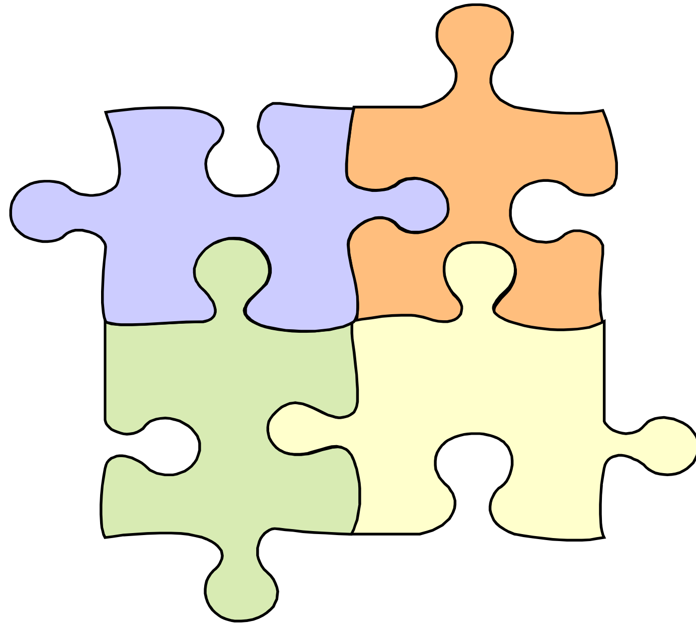

Maine's Health Care Reform
and other cost saving opportunities

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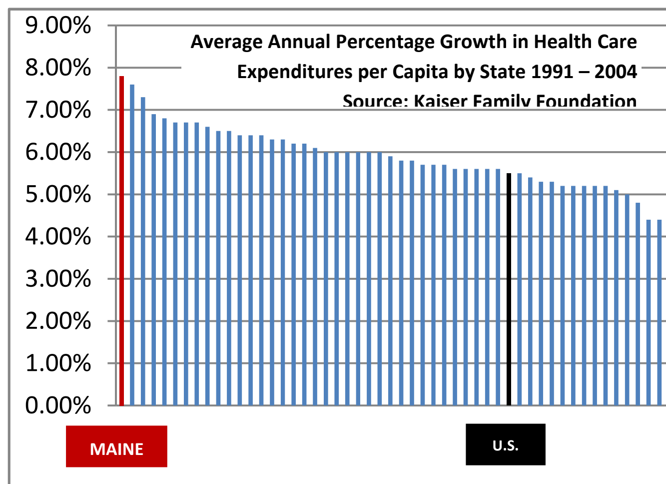
What does Maine's health care reform mean to you and your organization?

According to the Kaiser Family Foundation, from 1991 – 2004, Maine led the nation in the average annual percentage growth in health care expenditures per capita. Though policy decisions made in Augusta over the years attempted to improve quality and control costs, the experiment failed. It removed competition and protected special interests from natural economic forces and raised prices.

The recently adopted health care reforms in Maine are designed to introduce competition back into the Maine market, improve quality as well as control the underlying costs.



Multiple factors will reduce costs

There are four major factors in the Maine reform that should reduce costs and improve quality for both individuals and employers:

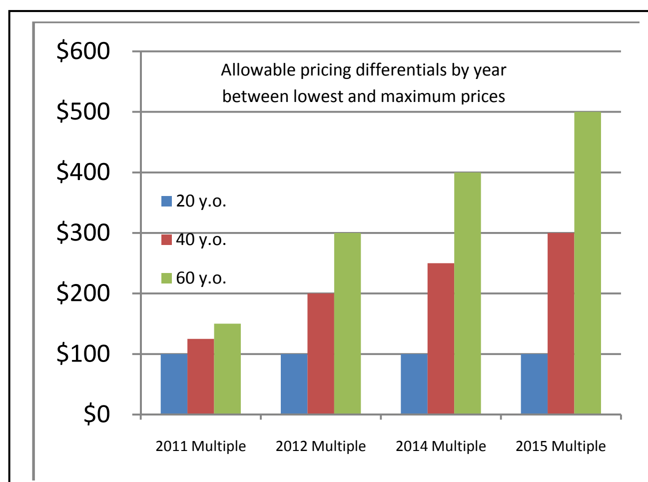
1) Pricing flexibility for individuals
2) Creation of a safety net for chronically ill individuals
3) Enabling insurers to negotiate rates with hospitals and doctors
4) Flexibility for insurers to offer more market-driven products

What remains the same?

