



Consumers for
**AFFORDABLE
Health Care**

Advocating the right to quality, affordable
health care for every man, woman, and child.

***Embargoed for Release:**
Tuesday, March 8, 2005,
at 11:30 AM*

Briefing Book to the Guiding Principles for Health Reform

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*Support for this project was made possible, in part, by
The Jessie B. Cox Charitable Trust, Nathan Cummings Foundation, and Public Welfare Foundation*

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Guiding Principles for Health Reform

4 Security

All Maine residents have comprehensive, quality coverage that is assured;

4 Fairness

Contributions for coverage are based on ability to pay;

4 Equality

Coverage is provided on an equal basis regardless of age, job status, employer size, geographic location, income, health status, or occupation;

4 Stability

Costs of care and administration are contained to make coverage and contributions affordable and predictable for Maine individuals, families and businesses from one year to the next; and,

4 Choice

Coverage allows consumers to choose their participating provider.



Advocating the right to quality, affordable health care for every man, woman, and child.

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Introduction

Consumers for Affordable Health Care is Maine’s largest consumer health coalition. Its 104 members include 50 labor, consumer and faith-based organizations, small businesses, and health care provider associations.

Consumers for Affordable Health Care developed the “*Guiding Principles for Health Reform*” to provide the public and policymakers with a tool to evaluate any health insurance or health care reform proposal offered as a solution to Maine’s health system crisis and to guide them in their choices.

In an article entitled “Is There Hope For The Uninsured?,” Princeton economist Uwe E. Reinhardt stated:

“Although the definition of universal health insurance lies somewhat in the eyes of the beholder, at a minimum the concept implies that no American should lack access to health care because he or she lacks the ability to pay for it when needed and that no American should suffer serious financial distress or personal bankruptcy as a result of unpaid medical bills.”¹

CAHC members agree with this statement and developed the following five guiding principles to express our values as Mainers and Americans.

4 Security

All Maine residents should have comprehensive, quality coverage that is assured

According to the *American Heritage Dictionary of the English Language*, the word “security” means “freedom from risk or danger; safety.”² Health insurance coverage is intended to protect health by enabling the insured to obtain needed services in a timely and appropriate manner. It also protects the insured from economic hardship if they get sick or injured or need preventive care by pooling risks across the young and old, and the healthy and sick.

Unfortunately, in reality, health coverage in Maine, and in the U.S., is anything but secure. Who gets coverage and what coverage is provided are a gamble. Of the 29 Organization for Economic Cooperation and Development (OECD) countries, almost all have 100% government assured coverage.³ However, coverage in Maine and in the U.S. usually depends on employment status, income, and employer size. Maine’s annual per capita income in 2003 was the lowest among New England states at \$28,935.⁴ Maine ranks 30th among all states in per capita income.⁵ Median annual

household income in Maine in 2003 was approximately \$37,619.⁶ A comprehensive HMO plan with reasonable cost-sharing in the small group market for employee only coverage costs \$5,634.24 and for family coverage costs \$16,902.72 in 2005.⁷ Premiums are higher in the non-group market. For example, for an individual standardized major medical plan (Standard Plan A), with a \$500 deductible, Anthem charges a single rate of \$8,067.24 per year and a family rate of \$21,378.24 per year.⁸ Given Maine's relatively low per capita and median household incomes, comprehensive health coverage is unaffordable for most individuals and families at these income levels.

Being employed in a large business doesn't always ensure security, as even the largest employers cannot guarantee coverage. There has been an overall decline in employer-provided coverage in Maine in recent years. Employer coverage dropped 5.4 percentage points, with 63,000 insured people losing coverage, over the course of the period 1999 - 2003.⁹ In addition to the decline in overall employer-based coverage, there is an emerging trend that shows a growing share of uninsured workers are employed by large firms. The number of uninsured workers in large firms rose sharply from 1987 to 2001, which heralded concerns about a new trend among businesses that are more likely to offer health benefits.¹⁰ In Maine, 19 percent of the uninsured work for a large business (i.e., an organization or business with 50 or more employees).¹¹ Changes in Maine's workforce, such as the decline in manufacturing jobs and the proportion of workers in large firms who are union members, are likely to account for this significant percentage of uninsured in Maine.¹² As a proportion of Maine's uninsured, a smaller share (10%) work for smaller firms (11 – 49 workers) than the share of those working for large firms (19%). This is important not only as a proportion, but also as a number, since 41 percent of Maine's population works for organizations or businesses with 50 or more employees.¹³

This trend of declining private coverage among workers in large firms is compounded by efforts by some employers to place the dependent children of their workers onto public programs, in particular, the State Children's Health Insurance Program (SCHIP). The Center for Studying Health System Change reported that "One employer response to rising premiums identified in HSC's 2002 – 2003 site visits was the promotion of the State Children's Health Insurance Program as an alternate source of coverage for low-income workers' children."¹⁴ This trend was recently documented by the Chattanooga Times Free Press on January 20, 2005 in the AP story "Study shows thousands of Walmart employees on TennCare."¹⁵ It stated that: "Walmart, with 9,617 employees listed as receiving benefits from the [TennCare] program, said it offers a health plan available to full-time workers after six months and to part-time employees after two years." Eligibility standards for employer-based coverage lead to fragmentation of the insurance pool and financing system.

