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Health Care Reform in Maine: Reversing "Obamacare Lite"

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Abstract: *This spring, after living under the costly failures of Obamacare-like health care legislation for two decades, the Maine Legislature enacted a set of patient-centered, market-based health care reforms. The Maine experience is both a warning of Obamacare's likely effects and a practical demonstration to other states of how to enact sound free-market health care reforms in spite of Obamacare. Maine has also shown how much more it and other states could accomplish if not hamstrung by Obamacare and how Congress could chart a better course toward more innovative and effective health care reform.*

Faced with the uncertainty surrounding Obamacare, legislators in many states have deferred action on health care reform, instead waiting for final resolution of the constitutional challenges making their way through the federal courts and the outcome of the 2012 elections. During their legislative sessions earlier this year, most states neither enacted Obamacare-enabling legislation nor advanced their own, alternative health care reform designs.

One notable exception is Maine, where a new Republican governor and legislative majorities charted a different course for health care reform. This spring, after living under the costly failures of Obamacare-like health care legislation for two decades, Maine's new state leadership enacted a set of patient-centered, market-based health care reforms. In the process, they reversed a set of policies that mirrored key elements of Obamacare.

Talking Points

- State policymakers should enact market-based health care reforms now. They need not wait for the U.S. Supreme Court to void Obamacare or for Congress to repeal it.
- Maine's past experience demonstrates what the adverse effects will be if Obamacare is fully implemented, while Maine's new approach to health care reform shows how to achieve patient-centered, market-based alternatives to Obamacare.
- States can provide guaranteed access to all without the harmful effects of unrestricted guaranteed issue by reinsuring only high-risk individuals identified at time of application.
- Facts and market forces should dictate how premiums vary for age to protect young adults from extreme premium hikes.
- Purchasing insurance across state lines offers citizens protections against costly regulations enacted by future state politicians.

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Thus, Maine's experience is instructive for other states in two important respects. Maine's past offers lessons on the likely adverse effects of Obamacare if fully implemented, and Maine's new direction shows how to reverse and replace Obamacare with better patient-centered, market-based approaches. In sum, Maine offers other states and Congress a practical example of how to repeal and replace Obamacare with sound free-market health care reforms.

Maine's Obamacare Precedents

Precursors to key elements of Obamacare can be found in health care legislation enacted in a number of states over the past two decades. For example, Maryland's 1993 small-group health insurance law imposed a minimum standard benefit package designed and annually updated by a commission. In 1994, Tennessee authorized TennCare, a massive Medicaid expansion, and in 2006, Massachusetts passed legislation that included an individual mandate to buy health insurance. During the same period, Maine arguably enacted more Obamacare building blocks than any other state.

Round 1: Guaranteed Issue and Community Rating in 1993. As in a handful of other states, Maine policymakers enacted various health insurance regulations in 1993 during the height of the Clinton Administration's failed federal health care reform effort. The Maine legislation phased in guaranteed issue and narrow community rating over three years. Guaranteed issue requires health insurance companies selling individual health insurance plans to issue all plans to all individuals applying for coverage, regardless of health condition or status. It prohibits varying premiums based on health.

Maine's modified community rating law allowed premiums in the individual and small-group markets to vary by just 1.5:1 for age and geography combined. This means that an individual could only be charged up to 1.5 times the lowest rate charged to any other individual for the same insurance.[1] However, pre-retirees consume five times more health care services than young adults do. Starting in 2014, Obamacare will limit insurers to a 3:1 age variation in premiums.

These legislative restrictions on age-rating health insurance force carriers to reduce rates for older individuals while significantly increasing rates for young adults. However, because most young adults are in good health and tend to have lower incomes, artificially increasing their cost of coverage induces more of them to become or remain uninsured.[2]

Today, only New York, Vermont, and Massachusetts retain the kind of harmful, unrestricted guaranteed-issue requirements that Obamacare could impose on the entire country starting in 2014.

Maine was one of eight states that mandated unrestricted guaranteed issue in their individual markets during the 1990s. The other seven states were Kentucky, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington. Maine has since become the fifth of the eight states to repeal or fundamentally rewrite their earlier legislation in response to the damage these laws have inflicted on health insurance markets.[3] Today, only New York, Vermont, and Massachusetts retain the kind of harmful, unrestricted guaranteed-issue requirements that Obamacare could impose on the entire country starting in 2014.

