligible retired members and increased administrative costs to maintain membership in multiple plans.

Our analysis shows that the bill's methodology will increase costs in several ways:

- The bill destroys the foundation of the competitive bidding process -- therefore, there is no incentive to be the lowest, responsible bidder.
- Because membership is spread over one or more insurers, bidders will be forced to increase bid premiums in anticipation of the greater risk associated with smaller pools of insured.
- Premiums for non-Medicare-eligible retirees will increase because insurers could no longer have active members subsidize retiree coverage.
- Dismantling the truly competitive bidding process will increase the risk to the state and require the state to appropriate greater funds to support the program. These higher premium rates will necessarily hurt the entire state program.

Additionally, dividing membership among various carriers will increase the administrative burden and therefore the administrative cost of running the State Employee Health Program. Each of these points is developed in the following discussion.

COMPETITIVE BIDDING PROCESS

The Maine Legislature requires the state to enlist a competitive bidding process to purchase all goods and services for the state in a manner that secures the greatest possible economy consistent with the required grade or quality of goods or services. (5 M.R.S.A. § 1825 et seq.) This competitive bidding process requires that all bidders be placed on an equal plane and that they bid on the same terms and conditions. The competitive bidding process is intended to ensure that the state consider the lowest bid possible for the highest quality services. Under the competitive bidding process, insurers have a powerful incentive to bid the lowest possible

price, the reward being the entire pool of eligible members under the Maine State Employees Health Insurance Program (MSEHIP).

The proposed legislation seeks to undo the foundation of the competitive bidding process by eliminating the reward for bidding the lowest possible price. Under the terms of this legislation, once the bid is awarded, every other bidder can vie for part of the membership as long as it is willing to offer the product at the bid price and has statewide access or the ability to provide statewide access. Therefore, insurers could bid high, wait until the bid lowest responsible price is established and then decide whether or not to offer the same insurance at the set price.

ADVERSE SELECTION CONCERNS

Even if an insurer decided to submit its lowest bid, that bid would be necessarily higher than that insurer's "lowest possible bid" if the entire MSEHIP membership were the reward for being the successful bidder. Under the current, competitive bidding process, the MSEHIP population is a known, measurable risk. If the MSEHIP population were divided among more than one insurer as required by L.D. 1444, an insurer could not be assured of underwriting the same level of risk represented by the MSEHIP population as a whole. An insurer which cannot expect to insure a broad cross-section of employees must add a surcharge to the premium rate to protect itself against insuring a disproportionate share of less healthy, more costly employees. Therefore, even if the insurer bid the "lowest rate possible," under the proposed legislation that "lowest rate" would be as much as 2 percent greater than the rate the

insurer would bid for the entire MSEHIP pool. This adverse risk factor could increase the state's costs $1.5 million over the premium dollars of $76 million.

Currently the state has a limited financial risk arrangement with Blue Cross in which the state is at risk for the difference between the premium paid and the actual claims expense, up to 110 percent of the premium. Once claims expense and other expenses exceed 110 percent of the premium (the "stop-loss"), Blue Cross fully insures the risk. If the membership were spread across more than one insurer as required by the proposed legislation, risk pools would be smaller. There is a greater chance that claims expenses would exceed the "stop-loss" amount under a smaller risk pool, since a larger pool (i.e., the entire MSEHIP membership) can more easily absorb large claims. If it is more likely that claims expenses will exceed the "stop-loss" amount, an insurer assumes more risk and may increase the charge for the stop-loss by as much as 1 percent in anticipation of the increased risk.

In sum, the potential costs associated with adverse selection and smaller risk pools would be as much as 3 percent greater than the rate the insurer would bid for the entire MSEHIP pool. This could increase the state's costs $2.3 million over the premium dollars of $76 million.

RETIREE COVERAGE

Under the current contract with Blue Cross, active and non-Medicare-eligible retired members are charged the same premium rates although most retirees are older than active employees and, therefore, more likely to use health care services. The claims experience (risk factor) of

the MSEHIP non-Medicare-eligible retiree population is almost twice the experience of the active employee population. By charging active and non-Medicare-eligible retired employees the same premium, active employees essentially subsidize the retired membership's premiums. This subsidy if discontinued, would add $7.4 million to the premiums for non-Medicare eligible retirees. This type of "subsidy" may not be feasible under the proposed bill. Because an insurer could not rely on covering the entire MSEHIP membership or receiving proportionate shares of non-Medicare-eligible retirees and active employees, no insurer could offer a rate that would continue the current subsidy practice. As a result, premium costs for retirees would be increased to include the amount by which they are now subsidized. This may not be a desirable result for the members of the Maine State Retirement System.

Any insurer could enroll a disproportionate number of retirees. If the state continued to have active employees subsidize retirees, every insurer would be compelled to include a factor in its rates to protect against adverse risks associated with enrolling disproportionately more of this older population. This increased factor could be as much as 6 percent. Again, rather than arriving at the lowest possible price, an insurer bidding in compliance with the proposed legislation would increase the state's costs. For example, if an insurer enrolls 50 percent of the active employees and 80 percent of the non-Medicare-eligible retirees, the overall, average risk level of the insured population compared to the entire pool would increase by as much as 6 percent, representing a $4.6 million increase in the state's premium cost.