- Anyone in Maine can still get health insurance, guaranteed.
- The state continues to control the cost of insurance but allows more flexibility.

IMPORTANT: Understanding individual health insurance rates

Insurance companies use a lot of data to determine how much a person or group should pay for health insurance. Age, geography, smoking and gender are some of the common factors that predict how much it will cost to pay medical expenses.



Before the Maine reforms, state government severely limited how much or how little an insurance company could charge an individual for health insurance. For example, if a healthy 20 year old paid the lowest rate available, say, $100 per month, the state would only allow the insurance company to charge a 60 year old no more than 50% more, or $150 per month.

The only problem is that on average, a sixty year old has five times more medical expenses than a twenty year old. To pay the 60 year old's expenses, the restrictions on pricing meant all the younger people would have to pay far more than they could afford so most young people chose not to buy *any* health insurance. The result is that the average costs went up for everyone else.

The new law allows insurance companies to begin charging individuals more appropriate amounts for their insurance. Lower pricing will attract young people to the market which will spread the risk and reduce the cost for older individuals.

Changes in pricing for individuals also are expected to positively impact employer plans, particularly for groups of fifty or fewer.

Looser Pricing Restrictions Begin July 1, 2012

As of July 1, 2012, for every $100 paid by a 20 year old for health insurance, insurance companies can charge three times that amount ($300) to the oldest individual. If allowed by federal law, by 2014 the difference could be four times greater and in 2015 five times greater. Currently, federal law restricts the pricing difference to no more than three times the lowest price.

Expectations for individual health insurance

The amount that younger people will pay for health insurance is expected to be far lower than it is today for individual policies. That means older, individually insured people should also see their insurance costs drop. For example, in North

Dakota, a state that has a law similar to Maine's new law, the cost for a 20 year old is less than $200 per month. If that were the case in Maine, the oldest individual would pay no more than three times that amount or $600 per month, a substantial savings compared to current costs.

Maine Guaranteed Access Reinsurance Association (MGARA)

Approximately 1,000 to 2,000 chronically ill people in Maine are considered to be high risk both in terms of cost and wellness. To be certain they can continue getting health insurance, the new law created the Maine Guaranteed Access Reinsurance Association. This private association is subject to appropriate regulation but is *not* part of government. It will be funded by a monthly fee of no more than $4 on every covered individual. The pool of money that will be created will help pay the health expenses for the sickest people who have individual policies. In other states where similar funds exist, the monthly fee is actually less. Most analysts expect that if the law in Maine remains unchanged, our MGARA fees eventually should be closer to $2 per month.

At $4 per month per policy, the amount raised is expected to be about $25 million, substantially less than the $43 million Maine people have been paying to fund the state government's Dirigo Health Plan, a program that will cease to exist in another year. By eliminating the government-run program, approximately $20 million will remain in the economy, right where it belongs.

Individual Market Impact on Small Group Health Plans

Currently, the smallest group plans (1-3 people) have poor experience in terms of health costs. When the smallest groups' experience is mixed in with employer plans that cover 4-50 people, it adversely impacts all small group rates making health insurance more expensive for everyone.

By creating a far more reasonable market for individuals with rates similar to the national average, it is expected that **many small groups will choose to switch to individual policies.** That will make the remaining small employer health plans better risks. That's why we expect insurance companies will lower their rates for the small group employers over the next few years. We also expect that changes in both state and federal law will attract more companies to compete for business in Maine which also should lower prices and increase the number of insurance options available.

Rules Repealed That Limited Competition

Rule 750 (repealed)

First, this rule required insurance companies to file eleven insurance plans if they wished to do business in Maine. The problem was that no one wanted to buy the health plans required by the government. The added costs of filing such plans and maintain rates made doing business in Maine unattractive to most insurance companies.

Second, the rule also restricted health maintenance organizations (HMOs) from offering insurance plans with deductibles greater the $1,000. Again, such restrictions made it unattractive to offer an HMO option. With the repeal of Rule 750, insurance companies may now be more creative with their HMO options and file only one or two plans rather than eleven.

