PRELIMINARY REPORT:
THE HEALTH INSURANCE MARKET IN MAINE

PREPARED BY BUREAU OF INSURANCE STAFF
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John Elias Baldacci
Governor

Anne L. Head
Commissioner

Mila Kofman
Superintendent

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I. INTRODUCTION

This report is submitted pursuant to P.L. 2009, ch. 439, § D-4, which directs the Superintendent of Insurance to:

> review possible ways to improve the availability and affordability of the State's individual health insurance market, including, but not limited to, increases in the minimum loss-ratio standards applicable to that market and consideration of an insurer's loss experience in all lines of insurance marketed by a carrier in this State when reviewing health insurance rate filings [and to] report the results of the review, including any recommendations for legislation, to the Joint Standing Committee on Insurance and Financial Services.

This is a preliminary report. Options for future state reforms will vary depending on what (if any) federal reforms are enacted. The U.S. House of Representatives passed H.R. 3962, the Affordable Health Care for America Act, on November 7, 2009. The U.S. Senate passed H.R. 3590, the Patient Protection and Affordable Care Act, on December 24, 2009. The Bureau will supplement this report after the nature and extent of any federal health reform legislation is known.

This preliminary report provides background on both Maine's individual and small group markets, including information about types of policies available, prices, number of insurers, market share, and medical loss ratios, as well as standards and consumer protections under current law. Unless otherwise indicated, the data on the Maine insurance market are from annual reports filed by health insurers pursuant to Bureau of Insurance Rule 945 and from insurers' rate filings.[1] The report summarizes some of the insurance reforms in the two pending federal bills, and how they relate to the Maine market.

[1] The reports are available at: http://www.maine.gov/pfr/insurance/consumer/financial_results_health_insurers.htm
http://www.maine.gov/pfr/insurance/MarketSnapshot/snapshot_individual.htm
http://www.maine.gov/pfr/insurance/MarketSnapshot/snapshot_small_group.htm

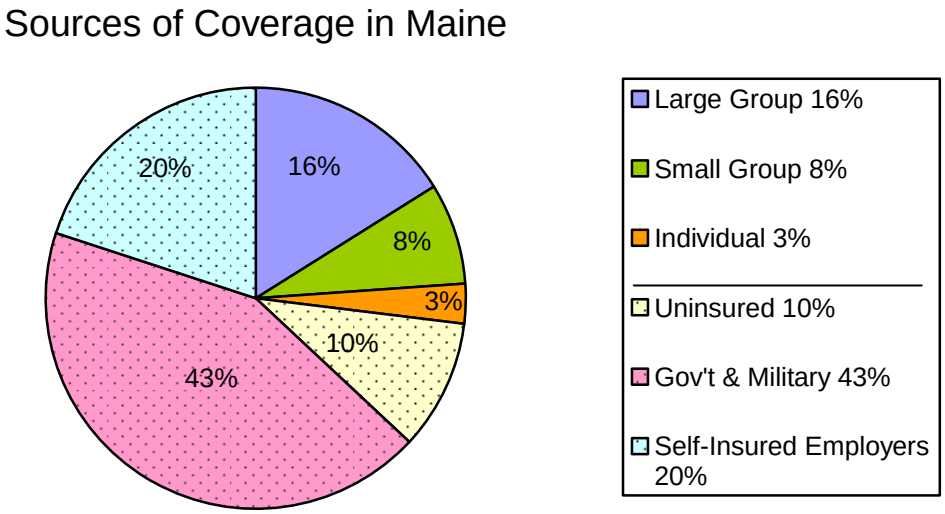
II. OVERVIEW OF THE INDIVIDUAL AND SMALL GROUP MARKETS

This section of the report provides information on the individual and small group health insurance markets in Maine.

A. SOURCES OF COVERAGE

According to the most recent data available, approximately 40,000 Mainers have major medical coverage in Maine's individual market, and approximately 106,000 have coverage as employees or dependents in the small group market. Maine's uninsured rate of 9.6% is the sixth lowest in the nation, well below the national average of 15.4%.[2]

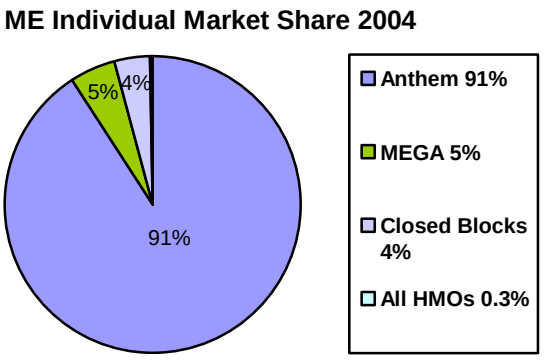
The following chart shows the sources of coverage by percentage of the Maine population. Slightly more than a quarter of the population has individual or group health insurance coverage that is regulated by the Bureau of Insurance. The others are covered by Medicare, MaineCare (Medicaid), military, self-insured employer plans exempt from state insurance regulation, or are uninsured.