Round 2: Dirigo Health in 2003. In 2002, then-Representative John Baldacci (D–ME) campaigned for governor on a universal health care platform.

1. Georgetown University, Health Policy Institute, "Maine Consumer Guide to Getting and Keeping Health Insurance," January 2006, at *http://healthinsuranceinfo.net/getinsured/maine/individual-health-plans/individual-health-insurance-sold-by-private-insurers/* (July 8, 2011).
2. Edmund F. Haislmaier, "Obamacare and Insurance Rating Rules: Increasing Costs and Destabilizing Markets," Heritage Foundation *WebMemo* No. 3111, January 20, 2011, at *http://www.heritage.org/Research/Reports/2011/01/Obamacare-and-Insurance-Rating-Rules-Increasing-Costs-and-Destabilizing-Markets*.
3. Leigh Wachenheim and Hans Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman, July 10, 2007, pp. 1–2, at *http://alankatz.files.wordpress.com/2007/09/milliman-study-on-gi-20070912.pdf* (July 8, 2011).

After elected, he ushered his Dirigo[4] Health Reform through the Democrat-controlled legislature in June 2003. Dirigo Health dramatically expanded Medicaid, imposed a vast array of new regulations on Maine's health care and health insurance industries, and created DirigoChoice, a state-designed, privately administered health plan with premium and deductible subsidies based on family income. Echoes of each of these elements of Dirigo Health are found in Obamacare.

Dirigo cost taxpayers $183 million over six and one-half years but failed to reduce the number of uninsured even slightly.

Dirigo Health's stated goal was to eliminate all uninsured by 2009,[5] but it failed to meet this goal. In fact, slightly more Maine people were uninsured in 2009 than in 2003,[6] even though taxpayers had spent more than $183 million in premium subsidies alone since DirigoChoice's inception in 2005.[7]

Because of similarities in size, scope, subsidy structure, and insurance market regulations, Dirigo Health has been compared by both supporters[8] and opponents[9] to Obamacare, officially known as the Patient Protection and Affordable Care Act (PPACA). Given that Dirigo cost taxpayers $183 million over six and one-half years but failed to reduce the number of uninsured even slightly, the similarities between the two programs should give both supporters and opponents of Obamacare pause.

On June 16, 2011, the Maine Legislature acknowledged Dirigo's failure by approving—by large bipartisan majorities—legislation that will eliminate the Dirigo Health Program by December 2013.[10]

The Individual Market's "Death Spiral." Since the 1993 so-called reforms, Maine's individual market has gone from covering 102,000 individuals to covering just 57,000 in 2009, a 44 percent drop.[11] The cause is clear. When guaranteed issue and narrow community rating took effect, premiums and deductibles skyrocketed. Essentially, insurance became priced for—and therefore only attractive to—the oldest and sickest enrollees. The young and healthy dropped coverage, leaving fewer and sicker enrollees.

Every state with guaranteed issue and community rating has replicated this death spiral. A recent study of the impact of guaranteed issue and community rating found that "for those reporting excellent health, community rating was associated with

4. The name was taken from the state's Latin motto *Dirigo*, which translates as "I lead."
5. Tarren Bragdon, "Command and Control: Maine's Dirigo Health Care Program," Heritage Foundation *Backgrounder* No. 1878, September 19, 2005, at *http://www.heritage.org/Research/Reports/2005/09/Command-and-Control-Maines-Dirigo-Health-Care-Program* (July 8, 2011).
6. U.S. Census Bureau, Health Insurance Historical Tables, Table HIA-6, at *http://www.census.gov/hhes/www/hlthins/data/historical/files/hihistt6.xls* (July 8, 2011).
7. Authors' calculations based on annual reports and income statements for January 2005 through June 2011 (estimated) from the Dirigo Health Agency.
8. Press release, "Maine Recognized for Leadership in Covering Maine Citizens," Office of Governor John E. Baldacci, September 10, 2010, at *http://www.maine.gov/tools/whatsnew/index.php?topic=Gov+News&id=132377&v=Article-2006* (July 8, 2011).
9. Editorial, "No Maine Miracle Cure: Another State 'Public Option' That Failed," *The Wall Street Journal*, August 21, 2009, at *http://online.wsj.com/article/SB10001424052970204619004574322401816501182.html* (July 8, 2011).
10. It was enacted as part of Maine's FY 2012/FY 2013 biennial budget. An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2012 and June 30, 2013, L.D. 1043, 125th Maine Legislature, 2011, Part BBB-2, p. 593, at *http://www.mainelegislature.org/legis/bills/bills_125th/chappdfs/PUBLIC380.pdf* (July 12, 2011). L.D. 1043 was passed by votes of 123 to 19 in the Maine House and 29 to 5 in the Maine Senate on June 16, 2011, and was signed by Governor Paul LePage on June 20, 2011. Maine Legislature, "Summary of LD 1043," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280040546* (July 8, 2011).
11. U.S. Census Bureau, Health Insurance Historical Tables, Table HIA-6.