Rule 850 (repealed)

The other and more significant rule that was repealed placed restrictions on patient travel. It essentially said that people did not have to travel more than a half hour from home to receive routine care or no more than an hour for specialist care. The effect of this rule protected rural hospitals and providers from competition. If patients did not have to travel then those providers could charge what they wished for services. For example, a hip replacement at Eastern Maine Medical Center in Bangor costs $31,934 according to the Maine Health Data Organization. At Mercy Hospital in Portland, the same procedure costs $18,068, a difference of $13,866!

By allowing insurance companies to create incentives for patients to travel for specialized services such as joint replacements, cardiac and cancer-related surgeries, three things are expected to happen:

1) Medical centers that perform the most surgeries normally have lower costs and better outcomes because of their expertise from doing so many procedures. They also do not have to rely on a few high-priced surgeries to support the rest of their hospital's operations as rural hospitals must.

2) Lifting the travel restriction also is expected to open pricing negotiations with high-cost rural hospitals if they want to retain those surgeries.

3) Performing fewer or lower cost surgeries will force smaller and rural hospitals to evaluate how they conduct business as full service health care centers. In a place like Aroostook County that has four such hospitals, it may mean consolidating operations to only one or two for the smaller population that now resides in the County. There is little doubt that the law will change how and where we deliver health care in Maine.

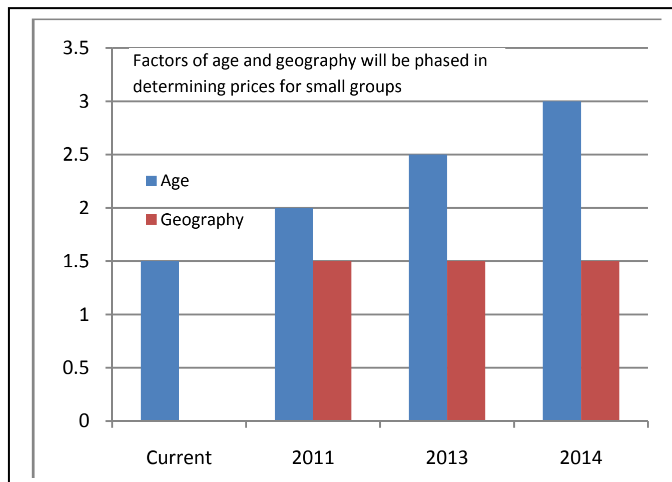
Special thanks to attorney Daniel Bernier, lead lobbyist for Maine insurance agents and brokers, in preparing information for this presentation.

Insurance factors for the small group market (<50)

Currently no small group may be charged more than 50% more than the best available rate for their health insurance. Beginning October 1, 2011, the law will allow small groups to be charged as much as two times more for their employees based on participants' age and fifty percent more based on their geographic location.

In 2013, the differential will be as much as two and a half times their best rate to groups with older workers. By 2014, the highest rate may rise to three times the best rates available.

While rates will be allowed greater fluctuation, the repeal of Rules 750 and 850 are expected to change the underlying cost of health care services which should contribute to lower increases or lower overall pricing.



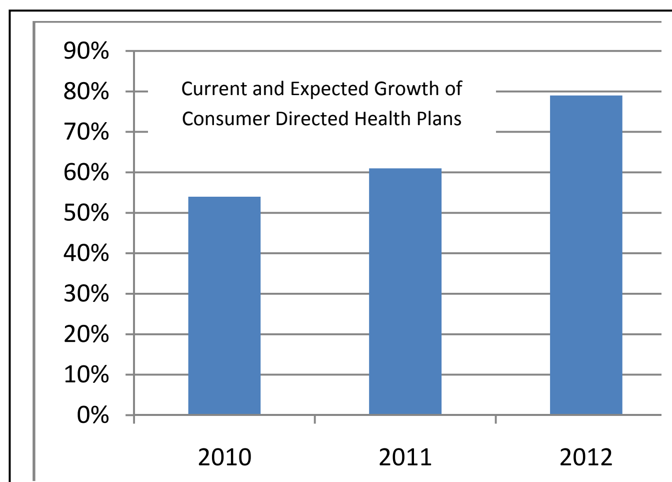
Warning: Federal Health Care Consequences

In 2016, federal law will define small employer groups as 2-100 employees instead of the current 1-50 employees. Analysts expect the change will negatively impact employers with groups of 75-100 employees though smaller groups are expected to benefit.

