



CSU
College of Law Library

2011

The Skeleton Key: Will the Federal Health Care Reform Legislation Unlock the Solutions to Diverse Dilemmas Arising from the State Health Care Reform Laboratories

Christopher R. Smith

Follow this and additional works at: <https://engagedscholarship.csuohio.edu/jlh>

 Part of the [Health Law and Policy Commons](#), and the [Legislation Commons](#)

[How does access to this work benefit you? Let us know!](#)

Recommended Citation

Christopher R. Smith, *The Skeleton Key: Will the Federal Health Care Reform Legislation Unlock the Solutions to Diverse Dilemmas Arising from the State Health Care Reform Laboratories*, 24 J.L. & Health 79 (2011)

available at <https://engagedscholarship.csuohio.edu/jlh/vol24/iss1/5>

This Article is brought to you for free and open access by the Journals at EngagedScholarship@CSU. It has been accepted for inclusion in Journal of Law and Health by an authorized editor of EngagedScholarship@CSU. For more information, please contact library.es@csuohio.edu.

**THE SKELETON KEY: WILL THE FEDERAL
HEALTH CARE REFORM LEGISLATION UNLOCK
THE SOLUTIONS TO DIVERSE DILEMMAS
ARISING FROM THE STATE HEALTH CARE
REFORM LABORATORIES?***

CHRISTOPHER R. SMITH

I.	INTRODUCTION	79
II.	HAWAII.....	81
	A. <i>The Hawaii Prepaid Health Care Act</i>	81
	B. <i>Hawaii’s Coverage Outcomes</i>	83
	C. <i>The Impact of the National Health Reform Law on Hawaii</i>	85
III.	MAINE	91
	A. <i>The Dirigo Health Reform Act</i>	91
	B. <i>Maine’s Coverage Outcomes</i>	93
	C. <i>The Impact of the National Health Reform Law on Maine</i>	95
IV.	VERMONT	100
	A. <i>The Health Care Affordability Act</i>	100
	B. <i>Vermont’s Coverage Outcomes</i>	103
	C. <i>The Impact of the National Health Reform Law on Vermont</i>	104
V.	CONCLUSION	109

I. INTRODUCTION

Almost two years ago, the late Senator Edward Kennedy declared:

For me, this is a season of hope, new hope for a justice and fair prosperity for the many and not just for the few, new hope. And this is the cause of my life, new hope that we will break the old gridlock and guarantee that

* Christopher Robert Smith; J.D. 2001, Vanderbilt University Law School; B.A. 1998, University of Richmond. Christopher Smith is a Law and Government LL.M. candidate at American University’s Washington College of Law and Director of Policy and Regulatory Affairs with the National Community Pharmacists Association. The author wishes to thank Professor Corrine Parver at American University’s Washington College of Law for her inspiration, guidance and dedication to teaching her students about the importance of health care reform and coverage for all Americans, even when it seemed like comprehensive health care reform would fail.

every American -- north, south, east, west, young, old -- will have decent, quality health care as a fundamental right and not a privilege.¹

Today, Senator Kennedy's "new hope" for universal health care coverage is a reality. In March 2010, Congress finally enacted nationwide health care reform and an overhaul of the United States health insurance system, which aims to deliver near-universal coverage for all Americans. On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act² ("PPACA") and, on March 30, 2010, he signed the Health Care and Education Reconciliation Act of 2010³ ("HCERA") (collectively the "Reform Law"), together representing the biggest overhaul of the United States health care system in the last 50 or 60 years.⁴ The Congressional Budget Office has predicted that the final legislation "will provide coverage to more than 95% of all Americans."⁵

The significance of the federal health care reform legislation cannot be understated; the 111th Congress has succeeded where so many before have failed.⁶ Still, Congress has arrived "late to the health care reform ball," as a number of states, starting with Hawaii in the 1970s, and more recently, Maine, Vermont and Massachusetts, have been progressing towards universal health care coverage for many years. These states have often been described as laboratories of innovation for health care reform efforts.⁷ In fact, Massachusetts' recent health care reform legislation is seen as a model for the Reform Law.⁸

¹ Senator Edward Kennedy, Speech at 2008 Democratic National Convention (Aug. 26, 2008), available at http://www.nydailynews.com/news/2008/08/25/2008-08-25_text_of_ted_kennedys_speech_at_the_democ.html.

² Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

³ See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

⁴ David E. Theiss, *The Medicare Hospice Benefit After Health Reform: Cost Controls, Expanded Access, and System-Induced Pressures*, 3 J. Health & Life Sci. L. 39, 39 (July, 2010) (citing President Obama's campaign adviser on health policy as stating that the PPACA is "essentially the biggest transformation of government since World War II").

⁵ STAFF OF H. COMMS. ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUC. AND LABOR, 111th CONG., REPORT ON AFFORDABLE HEALTH CARE FOR AMERICA 1, (Comm. Print 2010), <http://docs.house.gov/energycommerce/SUMMARY.pdf>.

⁶ William P. Gunnar, M.D., *The Fundamental Law that Shapes the United States Health Care System: Is Universal Health Care Realistic within the Established Paradigm*, 15 Annals Health L. 151, 157 (Winter, 2006) (noting that Presidents Roosevelt, Truman, Nixon and Carter all failed to implement health care reform); J. Paul Singleton, *The Good, The Bad and The Ugly: How the Due Process Clause May Limit Comprehensive Health Care Reform*, 77 Tenn. L. Rev. 413, 414 (Winter, 2010) (citing the failures of Presidents Roosevelt, Truman and Clinton to pass health care reform).

⁷ Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 Law & Ineq. 1, 9 (2010).

⁸ Joan Venocchi, Op-Ed., *Fine-Tuning Health Care Costs*, BOSTON GLOBE, Apr. 1, 2010, at A13, available at http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2010/04/01/fine_tuning_health_care_costs (stating that the recently enacted federal health care reform law used Massachusetts' law as a template).

Given that the Reform Law is not operating on a blank slate, this article examines its impact on the health care reform efforts of three states: Hawaii, Maine, and Vermont. More specifically, this article examines each state's health care reform plan, the outcomes of each plan in terms of achieving universal coverage or near-universal coverage, and the likely impact of the federal health care reform legislation on these plans, with a particular focus on how the federal legislation and state laws will or will not work together to achieve near-universal coverage. The article aims to determine whether the Reform Law unlocks the solutions to some of the dilemmas resulting from state health care reform efforts, or whether the Reform Law fails to do so or even exacerbates existing problems.

This article focuses on the health care reform efforts of Hawaii, Maine and Vermont for three reasons. First, each of the three states has taken different approaches toward achieving universal coverage. Second, all three rank highly in terms of their low rate of uninsured residents, but have yet to achieve near-universal or universal coverage.⁹ Third, Maine and Vermont were chosen because the Kaiser Family Foundation has identified those two states as two of three states, Massachusetts being the third, which have enacted universal health care coverage legislation.¹⁰

II. HAWAII

A. *The Hawaii Prepaid Health Care Act*

Hawaii may be viewed as the “grandfather” of state health care reform in the United States, given that it first implemented health care reform over 30 years ago. In 1974, Hawaii passed the Hawaii Prepaid Health Care Act (“PHCA”), which ties health care reform to an employer mandate.¹¹ Hawaii's employer mandate provision is unique among the states because state employer mandates are generally preempted by the federal Employee Retirement Income Security Act (“ERISA”).¹² In fact,

⁹ Massachusetts was another potential candidate for analysis, as well. However, as of the end of 2008, the Massachusetts Health Connector reports that Massachusetts' uninsured rate is only 2.7%. Commonwealth Health Ins. Connector Auth., *Massachusetts Health Care Reform 2009 Progress Report*, HEALTH CONNECTOR, 4 (2009), <https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/Connector%2520Progress%2520Report%252009.pdf>. This represents near-universal coverage, so it is unlikely that the Reform Law will improve Massachusetts' scope of coverage, particularly given that the Reform Law is modeled after Massachusetts' plan.