a 22 percent reduction in the probability of having non-group [individual] coverage" and a drop of up to 59 percent in coverage for certain young individuals, yet "no significant change in overall coverage rates among the higher risk individuals." The study also found some higher-risk individuals switching from group to individual coverage, spreading their higher costs across a smaller pool.[12] In sum, the young dropped coverage, but no additional older individuals signed up.

The average premium for individual coverage in Maine in 2009 was $4,061, compared to the national average of $2,985, and family coverage cost $7,260, compared to the national average of $6,328.

Anthem, the dominant carrier in Maine's individual market, accounts for about half of that market.[13] By 2008, 88 percent of those with individual market coverage through Anthem in Maine had a deductible of at least $5,000,[14] and an astounding 40 percent had a deductible of $10,000 or more.[15] In comparison, a national survey of carriers found just 41 percent of individual market enrollees with deductibles of at least $5,000 and just 13 percent with deductibles of $10,000 or more in 2009.[16]

Even with more than three times as many enrollees with extremely high deductibles, the average premium for individual coverage in Maine in 2009 was $4,061, compared to the national average of $2,985, and family coverage cost $7,260, compared to the national average of $6,328. Thus, Maine consumers are paying an average of 36 percent more for single coverage and 15 percent more for family coverage—and that is for plans with much higher deductibles than comparable plans in other states.[17]

According to the Maine Bureau of Insurance, since the beginning of the recession in February 2008, the number of covered individuals in Maine's individual market has declined from 40,932 in December 2007[18] to just 36,195 by March 2011,[19] a 12 percent drop. Typically, enrollment in the individual market expands during a recession as individuals lose access to employer-sponsored coverage.[20] Maine's regulations produced the opposite result.

Maine's experience is a warning about Obamacare, because Obamacare includes similar provisions for guaranteed issue and narrow community rating, which will take effect in January 2014.

A New Way: Proven Patient-Centered, Market-Based Reform in 2011

For years, Maine legislators had proposed and debated reforms in the state's individual insurance market. Usually these reforms proposed repealing

12. Anthony T. Lo Sasso, "Community Rating and Guaranteed Issue in the Individual Health Insurance Market," National Institute for Health Care Management, *Expert Voices*, January 2011, p. 1, at *http://nihcm.org/pdf/EV-LoSassoFINAL.pdf* (July 8, 2011).
13. Maine Bureau of Insurance, "Market Snapshot—Individual Medical," June 9, 2011, at *http://www.maine.gov/pfr/insurance/employer/snapshot_individual.htm* (July 8, 2011).
14. Maine Bureau of Insurance, "Preliminary Report: The Health Insurance Market in Maine," February 2010, Part II.C, at *http://www.maine.gov/pfr/insurance/reports/BOIHealth_Insurance_report2-12-2010finalFSl.htm* (July 8, 2011).
15. William Whitmore, "Prefiled Testimony of William Whitmore," April 7, 2011, p. 6, at *http://www.maine.gov/pfr/insurance/filings/2011_Anthem/Anthem_Prefiled_Testimony_of_Bill_Whitmore_04072011.pdf* (July 8, 2011).
16. America's Health Insurance Plans, Center for Policy Research, "Individual Health Insurance 2009: A Comprehensive Survey of Premiums, Availability, and Benefits," October 2009, p. 19, at *http://www.ahipresearch.org/pdfs/2009IndividualMarketSurveyFinalReport.pdf* (July 8, 2011). Nationally, only 3 percent of individuals are in plans with deductibles over $10,000, but 37 percent of Maine policyholders have deductibles of $15,000 or more.
17. *Ibid.*, pp. 5–6.
18. Maine Bureau of Insurance, "Preliminary Report," Appendix B.
19. Maine Bureau of Insurance, "Individual Insurance—Market Snapshot." Census Bureau figures include sole proprietors, which are sometimes included in Maine's small-group market, depending on the carrier.
20. U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements, 2001–2003 and 2008–2009.