In addition, as employers have been faced with rapidly rising health insurance premiums, benefits have been routinely taken away and costs have been shifted onto employees and consumers. Increasing employee cost sharing has included passing a larger share of premiums to workers or increasing

copayments, deductibles, and coinsurance.¹⁶ One national survey of employers found that, among those offering health insurance, one-third increased employees' copayments or coinsurance in 2002, a third (31%) increased their employees' share of premiums, and a quarter (25%) raised deductibles. One in five (18%) eliminated benefits or imposed new limits on benefits such as reductions in the number of hospital days covered, physician visits, or prescriptions.¹⁷ Nationally, employers are estimated to have raised patient cost sharing to reduce average health insurance premiums by 2-3 percent in 2002 and an additional 3 percent in 2003.¹⁸ One study found that while almost all employers increased workers' share of total costs, the proportion shifted to employees varied substantially across communities and employers.¹⁹

Shifting costs onto employees can have serious negative consequences, especially for employees that cannot afford the higher out-of-pocket expenses. Faced with these higher out-of-pocket costs, some employees will choose to cut back on both needed and discretionary care. If these employees are seriously ill or are low-income, they may face serious financial and medical hardship.²⁰ These effects have become evident in studies of bankruptcies due to medical debt and in the difficulty that families at all income levels are faced with in paying their medical bills. A recent national study of the impact of cost-shifting found that a plan offering a \$2,500 deductible with a 30% coinsurance rate would consume more than 10% of household income for 47% of households living at or below 100% of the federal eligibility level, 34% of households living between 100 – 125% of the federal eligibility level, 23% of households between 125 – 200%, 16% of households between 200 – 400%, and 6% of households at or above 400% of federal eligibility levels.²¹ A national household tracking survey found that 11.4% of families in which all family members were insured faced problems in paying their medical bills.²² Moreover, according to a study recently published by *Health Affairs*, Harvard researchers found that 46% of people who declared bankruptcy in 2001 cited major medical incidents as the cause of bankruptcy. In addition, among those who declared medical reasons for their bankruptcy, 76% had health insurance at the onset of their illness.²³

As costs have risen, benefits have been reduced especially those offered by small employers in Maine.²⁴ Maine provides a good example of how insurance carriers, including Health Maintenance Organizations (HMOs), have led the drive to reduce “coverage” as the primary method of “controlling” costs. Contrary to the oft-touted objective of providing “comprehensive” benefits that include primary and preventive care, HMOs in Maine were successful in advocating an amendment to Maine’s HMO Act that defines “basic health care services” in 1999²⁵ and Bureau of Insurance Rule 750. These and other statutory and regulatory changes have contributed to the domination of “high-deductible” plans in the non-group market and their rapid growth in the small group market.

Insurance carriers have moved non-group enrollees into high-deductible indemnity plans by rate increases. For example, Anthem discontinued the sale of its low-deductible HMO products in 2002

and, thereby, moved almost all of its non-group enrollees from low-deductible HMO plans to high-deductible indemnity plans. Of its 16,000 non-group enrollees, representing 28,000 covered lives, over 15,500 were enrolled in \$5,000, \$10,000 or \$15,000 deductible products.²⁶ Moreover, after these enrollees moved into high-deductible plans based on lower premiums, the lower premiums proved short-lived.²⁷

4 Fairness

Contributions for coverage
should be based on
ability to pay

“Fairness” means free from favoritism or bias; impartial; or just to all parties.²⁸ Given the purpose of health insurance and given the most effective way to achieve that purpose (i.e., pooling the greatest number of people into one risk pool), affordable health coverage should be available to all Maine people regardless of their ability to pay. Health care coverage in the U.S., and in Maine, is anything but fair. Some have coverage.²⁹ Many don’t.³⁰ Despite the fact that

over 80 percent of the uninsured in Maine have at least one family member who is working on a full-time basis,³¹ they are financially locked out of coverage. Despite their willingness to contribute *something* toward their coverage, they are not permitted to do so. Premiums (and copays) are flat rates – one size fits all regardless of wage or salary rate – and, therefore, are disproportionate to their incomes.

Moreover, some have *good* coverage.³² Many have *inadequate* coverage.³³ Many have *no* coverage at all.³⁴ Those with no coverage often have to rely on the local hospital emergency room.³⁵ They often have to enter repayment agreements with providers – hospitals, doctors and pharmacists. These medical debts often force them into bankruptcy.³⁶

Unfair: Contribution lock-out. Premiums and copays are *flat rates* that all enrollees must pay regardless of their financial ability. For example, a secretary working in a small law firm earning \$25,000 per year that offers coverage for only the employee has to pay the same premium - \$11,268.48 per year premium for her or his family’s dependent coverage³⁷ - as the highest paid partner earning \$155,000 per year pays for her or his family coverage. As a proportion of the secretary’s gross income, s/he contributes 45 percent to coverage, whereas, the law firm partner contributes 7 percent to her/his coverage. Clearly, the secretary faces being locked out of coverage. Her/his proportional contribution to coverage is *almost 7 times* that of the highest paid lawyer in the firm. The secretary will not only have been prevented from paying into the larger pool of “contributions” for insurance coverage, but all insureds in the larger insurance pool will have lost those additional dollars to support their coverage. Since mostly young, healthy people are “locked out” of coverage because their “starting”

wages do not allow them to pay the mandatory *flat rate*, the insured pool is losing the opportunity for attracting better “medical risks.” As a corollary, the financing system has prevented those largely “unencumbered”³⁸ dollars from entering the insurance pool. That’s not only unfair – it’s economically foolish. Dirigo Health, Maine’s universal access to health coverage plan, enacted into law in June 2003, attempts to reverse the “one-size-fits-all” approach for premiums in traditional insurance by discounting premiums based on household income in its DirigoChoice product. DirigoChoice enables all participants to have the same comprehensive benefits, contribute funding into the insurance pool based on the household’s income, avoid insurance premium “lock-out” and, hence, avoid financial ruin due to medical debt.