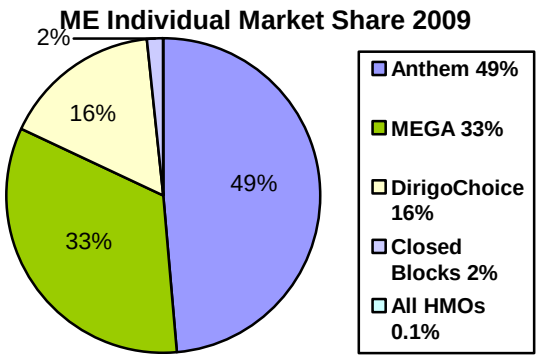


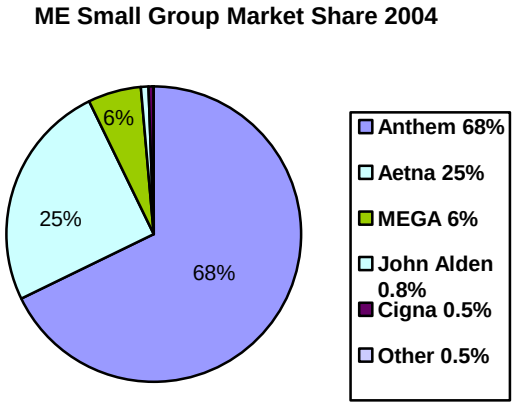
[2] See Current Population Survey, compiled jointly by the U.S. Census Bureau and Bureau of Labor Statistics, and the health coverage statistics compiled by the Kaiser Family Foundation at http://www.statehealthfacts.org.

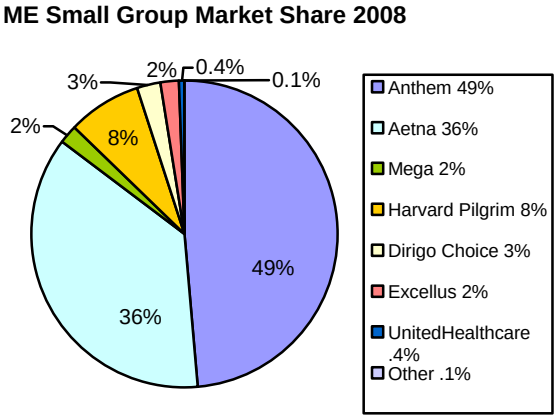
B. INSURERS AND MARKET SHARE

The following charts show the market shares of insurers in the individual and small group markets – providing a comparison between the markets before and after State health care financing reforms.[3]



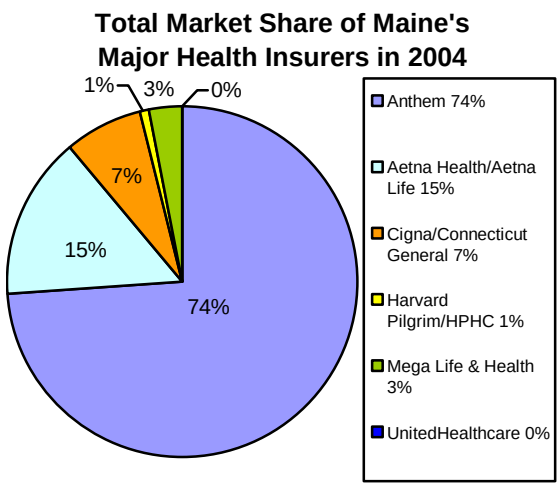


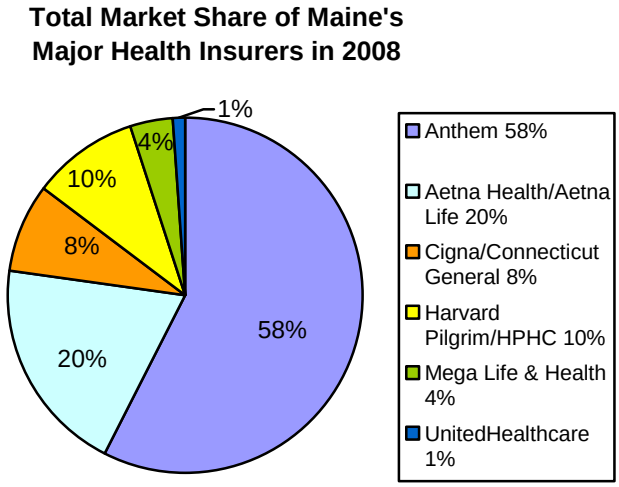




[3] Individual market data as of December 31, 2004, and September 30, 2009, small group data as of December 31, 2004, and December 31, 2008. "Closed blocks" consist of individual policies written by insurers that have left the market but continue to renew existing policies. Affiliated companies are recorded together in these charts. HPHC is an insurance subsidiary of Harvard Pilgrim, which currently provides the coverage for DirigoChoice enrollees. Harvard Pilgrim small group figures include HPHC's private market coverage, but not DirigoChoice.

Total market share of the major health insurers is shown below. This reflects the insurers' individual, small group and large group business in Maine.





The following table shows total Maine health insurance premium in 2008, by company and by market sector, along with the change from the previous year. These figures include Dirigo Health Plan premium, so the changes for Anthem and Harvard Pilgrim reflect the transfer of DirigoChoice coverage from Anthem to HPHC as of January 1, 2008.