guaranteed issue, expanding the rating bands for age and health, and setting up a high-risk pool. In 2006, a Republican-sponsored bill to do just that was passed by the Maine House of Representatives, but it failed in the Senate.[21] In 2007, the Maine Bureau of Insurance commissioned an extensive study on the actuarial and enrollment impact of various reforms.[22] In 2008, a Democrat-sponsored bill proposed to adopt Idaho's hybrid model of a high-risk reinsurance system, in which all individuals applying for individual insurance have guaranteed access to five plans, which are reinsured to fund premiums. This bill was also passed by the Maine House but failed in the Senate.[23]

During the 2011 legislative session, after the 2010 elections had produced a new Republican governor and Republican control of both legislative chambers for the first time since 1964, health care reform was again on the agenda. A group of Republican legislators and health system stakeholders began developing a comprehensive health care reform package.[24] Their work was guided by Maine's past experience, focused on what would most help Maine's citizens and small businesses, and mindful of the constraints imposed by Obamacare. On the last point, given Maine's history of failed health care reforms, they did not want to risk further uncertainty and market instability by enacting measures that directly contravened Obamacare. With minor modifications, the proposal developed by this working group was ultimately passed as Legislative Document (LD) 1333, which became Public Law 90.[25]

The Obamacare Straightjacket

Obamacare imposes expansive new regulations on the health insurance and health care marketplaces. The U.S. Department of Health and Human Services (HHS) has yet to issue regulations filling in the details of many of the Obamacare provisions, and this has created much uncertainty. Among other provisions, Obamacare requires guaranteed access for any individuals applying for coverage from any insurance company,[26] prohibits exclusions for pre-existing conditions,[27] limits variations in premiums for age to 3:1,[28] limits variations in premiums for tobacco use to 1.5:1,[29] limits varia-

21. L.D. 1465 was passed by a vote of 74 to 72 in the Maine House and failed by a vote of 19 to 16 in the Maine Senate. State of Maine Legislature, "Summary of LD 1465," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280020080* (July 11, 2011).
22. Bela Gorman, Don Gorman, Elizabeth Kilbreth, Taryn Bowe, Gino Nalli, and Richard Diamond, "Reform Options for Maine's Individual Health Insurance Market," Maine Bureau of Insurance, May 30, 2007, at *http://www.maine.gov/pfr/insurance/reports/reform_options_individual_health_market.doc* (July 11, 2011).
23. L.D. 1760 was passed by a vote of 79 to 63 in the Maine House but failed by a vote of 18 to 17 in the Maine Senate. State of Maine Legislature, "Summary of LD 1760," at *http://www.mainelegislature.org/LawMakerWeb/summary.asp?ID=280024649* (July 11, 2011).
24. This group included Republicans from the legislative leadership; representatives from the governor's office and Department of Professional and Financial Regulation (which includes the Bureau of Insurance); the Attorney General's office; health providers; health insurers; health insurance brokers; health policy experts (including the authors); and representatives of the business community.
25. An Act to Modify Rating Practices for Individual and Small Group Health Plans and to Encourage Value-Based Purchasing of Health Care Services," L.D. 1333, 125th Maine Legislature, 2011, at *http://www.mainelegislature.org/legis/bills/bills_125th/chapters/PUBLIC90.asp* (July 11, 2011).
26. Patient Protection and Affordable Care Act, Public Law 111–148, § 2702, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111–152. For the text of select PPACA provisions incorporating changes by subsequent amendments, see National Association of Insurance Commissioners and Center for Insurance Policy and Research, "The Patient Protection and Affordable Care Act P.L. 111–148: Selected Health Insurance Provisions Incorporating Changes in the Manager's Amendment and the Health Care and Education Reconciliation Act (P.L. 111–152)," January 21, 2011, at *http://www.naic.org/documents/index_health_reform_general_ppaca_ins_provs.pdf* (July 11, 2011).
27. Patient Protection and Affordable Care Act, § 2704.
28. *Ibid.*, § 2701.
29. *Ibid.*

tions in premiums for geography to state-set factors,[30] and prohibits variations in premiums for health or any other status.[31]

The challenge of the Maine reform was to work within the confines of Obamacare while developing a sufficiently robust and flexible design that could also accommodate the Supreme Court voiding Obamacare or Congress repealing or amending it.