¹⁰ KAISER COMM'N ON MEDICAID AND THE INSURED, *States Moving Toward Comprehensive Health Care Reform*, Kaiser Family Foundation (May 19, 2009), http://www.kff.org/uninsured/kcmu_statehealthreform.cfm (stating that “[t]hree states, Maine, Massachusetts and Vermont, have enacted and are implementing reform plans that seek to achieve near universal coverage of state residents”).

¹¹ HAW. REV. STAT. §§ 393-1 to 393-51 (1974). See Peter D. Jacobson & Rebecca L. Braun, *Let 1000 Flowers Wilt: The Futility of State-Level Health Care Reform*, 55 U. Kan. L. Rev. 1173, 1175 (2007) (summarizing the history of Hawaiian health care reform legislation and why it has not been successful).

¹² Jacobson & Braun, *supra* note 11, at 1176 (discussing ERISA exemption of employee benefit plans from state insurance regulation).

Hawaii was forced to obtain a Congressional waiver to implement its employer mandate, and no other state, to date, has obtained such a waiver.¹³ Significantly, the Hawaii ERISA exemption only applies to the PHCA as it existed in 1974, when ERISA was first enacted, and Hawaii may not modify the PHCA in any way.¹⁴

The PHCA employer mandate requires all Hawaiian employers to provide coverage to any employee who is paid monthly wages that are 86.67 times the minimum hourly wage, works more than twenty hours per week for four consecutive weeks, and does not have an alternative source of health insurance.¹⁵ The PHCA also requires employers to meet certain minimum benefit standards, defined as “health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, . . . which have the largest numbers of subscribers in the State.”¹⁶ The minimum benefit requirements specified within the statute include hospital benefits, surgical benefits, medical benefits, diagnostic laboratory services, maternity benefits, and substance abuse benefits.¹⁷ Notably absent is any requirement that employers’ plans provide mental health benefits, other than substance abuse benefits, dental or vision benefits.

Along with benefit requirements, the PHCA also imposes cost requirements on employers. The PHCA requires covered employers to contribute at least one-half of their employees’ premium costs, and “in no case shall the employee contribute more than 1.5 per cent of the employee’s wages.”¹⁸ Although the employer foots a large share of the premium costs, “an employer who employs less than eight employees . . . shall be entitled to premium supplementation . . . if the employer’s share of the cost of providing such coverage . . . exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer’s income before taxes.”¹⁹

Although the PHCA addressed coverage for most employed Hawaiians, it failed to address coverage for the unemployed. Accordingly, in 1994, Hawaii obtained a Medicaid waiver to create the QUEST program, which “stands for Quality of care, Universal access, Efficient utilization, Stable cost, and Transformation.”²⁰ QUEST began as a demonstration project and operated to shift Medicaid enrollees onto private managed care and to offer a limited benefits package to low income, uninsured, adult Medicaid ineligible Hawaiians who earn up to 300% of the Federal Poverty Level (“FPL”).²¹ Although QUEST is designed to fully cover parents and

¹³ Jacobson & Braun, *supra* note 11, at 1176.

¹⁴ Christen Linke Young, *Pay or Play Programs and ERISA Section 514: Proposals for Amending the Statutory Scheme*, 10 *Yale J. Health Pol’y, L. & Ethics* 197, 206, 231 (2010) (describing how Hawaii avoided ERISA preemption). See 29 U.S.C. § 1144(b)(5)(B)(ii) (2006).

¹⁵ HAW. REV. STAT. §§ 393-3, 393-11, 393-14 (1974).

¹⁶ *Id.* § 393-7(a).

¹⁷ *Id.* § 393-7(c).

¹⁸ *Id.* § 393-13.

¹⁹ *Id.* § 393-45(a).