GREATER RISK TO THE STATE

The "lowest possible bid" submitted to the state under the proposed legislation will be greater than the "lowest possible bid" under a true, competitive bidding process. This increase in premium dollars also increases the state's "corridor of risk" by raising the "stop-loss" amount. For example, if $76 million is assumed to be the lowest responsible bid under a truly competitive bidding process, the state is at risk up to approximately $84 million (110 percent of premium). Under L.D. 1444, the lowest responsible bid would include increased costs for adverse selection, smaller risk pools, and the chance that the insurer could receive a disproportionate share of non-Medicare-eligible retirees. Assuming the addition of a 9 percent factor (3 percent for adverse selection and smaller risk pools and 6 percent for the disproportionate share of retirees), the "lowest responsible bid" under the proposed legislation would be $83 million. Not only must the state appropriate the additional $7 million in premiums, it is at risk for claims expenses up to $91 million (110% percent of premiums). Therefore, in this example, the state's maximum liability has also increased by $7 million.

ADMINISTRATIVE COSTS

Under the proposed legislation, the cost of more than one insurer's preparing and distributing employee marketing materials and booklets would be passed on to the state. The MSEHIP would also incur additional administrative costs to maintain membership in multiple plans. Significantly, no two organizations or insurers will process claims identically or have identical agreements with providers. Therefore, the state would have the added burden of guiding its membership through the process of receiving appropriate benefits from various insurers. In addition, if the MSEHIP pool were split into smaller

pools, some economies of scale would be lost, resulting in vendors increasing the administrative expense charge.

CHOICE

The preamble to L.D. 1444 suggests that state employees will have a greater choice among providers if more than one insurer or other organization offers the plan at the lowest price. That would possibly be true if the state were to offer a traditional HMO plan from one insurer, under which members could receive services only from a designated panel of providers. However, it is not true under a point of service plan. Point of service plans are designed to give members maximum freedom of choice, by enabling them to use any provider while providing financial incentives to have their health care managed by a gatekeeper. Under the state's current point of service plan, Maine State Select, members can choose to obtain services from, or with the authorization of, a Select Physician. Significantly, two-thirds of Maine's primary care physicians are Select Physicians. When members receive services that are rendered or authorized by a Select Physician, they receive the highest level of benefits. Members can choose to receive services from any other provider by self-referring -- that is, without going through a Select Physician -- whether or not providers contract with Blue Cross. If the provider does contract with Blue Cross -- and 93 percent of eligible providers in Maine do -- members are protected from being billed for balances over Blue Cross's maximum allowance.

Although members can receive varying levels of benefits, depending on whether a service is received from or authorized by a Select Physician or whether it is member self-referred, every member always has the choice of receiving health care services from any provider.

In conclusion, the implementation of L.D. 1444 would not result in increased choice for state members, nor will it avoid increased costs to the state. The implementation of L.D. 1444 would operate to increase the premium cost contained in the bids due to adverse selection, smaller risk pools, the risk that an insurer would enroll a disproportionate share of active and non-Medicare eligible retirees, and increased administrative costs.

APPENDIX E

Testimony of Carl Leinonen

Maine State Employees Association ■ Service Employees International Union
Dan Glidden, President
Carl Leinonen, Executive Director

Testimony Before the State Employee Health Commission Regarding
LD 1444
An Act to Provide Choice Within
the Maine State Employee Health Insurance Program
October 20, 1993

My name is Carl Leinonen and I am the Executive Director of the Maine State Employees Association, SEIU, AFL-CIO. I am here today to speak on behalf of the 11,000 active and retiree members of MSEA who are enrolled in the Maine State Employee Health Insurance Program.

As anyone who has followed the events of the past several years can attest, MSEA is extremely involved in the issue of health insurance. Yet our only interest is securing for our members the greatest access to health care at the lowest possible price. We are not beholding to any insurance company and are in fact philosophically supportive of a public single payer system which would effectively eliminate the need for much of the health insurance industry.

But, we are realists. As we strive for change, we need to function in the world as it exists. That means we are constantly looking for ways to improve the State Employee Health Insurance Program.

One way is to enhance the network of primary care providers under the Maine Select program. That includes investigating the practicality of utilizing more than one provider network.

MSEA first raised this issue in 1989-1990 when the Health Commission attempted to implement an HMO alternative. Unfortunately, that effort was interrupted first by an appeal and then by a protracted labor-management dispute. MSEA has reviewed the issue of multiple providers on several occasions since then; in the course of our involvement with the evolution of the State health insurance plan, in deliberations with the Maine Legislature and in internal discussions with the experts and consultants of our international union.

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But despite our keen interest in this concept, MSEA testified neither for nor against LD 1444 when the bill first came before the Legislature. We took that position because of serious doubts about the practicality of the specific proposal.

I am here today to provide testimony against LD 1444. The reason our initial caution has turned to opposition is that although the idea of multiple provider networks is extremely appealing in theory, it is proving to be unworkable in practice. This is especially true in Maine where most of the state has low population densities and very little competition between health care providers outside of a few urban areas.

The problems with implementing the concepts advanced by LD 1444 can be grouped into two basic categories: Cost and Plan Disruption.

The recent Mercer report identifies many of the same cost concerns MSEA raised to the Legislature last winter. We will not waste the Commission's time by repeating each of the issues except to say that Mercer's independent confirmation of our concerns only serves to reinforce our doubts about the technical effectiveness of the scheme advocated by LD 1444.

LD 1444 contends that it is designed to increase quality while lowering costs. But, as Mercer concludes, the evidence to date suggests the opposite is more likely to hold true. In fact, the only support for cost savings are the rhetorical assertions contained in the bill itself.

Instead of rehashing these points, I would like to focus on what MSEA sees as the disruptive aspects of LD 1444.