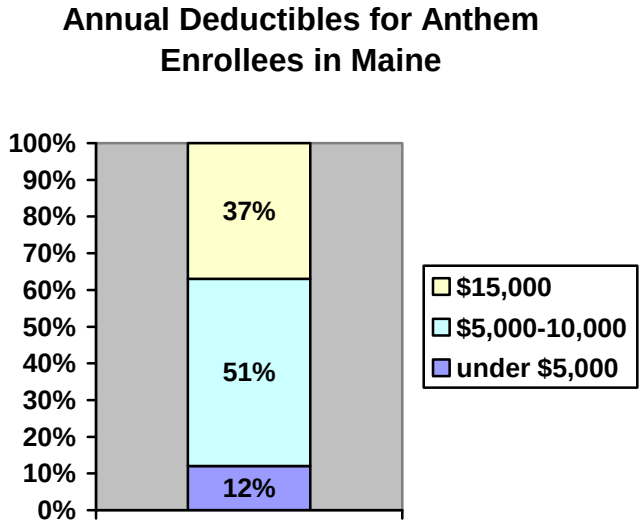
2008 Maine Premiums								
	Totals		Large Group		Small Group		Individual	
Insurers	12/31/08	% Change	12/31/08	% Change	12/31/08	% Change	12/31/08	% Change
Aetna Health Inc & Aetna Life Ins. Co	$278,628,101	17%	$154,913,707	14%	$123,583,562	22%	130,832	25%
Anthem Health Plans of ME Inc.	$928,388,393	-8%	$635,899,126	3%	$225,316,648	-20%	$67,172,619	-38%
Cigna Healthcare of Me Inc & Connecticut General Life Ins. Co.	$143,006,708	13%	$142,942,246	13%	$0	0%	$64,462	-17%
Harvard Pilgrim Health Care Inc. and HPHC	$151,925,919	74%	$46,007,999	-8%	$50,838,450	38%	$55,079,470	(new to market) [4]
MEGA Life & Health Ins. Co.	$27,025,064	14%	$0	0%	$5,475,463	-25% [5]	$21,549,601	31%
United Healthcare Ins. Co.	$11,152,427	39%	$9,428,899	37%	$1,723,528	48%	$0	0%
All Other Companies	$9,248,451	-23%	$3,858,380	-34%	$1,572,883	-8%	$3,817,188	-14%
Totals:	**$1,549,375,063**	**3%**	**$993,050,356**	**6%**	**$408,510,534**	**-5%**	**$147,814,172**	**14%**

[4] HPHC wrote no individual business before 2008. Harvard Pilgrim had six covered lives in individual HMO products in 2007.

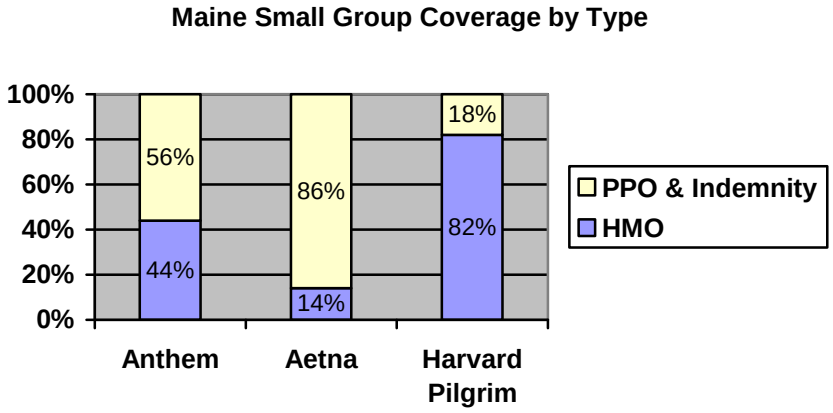
[5] Renewal business only. Ceased writing new small group business in 2004.

C. TYPE OF COVERAGE

There has been significant movement in the market away from coverage with relatively low deductibles. This is especially pronounced in the individual market. Although statistics on the type of plan purchased are not reported on a market-wide basis, rate filing information from Anthem, the largest health insurer, shows that approximately 88% of Anthem's individual enrollees have deductibles of $5000 per year or higher, with almost 37% covered under policies that have a $15,000 annual individual deductible and a $30,000 family deductible.



HMO coverage in the individual market represents only one-tenth of one percent (0.1%) of the covered lives. HMO coverage in the small group market accounts for one-third of the covered lives:[6]



[6] Anthem provides HMO coverage through its HMO Maine business unit. All other HMOs in Maine are incorporated as separate companies. PPO data for Harvard Pilgrim excludes HPHC's DirigoChoice coverage.

D. PREMIUMS

The average premium per covered life in 2008 was $299 per month (approximately $3600 per year) for individual coverage, $324 per month (approximately $3900 per year) for small group coverage, and $380 for large group coverage. However, these prices are not comparable because the products purchased differ in each sector of the market. More comprehensive benefits and lower deductibles are more common in the large group market, where the employer is more likely to pay a substantial share of the premium.[7] The following table shows the 2008 average monthly premium per person. It is important to note that these "per covered life" estimates are averages and do not reflect what businesses and individuals are actually charged. The actual price depends on the benefits package purchased and adjustments for permissible rating factors such as age.