The 2011 Maine reform includes five major provisions:

- Guaranteed access to reinsurance funding only for high-risk individuals;
- Individualized pricing for affordable options;
- Purchase of insurance across state lines;
- New options for businesses joining together; and
- New options for long-term unemployed.

Guaranteed Access to Reinsurance Funding Only for High-Risk Individuals. For years, states have created and supported high-risk pools to fund the cost of high-risk individuals who otherwise would not have access to health insurance in an underwritten market. Today, 34 states have high-risk pools.[32]

In 2001, Idaho created a variation on the high-risk funding concept. Idaho guaranteed all individuals continuous access to certain plans, which would be funded through a reinsurance arrangement. Idaho's Individual High-Risk Reinsurance Pool design offers five guaranteed access plans at premiums that vary only by age, gender, and smoking status. All carriers must offer these plans at the designated premiums to all individuals who meet a certain health risk threshold, based on a uniform health questionnaire that all individuals complete as part of their insurance application. Unlike a traditional high-risk pool, these high-risk individuals are not transferred to a separate plan and administrator, and only those individuals within the five designated plans have their claims reinsured. High-cost individuals not identified at time of application are not eligible for reinsurance.

Carriers must contribute a portion of the premium collected for these individuals to the reinsurance pool.[33] These contributions ensure that carriers have no incentive to "push" more people into the reinsurance pool. In addition, Idaho allows premiums to vary based on health status by up to 1.5:1.[34]

Idaho's reinsurance plan has proven to be an effective, targeted solution with little cost to taxpayers. Taxpayers spent only about $6.5 million to cover the 1,430 individuals in the reinsurance plan in 2009 and just $4.4 million to cover the 1,569 individuals in the plan in 2010.[35] In 2009, 165,000 individuals had coverage through Idaho's individual market, more than 12 percent of Idaho's 1.344 million residents under age 65. Since 2000, the size of Idaho's individual market has grown by 47 percent. The reinsurance program covers just 0.8 percent of Idaho's individual market and just 0.1 percent of the total population under 65.[36]

The Maine reform applies the reinsurance structure to all plans, not just a select few as Idaho's plan does. It also allows premiums to vary only for individuals of similar age, geography, and smoking

30. *Ibid.*
31. *Ibid.*, § 2705.
32. Henry J. Kaiser Family Foundation, "State High Risk Pool Programs and Enrollment, as of December 31, 2010," at *http://www.statehealthfacts.org/comparetable.jsp?ind=602&cat=7* (July 11, 2011).
33. Idaho Department of Insurance, "Individual High Risk Reinsurance Pool Plans for Idaho Residents," July 2010, at *http://www.doi.idaho.gov/Pubs/high_riskbr.pdf* (July 11, 2011), and "Idaho Individual High Risk Reinsurance Pool Mandated Plan Street Premium Rates: Monthly Premium Rates for Policies Issued or Renewed Effective 10/1/2011 Through 12/31/2011," at *http://www.doi.idaho.gov/health/Quarterly_A4.pdf* (July 11, 2011).
34. National Women's Law Center, "The Individual Insurance Market: A Hostile Environment for Women," June 9, 2008, p. 14, at *http://www.nwlc.org/sites/default/files/pdfs/Individual%20Insurance.pdf* (July 11, 2011).
35. AmeriBen, "Idaho Individual High Risk Reinsurance Pool: Monthly Report for February 2011," March 2011, pp. 4 and 9.
36. U.S. Census Bureau, Current Population Survey, 2000 and 2009 Annual Social and Economic Supplements.

status within the applicable rating factor limits of Obamacare.[37]

Beginning July 2012, the Maine reform amends (and functionally repeals) Maine's strict guaranteed-issue requirement and replaces it with a reinsurance structure that provides lower-cost unsubsidized plans to healthy individuals and subsidized coverage, at the same rate, to high-risk individuals. The design will work as follows:

1. A Maine resident applies for individual health insurance with any carrier and completes a health statement as part of the coverage application. The statement is used only to determine eligibility for the Maine Guaranteed Access Reinsurance Plan.
2. If the individual meets the threshold, the qualifying individual will be charged the standard premium, and the carrier will contribute a portion of the premium to the reinsurance plan and be reimbursed for claims for that individual according to the following formula: 0 percent for the first $7,500 in claims; 90 percent for claims between $7,500 and $32,500, and 100 percent for claims over $32,500, with the amounts indexed to the medical Consumer Price Index.
3. If the individual does not meet the threshold, the carrier will not be eligible for reinsurance.
4. In either scenario, the individual will have guaranteed access to the desired plan at the quoted premium—rated only for age, tobacco use, and geography.