LD 1444 was submitted on behalf of a single company. Their objective is to secure at least a portion of a very large and potentially lucrative state contract. The advantage and appeal this has for that company are obvious, and from their perspective, understandable.

But the State Employee Health Insurance Program does not exist to generate profit for private industry. It exists to provide access to health care for State workers and their families. To the extent these two separate interests coincide - that is to say where providing health care coverage at the lowest cost results in financial gain for a given firm - the relationship to the private sector can and does work.

But if we artificially modify the plan to accommodate the bottom line of a particular vendor, we would betray the members of the

plan, and the taxpayers of this state. We would be turning an employee health program into welfare for private industry.

Over the past year, the state plan has undergone a radical transformation. What began as expensive, outdated indemnity insurance is now an extremely aggressive managed care program. The plan has gone from "behind the times", to a leading edge point-of-service plan that MSEA believes sets a standard for the rest of the state.

Implementing the new plan has taken enormous amounts of time and energy for the Maine State Employees Association as well as the State Employee Health Commission. A massive education effort was required. There was a great deal of fear, frustration and confusion to overcome. Yet in spite of the daunting task, the new plan has been brought on line in an amazingly short time. And it is working well.

We cannot justify disrupting the plan again in such a short period of time just to satisfy the marketing needs of a single company. **We should only undertake interim modifications such as this if and only if it can be conclusively shown that change will lead to immediate savings.** Upsetting the lives and physician-patient relationships of plan members without good cause is simply wrong.

In light of the intense debate over national health care reform, now is not the time for the State Legislature to be interfering in the internal working of an isolated plan. If the State of Maine truly wants to explore the efficacy of multiple provider networks, it should be discussing the issue within the context of a statewide response to national reform initiatives. MSEA is not interested in redesigning the state plan now only to have to change it again in six months to conform to a new national poicy.

MSEA would be pleased to participate in a discussion which is aimed towards greater coordination and integration of the myriad of health plans in Maine. We would welcome an opportunity to develop a state plan which becomes the basis of a State of Maine health insurance program. But we are opposed to gerrymandering the State Employee Health Insurance Program to satisfy any company's quarterly report.

APPENDIX F

Response of Nancy Nelson of Tillinghast

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Tillinghast

A Towers Perrin Company

November 10, 1993

Mr. William McPeck, Co-Chair
Mr. Frank Johnson, Co-Chair
Maine State Employee Health Commission
State House Station 114
Augusta, Maine 04333

Dear Messrs. McPeck and Johnson:

Re: Proposal for Multiple Vendors

This letter responds to the questions raised in your letter of October 17, 1993. The questions in this letter related to Tillinghast's October 14, 1993 report to Healthsource Maine regarding Legislative Document No. 1444. The questions are addressed in the order posed in your letter.

1. Q. "On page 2, you cite the need for each vendor to compete for membership. Please indicate how that competition might proceed and provide examples of similar competitive plans."

   A. Competition for membership in the multiple vendor situation would be similar to that which occurs in an open enrollment situation when a large employer provides a choice of HMOs and an indemnity plan. The employee would receive materials from each of the competing plans describing the benefits available and employee contributions (which would be identical in the one plan/multiple vendor situation), the network of providers, the member services provided and the provider referral and utilization review requirements of each plan. This information would allow the employee to make an initial election. After the initial election, each vendor would compete to retain membership through the level of service provided.

2. Q."On Page 2, you state that a choice of vendors creates a basis for comparison. Using the one plan/two vendors proposal, how would a comparative review differ from the evaluations which are employed under the present competitive bid process?"

A. We are not completely familiar with the process used to compare plans presently. However, during the evaluation of proposals, we would not expect the comparative information to be considerably different than that currently collected as part of the bid process.

Our comment regarding comparison information was intended to relate to an evaluation of competitor plan's experience after the one plan/multiple vendor program was operational and credible experience had developed.

3. Q. "On page 3, there is reference to the measurement and comparison of utilization and cost patterns. Please amplify this point and provide specific examples. Also, explain why similar measurements and evaluations couldn't be accomplished under the current plan with one vendor. Further, you indicate that should significant differences be found, the Commission would be able to establish goals for improvement for the plan(s) with less favorable results. While this would be a reasonable course to take, we would ask why the Commission would want to invest in improving the performance of a deficient vendor rather than just replacing the vendor?"

A. In our opinion, it is useful at minimum to have available information on utilization statistics regarding hospital admissions and days by type of admission, outpatient surgical cases, emergency room visits, office visits, preventive visits, psychiatric visits, surgeries, and prescription drugs. Comparable cost information, expressed in terms of total claims and claims per subscriber or contract, is also desirable. The majority of our HMO clients are able to provide this type of detail to large employer groups. In addition, we find that employee benefit consulting firms that represent large employers expect this type of information to be available.

This type of information is useful in evaluating trends in costs and areas where changes in consumption patterns are occurring. In turn, the information may be used to prepare more accurate projections of future experience, and is also valuable in evaluating potential changes to benefit design. Comparing the information among vendors serving the same employer, with adjustment for differences in age/sex mix and any benefit differences, provides some indication of the effectiveness of the competitor plans.

There is no reason that this type of information could not be collected for a single vendor, and we believe that it should be collected. However, based on the data provided as part of the Spring 1993 bid process, we have no indication

that this information is currently available to the SEHC. Also, with one vendor, a historical framework is needed in order to evaluate the vendor's managed care results.