²⁰ Sylvia A. Law, *Health Care in Hawai’i: An Agenda for Research and Reform*, 26 *Am. J.L. & Med.* 205, 207 (2000) (describing Hawaii’s QUEST program).

²¹ Jacobson & Braun, *supra* note 11, at 1177; Law, *supra* note 20, at 207-08.

childless adults who earn up to 100% of the FPL, enrollment is presently closed for childless adults.²² For those with family incomes above 133% of the FPL and pregnant women with incomes above 185% of the FPL, QUEST requires the payment of premiums on a sliding scale basis.²³

Beyond the PHCA and QUEST, Hawaii's Blue Cross/Blue Shield organization, the Hawaii Medical Services Association ("HMSA"), has also played a significant role in Hawaii's progress toward universal coverage.²⁴ HMSA is essentially a monopsony and has established a de facto private single payor system in Hawaii.²⁵ It is responsible for administering Medicare and provides administrative services for some Hawaiian managed care organizations and enrolls almost half of Hawaii's non-government employees.²⁶ Some scholars contend that Hawaii's low health care costs are due in part to HMSA's monopsony power.²⁷

Another angle to Hawaiian health care reform is Hawaii's focus on primary health care and its "large, strong network of community health centers."²⁸ Hawaiian health centers have proven important because they help to identify sectors of the population without health insurance and provide assistance to individuals with applying for coverage.²⁹ The health centers also lower health care costs by providing less costly preventive care to vulnerable populations and by shifting patients' reliance on care away from more costly hospital out-patient clinics and emergency rooms.³⁰

B. Hawaii's Coverage Outcomes

Since enactment of the PHCA, Hawaii's coverage outcomes have resembled a roller coaster. In the beginning, Hawaii's employer "mandate had dramatic effects . . . reducing Hawaii's uninsured population from 30% in the early 1970s to as low as 5% in the 1980s."³¹ However, there were a number of unintended negative consequences of the employer mandate, as 55% of employers restricted wage increases, 33% reduced other benefits, 40% reduced the number of employees, 10% hired part-time employees to replace full-time employees, and 60% raised prices to

²² Henry J. Kaiser Family Foundation, *Medicaid and State Funded Coverage Income Eligibility Limits for Low-Income Adults, 2009*, STATEHEALTHFACTS.ORG, n.5 (2009), <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4>.

²³ Law, *supra* note 20, at 208.

²⁴ Law, *supra* note 20, at 210 (describing HMSA's role in Hawaii's health care reform success).

²⁵ Law, *supra* note 20, at 210-11.

²⁶ Law, *supra* note 20, . at 210.

²⁷ Law, *supra* note 20, at 211.

²⁸ Law, *supra* note 20, at 209 (arguing that Hawaii's community health centers assure care and promote health insurance coverage).

²⁹ Law, *supra* note 20,

³⁰ Law, *supra* note 20, at 209-10.

³¹ Carolyn V. Juarez, *Liberty, Justice, and Insurance for All: Re-Imagining the Employment-Based Health Insurance System*, 37 U. Mich. J.L. Reform 881, 891 (2004) (describing Hawaii's employer mandate as a failed attempt at health care reform).

offset health care costs.³² Moreover, Hawaii's initial success waned by the early to mid 2000's, as the percentage of uninsured Hawaiians increased to 10% of the population and the percentage of uninsured workers or employees stood at 58%.³³ Analysts attribute the increased uninsured rate to a combination of "sharply rising insurance rates, [increased] hiring [of] part-time workers, and an increase in the number of self-employed workers."³⁴ Generally, employers shifted their workforce to a part-time workforce, and even laid off employees for a few days every four weeks in order to have them categorized as part-time employees.³⁵

The most recent statistics show a slight improvement in health care coverage rates for Hawaii, but they have still not returned to their 1980s levels. In 2008, an average of 7.8% of Hawaiian residents remained uninsured, which is the second best uninsured rate in the country behind Massachusetts.³⁶ By comparison, in 1994, Hawaii's uninsured rate was 9.4% and from 2005 to 2008, Hawaii decreased its uninsured rate by .9%.³⁷ Accordingly, Hawaii seems to be slowly making improvements in its coverage rates.

