The Maine View

Published by The Maine Heritage Policy Center

August 4, 2011

Historical Perspective: Why LD 1333 - Maine's New Health Insurance Reform?

Joel Allumbaugh
Director, Center for Health Reform Initiatives

On May 17, 2011, Governor Paul LePage signed into law a major health reform package to help contain the spiraling cost of health insurance for all Mainers. Before becoming law, the reform bill was known as LD 1333: "An Act To Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-Based Purchasing of Health Care Services."[1]

Since its passage, there have been many questions about what led to this important legislation. This report provides historic perspective on health insurance regulation in Maine and explains why LD 1333 is so critically needed.

WHY DOES MAINE NEED LD 1333?

There has been a great deal of attention directed at the new health insurance reform bill signed by Governor LePage in May. As we evaluate this new law, it is helpful to look back at the history of health reform in Maine over the last couple of decades, and how these short-sighted policies created the need for patient-centered reform.

In the early 1990's Maine passed sweeping health care reform legislation that defines how our market is regulated today. The two main components were **guaranteed issue** and **community rating**.[2]

Guaranteed issue requires health insurance companies to give coverage to anyone who applies. They cannot ask health questions or vary rates based on a person's health. And while insurers must offer coverage, there is no requirement for individuals to purchase coverage. This is an important distinction from the federal Affordable Care Act (ACA), which couples guaranteed issue with an individual mandate to purchase insurance. In other words, if insurers have to guarantee coverage to those who apply without any requirement to purchase, economics will create incentives for consumers to delay the purchase of insurance until they have a health condition that requires care. This undermines a fundamental principle of insurance to spread cost among many for the few who may incur expenses.

The result is commonly referred to as a "death spiral" whereby those with a financial interest or expectation of future medical claims purchase insurance at a larger rate than those who do not anticipate incurring medical claims. This leads to higher average insurance premiums for those who do purchase insurance, which exacerbates the problem as the incentive to purchase diminishes for those without anticipated medical expenses. Put simply, healthy individuals are less likely to justify spending money on insurance premiums when they do not perceive the expense to be at an appropriate level to protect against potential, unknown future expenses. How much are you willing to spend each month on health insurance if you don't anticipate needing the coverage in the near future?

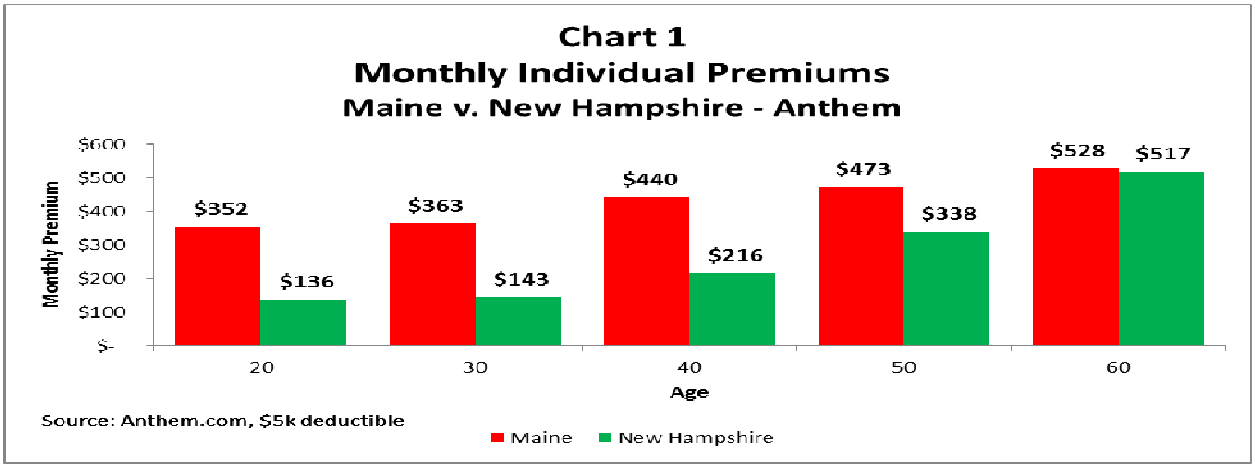
Community rating sets limits regarding how much an insurer can vary rates from one person to another. For example, we know statistically that a 64 year old adult consumes about five times the health care services of a 20 year old adult. In other words, a 64 year old spends 500% more on health care than a 20 year old. Maine's community rating law restricts insurers to varying rates by only 150%. If a 20 year old is charged $100 for a policy, the insurer could charge no more than $150 for the same coverage for a 64 year old.[3]