Several arguments could be made with regard to why it might be desirable to set goals for a vendor with less favorable experience rather than eliminating that vendor. First, the objective of having a multiple vendor arrangement would be to promote employee choice. Eliminating the vendor would eliminate the choice. Second, contracts with the vendors might be multi-year, such that it would be impossible to drop a vendor, although it might be possible to place pressure on the vendor for improved performance. A third reason would be the potential disruption and confusion that dropping a vendor might create among the affected employees and their families. Also, each vendor may be more responsive to improving their programs in a multiple-vendor situation. Nevertheless, after several years, selection of the single vendor most superior in overall performance may be the best long term decision.

4. Q. "In reference to innovation cited on page 3, we would ask why innovative services or operations would be introduced at the negotiated rate? Why would the adoption of the one plan/two vendor proposal encourage more innovation than the present competitive process? Please explain how the collection of data over and above the data we now collect would enhance innovation."

   During the discussion at the October 20, 1993 meeting, the possibility of adding benefits without an increase in cost was raised. Considering that the SEHIP is essentially self-funded, and that the State's objective would appear to be to offer a specific standard of benefits to all members while minimizing cost, providing expanded benefits to members is not likely to be possible. However, innovation through improved services to members in the areas of member services, the enrollment process, handling of claims, utilization review and case management services and member education should be possible without premium increases. Similarly, innovation through improved service to the SEHC in the form of data presentation and interpretation should be possible at the negotiated rate.

   Commenting on the uses of data beyond what is currently collected is somewhat difficult, as we are not fully advised of the information that is currently provided to the SEHC. If, however, the data is limited to that which was made available during the Spring 1993 bidding process, we believe that much more information could be captured with regard to utilization of various services. Collection and analysis of this type of information might identify problem areas that are

recurring, where targeted education and communication to employees or providers could be desirable and reduce costs. These could potentially relate to conditions that have a relationship to the workplace, or could be related to dependents. Examples that come to mind are mental health diagnoses, chronic back conditions, maternity related services, or well child care.

5. Q. "On page 4, you note that more complex risk assessment methods are available beyond age and sex. Please indicate what the costs may be for these more complex methods and which party would bear those costs."

   A. We do not have information available regarding specific costs for more complex risk assessment methods. However, as noted in our report, we doubt that the continuous prior data needed for evaluation of past claims as an indicator of future consumption of services is available. We also expressed our opinion that methods involving self-assessment would be administratively cumbersome. Our general opinion with regard to these methods is that the associated costs would not be justified.

6. Q. "With multiple vendors, the Commission would have to assume the responsibility for managing risk assessment and adjustments. How would you advise the Commission to proceed in this role given the current conditions under which the Commission operates (volunteers, monthly meetings at best, etc.)?"

   A. Assuming an approach that used age and sex factors as a method to adjust for risk, we believe that the process to adjust payment rates would be established prospectively. Once the process is defined and the factors established, we would anticipate that the information systems used to administer enrollment and make payments to the vendors would be modified to incorporate the adjustment factors. The role of the Commission (and its advisors) in the process would be to ensure that the process and the factors selected were reasonable, that the needed systems' changes were made, and to conduct periodic audits of the process after it became operational. Obviously, it would be desirable for the commission to have a staff member who would be knowledgeable about managed care who could oversee the process. If this type of expertise does not currently exist among SEHC staff, adding staff with this type of experience may be prudent. An independent consultant could also be retained to provide oversight of the process.

7. Q. "Would you please provide any examples of health insurance programs that have utilized age/sex risk adjustments in a one plan/two vendor format. Please

provide a bibliography of the development and results of various risk adjustment methods."

A. We are not aware of any employer health insurance program that involves two vendors with a single plan format and no variation in price to employees.

8. Q. "Please explain the impact on the one plan/two vendor proposal if we were to eliminate the current limited guaranteed deficit recovery provision."

A. From the question, it is not clear whether the SEHIP would be self-funded or fully insured after elimination of the deficit recovery agreement. If the SEHIP program becomes fully insured, we would expect retention provisions to increase. If the program became self-funded, the protection against catastrophic aggregate results would be lost. In practice, however, the actual results of the program would most likely be essentially unchanged.

9. Q. "On page 7, you argue that the Commission could manage administrative costs and you cite several examples. What would be the effect on the bid process by employing these strategies. Also, can you affirm or refute the contention of the Mercer report that there may be less incentive to submit a low bid for the administrative component of the proposal."

A. Allowing (or requiring) the administrative expense proposals to be made on a different bases should provide the SEHC with additional information to use in evaluating competitor bids, and should facilitate more direct comparison between vendors. It will also allow the SEHC to assess vendor willingness to make longer term commitments to the SEHIP program. We would generally agree with Mercer that there would be less incentive to submit the lowest bid for the administrative services in the one plan/two vendor situation. However, as noted in our reports, we feel the administrative expense portion of the bidding process could be managed in a way that would produce a reasonable result.

10. Q. "On page 8, you comment that "if one of the networks is more tightly controlled, costs for members in that plan should be lower relative to those for comparable members in the other plan." Are you suggesting that different premium rates be established for competing networks within the one plan/multiple vendor format?"

A. We are not suggesting in the one plan/multiple vendor format that different rates should be established. We are merely stating our opinion that the result of

an effective managed care program should be a reduction in costs through the reduction/elimination of unnecessary services and effective coordination of care. In a one plan/two vendor environment, we feel it would be logical to expect reduced costs for the network that was more tightly controlled or managed, if all other factors (i.e., fee levels, member demographics, etc.) are equal.

