

# Issue Brief

## How Health Insurance Works in Maine and Looking to the Future

This issue brief reviews current health insurance coverage in Maine, how insurance is supposed to work (and why it oftentimes does not) and how can/should Maine position itself in light of expected health care reform at the national level.

Health care in Maine (and elsewhere) is very expensive. Insurance costs reflect the underlying costs of medical care (plus administration and profit or surplus, which are usually modest compared to the cost of care). Advanced technology; provider and consumer driven demand for services, i.e., utilization; malpractice expenses; the aging of the population; unhealthy lifestyles and other factors are major contributing factors that would still drive the high cost of health care even if Maine established a perfectly efficient and effective insurance program.

### Who has Health Insurance Coverage?<sup>1</sup>

When it comes to paying medical bills, nearly all Mainers fall into one of five categories:

- Employee-sponsored. For more than half of us (704,000), health insurance is provided through a place of work<sup>2</sup>. This coverage varies widely from employer to employer and often depends on the size of the company, whether it is unionized, pressures on the company's bottom line and competitive pressures to retain a workforce.
- Individual. About 5% of Maine's population (63,000) purchases a private health insurance plan directly. These individuals often pay the entire premium cost directly. In order to reduce these premium costs, individual policies are often characterized by a very significant front end deductible. Such plans are increasingly purchased through a Health Savings Account ("HSA") which permits individuals to deposit, invest and withdraw funds to pay cost sharing expenses under favorable, federal tax treatment.<sup>3,4</sup>
- Medicare. A federal insurance system for people over age 65 or disabled, coverage is provided to about 18% of Maine's population (243,000). Medicare premiums are collected through payroll taxes and payments by individuals covered by the program.
- Medicaid. More than one out of five Mainers (305,000) is covered by Medicaid, known as "MaineCare" in Maine. This program is generally available to low and lower income individuals and families. Medicaid is jointly funded by both the state and the federal governments; for every dollar that Maine pays for health care services, the federal government "matches" approximately two dollars.
- A subset of the Medicaid population (about 66,000) is also covered by Medicare. An example of a "dual eligible" would be someone with very low income who is over age 65 (Medicare eligible for hospital and physician services) and resides in a nursing home (covered by Medicaid). Dual eligible individuals are typically the most expensive population covered by the Medicaid program
- No coverage. Less than 9% of the population (119,000) is estimated to be uninsured and pays directly for health services. This population is the greatest source of

### Fast Facts

- For more than half of us (704,000), health insurance is provided through a place of work.
- About 5% of Maine's population (63,000) purchase insurance directly.
- Over 18% of Maine's population (243,000) has Medicare coverage.
- About 23% of Maine's population (305,000) is covered by Medicaid.
- Less than 9% of the population (119,000) does not have any insurance and pay directly for health services.

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bad debt and charity care for health care providers. As a consequence of Medicaid expansion activities and the Dirigo Health Plan, this population has diminished by about 13,000 people since our 2007 Issues Brief.

## How Insurance is Supposed to Work, and Doesn't

The underlying principle behind insurance is simple: everyone pays a little in order to have funds on hand to pay the medical bills incurred by a few. This principle is dramatically illustrated by the fact that 80% of the costs of care for a large population of people will be incurred by about 20% of the individuals in that population. This principle is described as “pooling” risk for health care expenses and it works best when the risk is distributed across a large population.

This basic concept starts to break down when there is “fragmentation” in the risk pool. Fragmentation means that a population of individuals is divided in one or more subgroups and separate premium costs are calculated for these groups. To the extent that the underlying health risk (and likely costs) for these subgroups is different, the sharing of insurance risk across a large group has been undermined. And, premium costs will vary among subgroups.