Unfair: Widely differing benefits. In most cases, good coverage³⁹ depends on a well-paying job with a large employer. But even employer size is not a guarantee of good coverage. Large employers like Hannaford Bros., Walmart, K-Mart, Dunkin’ Donuts, and McDonald’s limit or avoid contribution toward coverage for their mostly part-time workforces. According to an Associated Press article appearing in the Chattanooga Times Free Press, “Walmart, with 9,617 employees listed as receiving benefits from the [TennCare] program, said it offers a health plan available to full-time workers after six months and to part-time employees after two years.”⁴⁰ Moreover, large “self-insured” plans are not subject to state regulation or mandated benefit requirements. These companies can pick and choose benefits covered by their health plans. For instance, last year, Walmart dropped coverage of “chiropractic benefits.”⁴¹

Unlike large employers, small employers and self-employed persons don’t have bargaining clout to negotiate lower rates or better benefits. These businesses are left to fend for themselves. Benefits in small firms are moving toward higher-deductibles⁴² (over \$2500 per family⁴³) and increased cost-sharing requirements that make the accessibility of the benefit out-of-reach for many. This benefit disparity can result in increased uncompensated care costs that are shifted onto other payors. If left unchecked, cost-shifting will result in an endless upward spiral that will leave only the wealthiest able to afford (and obtain) care. That’s not only unfair – it can be deadly.⁴⁴ The Institute of Medicine recently reported the lack of universal health coverage in the U.S. results in the death of 18,000 people each year annually in preventable disease and lost productivity.⁴⁵

Benefit disparities can also be a substantial cost to Maine taxpayers. For example, Governor Baldacci’s budget estimated that if the state had a mental health parity benefit in private insurance, it would save the MaineCare program about \$11.7 million in state dollars over two years.⁴⁶ These are state dollars that are paid for adults and children whose private insurance does not cover their full mental health needs.

4 Equality

Coverage should be provided on an equal basis regardless of age, job status, employer size, geographic location, income, health status, or occupation

“Equal” means having the same rights, privileges, or status; impartial.⁴⁷ Health coverage in the U.S., and in Maine, is anything but equitable. Age, job status, employer size, geographic location, income, health status, and occupation are often significant determinants in whether an individual or family has health coverage.

Inequality based on age: In Maine, carriers in the non-group and small group “markets”⁴⁸ are permitted to vary their rates by 50 percent from top (highest rate charged) to bottom (lowest rate charged). Carriers in these markets are permitted to use age, geographic location and industry/

occupation to vary rates within the rate bands.⁴⁹ Carriers can vary their rates on an unlimited basis outside of the bands for the following factors: family size, wellness program participation, smoking status and group size.⁵⁰ In other words, an older insured person (55 – 64 years) will pay a rate that is 50% higher than the rate paid by a younger insured person (under age 45 years). For example, on a monthly basis, a 43-year-old person may be required to pay \$300 while a 56-year-old person may be required to pay \$450. Moreover, someone 65 years of age or older can be made to pay rates that are much higher because Maine law allows a “separate community rate” for them. Also, whereas most large employers used to provide health coverage to their retirees, that is no longer the case. Most employers dump the costs of health coverage for retirees onto the federal Medicare program once the retiree reaches age 65.

It is important to note that according to a 2002 household survey, nearly all of Maine’s senior citizens (age 65+) have some type of health insurance coverage, including “near universal Medicare coverage.” However, nearly one-fourth of Maine’s elderly residents do not have any type of Medicare supplemental coverage and, as a result, may face high out-of-pocket costs for their health care.⁵¹ Equally concerning is the fact that although elderly Maine residents are likely to have much greater needs for prescription drugs and dental care than younger adults, they are less likely to have coverage for dental care or prescription medications. Less than one-fifth of Maine’s seniors have insurance coverage that pays for dental care, compared to over half of other Maine adults.⁵²

Inequality based on job status: Great Northern Paper’s bankruptcy lends an unfortunate but accurate example of the inequality in our health coverage system. When GNP workers lost their jobs, they also lost their health coverage. That loss of health coverage extended beyond the 1200 active workers.⁵³ GNP’s 700 retirees also lost their health coverage.⁵⁴

As a percent of Maine residents (age 18 – 65) who were uninsured during 2002, almost half (48.2%) were either self-employed or employed by a firm, and 23.2% were between jobs.⁵⁵ Fourteen percent (14%) of Maine workers (age 18 – 64) who were uninsured during 2002 were employed on a full-time basis and twenty-six percent were employed on a part-time basis.⁵⁶ As a percent of Maine workers (age 18 – 65) who were uninsured during 2002 by job type, 16.6% worked permanent jobs and 45.9% worked temporary or seasonal jobs.⁵⁷

Our health coverage “system” is punitive to job seekers who themselves have a medical condition or have a family member with a health condition. If a job seeker has lost their coverage for more than 90 days, their “pre-existing medical conditions” can be denied coverage by their succeeding employer’s insurance carrier for one-year.⁵⁸