2008 Average Monthly Premium per Person in Maine						
	Large Group		Small Group		Individual	
	2008	% Change	2008	% Change	2008	% Change
Aetna (Aetna Health Inc & Aetna Life Ins. Co.)	$387	9%	$282	-4%	$221	65%
Anthem Health Plans of ME Inc.	$379	5%	$347	9%	$254	-19%
CIGNA (Cigna Healthcare of ME Inc. & Connecticut General Life Ins. Co)	$421	26%	$0	0%	$366	-13%
Harvard Pilgrim Health Care Inc.	$258	-19%	$370	12%	$519	-54%
Mega Life & Health Ins. Co.	$0	0%	$202	-8%	$174	4%
United Healthcare Ins. Co.	$452	31%	$279	-16%	$0	0%
Total:	**$380**	**8%**	**$324**	**5%**	**$299**	**6%**

Note: The average premium is calculated by dividing the premium from the 2008 Premium table by the number of member months.

A recent Commonwealth Fund report lists Maine as the state with the ninth-highest premiums for employer-sponsored coverage in 2008. Massachusetts was highest, followed by Minnesota, New Hampshire, Indiana, Connecticut, Delaware, Alaska, Rhode Island and Maine, in that order. [8]

Premiums for health insurance have been increasing across the country. Average family premiums for employer-sponsored coverage increased from $9249 in 2003 to $12,298 in 2008.[9] This year, Oregon's largest individual health insurer has requested a 25.3% rate increase in

[7] There are 166 people in the individual market (0.4% of the total enrollment) with coverage under standardized plans offered pursuant to Bureau of Insurance Rule 750. Depending on the insurer and the plan design prices range from $678.40 to $1068.42 for single coverage, and from $1663.45 to $2619.80 for family coverage per month.
[8] *See* Schoen, Nicholson, & Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," available at http://www.commonwealthfund.org/Publications.aspx.
[9] *See* Schoen, Nicholson, & Rustgi, "Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes," available at http://www.commonwealthfund.org/Publications.aspx.

addition to the 24.4% increase last year according to news reports.[10] In California, rate increases of up to 39% have been announced; the insurer indicated that rates may be adjusted more frequently than its typical yearly increases.[11] According to news reports, rate increases in Indiana are up to 38%.[12] In Rhode Island, insurers had deferred rate increases last year at the request of the Health Insurance Commissioner, but recently requested small group increases ranging from 4% to 14.6%.[13] A few of the states reporting increases last year are Michigan (56% requested, 22% approved)[14], Pennsylvania (46.5% requested[15], 15% approved[16]), and Connecticut (22% to 30% requested, 13% to 20% approved).[17]

[10] *See* "Insurers Ready Another Round of Double-Digit Hikes," The Lund Report, February 4, 2010: http://www.thelundreport.org/resource/insurers_ready_another_round_of_double_digit_hikes

[11] Insurance Commissioner Poizner has requested that the insurer postpone implementation of the rate increase http://www.insurance.ca.gov/0400-news/0100-press-releases/2010/release020-10.cfm
See also "Anthem Blue Cross dramatically raising rates," Los Angeles Times, February 5, 2010: http://www.latimes.com/business/la-fi-insure-anthem5-2010feb05,0,3002094.story

[12] *See* "Hoosiers livid over insurance increases," Indianapolis Star, February 11, 2010: http://www.indystar.com/apps/pbcs.dll/article?AID=/20100211/BUSINESS03/2110419

[13] *See* "Lynch seeks hearing on insurance rates," Providence Journal, February 12, 2010: http://www.projo.com/news/stategovernment/content/AG_REACTS_TO_HIKES_02-12 10_TBHE6VQ_v14.3b3e406.html

[14] Final Order Granting Rate Increase for BCBSM Nongroup and Group Conversion Subscribers, Order Comm'r (Aug. 12, 2009).

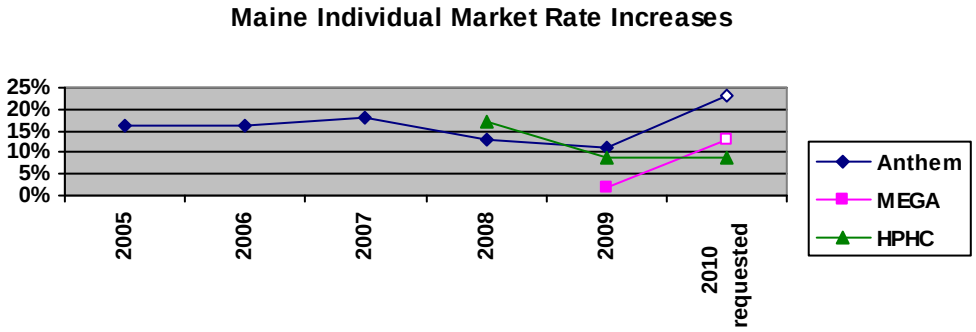
[15] Blue Cross of Northeastern Pennsylvania Filing # 1535-BLC-33-PPO-BASERATE

[16] E-mail from Melissa Fox, Deputy Press Secretary, Pennsylvania Insurance Department, Communications Office (Feb. 4, 2010, 14:20 EST) (on file with author).