The reinsurance is financed from a per-life assessment on almost all privately insured individuals in the state. The assessment is capped at $4 per person per month, but experiences in Idaho and other states indicate that the necessary assessment level will be much less. The assessment could generate as much as $20 million in funding for the Maine reinsurance plan.

Strict guaranteed issue drives up the costs of health insurance by encouraging young and healthy people to drop out of the market. A traditional high-risk pool design diverts high-risk individuals into plans that may differ significantly from the plans available to others. The Maine reform, inspired by Idaho's reinsurance plan, funds high-risk individuals but guarantees access to all. It also adapts to the tight restrictions in Obamacare. If Obamacare is repealed or found unconstitutional, the Maine reforms would allow even greater flexibility and affordability to cover the young and old and the sick and healthy.

Individualized Pricing for Affordable Options. The Maine reform expands Maine's age rating bands from 1.5:1 to 3:1 beginning in July 2012 for the individual market and phases in the shift from 1.5:1 to 3:1 from 2011 to 2014 for the small-group market. If Obamacare is altered or repealed, the Maine reform will extend the age rating bands to 5:1, which is the naturally occurring age-related variation in health care utilization.

Health premiums ultimately reflect actual health care costs and utilization. Thus, premiums that vary according to expected health care utilization for an individual based on the person's age reflect an accurate value proposition. Tighter age rating bands result in premiums that are too high for some and too low for others given their expected use. In reality, age rating bands of less than 5:1 drive up costs for young people while keeping costs for older individuals constant.

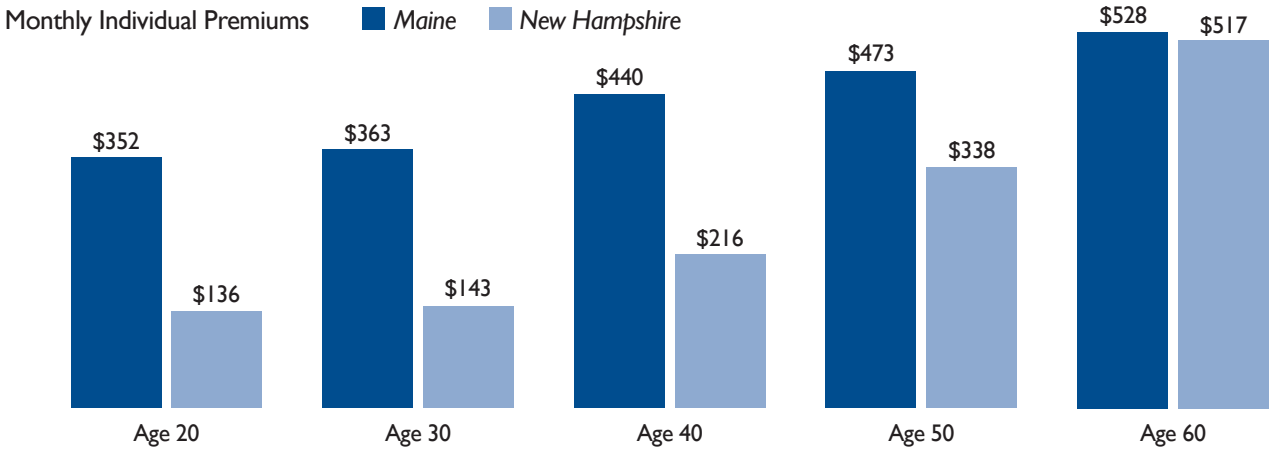
This effect is shown in Chart 1, which compares similar individual plans in Maine with a 1.5:1 pre-reform rating band and New Hampshire with a 4:1 rating band. A 60-year-old pays the same whether in Maine or New Hampshire, but a 20-year-old in Maine pays $352 per month ($4,224 per year) for a plan that costs just $136 per month ($1,632 per year) in New Hampshire. The Maine young adult faces a premium that is 159 percent higher.[38]

The Maine reform changes these age rating bands to the Obamacare standard of 3:1. A more reasonable

37. William Schneider, Maine Attorney General, letter to Robert Nutting, Speaker of the Maine House of Representatives, May 9, 2011.
38. Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Comparing Health Care Premiums: Maine and New Hampshire

Residents of Maine pay more for health care premiums than those living in New Hampshire, especially young adults. Even those age 40 pay twice as much in Maine.