Inequality based on employer size: Many are not fortunate to work for a large employer that provides coverage. Many work for small businesses or are self-employed. Small businesses are much less likely to provide coverage than large businesses.⁵⁹ When small employers do *offer* coverage it often involves higher cost-sharing with the employees.⁶⁰ Workers earning less than \$10 per hour are unlikely to “take-up” coverage where offered but not paid for by the employer.⁶¹

Inequality based on income: The American private health insurance system of coverage favors those who can afford it (and the healthy who do not use or rely on their coverage). Premiums and cost-sharing are not adjusted to income level. In other words, in our “one-size-fits-all” financing system, those who would like to contribute something toward their coverage are not allowed to do so. In effect, low- and moderate-wage earners are locked out of coverage simply because they cannot pay the full rate. In fact, three-fourths of the uninsured in Maine who have declined employer-sponsored coverage for health insurance (through their own or family members’ workplace) indicated that the expense of the coverage was the primary factor for the decision.⁶² However, due to recent expansions offering higher rates of public coverage, primarily under MaineCare, Maine residents who live in poverty (i.e., those with family incomes at or below 100% of the federal eligibility level – an annual income of \$9,570 for an individual and annual income of \$12,830 for a couple without children) are less likely to be uninsured than those who are sometimes referred to as the “near poor,” meaning they have family incomes between 100% and 199% of the federal poverty level.⁶³ The State Children’s Health Insurance Program (SCHIP) and modest expansions of MaineCare for parents of children have helped to keep families insured. MaineCare covers children in households with incomes at or below 200% of the federal eligibility levels. In 2005, as a result of the implementation of the Dirigo Health program, MaineCare coverage will be expanded to 200% for the parents of children.⁶⁴ In Maine, individuals with family income between one and two times the federal poverty level make up almost a third of the uninsured, even though they represent only 17 percent of Maine’s population.⁶⁵ This trend is similar in most states across the nation.

In addition, while higher income individuals are more likely to be insured due to a greater likelihood of having access to job-based coverage and a greater ability to afford coverage, a May 2003 *Wall Street Journal* article demonstrates how executives are often protected from employer cost-shifting. According to the article, executives at about one in eight U.S. employers receive reimbursement for out-of-pocket medical expenses not covered by insurance plans, “in some cases even as their companies are cutting back on basic medical coverage.”⁶⁶

Inequality based on condition: In Maine, as in most states in the U.S., private insurance companies are permitted to deny coverage for “medical conditions” to anyone who has been without coverage for 90 days or more. In Maine, if someone loses their coverage, usually as the result of losing their job, the costs of services related to the treatment of a “prior” medical condition can be denied coverage for up to one-year.⁶⁷

4 Stability

Costs of care and administration should be contained to make coverage and contributions affordable and predictable for Maine individuals, families and businesses from one year to the next

“Stability” means resistant to change; being reliable or dependable.⁶⁸ As mentioned previously, health insurance is meant to keep someone safe from harm when he/she gets sick or injured. Thus, health insurance should be “stable.” Yet, health coverage in the U.S., and in Maine, is anything but stable. One year you can afford it, the next year you can’t. One employer contributes toward an employee’s coverage, another doesn’t. Insurers often use pricing patterns that force insured consumers with low deductibles into products with high deductibles. All of these factors make coverage anything but stable.

The root of all of these issues is the high cost of health care in Maine and nationally. High costs of health care contribute to high costs of health insurance premiums. A growing number of employers, families, and individuals are struggling to afford these costs. Hospital spending constitutes the single largest category of health spending nationally, as it does in Maine. Between 1996 and 2002, the cost of a family policy for Maine businesses and employees increased by 77%, while median household income increased by only 6%; increases for small businesses have been even steeper.⁶⁹ Health care spending, as a percentage of personal income, ranks Maine 6th highest in the nation.⁷⁰ Nationally, the U.S. Bureau of Labor Statistics has reported that employee benefits spending by private sector employers rose 24% over the past four years, primarily because of escalating health insurance premiums, while wages increased only 15%.⁷¹

Hospital spending-accounts for approximately 37 percent of total health spending in Maine.⁷² Total hospital revenues in Maine will reach almost \$2.7 billion in 2005.⁷³ In 2002, Maine hospitals' median cost per adjusted hospital inpatient discharge was the 6th highest of 39 reporting states in the nation.⁷⁴ Maine's median cost of \$6,917 per discharge was 19% higher than the national average and 45% higher than the northeast region's average of \$4,759.⁷⁵ In a voluntary survey of commercial insurance carriers in Maine, Massachusetts, and New Hampshire conducted by Milliman Consultants and Actuaries for the Maine Association of Health Plans, participating insurers reported paying 31% more per hospital stay in Maine than they do in Massachusetts and New Hampshire.⁷⁶ That means for every \$1.00 that the participating insurers pay for a hospital visit in Massachusetts or New Hampshire, they pay \$1.31 in Maine.⁷⁷ These higher costs impact our economy.