[17] Proposed Rate Increase Application of Anthem Blue Cross and Blue Shield, Docket No. LH09-51, Order Comm'r (Aug. 6, 2009).

The following charts show the rate increase history over the last five years for the three major carriers in the individual and small group markets in Maine:

Maine Individual Market Rate Increases						
	2005	2006	2007	2008	2009	2010
Anthem	16%	16%	18%	13%	11%	23% request
MEGA[18]	N/A	N/A	N/A	N/A	2%	13% request
HPHC	(entered market 2008)			17[19]%	9%[20]	9%



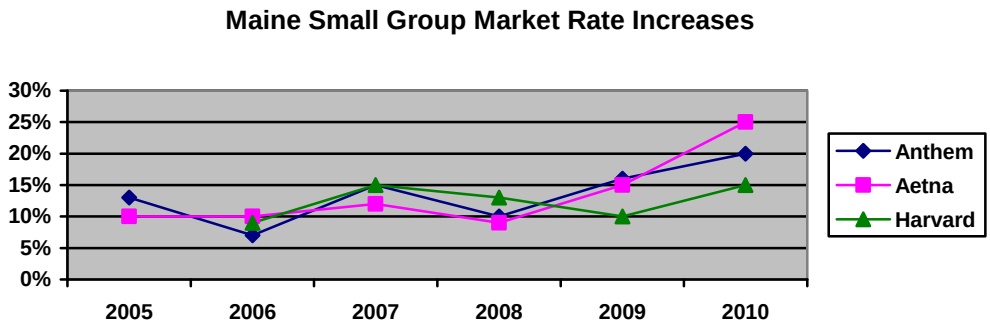
Maine Small Group Market Rate Increases[21]						
	2005	2006	2007	2008	2009	2010
Anthem	13%	7%	15%	10%	16%	20%
Aetna	10%	10%	12%	9%	15%	25%
Harvard Pilgrim	(entered market 2006)	9%	15%	13%	10%	15%

[18] Averages are not available for rate changes in 2005 through 2008. The most significant was a 14% rate reduction for the "catastrophic" plan, which represents the majority of MEGA's individual business, and a 10% rate increase for the same plan in 2008 and for the required standardized plans. Also in 2008, rates for the scheduled benefit plan were reduced by 25%. In addition, there were rate increases and decreases in 2005 and 2008 that applied only to certain optional benefits.

[19] This is the 2008 rate increase for DirigoChoice individual coverage, which was issued by Anthem in 2007.

[20] In its rate filings, HPHC indicated that the rate increase would have been 11% if the benefits had remained at 2008 levels.

[21] The earliest data in the Bureau's market snapshot series is for May 2005 renewals.



The table below shows the average increases for individual market products with most enrollment -- requested rate and approved rate.

Maine: HealthChoice Individual Rate Increases

Effective Date	Requested	Approved
January 2001	23.5%	23.5%
February 2002	13.6%	12.7%
January 2003	7.1%	3.4%
March 2005	14.7%	14.5%
March 2006	19.8%	16.3%
January 2007	20.5%	16.7%
January 2008	18.6%	12.5%
July 2009	18.5%	10.9%
Pending request for effective date July 2010	23.6%	Pending rate hearing

The following table includes average annual small group rate increases between 2001 and 2009. This table does not show requests. Most small group coverage has been exempt from the prior review rate approval process,[22] because it was issued on a guaranteed loss ratio basis, meaning that it is subject to premium refunds if benefit payments do not equal or exceed 78% of premium.

[22] Rate review in Maine did not apply to any group rates taking effect before 2004.

Maine: average annual small group increases	
Year	Average
2001	33%
2002	29%
2003	16%
2004	6%
2005	13%
2006	8%
2007	14%
2008	10%
2009	15%
2010	21%

E. MEDICAL LOSS RATIOS, PROFIT INFORMATION, AND DIVIDENDS

The following tables show medical loss ratios and underwriting gain (a way to measure the profitability of a line of business, before taxes and investment income), expressed as a percentage of premium, for each of the major insurers in the individual and small group markets, and combined figures for each market.

Maine's Small Group and Individual Market: MLR and Underwriting Gain/Loss

Maine Small Group Loss Ratios

	2004	2005	2006	2007	2008	5 year average
Aetna Health Inc	78%	76%	81%	83%	87%	80%
Aetna Life Ins Co	67%	64%	74%	77%	76%	74%
Anthem	76%	79%	79%	79%	82%	79%
Harvard Pilgrim Health Care	112%	76%	94%	91%	86%	89%
HPHC Insurance Company	entered market 2006		75%	95%	86%	87%
Small Group Totals (5 Companies)	**76%**	**77%**	**79%**	**81%**	**82%**	**79%**

Maine Individual Loss Ratios

	2004	2005	2006	2007	2008	5 year average
Anthem	83%	90%	90%	88%	85%	88%
MEGA (before refunds)[23]	14%	43%	38%	53%	62%	51%
HPHC Insurance Company	entered market 2008				90%	90%
Individual Totals (3 Companies)	**81%**	**87%**	**85%**	**84%**	**83%**	**84%**

