

## Responses to Committee Questions – Governor’s Office of Health Policy & Finance

1. Why is the proposal funded solely from a tax on insurers and not a broader funding mechanism?

The purpose of the assessment is to recover bad debt and charity care now implicit in prices. It makes sense to remove this directly from prices via insurer negotiation with providers, rather than adding to a complex system of offsets (as would be the case with a more diversified assessment or any assessment on providers). Dirigo will monitor the distribution of claims payments among providers by sector and within sector to assist insurers in renegotiating reimbursement levels with providers as Dirigo enrollment increases.

Providers currently deliver services to people who lack the ability to pay for care, wither in part or in whole. There is a cost to providing services to such patients, which must be met in some manner if the provider is to continue operating a viable business. Payment of these costs fall to those who are able to pay for services; the cost of bad debt and charity care is shifted to paying patients, reflected in the rate structure of the provider. There is currently \$275 million built into the provider rate structure in order to ensure providers’ costs for bad debt and charity care are met. Our insurance premiums presently reflect that level of cost.

A reduction in providers’ bad debt and charity care experience would relieve the need to inflate rates to recover these costs from those who pay for care. One objective of Dirigo Health Insurance is to provide currently un- and underinsured individuals with comprehensive coverage, thus reducing the level of bad debt and charity care in the system. While service rates moderate to reflect declining costs, premium levels will remain at levels which continue to reflect the very same costs. The reimbursement rates paid by insurers will not incorporate the cost of bad debt and charity care, but the premiums paid by rate payers will, resulting in a potential windfall to insurers (most of which, in Maine, are for profit organizations).

The recovery against insurers is intended to avoid that scenario, using a strategy that is easy to implement and track. Our intent was to assess the premium associated with each covered life only once. We propose an assessment on commercial insurers as well as on reinsurers providing excess loss protection to self funded plans. If a plan does not purchase reinsurance, the proposal calls for an assessment of the third party administrator. Use of this type of assessment is limited to those situations where a group or individual is fully insured, is reinsured or uses an administrator; if none of these three situations apply, this particular assessment approach will fail to include the group in the recovery effort.

Insurers have asserted that they will be unable to negotiate rates with providers that reflect the reduction in bad debt and charity care, citing their historical difficulty in

negotiating favorable provider contracts, generally. They point out that if, in fact, they are unable to negotiate new rates, a prohibition against passing the assessment on to premium payers will result in a substantial reduction to their bottom lines, which they believe is unaffordable. At the same time, the providers have asserted that insurers will extract the reduction from them in any number of hidden ways, perhaps using expanded withhold provisions to reduce overall reimbursements.

An alternative approach to recovering the monies would be to institute a surcharge on health services rendered, either system wide or at hospitals alone (where the greatest bulk of charges are generated). This is, in fact, a broader based approach, easily reaching those who are covered by self-funded plans. This approach may be more difficult to track, however.

Providers and insurers present almost diametrically opposing views regarding the assessment issue. However, they both contend that it is absolutely necessary to pass the cost of the assessment on to those paying for the services, either directly or through the insurance premium. We believe any approach requiring consumers to pay for bad debt and charity care more than once is fundamentally unfair, but do not see how to reconcile the parties' criticisms to a should approach without relying on some form of oversight of rates to protect the interests of consumers.

2. Why does Dirigo need reserves if it is not an insurance company?

It doesn't; the reference to reserves was somewhat misplaced. Given the pace of enrollment we expect to see, Dirigo will be in a position to end Year One with approximately \$6 million. A portion of those funds will be used to fund the Maine Quality Forum (approximately \$1.5 million in Year One). The rest of the monies provide a safety cushion between the estimated cost and actual experience in the initial years of enrollment.