Based on the findings of a report⁷⁸ prepared by Dr. Nancy M. Kane, Harvard School of Public Health, who reviewed the audited financial statements of 36 hospitals, the Commission to Study Maine's Hospitals' February 5, 2005 report to the Maine Legislature found that "The profit margins of two-thirds of Maine's hospitals were *significantly* higher than the national and northeast region medians for hospitals in five out of the six years from 1997 to 2002."⁷⁹ (Emphasis added) These high profit margins, which are higher than those of other hospitals in the U.S. and the northeast region, have a major fiscal impact on Maine's consumers and businesses. For example, the Commission reported that if there had been a 3% limit on profit margins in 2003, 13 Maine hospitals would have exceeded that limit. If those 13 hospitals had met such a limit, consumers and businesses would have saved an additional \$16 million in 2003 and those hospitals would have remained financially healthy.⁸⁰

The Commission to Study Maine's Hospitals found that Maine's hospitals' administrative costs offer an area for large improvement.⁸¹ Medicare Cost Reports report administrative costs in Maine hospitals at about 16 – 17% of costs.⁸² Spending on hospital care is often used as a "proxy" for hospital costs. In 2005, hospital spending in Maine is projected to reach \$2.7 billion. Applying the rate of administrative costs from the Medicare Cost Reports results in about \$459 million that can be attributed to administrative functions in 2005.

There are other aspects of our fragmented health insurance system that result in less stability for health care consumers, for businesses and for Maine providers. For example, in the mid-1990s, large national and regional health insurance companies sought to gain market share in Maine. These companies engaged in "deep-discount" pricing patterns that were supported by their access to capital markets and large reserves. These pricing discounts de-stabilized Maine's health coverage system for tens of thousands of insureds and drove Maine's only non-profit insurer to the brink of insolvency.⁸⁴ Those pricing strategies were short-lived.⁸⁵ Two of the leaders in this pricing strategy, Tufts Health Plans and Harvard-Pilgrim, undercut prices so deeply that they couldn't bear the risk. Tufts Health Plans of Maine was dissolved and Harvard-Pilgrim Health Plans of Maine went into receivership in 1999. Tens of

thousands of Mainers insured by these corporate giants lost their premium payments and coverage.⁸⁶ The most significant result of these pricing patterns was the loss of Maine’s non-profit Blue Cross plan that converted to for-profit status in May 2000.⁸⁷ Shortly after the conversion, Anthem representatives appeared before the Banking and Insurance Committee to push a legislative agenda to “loosen community rating bands,” “sell flexible plans with high deductibles,” “lengthen the pre-existing condition exclusionary periods,” and “provide tax breaks” for individuals and others to purchase health coverage.⁸⁸

Most importantly, our fragmented health coverage system promotes cost-shifting⁸⁹ by purchasers and payors and risk-avoidance⁹⁰ by payors. Cost-shifting and risk-avoidance make it impossible to control health care costs in any meaningful way. Large employers often change insured status between operating a “self-funded”⁹¹ plan and purchasing a fully insured plan.⁹²

4 Choice

Coverage should allow consumers to choose their participating provider

“Choice” means having the ability to choose from a variety or number of options.⁹³ Often, people have different needs when they are sick and respond to different types of care. Thus, people should have the ability to choose the provider that best meets their needs. The concept of “choice” in health coverage in the U.S., and in Maine, is often a matter of the type of plan one’s employer chooses for her/his workers. If the employer chooses certain HMO plans, the

employees’ “choice” of provider can be drastically restricted. If an employer chooses a PPO (preferred provider organization) or a POS (point-of-service) plan, the issue of choice may depend on the employee’s ability to pay higher charges to obtain “out of-network” services that are subject to higher cost-sharing requirements.

Choice is often a matter relegated to those who can afford it. Most privately insured Mainers are restricted to choosing from providers with whom the insurer has a contract. This restriction was the hallmark of Health Maintenance Organizations. HMOs, by design, promised those who enrolled – or whose employer enrolled them – lower costs and comprehensive coverage including primary and preventive care for “trading off” the enrollee’s “free choice of provider.” Needless to say the promise of lower costs and comprehensive coverage proved elusive at best but loss of “choice” became a reality.

(Endnotes)