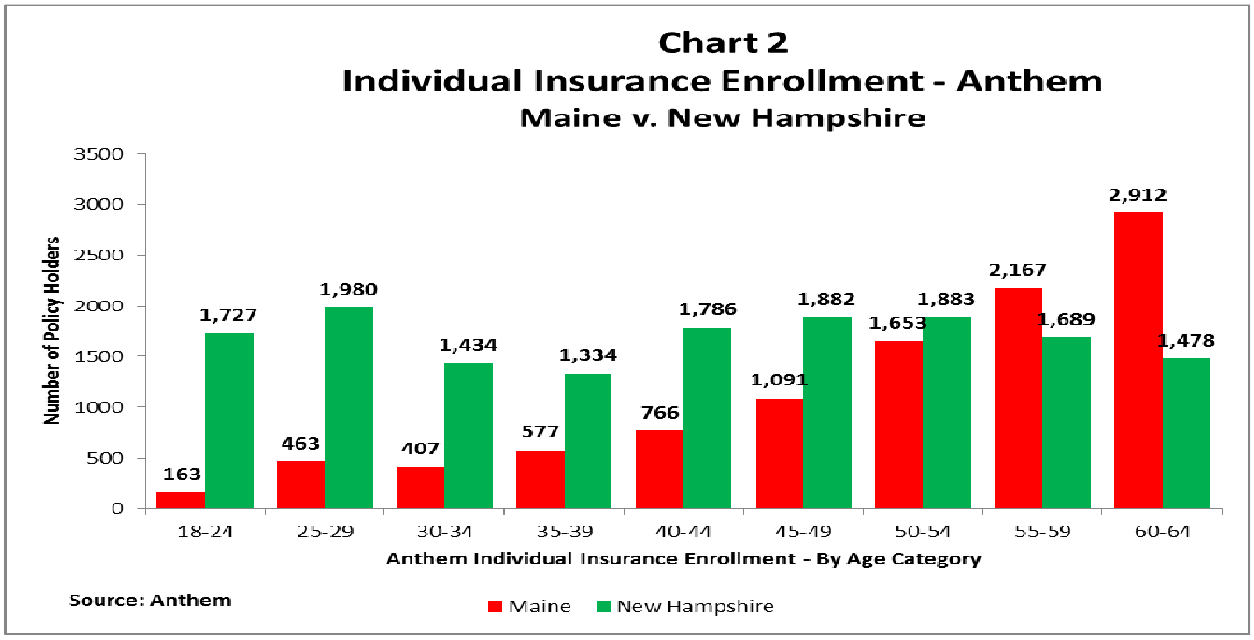
The intent of these laws was to both ensure that everyone could get coverage, even when sick, and also to lower rates for older adults. The theory was that by limiting how much insurers could vary rates, the rates for older people would come down, the rates for younger people would go up, and the rates would meet somewhere in the middle. This was the theory, NOT what happened.

One of the immediate effects was the mass exodus of insurers offering plans to individuals in Maine. When these laws were passed, 11 carriers left Maine's individual market within a few short years.[4] Today, we are left with only a handful of companies with one carrier, Anthem, covering the vast majority of policyholders.

In 1987, just before these regulations were implemented, 79% of Maine residents were covered by private health insurance, about 16% of whom had non-group coverage. By 2005 the rate of privately insured had dropped to 66.5% in Maine with less than 9% with non-group coverage.[5] The number of insured has been steadily declining.

The restrictions regarding varying rates between applicants did not result in lower rates for older adults, but it did dramatically raise rates for younger adults. If you compare Maine and New Hampshire Anthem premiums with a $5,000 deductible you will find similar rates for a 60 year old adult ($528 in Maine, $517 in NH) yet significantly lower monthly rates for a 20 year old in New Hampshire ($352 in Maine, $136 in NH) (see Chart 1). The result is a shrinking pool of insured with the younger and healthier people dropping out as prices increase, which causes prices to spike further as the sickest maintain coverage.[6] This is evidenced by the fact that Anthem insures just 163 18-24 year olds in Maine's individual market versus 1,727 in New Hampshire's (see Chart 2).[7]





CONCLUSION

Health insurance and health care are two separate things that operate on very different principles. Insurance simply spreads risk among a large group of people with varying health care needs. Our current regulations undermine the insurer's ability to effectively manage the risk they are assuming. We made coverage available to everyone but also made the cost of coverage unaffordable for many in the process. This addressed access without regard to the basic insurance principle that requires many people among whom to spread risk. Most importantly, we need young healthy people in the insurance market to offset the cost of older, sicker applicants. In our efforts to make coverage available and affordable for older and sicker people, we drove the young healthy people away. As a result, Maine now boasts some of the highest insurance premiums in the nation.

It is important that we evaluate the merits of the new health reform law in the context of our past reform efforts. LD 1333 addresses our ailing insurance market by recognizing the basic principles that allow it to operate effectively. Learning from our past experience, this is a long overdue step in the right direction for Maine.

Notes and Sources:

[1] To view the legislative language of LD 1333, now Public Law, Chapter 90, see: http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC90.pdf

[2] To view Maine's existing health insurance regulations under Title 24A, see: http://www.mainelegislature.org/legis/statutes/24-A/title24-Ach0sec0.html

[3] Based on correspondence with Anthem

[4] See Bureau of Insurance white paper on Maine's individual insurance market: http://www.maine.gov/pfr/legislative/documents/indiv_health_2001.pdf

[5] U.S. Census Bureau

[6] Taken from ehealth.com (NH) and Anthem.com on April 11, 2011; NH-$1,250 HSA-eligible 0% coins, maternity rider additional; ME-$1,500 deductible, 20% coins

[7] Anthem data provided to the Insurance and Financial Services Committee on April 27, 2011 with respect to LD 1333

Joel Allumbaugh directs the Center for Health Reform Initiatives at The Maine Heritage Policy Center. He may be reached at jallumbaugh@mainepolicy.org.

Editor and director of communications Chris Cinquemani may be reached at chris@mainepolicy.org.

P.O. Box 7829, Portland, ME 04112, Phone: 207.321.2550 Fax: 207.773.4385

http://www.mainepolicy.org http://mainefreedomforum.com info@mainepolicy.org