Maine Small Group Underwriting Gain

	2004	2005	2006	2007	2008	5 year average
Aetna Health Inc	8%	11%	3%	4%	-3%	6%
Aetna Life Ins Co	8%	17%	10%	8%	10%	10%
Anthem	12%	11%	10%	9%	5%	10%
Harvard Pilgrim Health Care[24]	-20%	12%	-9%	-5%	1%	-3%
HPHC Insurance Company	entered market 2006		8%	-12%	1%	-2%
Small Group Totals (5 Companies)	**11%**	**11%**	**8%**	**7%**	**5%**	**8%**

Maine Individual Underwriting Gain

	2004	2005	2006	2007	2008	5 year average
Anthem	-4%	-7%	-5%	1%	5%	-2%
MEGA (before refunds)	10%	3%	12%	-1%	-11%	-2%
HPHC Insurance Company	entered market 2008				0%	0%
Individual Totals (3 Companies)	**-4%**	**-6%**	**-3%**	**0%**	**1%**	**-2%**

[23] In 2008, the Bureau of Insurance found that MEGA Life & Health Insurance Company used a flawed method to determine premiums for individual health insurance policies. To remedy the violations of law, the insurer agreed to refund $4.6 million plus interest to policyholders in Maine and to pay a fine of $1 million to the State's general fund.
[24] Harvard Pilgrim is a nonprofit health plan.

In Maine, three nationwide insurance groups conduct some or all of their health insurance business through Maine subsidiaries.[25] These insurers have paid the following dividends to their parent companies in the last five years, shown in dollars and as a percentage of premium:[26]

Maine: Dividends Paid					
INSURER	**2005**	**2006**	**2007**	**2008**	**2009 (as of third quarter)**
Anthem	0	$35,600,000 (3.3%)	$40,400,000 (3.8%)	$75,700,000 (7.6%)	$47,700,000 (6.3%)
Aetna	$12,100,000 (6.9%)	0	$4,400,000 (2.8%)	$18,400,000 (12.1%)	$6,200,000 (6.1%)
Cigna	$18,700,000 (29.1%)	$3,000,000 (5.3%)	0	$4,500,000 (36.7%)	N/A[27]

Note: percentage information in table represents proportion of each Maine premium dollar that went to parent company out of state.

III. REGULATORY FRAMEWORK

A. MAINE'S REGULATORY FRAMEWORK

1. Guaranteed issue and rating reforms

Maine has been a pioneer in the areas of guaranteed issue and rating reforms. The Maine Continuity of Coverage Act was first enacted in 1990,[28] and guaranteed issue and community rating were extended to the individual market in 1993.[29] All Maine residents who are not eligible for Medicare have the right to buy health insurance from any insurer selling coverage in the individual market, and all small businesses have the same guaranteed issue right in the small group market.

[25] New York Governor David Paterson announced on December 10, 2009, that the New York Insurance Department "has received requests from three New York State insurers or their subsidiaries to issue dividends of more than $1.2 billion, which will be sent to out-of-state corporate parents. The requests follow initial dividend actions from the same three insurers last year that totaled $948 million." The Governor's press release, "Increase from Last Year Reinforces Need to Give Insurance Department the Authority to Review Insurance Rates," may be found at http://www.ins.state.ny.us/press/2009/p0912102.htm.

[26] Information on insurer dividends and investments in subsidiaries for prior years is available from the Bureau. Note that historically, many insurers have a practice of declaring dividends once per year.

[27] Cigna has discontinued offering HMO plans in many states, including Maine. It is closing its Maine subsidiary and renewing subscribers are being offered PPO coverage with another Cigna company.

[28] 24-A M.R.S.A. §§ 2848 through 2850-D, *enacted by* P.L. 1989, chapter 867.

[29] 24-A M.R.S.A. § 2736-C, *enacted by* P.L. 1993, chapter 477.

The following rate standards apply:

- Individual market: gender, health status/claims experience, and policy duration prohibited; age and geography allowed but limited to a maximum variation of 1.5 to 1 (for both factors combined).[30] Nonsmoker discounts allowed but must be actuarially justified.
- Small group market (2-50): gender, health status/claims experience, and policy duration prohibited; age, geography, and industry allowed but limited to a maximum variation of 1.5 to 1 (for all three factors combined). Smoking status, participation in wellness programs, and group size variations allowed but must be actuarially justified.
- Self-employed (groups of 1): Must be offered small group coverage; small group rate restrictions apply. If the insurer offers individual market coverage, then it does not have to offer small group coverage to groups of one; individual market rate restrictions apply.

Insurers also vary rates based on how many family members are covered, *e.g.*, single, two adults, children.

2. Premium rate approval and medical loss ratio requirements

The Bureau of Insurance reviews individual health insurance rates prior to their use by insurers.[31] Since 1993, Maine law has required a 65% medical loss ratio for individual health insurance.[32] This means that at least 65 cents of every premium dollar must be spent by the insurer on medical care and services. After an investigation by the Bureau, pursuant to a consent agreement, MEGA paid a $1 million fine and refunded $4.6 million plus interest to individual policyholders for charging excessive rates that were based on improper loss ratio calculations.[33]

Small group rates are subject to review by the Bureau in certain circumstances. Medical loss ratio requirements and rate review were extended to small group coverage as part of the Dirigo health reform act in 2003.[34] If an insurer guarantees a three year medical loss ratio averaging at least 78%, Maine law does not require rates to be approved by the Superintendent. Refunds are required if the insurer fails to achieve the 78% medical loss ratio. Aetna refunded $6.6 million in 2008 to small businesses under this provision. Maine law requires all other small group rates to be filed and approved prior to their use, and to meet a 75% loss ratio standard.