If the SEHC wants to consider different premium rates for competing networks, there must be a difference between the networks or benefits significant enough to justify the difference. Examples of differences that might justify different premiums would include benefit limits, breadth of network, inclusion/lack of a gatekeeper provision, or inclusion/exclusion of an out-of-network benefit option.

11. Q. "It is clear that any method to adjust for risk selection would be more complicated than the current process. Even if any increased costs may be of a short-term duration, what would our increased costs be to move to the one plan/two vendor arrangement?"

    A. We are not in a position to evaluate what the increased costs to the SEHC might be if the one plan/two vendor arrangement were adopted. At minimum, factors to consider in estimating this cost would include the cost of an additional RFP process, the cost of developing a process to recognize difference in risk factors, and the cost of system changes.

12. Q. "Your report indicates that vendor administrative expenses would not be adversely affected under this proposal. Please cite examples to support the contention that increased administrative costs to the vendor would be minimal."

    A. In our experience, health insurers and HMOs use employer group size as a way to categorize their business. Administrative expenses are analyzed in these group size categories as well. The typical result is that the expenses allocated decrease as a percentage of premium as employer group size increases. When an insurer or HMO develops a proposal for a particular employer, the administrative expense load is calculated using the average expense target for groups of that size. As a result, we would expect that the increases in expenses associated with the two-vendor scenario would have a minimal effect on the target expense load.

13. Q. "As you note on page 20, LD 1444 provides that consulting fees required to deal with multiple vendors would be passed back to the vendors. Isn't it

reasonable to expect that those expenses would ultimately add to the plan's costs?"

A. It is reasonable to expect that any consulting fees associated with multiple vendors that are passed to the vendors would ultimately be passed back to the SEHIP. However, this may or may not occur as a direct allocation. In any case, these fees are not likely to be material relative to either the total administrative expenses or claims for the SEHIP.

14. Q. "In your judgement, what impact would a more restrictive network have on access to care and quality of service to our subscribers who are located throughout the whole State?"

A. To address this question, an assumption regarding the phrase "more restrictive network" is necessary. If it is intended to mean a network with an inadequate network of providers, then a more restrictive network would be detrimental to the subscribers. If it is intended to mean a network that is operational in only selected areas of the state, then the network could have a very beneficial effect on service to subscribers who are in the service area of the network. If it is intended to mean a network that has relatively more tightly managed utilization review and referral practices, we would also expect the network to be beneficial to the SEHIP subscribers.

Your letter also asked for additional comments relating to more general questions on implications of LD 1444. We would like to respond to your question on how LD 1444 might fit in with the context of the current national health care reform discussion, and how it might be affected by national initiatives. Some comments on parallels between LD 1444 and discussions at the national level are given below.

a. Common Benefit Plans - The benefit packages offered by competing plans would be identical under the Clinton Proposal, although there would be an HMO, PPO and an indemnity benefit plan option available. LD 1444 would standardize a single benefit plan to be offered to the SEHIP members by competing vendors. If the Clinton Proposal were passed, the SEHIP members would have more choice in their health benefits than is offered currently, or would be offered under LD 1444.

b. Managed Care - The debate at the national level puts managed care plans in the forefront. LD 1444, through its requirement of a managed care benefit design, has a similar emphasis. The care management and coordination features of

managed care, as well as the use of limited provider networks will become increasingly accepted as the national reform activity progresses.

c. Network Development - Discussions at the national level are causing a huge amount of network development activity throughout the country. In particular, providers in more rural areas of the country are becoming very interested in participation in managed care plans -- perhaps out of a fear of being "left out." The requirement of LD 1444 for statewide networks in a state with a large rural area will be repeated again and again as national reform is pursued.

d. Premium Rates - LD 1444 would establish premium rates at the same levels for competing vendors. The Clinton Proposal would allow rates to vary for different vendors, but would require an employer's contribution to be based on the lowest premium rate. This feature would encourage more competition among plans to manage costs.

e. Risk Adjustment - Discussions regarding LD 1444 seem to anticipate that some type of adjustment for difference in risk mix is necessary. This is also recognized in discussions regarding adjustments to the rates paid to health plans that would be offered by a Health Alliance under the Clinton Proposal.

f. Data Collection - The national reform discussions anticipate that significant information on the results of different plans offered by a Health Alliance would be collected and made available to the public. This does not have a parallel with the LD 1444 proposal, but should be a desirable result of reform.

g. Competition - Competition among Health Plans under national reform will be on the basis of network, service and price. Health Plans will largely be marketing to individuals, rather than to employers, as is done today. The LD 1444 one plan/multiple vendor arrangement would also require a focus on marketing to employees.

Your letter concluded with an invitation to make additional comments on the presentations made by the other participants at the October 20, 1993 meeting. We would like to make additional comments regarding the issue of the current subsidy of retiree rates by active members.

In its comments, Blue Cross Blue Shield of Maine noted that the active and non-Medicare eligible retirees are charged the same premium rate, while the expected claims of the retirees are higher. The comments state that this practice would not be

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feasible under LD 1444. We would like to note that we believe that the issues of the cost to the State, and the employee contribution rates, must be separated, and that the conclusion reached by Blue Cross Blue Shield of Maine is incorrect.

Any projection of costs must recognize that the costs for the retirees will be higher than those for the actives. This difference may be recognized in the proposal process by either permitting the vendor to propose separate rates for the actives and the retirees, or by recognizing the cost difference through the age/sex factors used to recognize differences in enrollment mix between vendors.

Establishing the employee and retiree contribution rates is a separate issue, and the State may determine the rates in order to meet its objectives concerning retiree welfare. The relationship between the rates that the State chooses to charge the retirees and actives are not required to match the relationship in the rates (or age/sex adjustment factors) used to determine the working rate paid to each vendor.