- ¹ Reinhardt, Uwe E., Is There Hope For The Uninsured?, *Health Affairs*, Web Exclusive, W3-376, August 27, 2003 at W3-377
- ² <http://dictionary.reference.com/search?q=security>
- ³ G. Anderson and J.P. Poullier, Health Spending, Access, And Outcomes: Trends In Industrialized Countries, *Health Affairs*, Vol. 18, No. 1, May – June 1999. OECD is the Organization for Economic Cooperation and Development. Some of the OECD countries include Australia, Belgium, France, Germany, Korea, Turkey, the United Kingdom and the United States, among others. Five countries have less than 99% government assured coverage: Germany (92%), Mexico (72%), Netherlands (72%), Turkey (66%) and the United States (33%).
- ⁴ U.S. Department of Commerce, Bureau of Economic Analysis (2003)
- ⁵ Id.
- ⁶ U.S. Census Bureau, Current Population Surveys (2001– 2003)
- ⁷ *A Consumer’s Guide to Small Employers Health Insurance: A Guide for Employers With 50 or Fewer Employees*, Maine Bureau of Insurance, last updated February 14, 2005, Rate Comparison Chart, pp. 4 (web version). Premium cited is based on Anthem’s HMO Maine policy. Premiums cited are effective April 1, 2005.
- ⁸ *A Consumer’s Guide to Individual Health Insurance*, Maine Bureau of Insurance, last updated February 14, 2005, Rate Comparison Chart, p. 4 (web version). Premium cited is based on Anthem’s Standard Plan A policy with a \$500 deductible. Premiums cited are effective March 1, 2005.
- ⁹ Gould, Elise, “The Chronic Problem of Declining Health Coverage,” EPI Issue Brief # 202, Sept. 16, 2004, Maine portion, Table 4 at p. 8.
- ¹⁰ Glied, Sherry, Lambrew, Jeanne M., and Little, Sarah, “The Growing Share of Uninsured Workers Employed by Large Firms,” (October 2003), Commonwealth Fund
- ¹¹ Ziller, Erika, MS and Kilbreth, Elizabeth, PhD, “Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002,” (May 2003) at p. 19.
- ¹² See St. John, Christopher, Choices, The State of Working Maine 2004, Vol. 10, No. 10, Sept. 6, 2004; see also, Glied, Sherry, Lambrew, Jeanne M., and Little, Sarah, “The Growing Share of Uninsured Workers Employed by Large Firms,” (October 2003), Commonwealth Fund
- ¹³ According to “Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002,” (May 2003), “41% of Maine’s population works for an organization or business with 50 or more employees (or, in the case of children, has a parent who does).” at p. 19
- ¹⁴ Regopoulos, Lydia E., Trude Sally, “Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight,” (May 2004), Issue Brief No. 83, Center for Studying Health System Change at p. 4
- ¹⁵ “Study shows thousands of Walmart employees on TennCare,” Associated Press, January 20, 2005, Chattanooga Times Free Press
- ¹⁶ Regopoulos, Lydia E., Trude Sally, “Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight,” (May 2004), Issue Brief No. 83, Center for Studying Health System Change at p. 1
- ¹⁷ Collins, Sara R., Schoen Cathy, Doty Michelle M, and Homgren Alyssa L, “Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace,” (March 2004), Issue Brief, The Commonwealth Fund at p.2.
- ¹⁸ Trude, Sally, Gorssman Joy M, “Patient Cost-Sharing: Promises and Pitfalls,” (January 2004), Issue Brief No. 75, Center for Studying Health System Change at p. 1.
- ¹⁹ Regopoulos, Lydia E., Trude Sally, “Employers Shift Rising Health Care Costs to Workers: No Long-term Solution in Sight,” (May 2004), Issue Brief No. 83, Center for Studying Health System Change at p. 2
- ²⁰ Trude, Sally, Gorssman Joy M, “Patient Cost-Sharing: Promises and Pitfalls,” (January 2004), Issue Brief No. 75, Center for Studying Health System Change at p. 1.
- ²¹ Issue Brief No. 72, Patient Cost-Sharing: How Much Is Too Much?, December 2003, Center for Studying Health System Change at p. 4

- ²² Center for Studying Health System Change, Community Tracking Study Household Survey, 2003 In families where all members were uninsured, 23.7% had problems paying medical bills.
- ²³ Himmelstein, David U., Elizabeth Warren, Deborah Thorne, and Steffie Woolhandler, Market Watch: “Illness and Injury as Contributors to Bankruptcy,” *Health Affairs*, February 2005.
- ²⁴ C. St. John, J. Ditre, and L. Pohlman, “At Risk: Small Business Health Insurance in Maine”, Maine Center for Economic Policy (August 2000)
- ²⁵ 24-A M.R.S.A. §4202-A(1) defines basic health services. Carriers were successful in lobbying the passage of LD 1664, now P.L. 1999, ch. 222 “An Act to Clarify Basic Health Care Services to be Offered by Maine Health Maintenance Organizations.” The “clarification” prohibited the superintendent from requiring that all health benefit plans offered by HMOs meet the then required services under Bureau of Insurance Rule 750. It gave the superintendent authority to adopt rules “defining ‘basic health care services’ ... and the “need for flexibility in the marketplace.” The superintendent adopted changes to Rule 750 that allowed for the sale of high deductible plans.
- ²⁶ Anthem 2003 Individual Rate Filing, INS-02-785, Oct.–Nov. 2002, Public Exhibits, Ex. XIV
- ²⁷ For a non-standardized, individual plan for a family with a \$2,250 deductible, Anthem charges \$11,039 per year and for a \$5,000 deductible plan, Anthem charges \$6,456 per year. Rates cited are effective March 1, 2005.
- ²⁸ <http://dictionary.reference.com/search?q=fairness>
- ²⁹ University of Southern Maine, Muskie School, Data on the Uninsured in Maine, based on Mathematica Policy Research Dec. 2002 survey, show that an estimated 85% of the total Maine population had some level of coverage during 2002. (n=3500)
- ³⁰ Id. Data show that 15% of the total population and 17.3% (or 189,000 people) of the under age 65 years population had no health insurance during 2002. The data also show that 93.7% of Maine’s uninsured without access to employer coverage (under age 65) worked for firms with 10 or fewer employees.
- ³¹ Id.
- ³² Id. Good coverage is often defined as a comprehensive major medical policy with low cost sharing. In terms of low premium sharing, Mainers working for large employers are better off than those working in smaller firms. Eighty percent (80.3%) of Mainers under age 65 with private coverage in which the annual premium is less than 5% of their income work for large firms with 50-plus employees. Comparatively only 68.5% of workers in firms with 11–50 employees and only 45.1% of workers in firms with 10 or fewer workers can claim that premium-to-income ratio. Larger employers usually offer more comprehensive benefit packages than smaller firms. See also, footnote 19 infra.
- ³³ Id. For individuals with non-group private coverage under age 65 in Maine, the data show that the median annual premium is \$3,242 and the median annual deductible is \$4,138.
- ³⁴ Supra, fn 5 showing that 189,000 Mainers under age 65 had no health insurance during the year 2002.
- ³⁵ Institute of Medicine, Care Without Coverage: Too Little, Too Late, p. 27 says “In 1998, nearly 70 percent of uninsured adults could not see a doctor at some time during the year because of cost. A study that polled 1,100 patients four months after their initial visit to an emergency department found that patients who lost their health insurance were more than twice as likely as those who maintained their coverage to have delayed seeking care in the four month interval.” (Citations omitted) (May 2002).
- ³⁶ E. Warren, T. Sullivan and M. Jacoby, Report published in Norton’s Bankruptcy Advisor (May 2000). Prof. Warren, Harvard Law School and advisor to the National Bankruptcy Review Commission, found that 50% (or 500,000) of the one million personal bankruptcies filed in 1999 were due to crushing medical expenses. See www.commondreams.org website for news release. See also, fn 23
- ³⁷ *A Consumer’s Guide to Small Employers Health Insurance: A Guide for Employers With 50 or Fewer Employees*, Maine Bureau of Insurance, last updated February 14, 2005, Rate Comparison Chart, pp. 4 (web version). Premium cited is based on Anthem’s HMO Maine policy. Premiums cited are effective April 1, 2005. Premiums vary based on family composition. The monthly premium for employee only coverage is \$469.52, for an employee and spouse is