- The estimates already include an adjustment for adverse selection, but it is possible that the adverse selection factor is not adequate (our estimates assume that initial Dirigo enrollment is 35 percent more costly than the population average). A margin of funds will make it possible to offer participating carrier(s) at least partial indemnification for extreme adverse selection.
- In addition, when the take up rate for Dirigo reaches 50% of the uninsured, the model demonstrates a relatively slim margin – too slim to underwrite the cost of the Maine Quality Forum in that year. A portion of the Year One surplus will need to be carried over into Year Two to meet those on-going costs.

Finally, it might be advisable to use a portion of the surplus monies to provide additional subsidy payments to employers for coverage of dependents or part-time workers without access to other group coverage.

3. What evidence is there to support the premise that small employers who do not currently offer insurance will be able to afford 60% of family premiums for their employees and dependents?

National research shows that workers in small firms pay an average of 34% of the premium for family coverage. The same research (Kaiser Family Foundation and Health Research and Educational Trust) finds that businesses with a high proportion of low wage workers (workers earning less than \$20,000 annually) pay about 65% of the family premium. These observations have remained relatively constant since 1988.<sup>1</sup> Any actuarial evidence available to us would mirror these trends.

A recent survey conducted by the Greater Portland Chamber of Commerce found that most small businesses in Maine pay an average of 56% of premium (family, individual or otherwise)<sup>2</sup> albeit of a lower premium level. It is important to be aware that these surveys do not adjust for differences in the comprehensiveness of any given benefit package. Dirigo Health Insurance is likely to be broader in scope than packages currently available in the small group market at a lower price. If employers are primarily concerned with cost, the comprehensive nature of the DHI package will be irrelevant to them. If they are concerned with obtaining a comprehensive product at a very competitive price, they will be interested in DHI.

We are open to discussing ways to make DHI more attractive to employers. However, we do not believe that offering a catastrophic plan is sensible from a policy perspective.

4. Should we fear that people with chronic conditions will move to Maine to join the plan? How can the plan be protected from excessive rate increases?

We should not fear that people will flood into the state just to obtain Dirigo Health Insurance. Other states that have implemented state sponsored health plans (including Tennessee, Minnesota and Washington) none of those programs attracted sick people to relocate to those states.

Even so, the premium rates used to model the plan include substantial selection rate factors. This means that from the outset, the premium is set to accommodate adverse selection into the program. This is one mechanism that will protect against substantial rate increases from one contract period to the next, arising from poor experience.

The proposal also specifies a residency requirement for premium subsidies, which is presently crafted in a manner intended to be liberal. That definition could be made more restrictive.

It is also important to view Dirigo as part of the comprehensive systems improvement initiative presented in the proposal. Cost containment is clearly a vital piece of the plan;

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<sup>1</sup> The Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits 2002 Annual Survey.

<sup>2</sup> Personal communication with Godfrey Wood, May 13, 2003.

Dirigo, like other insurance plans, will benefit from the impact cost containment exercises on the system.

Finally, we view this reform package and its attention to cost, quality and access as part of a larger economic development tool. The proposal is intended to improve Maine's health care system – from the planning of services to the provision of services to the paying for services – in an effort to help make Maine a more attractive place to do business. To that end, we hope to see an influx of business to our state.

5. How will large self-insured employers without reinsurance participate financially?

Under the plan as proposed, if a self-funded plan does not purchase reinsurance, the bad debt charity care recovery will be assessed on the plan's third party administrator. If the plan does not use a TPA it will not participate financially.

Like insurers, self-insured plans are expected to act as prudent purchasers and negotiate rates with providers. To the extent that they do not negotiate rates, they may be subject to unfair pricing now, and will remain vulnerable when Dirigo is implemented.

If a surcharge was imposed on health care services, instead, everyone using services would support the recovery, regardless of the type of coverage they have.

6. Will this proposal weaken the insurance market to the point where carriers might leave? Why are there no provisions to strengthen the market?