There are many examples in Maine (and elsewhere) where fragmentation of the risk pool occurs. Employers that choose to self-insure their employees and dependents effectively fragment the commercial insurance pool.<sup>5</sup> The medical expenses associated with a self-insured group are not blended with other groups. Employers choose to self-insure for a number of reasons. First, they believe (usually correctly) that the medical expenses of their employees and dependents will be less, on average, than the general population. Secondly, self-insurance provides greater flexibility for companies to design their medical benefit plans (see The Role of Regulation, below). To the extent that an employer adopts wellness, case management and other cost management programs, a self-insured arrangement assures that any realized savings will accrue to the company and its workers. Finally and particularly for a company that has multi-state locations, a self-insured plan simplifies administration.

Insurance companies also establish separate risk pools for different segments of the market, usually in response to regulatory requirements and competitive pressures. For example, small businesses may be grouped together with a premium rate that reflects the expected medical expenses of this market segment; a “community rate” is established. If the cost of insurance becomes disproportionately more expensive for certain small businesses, these businesses may leave the pool. A small employer with a relatively young and healthy workforce may discontinue coverage, providing additional cash compensation instead. The groups remaining are increasingly less healthy and their costs will increase even faster. This phenomenon is known as adverse selection and more likely to occur among insured individuals and small groups, two market segments which insurance companies are required to community rate. Among market segments that include mid and large employers, there

is more stability in the group and virtually no migration due to health insurance costs.

Taken to its logical conclusion, adverse selection will result in a risk pool that contains only very sick people who pay exorbitant premiums. Many argue that adverse selection is happening in Maine today for individuals who purchase Anthem's individual policies and that this will lead to the eventual demise of this product.

One final word on fragmentation: Medicare and Medicaid represent subsets of the general population that have been segregated for purposes of providing health insurance. On one level, this fragmentation of the risk pool has had a positive impact on the cost of private health insurance. Medicare and Medicaid provide coverage to populations who are sicker and consequently more costly. These public programs effectively remove these populations from the general risk pool. However both programs reimburse providers at levels below what providers believe are adequate. In order to recover this shortfall, providers charge commercial insurance programs more than would otherwise be the case. This is referred to as “cost shifting” and is a separate consequence of fragmentation of the State's insurance pools.

## The Role of Regulation

Maine, like all states, regulates health insurance sold within its borders. This regulation does not extend to self-insured companies that are regulated by the Department of Labor and the federal Employee Retirement Income Security Act or ERISA. In Maine, the Bureau of Insurance, within the Department of Professional and Financial Regulation, regulates health insurance companies selling policies within the state. The chief regulatory authority is the Superintendent of Insurance.

There are two major components of Maine's regulatory activity. The first is to assure that a company will be able to pay claims to individuals for whom premiums have been collected, either directly or through an employer. Insurance is a form of promise. A premium is paid today in exchange for the promise that medical expenses, if incurred, will be paid at some future date. The regulators' job is to assure that the insurance company will be in business to fulfill this promise.

Secondly, the Bureau of Insurance is required to implement various legislative requirements. Many states, including Maine, have identified certain benefits and services that are required to be included in any medical insurance plan that is operating in the state. Examples of “mandated benefits” include a minimum number of chiropractic exams, certain annual preventive services and the like. In Maine, there are over 40 such mandated benefits. If a company is self-insured, it is not required to provide mandated benefits because federal ERISA laws preempt the state.

Another example of the Bureau's regulatory authority is around rules governing how insurance companies can provide coverage to individuals and small groups. For example, Maine

has a “guarantee issuance” law which requires an insurance company, if it provides individual coverage, to enroll anyone who applies, regardless of prior medical condition. Similarly, there are regulations around the price that can be charged to an individual. Someone who is at higher risk to be sick cannot be charged an excessively higher premium than someone who is at lower risk. These provisions represent attempts to assure available and affordable health insurance for individuals. According to the insurance industry, however, these provisions make it very difficult to insure individuals profitably and, consequently, only a few companies offer individual coverage in Maine.