Sincerely,

Nancy F. Nelson, F.S.A.
Principal

NFN/jdl

cc: Richard White, Healthsource Maine, Inc.

APPENDIX G

Response of Richard White of Healthsource

Dated 11/12/93

Healthsource Maine, Inc.

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November 12, 1993

Mr. William McPeck, Co–Chair
Mr. Frank Johnson, Co–Chair
Maine State Employee Health Commission
State House Station 114
Augusta, Maine 04332

Dear Messrs. McPeck and Johnson:

This letter responds to the questions raised in your letter of October 27, 1993. The questions are addressed in the order posed in your letter.

1) *Q. We would ask that you expand upon your remarks on Page 2 where you cite existing and future challenges and benefit design options. We're interested in your comments as they relate to the one plan/two vendor model and any other scenario.*

   A. The existing and future challenge is to provide high quality health care more efficiently to reduce the rate of increase in the cost of providing health care. Under a one plan/two vender approach the benefit design options could include additional educational and wellness programs as well as greater choice of primary care physicians. Also, if the Commission is willing to explore offering multiple plan options, for example a traditional HMO along side the POS option, additional benefit design options could be developed. The benefit design options under a traditional HMO could include reduced premium cost to the State in addition to enhanced wellness programs for employees.

2) *Q. Would you identify how the administration of a multi–vendor plan can be more efficient (in terms of overall costs) than a one vendor plan.*

   A. Under a multi–vendor plan approach the State would be supporting the development of additional managed care networks in Maine. Combining a portion of the State's enrollment with the existing enrollment of the managed care vendors would provide increased opportunities for the managed care vendors to develop cost effective arrangements with providers. The ongoing competition among vendors would generate innovation in the delivery of care which would result in cost savings for the State.

3) *Q. Please define the "competitive negotiated procurement" process, how it is designed to work, and how it can be structured to encourage the lowest bids for claims and administration, particularly as it differs from the current bid process.*

A. The competitive negotiated procurement would allow the State to negotiate with the lowest cost bidder for claims and administration costs. The reimbursement for the vendor varies by age and sex of the enrollee. Therefore, the vendor is not subject to adverse selection because a high payment is provided for higher risk patients. the administrative component of the payment to the vendors is fixed by the Commission based on the rate that was negotiated with the lowest vendor. Therefore, the State is assured of receiving as good an administrative rate as it can negotiate. The vendor is willing to negotiate a low administrative fee with the State because the State's enrollment will enhance the vendors ability to develop cost effective arrangements with providers which can be used to generate cost savings for other businesses.

4) *Q. Please explain how the multi–vendor approach induces a more pro–active posture on the part of the Commission (see Page 3).*

A. Working with more than one vendor will support the development of more than one managed care vendor in Maine. The addition of more vendors will foster competition to present to the Commission creative approaches to provider contracting, member servicing, quality monitoring and benefit design. If the Commission chooses it could offer more than one benefit option for all State employees, i.e., a POS option and a traditional HMO option.

5) *Q. On what is the following statement on page 3 based: "Based upon the policy decision already established by the Commission, i.e., the offering of a point–of–service benefit plan, choice of health plans will increase access to primary care physicians", as it relates to Maine's limited primary care physician community? Further, how does this model provide that long–term costs can be effectively controlled?*

A. First, there are about 50 primary care physicians in the Healthsource network that are not in the Maine State Select Network. Multiple vendors would add these physicians as a choice for State employees. Secondly, adding State employees to the enrollment of multiple vendors would provide additional incentive for multiple managed care vendors to work on their own or in concert with hospitals and/or physicians to increase the capacity of primary care providers in the State. This could include expanded use of physician extenders as well as recruiting more primary care physicians to Maine. An increased supply of primary care physicians will improve the ability of the delivery system to control costs.

6) *Q. Your statement on page 4 that "competing health benefit plans hold the best potential for controlling the medical costs" appears to run counter to LD 1444. Perhaps it's merely a choice of terms, but aren't we discussing identified plans with competing vendors? Please clarify.*

A. The current discussion is focused on one identified benefit plan. In that context we are discussing competing vendors, not competing health benefit plans, as having the best potential for controlling cost. If the Commission was to decide to offer more than one benefit plan, i.e., a POS plan and a traditional HMO, that would increase the cost saving potential over a single plan approach. The attached Table 9, from the 1992 Segal Survey of State Employee Health Benefit Plans indicates HMO premiums are lower in the majority of the state's listed.

7) *Q. On page 5 you have identified four benefits resulting from choice in a one plan/multiple vendor healthcare delivery systems. We would ask that your be more specific on each of these points and please cite evidence or examples to support these arguments.*

A. Although we are not aware of any one plan/multiple vendor healthcare delivery systems, 42 of the 50 states do offer multiple plan options for state employees.

1. *Consumer satisfaction/convenience, and increased availability or primary care providers.*

   Choice of vendors will provide consumers and providers varying approaches to managed care. Choice will encourage vendors to find new approaches to meeting consumer needs in a managed care environment. Primary care physician availability will increase when a second vendor adds the additional physicians in its network that are not available in the single network.

2. *Quality assessment of the delivery of healthcare to employees.*

   HMO managed care programs are required by statute to assess the quality of care provided. That is not true in the current single, non–HMO vendor approach.

3. *Long–term cost savings from competition which would be in place with competing managed care plans.*

The Segal study indicates that the majority of cases HMO's offered in a dual plan environment are less costly than indemnity plans. We believe competition in the managed care environment will also reduce costs in the long term when compared to a single vendor approach.