Given that Hawaii's health care reform efforts are centered upon an employer mandate, it is also important to evaluate the Hawaiian reform effort by examining its employer-based coverage statistics. Examining Hawaii in isolation from other states, the outcomes are underwhelming, as in 2007 and 2008, 58.7% of uninsured Hawaiians were part of families with at least one full-time worker ("worker families"), a surprising statistic in light of Hawaii's employer mandate.³⁸ In fact, the percentage of employer-based coverage in Hawaii increased by only .6% between 2005 and 2008.³⁹

Although Hawaii's employer-based coverage statistics are lackluster in isolation, when comparing Hawaii to other states, it has the second smallest percentage of uninsureds who are part of worker families.⁴⁰ Moreover, 85.4% of private firms in Hawaii offered health insurance to their employees in 2009, the highest of any state

³² *Id.* at 892.

³³ *Id.* at 891.

³⁴ *Id.* at 891-92.

³⁵ Law, *supra* note 20, at 212 (questioning Hawaii's health care reforms as a model for other states).

³⁶ U.S. Census Bureau, *Health Insurance Coverage Status by State for All People: 2008*, Current Population Survey (2009), http://www.census.gov/hhes/www/cpstables/032009/health/h06_000.htm.

³⁷ Robert L. Bennefield, U.S. Census Bureau, *Health Insurance Coverage – 1994*, Current Population Reports, 4 (Oct. 1995), <http://www.census.gov/prod/1/pop/p60-190.pdf>; Kaiser Family Foundation, *Percentage Point Change Among Nonelderly Adults 19-64 by Coverage Type, 2005-2008*, WWW.STATEHEALTHFACTS.ORG (2009), <http://www.statehealthfacts.org/comparable.jsp?ind=171&cat=3>.

³⁸ Kaiser Family Foundation, *Distribution of the Nonelderly Uninsured by Family Work Status, States (2007-2008), U.S. (2008)*, WWW.STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparable.jsp?ind=135&cat=3&sub=40&yr=134&typ=2>.

³⁹ Kaiser Family Foundation, *supra* note 37.

⁴⁰ Kaiser Family Foundation, *supra* note 38.

in the country by 11.3%.⁴¹ The cost of employer-based coverage in Hawaii is also among the lowest of any state, probably as a result of increased primary care, preventative care, and bargaining by employers who are required to pay for coverage.⁴²

Hawaii's employer-based coverage percentages are confusing. There is a high percentage of uninsureds who are members of worker families, and yet there is an employer mandate and Hawaii has the highest percentage of employers offering coverage in the nation. One possible answer is that the PHCA does not require employers to provide coverage for employees' dependents, which may explain why some children and unemployed or part-time working spouses may not have health care coverage, even though the full-time worker in the family does have coverage.⁴³ An alternative or additional explanation is that the PHCA allows employees to waive employer-based coverage.⁴⁴ This explains a higher than expected percentage of working uninsureds, particularly if some employees have decided that they are healthy enough to do without health insurance or that they cannot afford insurance.

Depending on the rate of unemployment, one would expect the Hawaiian employer mandate to yield a fairly low rate of Medicaid enrollees in Hawaii. The statistics are supportive to some extent, as in 2008, 12.3% of the Hawaiian population received Medicaid, the 22nd lowest rate in the nation.⁴⁵ As a result, Hawaii's health care spending is low compared to other states and the portion of its budget going toward Medicaid costs is lower than most other states.⁴⁶ Arguably, Hawaii's unique focus on employer-provided coverage should probably result in an even smaller Medicaid population. However, a somewhat larger than expected Medicaid population may be the result of economic downturns, elevated unemployment statistics, employers not providing coverage for employee dependents, employers cutting full-time jobs, employers cutting wages and/or employers shifting to a part-time workforce.