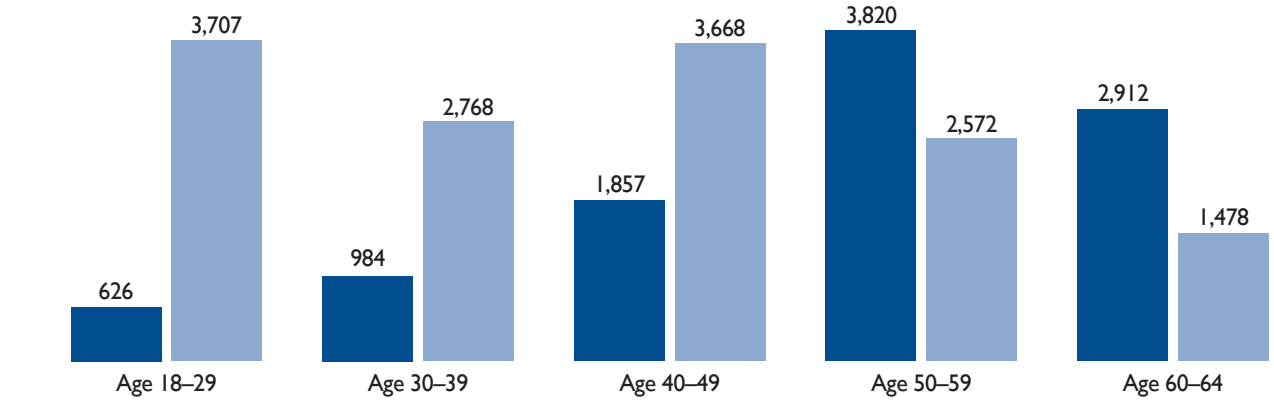
Source: Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Chart 1 • B 2582 heritage.org

rating band would be 4:1 or higher. If Obamacare is voided or repealed, the Maine reform defaults to the more appropriate band of 4:1 and then 5:1 the following year. State lawmakers felt that it was important to build in provisions that would automatically move Maine to the ideal age rating bands if future federal law allows rather than relying on future legislatures to enact additional reforms.

The impact of driving up premiums for young people can be seen in Chart 2, which shows enrollment by age for individual health insurance for Anthem Blue Cross Blue Shield (WellPoint) in Maine and New Hampshire. Just 626 Maine young adults buy this unnecessarily expensive insurance compared to 3,707 in New Hampshire. Costly regulations cause young people to drop or not buy coverage.[39]

Younger Adults in Maine Less Likely to Hold Individual Health Policies



Source: Anthem Blue Cross and Blue Shield, document for public hearing on L.D. 1333, April 26, 2011, p. 1.

Chart 2 • B 2582 heritage.org

The Maine rating reforms allow insurers to phase in these expanded rating bands for plans already in force in order to close their current block of business.

Purchase of Insurance Across State Lines. The Maine reform establishes a process for Maine residents to buy individual insurance from most other New England states, beginning in 2014. The reform disregards Obamacare's convoluted and unnecessary Health Care Choice Compact provisions, which require two or more states each to pass a law authorizing a compact and then apply to HHS for approval.

Maine's reform takes a more free-market approach, relying instead on the reciprocity that states typically grant each other in other areas, such as traffic law enforcement and permits to carry concealed firearms. Under the Maine reform, an insurer approved to sell an individual-market product in any of four other New England states (New Hampshire, Massachusetts, Rhode Island, and Connecticut) may request certification from the Maine Bureau of Insurance to sell the same product in Maine.