\$985.99, for an employee and children is \$845.14, and for family coverage (an employee, spouse and children) is \$1,408.56. Premiums do not include other cost sharing such as copays and coinsurances.

³⁸ Premium dollars that cover healthy lives with relatively low medical costs.

³⁹ Coverage that is similar to the benefit designs provided in Table II.2., *Feasibility of a Single-Payer Health Plan Model for the State of Maine*, Final Report, December 13, 2002, Mathematica Policy Research Inc.

⁴⁰ “Study shows thousands of Walmart employees on TennCare,” Associated Press, January 20, 2005, Chattanooga Times Free Press

⁴¹ See *Chiropractic Wellness and Fitness Magazine*, Vol. 3, Issue 1 at p. 7 “Walmart Agrees to Meet With ACA Officials to Discuss Company’s Elimination of Chiropractic Benefits.”

⁴² Statement, John Benoit, Employee Benefit Solutions at the March 14, 2003 meeting of the Governor’s Health Action Team.

⁴³ Id. at p. 11 defining “high deductible” as plans with “at least \$2,500” deductibles.

⁴⁴ Institute of Medicine, *Care Without Coverage: Too Little, Too Late* (2002), pg. 81– 82. “Two studies provide evidence that uninsured adults are more likely to die prematurely than are their privately insured counterparts.

...Controlling for sociodemographic characteristics, health examination findings, self-reported health status, and health behaviors, the risk of death for adults who initially were uninsured was **25 percent greater** than for those who had private health insurance at the time of the initial interview (mortality hazard ratio = 1.25, CI: 1.00– 1.55).”

⁴⁵ “Insuring America’s Health Principles and Recommendations,” Institute of Medicine, January 2004

⁴⁶ Testimony of Maine DHHS Commissioner John Nicholas before the Joint Standing Committee on Appropriations and Financial Affairs, February 14, 2005

⁴⁷ <http://dictionary.reference.com/search?q=equal>

⁴⁸ Anthem Non-Group Rate Filing, Oct.– Nov. 2002, Maine Bureau of Insurance. Anthem controls 98% of the non-group insured lives in Maine. As of year end 1999, the Bureau of Insurance reported that there were about 84,000 insureds in the small group market. See www.maineinsurancereg.gov, Report “Maine’s Health Insurance Market.”

⁴⁹ 24-A M.R.S.A. §2808-B(2)(D)

⁵⁰ 24-A M.R.S.A. §2808-B(2)(C)

⁵¹ Ziller, Erika, Kilbreth Elizabeth, “Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002,” (May 2003), Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine at p. 33

⁵² Id

⁵³ Combined workforce at the Millinocket and East Millinocket mills according to the Governor’s Office on Health Policy and Finance, Feb. 11, 2003 meeting handout on Trade Assistance Adjustment Act.

⁵⁴ Id.

⁵⁵ University of Southern Maine, Muskie School, Data on the Uninsured in Maine, based on Mathematica Policy Research Dec. 2002 survey, show that an estimated 85% of the total Maine population had some level of coverage during 2002. (n=3500)

⁵⁶ Id. These figures exclude self-employed persons.

⁵⁷ Id.

⁵⁸ 24-A M.R.S.A. §2848 et seq. set forth the “Continuity of Coverage” requirements.

⁵⁹ Only 42% of small businesses in Maine offer coverage compared to 98% of large businesses. Kaiser Family Fund, State Health Facts Online, “Maine: Percent of Private Sector Establishments That Offer Health Insurance To Employees, by Firm Size, 2000.”