A final example is the Bureau’s authority around provider contracting by an insurance company. Rule 850 requires an insurance company to reimburse for services provided by a hospital or doctor in a patient’s geographic location, regardless of whether the insurance company has established a mutually acceptable contract with the provider. The purpose of this rule was to assure consumers that they would not be required to travel unreasonable distances for health care, simply because an insurance company could, or would, not contract with a local provider. Self insured companies are not subject to Rule 850. Some self insured companies are increasingly exercising their exemption to negotiate preferred contracts with a select network of hospitals and physicians that are determined, by the company, to provide greater value, as measured by quality indicators and/or cost effectiveness.

## Strategies and Limitations on Fixing the Insurance System

There are two broad policy perspectives that underscore efforts to reduce these costs through Maine’s insurance system.

The first advocates for a single, broad-based insurance program. This approach would eliminate the inefficiencies and disparities that exist in a fragmented insurance market. This approach advocates for a single risk pool that insures all persons at the same premium cost (i.e., “community rating”). It is important to note that a “single” payer system is not the same as nationalized health insurance. Doctors and hospitals would continue to be private enterprises and consumers would continue to access the doctor and hospital of their choice. A single payer system currently exists in the United States: Medicare provides coverage to all eligible elderly and disabled consumers through a single insurance pool. Medicare is administered through different insurance companies and consumers can almost always access the doctor or hospital of their choice.

While a single insurance pool may be appealing, it would be nearly impossible for a state to adopt this reform. The federal government’s authority extends over Medicare, a large part of Medicaid, and self-insured groups through ERISA. While a state could require the pooling of all insured populations within its regulatory authority, a decline in one population’s premium means an increase for another. For example, it has been suggested that Maine require small groups and individuals to be pooled together. This would likely result in a lower cost to individuals but a higher cost to small groups which might

cause more small groups to discontinue their health insurance program or attempt to self-insure.

The second often touted approach is one of deregulating Maine’s insurance markets. For example, it is estimated that Maine’s mandated benefits contribute from 4 to 6 percent to the annual premium for groups of 20 or fewer employees and approximately 8 percent for groups of more than 20 employees<sup>6</sup>. Many of these mandates, such as mammography, have become standardized benefits among both insured and self-insured plans. These benefits are not likely to be removed from benefit plans and therefore savings opportunities may be less than expected.

While many states, including Maine, have initiated health reform, Massachusetts’ recent effort has been particularly noteworthy in attempting to address underlying structural issues around insurance.

In early 2006, Massachusetts enacted legislation that explicitly required all citizens to have health insurance by July 1, 2007. A number of collateral steps were taken to implement this “individual mandate”. Employers were required to offer health insurance or pay a modest penalty. A new infrastructure was established, the Health Insurance Connector, to arrange for the provision of “quality, affordable insurance products”. In order to assure affordability, Massachusetts also provides state funded premium subsidies up to 300 percent of the federal poverty and expanded its Medicaid program to include children up to 300 percent of the federal poverty level. In an effort to provide greater underwriting stability and lower costs to the individual market, Massachusetts also required the merger of individual and small-group markets.

Not surprisingly, the individual mandate has led to significant, new enrollment. By August, 2008, in excess of 400,000 individuals had obtained health insurance coverage.

The policy shift that is embedded in the individual mandate cannot be understated. First, there is a clear affirmation of a market based approach to health reform. While government assures a minimum benefit levels and underwriting requirements, consumers select among alternative, private insurance plans. Secondly, while employers are encouraged to provide insurance, the responsibility clearly falls on the individual to secure coverage. Government’s role is one of assuring that affordable options exist, through subsidies and/or required benefit levels.

The Massachusetts approach and its evolving results have been noticed by other states. California enacted a similar approach based on the individual mandate; implementation of which has succumbed to broader state budget limitations. Vermont’s Catamount reform initiative references the imposition of an individual mandate in 2010 if coverage levels are less than 96 percent of the State’s population.

The Massachusetts effort is clearly aimed at rebuilding and “de-fragmenting” the insurance pool. As noted above, there are however limits to what an individual state can accomplish.