4. *Greater innovation in benefit design, service, cost control and quality.*

Competition will create opportunities for innovation in the rapidly developing managed health care development environment. The development of Healthsource Maine, HMO Maine and other managed care organizations in Maine has increased benefit plan options and reduced the rate of premium increases.

8) *Q. Considering the State's present financial situation, is the introduction of the one plan/two vendor model an economically viable proposal?*

A. Yes. We believe a one plan/two vendor model can reduce costs for the State.

9) *Q. Given the results of the most recent competitive bid process, would it appear to be in the State's best interests to create an artificial competitive environment as outlined in LD 1444?*

A. We believe the recent bid process was not a truly competitive process. The bid requested quotes on a program that had first been designed and implemented by the current vendor. We had considerably less data available in which to develop a truly competitive response. In addition, the administrative start up cost associated with servicing the entire account is far greater than the cost associated with servicing a portion of the account under a two vendor approach.

Healthsource Maine is recommending the issue of choice and competition for State employees be addressed in the context of a state wide response to national reform initiatives. Therefore, we are not responding to questions specific to LD 1444. The responses to the generic questions are listed below:

2) *Q. How would the vendors coordinate activities and services with respective subsidiary networks (utilization review and mental health/substance abuse managed care), and the prescription drug program?*

A. Subsidiary networks (utilization review, mental health/substance abuse managed care) would be specific to each vendor. The prescription drug program as it currently exists could support a multiple vendor approach.

3) *Q. With the one plan/two vendor model, employee choice is focused on which network to join. How does the average subscriber evaluate the quality of care and services within each network to arrive to an informed choice?*

A. In the near future managed care networks will have "report cards" developed by quality review organizations which will allow comparison by consumers.

4) *Q. Please summarize the advantages of the one plan/two vendor approach in terms of costs and improved quality of care delivered.*

A. The one plan/two vendor approach will allow the development of multiple managed care network which will provide greater opportunity for negotiating the development of cost effective delivery systems in Maine. Competing networks will generate greater innovation to improve the quality of care delivered.

5) *Q. Please identify examples of rural states such as Maine which may have introduced multiple vendors in one plan or multiple plans when an employer's workers are dispersed across the whole State. What are the costs associated with each program you identified?*

A. Please see the enclosed Segal Company summary of dual choice offerings.

Very truly yours,

Richard M. White

Richard M. White
Chief Executive Officer

RMW/lm
encl.

THE SEGAL COMPANY'S

1992 SURVEY OF STATE EMPLOYEE HEALTH BENEFIT PLANS

Summary of Findings

Table 9

Health Maintenance Organizations

State*	Number of HMOs Offered	Active Employees Enrolled in HMOs		How Do HMO Total Premiums Compare To Basic Plan? **		How Do HMO Employee Contributions Compare To Basic Plan? ***	
		Number	Percent	Emp	Emp+Fam	Emp	Emp+Fam
Alabama	1	3,300	8%	Same	Same	Same	Same
Arizona	2	39,200	84%	Lower	Lower	Lower	Lower
California	22	179,400	83%	Lower	Lower	Lower	Lower
Colorado	14	13,300	57%	Same	Same	Same	Same
Connecticut	19	13,400	24%	Same	Same	Same	Same
Delaware	3	15,500	42%	Lower	Lower	Lower	Lower
Florida	29	32,800	23%	Same	Same	Same	Same
Georgia	4	20,000	11%	Lower	Lower	Higher	Higher
Hawaii	3	11,600	29%	Higher	Higher	Higher	Higher
Idaho	2	1,800	11%	Same	Same	Same	Same
Illinois	10	56,800	25%	Same	Lower	Lower	Lower
Indiana	8	13,300	38%	Lower	Lower	Lower	Lower
Iowa	5	2,600	9%	Lower	Lower	Same	Lower

** The following eight states do not offer an HMO option: Alaska, Arkansas, Maine, Mississippi, Montana, North Dakota, South Dakota and Wyoming.*

*** Survey asked states to compare total monthly premium charged by the HMO with the highest enrollment against the total monthly premium/cost of the indemnity plan with the highest enrollment.*

**** Survey asked states to compare monthly contributions required of an employee for the HMO with the highest enrollment against the required monthly employee contribution for the indemnity plan with the highest enrollment.*

Table 9 (continued)

Health Maintenance Organizations

State	Number of HMOs Offered	Active Employees Enrolled in HMOs		How Do HMO Total Premiums Compare To Basic Plan? **		How Do HMO Employee Contributions Compare To Basic Plan? ***	
		Number	Percent	Emp	Emp+Fam	Emp	Emp+Fam
Kansas	3	14,000	28%	Lower	Lower	Same	Higher
Kentucky	5	33,000	28%	Lower	Higher	Lower	Higher
Louisiana	10	34,000	47%	Higher	Higher	Higher	Higher
Maryland	10	25,700	39%	Same	Same	Same	Same
Massachusetts	14	59,500	69%	Lower	Lower	Lower	Lower
Michigan	19	20,600	35%	Lower	Lower	Lower	Lower
Minnesota	5	32,200	58%	Lower	Lower	Lower	Lower
Missouri	5	5,300	14%	Higher	Higher	Higher	Higher
Nebraska	5	4,600	31%	Lower	Lower	Lower	Lower
Nevada	2	3,700	20%	Same	Higher	Same	Higher
New Hampshire	2	800	8%	Same	Same	Same	Same
New Jersey	15	73,700	29%	Lower	Lower	Same	Same
New Mexico	1	6,400	37%	Lower	Lower	Lower	Lower
New York	27	63,600	19%	Lower	Same	Same	Higher
North Carolina	4	26,600	12%	Higher	Higher	Higher	Higher
Ohio	21	29,800	56%	Lower	Lower	Lower	Lower
Oklahoma	3	23,100	35%	Lower	Lower	Lower	Lower