⁶⁰ C. St. John, J. Ditre, and L. Pohlman, “At Risk: Small Business Health Insurance in Maine”, Maine Center for Economic Policy (August 2000) and Gabel, Jon R., Pickreign Jeremy D., “Risky Business: When Mom and Pop Buy Health Insurance for Their Employees,” (April 2004), Issue Brief, The Commonwealth Fund at p. 2

- ⁶¹ P. Cooper and B. Steinberg-Shone, More Offers, Fewer Takers For Employment-Based Health Insurance 1987 – 1996, *Health Affairs*, Vol. 16, No. 6 (Nov.-Dec. 1997)
- ⁶² Ziller, Erika, Kilbreth Elizabeth, “Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002,” (May 2003), Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine at p. 25
- ⁶³ Id at p.10
- ⁶⁴ P.L. 2003, c. 469, Pt. A, §5 (amd.); c. 673, Pt. Y, §3 (aff.). In addition, MaineCare coverage for a qualified disabled person will be expanded to 125% FPL in 2005 under Dirigo Health.
- ⁶⁵ Id at p.16
- ⁶⁶ Lublin, Joann S, “Many Companies Reimburse Top Executives’ Health Costs,” *Wall Street Journal*, May 20, 2003, <http://online.wsj.com/article/0,,SB105337069099067000,00.html>
- ⁶⁷ 24-A M.R.S.A. §2848 et seq. Maine’s law is somewhat more generous than the federal law called the Health Insurance Portability and Accountability Act in that Maine permits someone to go without coverage for up to 90 days before the costs of treating their medical condition can be denied coverage by a succeeding insurance carrier.
- ⁶⁸ <http://dictionary.reference.com/search?q=stability>
- ⁶⁹ Maine’s State Health Plan, July 23, 2004, www.dirigohealth.maine.gov, at 18 and 49
- ⁷⁰ Id. at 17
- ⁷¹ Commission to Study Maine’s Hospitals Report to the Legislature, February 2005 at 23, www.dirigohealth.maine.gov
- ⁷² Maine’s State Health Plan, July 23, 2004, www.dirigohealth.maine.gov,
- ⁷³ Commission to Study Maine’s Hospitals Report to the Legislature, February 2005 at p. 22
- ⁷⁴ Id. at 13
- ⁷⁵ The 2004 Almanac of Hospital Financial & Operating Indicators, Ingenix, Inc. 2003
- ⁷⁶ Milliman Consultants and Actuaries, Exhibit 1, Maine Association of Health Plans, Hospital/Medical Costs Survey, Allowed Charges Reported as of 2003, at p. 1. See also, letter from Jack P. Burke, F.S.A., Consulting Actuary, Milliman Consultants and Actuaries, dated November 19, 2004 to Katherine D. Pelletreau, Maine Association of Health Plans, presented to the Commission to Study Maine’s Hospitals
- ⁷⁷ Id.
- ⁷⁸ Kane, Ph.D., Nancy M., Hospital Financial Performance: Differences Within Maine, November 22, 2004, at 5
- ⁷⁹ Commission to Study Maine’s Hospitals Report to the Legislature, February 2005 at 83, www.dirigohealth.maine.gov
- ⁸⁰ Id. at 84
- ⁸¹ Id. at 21
- ⁸² Id. at 21 Footnote 15 of the Commission Report on page 21 states “However, a number of hospital administrators indicated to the Chair of the Commission that they estimate that administrative costs are 20 – 25% of their total costs.”
- ⁸³ Id. at 23
- ⁸⁴ Andrew “Mickey” Greene, former CEO, Blue Cross and Blue Shield of Maine, testimony before the Banking and Insurance Committee in 1995 regarding “insufficient premiums in the Maine market to sustain current risks.”
- ⁸⁵ Cindy Mann, Slide Presentation at Consumers for Affordable Health Care Annual Conference September 23, 2002 showing premium increases compared to wage increases.
- ⁸⁶ Maine Bureau of Insurance website information
- ⁸⁷ Decision and Order, Superintendent of Insurance, In Re: Application of Associated Hospital Service of Maine to Convert to a Stock Insurer and Voluntarily Liquidate and Dissolve, INS-99-14, May 5, 2000

⁸⁸ Testimony of Sharon Roberts, Anthem Insurance Co., before the Banking and Insurance, July 27, 2001.

⁸⁹ Cost-shifting is the practice of paying less than the amount required to deliver services. For example, private insurers negotiate discounts with providers on behalf of large groups. The balance of these discounts must be paid by small businesses and consumers who lack bargaining power. Private insurers also shift costs by limiting or capping benefits. Many insurers file revisions and amendments with the Bureau of Insurance each year to reduce or eliminate benefits. The costs for those services are passed onto consumers. Cost-shifting results from the failure of the system to assure all residents with coverage. While the uninsured pay about 60% of the costs of their care and the remainder is passed onto other payors.

⁹⁰ Risk-avoidance is the practice of insurance carriers to avoid paying claims of those in need of greater amounts of care. Carriers deny covered services as “not medically necessary” or “not a contract benefit.” This practice forces consumers or providers to persist in getting claims paid. In addition, high deductible plans have reduced carriers’ medical loss-ratios to 75% or below. That means for every dollar in premium paid the carrier spends 75 cents or less on direct medical care. Anthem’s net operating gain in the non-group line of business alone in 2000 was over \$3 million and in 2001 over \$2 million as the result of moving non-group insureds into \$5000 deductible plans.

⁹¹ “Self-funded” plans are preempted from state regulations that protect consumers and require types of coverage by a federal law called ERISA (1974). These employer-sponsored health plans are usually only nominally “self-funded” in that most employers offering them purchase “stop-loss” or “excess-loss” insurance coverage to cover claims that exceed a certain fixed dollar amount. Therefore, while the name “self-funded” implies that the employer is taking on all of the risk, most are not.

⁹² Fully insured plans are those in which the insurance carrier takes on all of the risk of coverage and the plan is subject to state insurance regulations to the extent that the regulation spreads risk.

⁹³ <http://dictionary.reference.com/search?q=choice>