Restructuring Your Health Plan

Though not part of the Maine reform, employers are quickly migrating to consumer directed health plans (CDHP) as they tend to further impact costs.

"The total savings generated in the first year of a consumer directed health plan can be as high as 12% to 20%."
- American Academy of Actuaries



Consumer directed health plans include health savings accounts (HSAs), health reimbursement accounts (HRAs) and flexible savings accounts (FSAs).

Health Savings Account (HSA)

This is a tax preferred account to which an employee and/or employer makes pre-tax contributions in 2011 up to $3,050 for an individual and $6,150 for a family annually. The employee then pays for allowable medical expenses as part of their deductible and for costs such as prescription medicines. If they do not use their contribution in a given year, the amount is rolled over and added to the next year's contribution. The entire amount in the account is owned by the employee and, therefore, goes with them for future medical costs should they choose to retire or change jobs.

Between March of 2005 and January of 2011, the number of Americans using health savings accounts or high deductible health plans rose from one million to eleven million.

Health Reimbursement Arrangement (HRA)

This also is a tax preferred mechanism in which the employer may choose to pay for certain employee health expenses of their choice such as deductibles, co-insurance or co-payments.

Flexible Spending Accounts (FSA)

The flexible spending account is a pre-tax vehicle for employees to set aside money to pay for medical expenses that are not covered by their primary health or dental plan but which they can reasonably anticipate during a given year. Elective dental work, eye glasses and prescription medicines often are paid for through FSAs. Currently, however, employees must "use it or lose it" by the end of each plan year.

There now is pending legislation in Washington (S.1098 and H.R.2010) that would allow up to $500 in an FSA to be carried forward to the following year.

Other Expected Changes

Elective Benefits - We also expect to see employers instituting more elective group disability, group life and long term care options for employees. These plans tend to be funded by employees through payroll deductions with little administrative cost to the employer while rendering a tremendous benefit to their valued employees.

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Performance Based Contracts – There is a high likelihood that insurance companies will begin negotiating contracts with hospitals and physicians based on quality and outcomes. If the cost of re-admission due to infection or early discharge can be avoided, everyone wins.

Data Gathering – Another key factor in consumer directed health plans is access to health care provider performance data. It is becoming more and more evident that consumers want and demand information to make conscious decisions about their health care. As more people find their money on the line with health savings accounts, that data will be in greater demand and will impact who gets the business.

Controlling Costs with Wellness

Information provided by Occupational Medical Consulting www.omcwellness.com

When Maine reformed its workers' compensation laws, workplace safety became the most important factor in determining the cost of insurance. Employers recognized that they "owned" the risk and that taking responsibility to reduce injuries meant lower insurance premiums.

With health care costs, wellness becomes the most controllable factor in reducing insurance and out-of-pocket costs for employers and employees.

According to the national Center for Disease Control (CDC), more than 50 percent of diseases are a result of individual behavior. Eighty percent of heart attacks and strokes and 40 percent of cancers are thought to be preventable with lifestyle changes.

As important, wellness programs positively impact employee productivity by reducing absenteeism and what is called "presenteeism", the cost of health-related low employee performance that is detected in customer satisfaction and variable product quality.

Health factors that drive medical and productivity costs

Absenteeism	Alcohol abuse
Existing medical condition	High blood pressure
Inactivity	Life dissatisfaction
Low back pain	High total cholesterol
Low HDL cholesterol	Smoking
No seat belt/helmet use	Overweight
Negative health perception	Stress

People with five or more factors add costs of 150 to 300 percent annually to their health care spending.

Why Do People Change Behavior?

- They want to *change (their idea)*;
- the behavior they have decided to change has become a significant liability to them *(importance)*;
- they have come to believe they can change *(confidence);*
- a particular change at a particular time in their life is a high priority *(readiness)*.

In short, people change behavior because they are motivated.

Summary from the Clark Insurance Benefits Group

- You own the risk and it impacts your ability to succeed.
- You have new tools to help manage the risk.
- Employee "ownership" of their health improves outcomes and lowers costs.
- Maine's new law provides the opportunity for new plans, competitive pricing and potential competition.

Let us help improve your benefits program and your bottom line.

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