Some of the insurers have argued that application of the bad debt/charity care assessment without the ability to pass the cost on to the consumer will encourage them to exit the Maine market. There will always be an issue of market exit any time the market is comprised primarily of national insurers. Maine is a very small market and virtually any type of intervention that departs from the practice observed nationally, is likely to elicit this type of reaction from those administering nationwide operations. This is an especially effective argument when the market is dominated by a very few insurers, as is the case in our state. Guaranteed renewal does ensure that groups currently insured with a plan can continue to maintain that coverage, if they are willing and able to support the premium charged.

The introduction of a competing product into the individual and small group markets will strengthen the market by introducing competition where there is little or none at present. At present, the individual market in Maine is, for all intents and purposes, a monopoly and the small group market is an oligopoly. By brokering coverage, fostering new demand for private insurance and encouraging the entry of new insurers, Dirigo will contribute to a competitive, healthy market in Maine.

As important, a reduction in the number of uninsured and in the shifting of costs associated with the care provided to people who are unable to pay, will serve to strengthen the market. Similarly, the cost containment and quality improvement

initiatives embodied by the proposal will serve to improve the health care “environment” in Maine which, in turn, will strengthen our marketplace.

7. Why haven't the actuarial data been shared yet?

The actuarial data are complex and require a detailed overview. Without explanation, the numbers can be misconstrued. We chose to focus on the underlying tenets of the reform plan at the hearing, which we believed to be the best starting point for discussion.

Committee members were provided with a summary sheet of the modeling at the public hearing. As noted in our testimony, we intend to provide the Committee with a full briefing on the model at work session, when we will make our economic/actuarial consultants available.

8. How will we encourage personal responsibility/accountability for individual health?

The model for Dirigo Health incorporates several features that encourage personal accountability. The package of benefits emphasizes primary and preventive care, without the imposition of cost sharing. This is intended to encourage consumers to seek care and intervention early, before problems arise or spiral out of control. The cost sharing requirements built into the product design in the form of premium cost sharing, copayments and deductibles all serve to heighten consumer sensitivity to the cost of care. These features have been proven to influence care seeking behavior. Similarly, the proposal's provisions for increased consumer information through price disclosure are intended to educate and sensitize people to the cost of care.

The reform package includes a focus on wellness, with particular attention paid to health living and steps people can take to improve their own health. This will be a function of the Maine Quality Forum, which will disseminate this type of information to the public.

A strong commitment to public health and health improvement is demonstrated by the proposed constitutional amendment to protect, in perpetuity, the Fund for Healthy Maine. These funds may be used to help encourage Maine residents to adopt healthier behaviors.

9. Why are individuals working for employers with self-funded plans prohibited from participating in Dirigo?

Employers who operate self-funded plans have done so, in part, to avoid State oversight and regulation. In some instances, the integrity of the plan is tenuous, as evidenced by the recent experience at Great Northern Paper. We do not view it as prudent public policy to support the development or operation of self funded plans.

10. Why is there a prohibition against employees enrolling in Dirigo until after a 12-month waiting period?

Only those individuals whose employers drop coverage and send their employees on to Dirigo as individual enrollees (without an employer contribution) are subject to the 12-month waiting period. This is known as a "crowd out" provision and is intended both to deter employers from ceasing to sponsor coverage and to protect Dirigo from adverse selection.

11. How many new agencies/regulatory bodies are created by the proposal?

Dirigo Health is the only new agency created by the Governor's proposal and it is entirely self-sustaining. The Maine Quality Forum is housed within Dirigo, but is not an agency, nor a regulatory body.

Certificate of Need will continue to be administered by the Department of Human Services. The Maine Health Data Organization will continue its work as will the Governor's Office.

There will be a new Council formed as part of the process of developing the State Health Plan; members will be paid expenses only (note that the CON Advisory Council has been disbanded). Similarly, the group of hospitals, providers and State officials called together to work on the Hospitals for Maine's Future initiative, will be paid expenses only. Neither of these groups can be characterized as an agency, nor do they have regulatory power.

12. Why does the Dirigo Health Board exclude insurance representatives, while DH is funded, in part, by an assessment on insurers?