Health reform has emerged as a principal policy initiative for the new federal administration. While few details exist, it is unlikely that a national health care system (similar to Britain) or even a single payer system will be adopted. Instead, early indications are that the many of the principles contained in the Massachusetts approach may be adopted by the Obama administration. These include:

- Maintaining the current employer based system, as well as Medicare and Medicaid.
- Identifying one or more options that will be available to individuals (outside of an employer based system) to access at an “affordable plan”.
- Providing premium subsidies for lower income individuals.
- Mandating enrollment for at least some populations. Children have been initially defined but this mandate may be expanded to ultimately include all Americans.

## Implications for Maine

Presuming the evolution of a national health care initiative in the next few years, what can and should Maine do to best position its citizens?

Ironically, the Dirigo Health Plan may ideally position Maine to serve as a pilot for the Obama administration’s reform initiative. If, as initially indicated, the federal program is grounded in the establishment of a “standard” plan that is available to individuals who do not or cannot qualify for an existing, current option, Dirigo could be re-engineered to serve as this option. In many ways, this evolution would be entirely consistent with Dirigo’s original goal to serve as an affordable program for the uninsured and underinsured. As a pilot for the federal program, additional funding and support are likely to be available and help resolve Dirigo’s perennial funding challenges which are largely due to premium and cost-sharing subsidies that were provided to low income Mainers.

In addition to maintaining the Dirigo program as a potential pilot to the federal program, policymakers can continue to identify and advance policies which:

- Promote the efficient and effective delivery of health care services. As noted in this brief, insurance costs are largely a function of the underlying cost of health care services. These costs can be positively impacted by:
  - Eliminating duplication and redundancy in service capacity. Maine’s certificate of need (CON) and state health plan are two important instruments for meeting this objective.
  - Advancing patient centered medical homes. There is an evolving crisis in the availability of primary care services. Patient centered medical homes,

which are grounded in primary care practices, offer to transform the financing and delivery of primary services in order to attract and retain these providers.

- Advance informational transparency that empowers consumers and providers. The Maine Quality Forum, an important agency created by the Dirigo legislation, is working with private organizations such as the Maine Health Management Coalition, Maine Health Information Center and others to identify and communicate quality and efficiency indicators that better inform value based purchasing of health care services.
- Educate Maine citizens as to their roles and responsibilities in advancing and maintaining good health practices that include but are not limited to tobacco and alcohol consumption, obesity and accident prevention. Rhode Island and New Hampshire have recently required health insurance companies to dramatically reduce premium costs for a small group product that explicitly requires consumers to comply with a set of good health practices.
- Advance a sustainable private insurance market in Maine. As already noted, federal reform is likely to be grounded in the current array of health insurance programs that meet established qualifying criteria. For Maine citizens, the opportunity to select a health plan from an array of current as well as hopefully new options will be welcomed.

## References

1. Enrollment data compiled from various sources, including Kaiser Family Foundation’s [www.statehealthfacts.org](http://www.statehealthfacts.org), MaineCare Caseload report for SFY 2008, Maine DHHS, as of September 2007 (unpublished) and HealthInfoNet Stakeholder Process, Final Report, Dec. 2008 (unpublished). Reported percentages are in excess of 100% because dual eligible Medicare/Medicaid beneficiaries are counted in each program.
2. Includes individuals covered through the military or Veteran’s Administration (approximately 17,000 persons in Maine). See Kaiser reference above.
3. Maine, unlike most states, does not parallel federal policy and provides no favorable tax treatment with regard to HSAs.
4. The Dirigo Health Plan provides coverage to individuals as well as employees in small groups (often times one person firms). Total enrollment is currently about 16,000. Premiums are established by an insurance company (with approval by state government) and collected from employers and individuals. For lower income individuals (who earn too much to be eligible for Medicaid), a subsidy is provided to help pay their share of the monthly premium. Dirigo provides a similar, income based subsidy to help eligible individuals pay the annual deductible expenses.
5. As a self-insured entity, large companies assume direct financial responsibility for only their employees and dependents. While an “insurance” card may be provided, the insurance company is providing only administrative services.
6. Bureau of Insurance, Estimate of Cumulative Impact of Mandates in Maine, 2005, 12/28/06.