The Bureau holds public hearings on most major health insurance rate filings that are subject to prior approval. The insurer must prove by a preponderance of the evidence that the rates it has filed will meet the minimum loss ratio standards and are neither excessive, inadequate nor

[30] Pursuant to 24-A M.R.S.A. § 2736-C(2)(D)(4), insurers may reduce rates for the lower age brackets to reflect savings from the Maine Individual Reinsurance Association, as long as the maximum rate variation for any product does not exceed 2½ to 1 for age and geography combined. However, the Maine Individual Reinsurance Association is not operational because its funding mechanism was repealed.
[31] 24-A M.R.S.A. § 2736.
[32] 24-A M.R.S.A. § 2736-C(5), *enacted by* P.L. 1993, chapter 477.
[33] *See* In re *MEGA Life and Health Insurance Company Rates for Individual Health Plans,* No. INS-07-1010 (April 3, 2008, amended May 27, 2008).
[34] 24-A M.R.S.A. §§ 2808-B(2-B) & (2-C), *enacted by* P.L. 2003, chapter 469.

unfairly discriminatory.[35] The Maine Attorney General usually participates as a party in rate hearings on behalf of consumers.

B. FEDERAL INITIATIVES

The discussion below summarizes a few provisions in the House (H.R. 3590) and Senate (H.R 3962) bills, and does not include all the proposed changes that would impact cost, delivery or financing of medical care.[36]

The insurance-related changes generally would not preempt existing Maine laws. The approach in the legislation is a federal "floor," which means the federal standards would be minimums and states could have stronger consumer protections.

1. Guaranteed issue and rating reforms

The federal government has enacted certain reforms applicable to private health insurance. Enacted in 1996, HIPAA[37] required insurers to offer coverage on a guaranteed-issue basis to all small businesses, but had only limited protections for people relying on the individual market. HIPAA did not establish standards for premiums. In other words, unless states had standards, insurers could use a variety of factors to vary rates, for example charging higher rates to small businesses with older and sicker workers. In the 1980s, continuation rights (known as COBRA) were enacted.[38] COBRA requires employers with 20 or more workers to allow people who no longer qualify for coverage, e.g., no longer employed, divorced, etc. to continue that coverage for a period of time.

Under current proposals, both the U. S. House and Senate bills would extend guaranteed issue rights to the individual market in every state, and establish "exchanges" to facilitate access to health insurance coverage. These bills would also establish rating standards. Insurers would be prohibited from setting premiums based on health status or claims experience – in individual and small group markets. Rates based on gender would not be allowed. Variation based on the size of a small business would also be prohibited. Under the House bill, premiums for any given health insurance policy may vary only based on one's age, geographic area and family composition. The House bill would limit variation based on age to 2:1, while the Senate bill would limit variation based on age to 3:1. The Senate bill would also allow variation based on tobacco use, limited to 1.5:1.[39]

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[35] 24-A M.R.S.A. § 2736-A.

[36] For example, the bills contain funding for community health centers, expand public programs like Medicaid, have Medicare reforms, health care quality research, liability reform pilot projects, and funding for a range of private and public initiatives.

[37] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191.

[38] *See* Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272.

[39] The Senate bill includes a 10-state pilot project that would allow discounts in the individual market for participation in wellness programs.

2. Minimum coverage levels (actuarial value)

Both bills would require a qualified plan to cover an essential package of health care services, based on a typical employer health plan, and to have a minimum actuarial value. In the House bill, the plan must be actuarially equivalent to at least 70% of the full actuarial value of the covered benefit package. In the Senate bill, the minimum is 60%, except for individuals who are under 30 or are unable to afford a qualified plan. A plan with an actuarial value of 60% means that a covered person pays approximately 40% of the total cost of covered medical care and services, and the insurer pays 60%. By comparison, the $15,000 deductible plan currently purchased in Maine by approximately 37% of Anthem's individual enrollees – this is 16.8% of the total individual market – has an estimated actuarial value of approximately 27%, according to estimates from Anthem.[40]

3. Subsidized coverage

Both the House and Senate bills would pay for a portion of the premium for low- and moderate-income families and individuals. The premium credit (also called "subsidies") would be based on one's income level and the cost of coverage. This would be available to all individuals and families with income up to four times the federal poverty level (FPL) who are not eligible for Medicaid. As of October 2009 federal poverty level for a family of four is $22,050. A family of four with income up to $88,200 would be eligible for some assistance.

In addition to the reduction in premium, both bills would lower out-of-pocket expenses like deductibles, copayments, and coinsurance. The House bill would lower out of pocket expenses for everyone who is eligible for the premium credits. The Senate bill would lower out of pocket expenses for people with incomes of up to two times FPL, currently $44,000 for a family of four.