It is important that DH maintain its independence from the industry. It would be very difficult for DH to bid out a contract with carriers, when carriers serve on the Board of Directors; that arrangement would constitute a conflict of interest. Moreover, Dirigo cannot be allowed to become a captive of the insurance industry. If it does, there will be good chance that the plan will become a reference plan for poor risks. It is also important that the plan be independent of provider interests as that, too, would present a conflict of interest.

As explained elsewhere, the BDCC recovery assessment reflects the recoupment of monies that are already reflected in the insurance premium. When a provider delivers care to someone who is unable (or unwilling) to pay, the provider incur a certain cost associated with that patient. Those costs of doing business are passed on to others who do pay for their care in the form of higher charges. This, in turn, generates higher insurance rates, which all rate payers pay.

If the cost of bad debt and charity care experienced by providers is reduced, there will a reduction in upward pressure on their rates and, then, on insurance premiums. If the bad debt and charity care costs are not there, they do not need to be underwritten by the insurance rate payers. In fact, if they continue to be paid by the rate payers, while not being charged by the providers, the insurer will experience a wind fall.

Insurers argue that they are in a poor position to negotiate rates with providers and fear that they will not be able to realize a reduction in provider rates for drops in bad debt and charity care, generated by enrollment of the uninsured in DH. By the same token, the providers express fears that the insurers will, in fact, use withholds and other similar mechanisms to lower reimbursement to providers, even if providers lower rates for the decline in bad debt and charity care. It is unclear at this point which position is more apt to be correct.

The comments of the parties seem to be an indication of flaws in the market. Perhaps a greater degree of insurance regulation is required to gain adequate oversight of this situation. By the same token, provider rate setting would also serve to ensure that every party was being treated fairly and that no one party was disadvantaged.

**Note: The Committee has asked on a previous occasion for an accounting of the costs associated with the development of this proposal. That accounting is attached for the Committee's review.**

**Consulting Expenditures in Support of the Governor's  
Office of Health Policy and Finance  
January through April, 2003**

(NO STATE FUNDS HAVE BEEN EXPENDED ON CONSULTANTS)

**SUMMARY**

1. Planning Grant – Funded by Federal Grant (DHHS/HRSA) Provides research assistance to the Governor's office	
Professional Staff time <sup>1</sup>	
Health Policy Institute, USM Muskie School	\$37,798
Research and Analysis <sup>2</sup>	
Health Policy Institute, USM Muskie School	\$44,281
Other direct costs	\$9,833
<b>Sub-total</b>	<b>\$91,912</b>
Sub-contracts (funds committed)	
Maine Health Information Center	\$84,000
Charlene Rydell	\$16,000
Colleen Rost-Banik	\$6,000
<b>TOTAL</b>	<b>\$197,912</b>
2. Health Action Team Logistical Support – National Academy for State Health Policy Maine Health Access Foundation Grant	
Provided logistical support to HAT and its 6 subcommittees and provided technical assistance	\$44,000
Support for Cost Containment Subcommittee – John Colmers, Milbank Memorial Fund	IN KIND
3. Technical Support and Research on Dirigo Health – Jeanne Lambrew, George Washington University	IN KIND
<b>TOTAL</b>	<b>\$241,912</b>

<sup>1</sup> Activities include:

- Technical Assistance to HAT committees
- Development of memoranda and policy papers
- Program modeling and cost projections

Staff Participants: Beth Kilbreth; Gino Nalli; Maureen Booth; and, Erika Ziller

<sup>2</sup> Activities include:

- Analysis and report development, household survey
- Focus groups of small business owners
- Key informant interviews of large employers and insurance industry representatives
- Multi-state comparisons of demographic, economic and health system features
- Trend analysis of health care costs and utilization in Maine

Staff participants: Beth Kilbreth; Gino Nalli; Susan Payne; Erika Ziller; Bob Keith; Stephenie Loux; and, Deborah Thayer