To obtain certification, the insurer need only meet Maine's standards for handling policyholder grievances and Maine's consumer protection provisions. Otherwise, the product conforms to the other state's benefit mandates and premium rate regulations. The Maine Superintendent of Insurance then enters into a memo of understanding with that other state's insurance commissioner to ensure communication if any consumer complaints arise and has 30 days to grant or deny certification. Once a regional insurer receives a Maine certificate, which is similar to a Maine license granted through a reciprocity agreement, Maine domestic insurers may start offering similar plans, provided they meet the other state's benefit and premium rate regulations.

Allowing the sale of health insurance across state lines is important for two reasons.

- It increases competition and choice for Maine residents buying insurance on the individual market.
- It protects Maine consumers from premium increases driven by additional benefit mandates or costly regulations added by future Maine legislatures.

Once Maine residents have such choice, it will be difficult to take it away. One New England state, Vermont, was not included in this arrangement because it just approved a single-payer health plan design that is incompatible with patient-centered, free-market health care reform.

This provision to allow the purchase of health insurance across state lines will not take effect until 2014 because Obamacare provisions, if they remain law, will establish uniform rating rules for all states beginning in 2014. This addresses an important concern of insurers worried about potential adverse selection effects. The 18-month implementation delay also allows time for the legislation's other market reforms to take effect, which is important to those insurers who have remained in the state's market. Finally, it will begin during the present term of the current governor, which was an important consideration for state legislators worried about the actions of future legislatures and governors.

New Options for Businesses Joining Together. The Maine reform also allows businesses to join together to create a "captive" health plan. This is akin to an association health plan, except that the participating businesses are not required to be in a similar industry or region, but they must be jointly and severally liable to meet necessary capital and reserve requirements.

The design for this arrangement more closely tracks the "captive insurer" model that states have authorized for other lines of coverage, particularly property insurance. For example, a large corporation might find it advantageous to set up a captive insurer to insure its buildings and equipment against damage. Authorizing a captive insurer model for health benefits gives Maine businesses another way to offer health coverage to their employees.

This provision was driven by a group of employers and health providers who wanted to design their own value-based, wellness-focused employee health benefit outside of traditional health insurance. The law requires the captive insurer to meet small-group

39. *Ibid.*

benefit mandates and rating regulations, although plans may be offered to participating employers of any size.

New Options for Long-Term Unemployed. Many individuals who are unemployed or just starting a new business need short-term health insurance ranging from a few months to two years until they can transition into more conventional coverage. Rather than force these individuals into the individual health insurance market, the Maine reform allows them to buy short-term health insurance for up to 24 months, an increase from the 12-month limit. Monthly premiums for short-term health insurance average $75 to $125, typically about one-third of the cost of traditional COBRA coverage.[40] These plans are fully underwritten and not subject to any state benefit mandate requirements or premium rate regulations, making them very customizable and affordable.

According to national figures for those with individual insurance, about 20 percent drop short-term coverage within six months, one-third within 12 months, and more than half within two years, mostly because they cycle back onto employer-sponsored plans.[41] Therefore, expanding temporary health insurance gives individuals access to plans that are completely underwritten, outside of Obamacare's reach, outside of state benefit mandates and premium rate regulations, and currently available in almost all states.[42]

Conclusion

Maine's experience with the costly failures of a big-government, command-and-control approach to health care reform is a salutary warning of the likely adverse effects of similar provisions in Obamacare. In contrast, Maine's new approach to health care reform shows other states and Congress how to chart a better course toward more innovative and effective health care reform using proven patient-centered, market-based designs.

For Congress, the best strategy is to repeal Obamacare and start anew with simple patient-centered, market-based reforms that allow states the flexibility to craft solutions that work best for each state's particular population and circumstances.

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40. Medsave.com, "Short Term Health Insurance," at *http://www.medsave.com/short-term-health-insurance.html* (July 11, 2011).
41. Henry J. Kaiser Family Foundation and eHealthInsurance, "Update on Individual Health Insurance," August 2004, p. 3, at *http://www.kff.org/insurance/upload/Update-on-Individual-Health-Insurance.pdf* (July 11, 2011).
42. Short-term coverage is not available in Massachusetts, New Jersey, New York, Washington, or Vermont, although individuals may buy coverage in another state and use it in these five states. See Medsave.com, "30 Fast Facts About Short Term Health Insurance," at *http://www.medsave.com/health-insurance-resources/fast-facts-about-short-term-health-insurance.htm* (July 11, 2011).