** Survey asked states to compare total monthly premium charged by the HMO with the highest enrollment against the total monthly premium/cost of the indemnity plan with the highest enrollment.*

** Survey asked states to compare monthly contributions required of an employee for the HMO with the highest enrollment against the required monthly employee contribution for the indemnity plan with the highest enrollment.*

Table 9 (continued)

Health Maintenance Organizations

State	Number of HMOs Offered	Active Employees Enrolled in HMOs		How Do HMO Total Premiums Compare To Basic Plan? **		How Do HMO Employee Contributions Compare To Basic Plan? ***	
		Number	Percent	Emp	Emp+Fam	Emp	Emp+Fam
Oregon – SEBB	4	8,100	31%	Higher	Higher	Same	Higher
– BUBB	3	9,400	58%	Same	Same	Same	Same
Pennsylvania	17	12,000	14%	Same	Same	Higher	Higher
Rhode Island	4	4,100	23%	Lower	Lower	Same	Same
South Carolina	2	12,500	9%	Lower	Higher	Lower	Higher
Tennessee	2	3,300	3%	Higher	Higher	Higher	Higher
Texas	21	61,400	46%	Same	Same	Same	Same
Utah	2	1,400	5%	Same	Same	Same	Same
Vermont	1	1,600	24%	Lower	Lower	Lower	Lower
Virginia	5	6,900	7%	Same	Same	Same	Same
Washington	8	56,400	53%	Lower	Lower	Same	Same
West Virginia	2	2,900	4%	Lower	Lower	Lower	Lower
Wisconsin	23	48,900	87%	Lower	Lower	Lower	Lower

*** Survey asked states to compare total monthly premium charged by the HMO with the highest enrollment against the total monthly premium/cost of the indemnity plan with the highest enrollment.*

**** Survey asked states to compare monthly contributions required of an employee for the HMO with the highest enrollment against the required monthly employee contribution for the indemnity plan with the highest enrollment.*

APPENDIX H

Testimony of Richard White of Healthsource

Dated 11/15/93

Testimony of Richard White

Healthsource Maine, Inc.

before

the State Employee Health Commission

on

Choice and Multiple Vendors

within the

State Employee Health Program

11/15/93

We appreciate the Commission's commitment to this process and their efforts in identifying remaining questions pertaining to the implementation of multiple vendors with the State Employee Health Insurance Program. We recognize and are grateful for the time and energy that the Commission has and continues to devote to this issue.

Clearly, LD 1444 was introduced in response to a particular situation. Indeed much has transpired since we first introduced this legislation last Spring which alters the environment in which we must evaluate the concepts contained within LD 1444.

In reviewing the comments which were submitted by other interested parties on October 20 as well as the follow-up questions which were posed to Healthsource and Tillinghast, we have prepared responses which we believe answer many of the concerns raised. We believe that choice and competition within the health care delivery system are inevitable given the developments on the State and Federal level. However, it is also our opinion that, based upon these questions the

State and the Commission must devote much more time than is currently available under the existing time constraints to adequately address all of the many issues raised by LD 1444.

We firmly believe that we have gained valuable insight and information to date based upon the dialogue which has taken place around LD 1444. The Commission clearly will have to determine its role in preparing the State Employee Health Program for what will come from the Federal government in terms of Health Care Reform. We also anticipate that the Commission will at some point have to consider plans currently pending in Washington to introduce choice within public employee health insurance programs. Therefore, in our opinion, there are broader ramifications to be considered as the Commission evaluates its response to the Banking & Insurance Committee which require a longer term vision.

Further we recognize that the state employee health insurance program has been through enough tumultuous change over the past few years. Unfortunately, from the perspective of state employees, LD 1444 in whatever form would mean more change if implemented in the near future. We believe at the national level, the beginnings of a vigorous debate on health care reform undoubtedly signals more change.

In light of this, it would be perfectly understandable if the Banking and Insurance Committee chooses not to approve LD 1444, even in a revised form, preferring instead to focus on the larger issues of/adequate health care for all Maine citizens. We at Healthsource will certainly understand such a decision. Moreover, we would readily support such a decision if it is accompanied by a broader evaluation of managed competitive health care in Maine.

We still believe the concept of choice and multiple vendors will improve the State Employee Health Insurance Program. However, this discussion should move forward in the context of a statewide response to the national reform initiative.

Therefore, we will devote our energies to supporting a more global approach to competition and choice in light of the developments at the federal and state level. We would hope that we could continue a constructive dialogue with the Commission as it prepares its comments to the Banking & Insurance Committee and as it evaluates its role in the health care public policy debate.

Healthsource will continue to demonstrate the value of competition as it exists in the private sector as well as its commitment to the development of quality managed care programs. We intend to continue to work within the legislative process to assist in the development of a comprehensive approach to the reform of our health care delivery system.

The decisions made by the State in terms of how it proceeds regarding universal access will have serious implications for the State Employee Health Program and the delivery of health care in Maine.

We look forward to building upon the gains we have made thus far in discussing choice and multiple vendor options. We also hope to assist the Commission in its efforts to address the issues being raised under Health Care Reform.