For example, a family of four with income of $46,419 (median income in Maine in 2008) would pay a monthly premium of $233 under the House bill. Additional subsidies would cut in half the average out of pocket cost (including deductible, coinsurance, and copays); and out of pocket costs could not be greater than $2000 per person per year.[41] Under the Senate bill, the premium would be $258 per month with an out-of-pocket limit of $5000 (this is a 70% actuarial value plan, meaning that the average out of pocket cost would be 30%).[42]

4. Individual and employer responsibility

Under both bills, with limited exceptions such as financial hardship, all people would be required to have either individual or job-based health insurance.

Both bills would require employers to help pay for coverage. However, both bills exempt small businesses from these requirements. Large and mid-sized employers would be required to offer

[40] "Health Care Reform Premium Impact in Maine," WellPoint Corp. (Oct. 2009). Explanations of the underlying actuarial data were provided to the Bureau of Insurance by Anthem.
[41] The base plan would have a 70% actuarial value, meaning the consumer's average out-of-pocket share is approximately 30%. The House cost sharing subsidies for this income level would increase the actuarial value to 85%, meaning the consumer's share would be reduced by half, to 15%.
[42] Based on the Kaiser Family Foundation Subsidy Calculator, http://healthreform.kff.org/SubsidyCalculator.aspx.

coverage to their workers or pay a fee. The Senate bill exempts businesses with 50 or fewer workers. Others would have to pay a fee of $750 per worker if coverage is not provided by the employer. The House bill would require businesses with payroll of $500,000 and higher to either provide coverage (paying for at least 72.5% of premium) or pay a fee of 8% of payroll. Employers with payroll between $500,000 and $1 million would pay a reduced fee.

5. Loss ratio requirements

Both federal bills would establish medical loss ratio (MLR) requirements for group market coverage. The Senate bill would also establish MLR requirements for individual market coverage. These require insurers to pay a specified percentage of what they collect in premiums for medical care and services. Minimum MLR standards would be the following:

- House bill: 85% for large group and small group;
- Senate bill: 85% for large group; 80% for small group and for individual coverage.

Both bills would use premium net of taxes and fees, rather than the total premium, as the base for the MLR. The Senate bill would consider "activities that improve health care quality" as part of medical care or service expenses in calculating whether the insurer has met the minimum requirement. Maine's MLR is different – subtracting taxes is not allowed. Except for an adjustment for Dirigo savings offset payments, MLR in Maine is simply the ratio of claims to earned premium.[43]

6. Immediate help for individuals and businesses

Although both bills provide grants to the states for making coverage available to the uninsured, assistance under the Senate bill generally would be limited to high-risk pools. Under the House bill, these grants would also be available to states like Maine that have already enacted guaranteed-issue reforms and make coverage available to the uninsured through public-private partnerships such as DirigoChoice.

The Senate bill would also provide assistance beginning in tax year 2010 directly to small businesses, through a tax credit for providing coverage to low- and moderate-wage workers. The employer must have 25 or fewer workers and must contribute at least 50% of the premium. The full credit would be available to businesses with 10 or fewer workers and average annual wages of less than $25,000, and phases out as firm size and average wage increase. The House bill includes tax credits for small businesses, beginning in 2013.

7. Health insurance exchange

Both bills establish health insurance exchanges, which would facilitate enrollment in health coverage and the administration of premium subsidies, determine whether health insurance products meet the standards for qualified health plans, and provide a web based informational tool for consumers to make it easier to shop for health insurance, to compare policies and to buy coverage. The Senate bill would allow states to establish and operate these. Federal regulators

[43] 24-A M.R.S.A. §§ 2736-C(5); 2808-B(2-B)(A) & (2-C)(C).

would establish these if a state is not willing or unable to do so. The House bill would set up one national exchange but allow states to opt-out and establish their own.

Individuals and small businesses would be able to purchase coverage through these exchanges. In the Senate bill, small businesses would be able to purchase coverage through Small Business Health Options exchanges, or "SHOP" for short. This is based on the SHOP Act sponsored by Senator Olympia Snowe.

8. Risk adjustment

Both bills include risk adjustment provisions, intended to ensure that prices for different health insurance policies are based on the benefits provided and not on differences in the health of the populations enrolled in each. The Senate bill would apply risk adjustment within the individual market and within the small group market both in and out of the exchanges (except for grandfathered plans). The Senate bill allows states to merge the individual and small group markets for rating purposes. The House bill adjusts risk within the exchange.

	House Bill	Senate Bill	Maine
Guaranteed Issue for individual market coverage	✔	✔	✔
Rating Reforms for individual and small group markets	✔	✔	✔
Premium and out of pocket cost subsidies for individuals	✔	✔	*
Tax credits for small businesses	✔	✔	
Individual Responsibility	✔	✔	
Required contribution by employers	✔	✔	
Medical Loss Ratio	✔	✔	✔

*DirigoChoice

IV. CONCLUSION

Options for continuing to address ways to improve access, affordability and security of health insurance for Mainers will depend on the nature and extent of federal health care reforms and flexibility for states to move ahead building on federal reforms. The Bureau will supplement this preliminary report.

APPENDIX A: Federal Health Reform Bills summary prepared by Kaiser Family Foundation (reprinted with permission from KFF)
APPENDIX B: Market Snapshot – individual medical
APPENDIX C: Market Snapshot – small group health