C. *The Impact of the National Health Reform Law on Hawaii*

The Senate Democratic Policy Committee ("DPC") has published a report predicting key benefits of the Reform Law for each state. In terms of overall

⁴¹ Kaiser Family Foundation, *Percent of Private Sector Establishments That Offer Health Insurance to Employees, 2009*, WWW.STATEHEALTHFACTS.ORG (2009), <http://www.statehealthfacts.org/comparemactable.jsp?ind=175&cat=3>.

⁴² Jason Burge, *Rethinking Fees and Taxes in Light of the New York City Health Care Security Act*, 61 N.Y.U. Ann. Surv. Am. L. 679, 685 (2006) (describing the cost benefits of the PHCA to employers).

⁴³ HAW. REV. STAT. §§ 393-7(b), 393-21(f) (1974).

⁴⁴ *Id.* §§ 393-7(b), 393-21.

⁴⁵ Kaiser Family Foundation, *Health Insurance Coverage of the Total Population, states (2007 - 2008), U.S. (2008)*, WWW.STATEHEALTHFACTS.ORG (2008), <http://www.statehealthfacts.org/comparetable.jsp?ind=125&cat=3>.

⁴⁶ Kaiser Family Foundation, *Health Care Expenditures Per Capita by State of Residence, 2004*, WWW.STATEHEALTHFACTS.ORG (Sept. 2007), <http://www.statehealthfacts.org/comparemactable.jsp?ind=596&cat=5>; Kaiser Family Foundation, *Distribution of State General Fund Expenditures (In Millions), SFY2008*, WWW.STATEHEALTHFACTS.ORG (2009), <http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=33&cat=1&sub=10>.

coverage, the DPC predicts that the Reform Law will provide new coverage options for 123,000 presently uninsured Hawaiians.⁴⁷ On the cost savings side, 78,200 Hawaiians will receive tax credits for health insurance premiums and average family health insurance premiums will be reduced by \$1,460 to \$2,080 a year.⁴⁸

Focusing on a more specific population, the DPC predicts that for the poorest Hawaiians, the Reform Law will expand Medicaid to cover an additional 116,666 Hawaiian residents.⁴⁹ Hawaii's poor will also benefit through additional federal funding for Hawaii's safety net in its 82 Community Health Centers.⁵⁰

Turning to Hawaiian employers, the DPC predicts that 18,000 Hawaiian small businesses will be eligible for tax credits to assist in paying for the employer's share of employee premiums.⁵¹ These 18,000 small businesses employ 75,820 Hawaii residents.⁵² Hopefully, the federal tax credits will encourage small employers to expand coverage and will stem the current movement toward hiring part-time help to avoid the mandate. Similarly, there may be optimism that the Reform Law will slow the growth rate of health care costs, resulting in possibly 1,100 to 1,800 new jobs each year in Hawaii, as businesses find it more profitable to expand employment.⁵³

Although the DPC's predictions look promising, the more important analysis is whether or how the PHCA and Reform Law will interact together to achieve near-universal coverage. One aspect of the interplay between the PHCA and the Reform Law is that the two laws create differing employer mandates. Hawaii's employer mandate covers almost all employers, whereas the Reform Law's employer mandate covers only employers with more than fifty employees and at least one full-time employee receiving a tax credit.⁵⁴ Moreover, unlike Hawaii's law, the Reform Law provides those employers with an option to either provide coverage or pay a fee per employee, excluding the first thirty employees.⁵⁵

From the employer-based coverage perspective, Hawaii's mandate is much more stringent than the federal mandate. Were the two provisions to compete, Hawaii's mandate would likely result in a higher insured rate. Fortunately, for scope of coverage purposes, the federal employer mandate does not preempt Hawaii's employer mandate, as the PPACA expressly provides that "nothing in this title . . . shall be construed to modify or limit the application of the exemption of Hawaii's Prepaid Health Care Act . . . as provided for under section 514(b)(5) of [ERISA.]"⁵⁶

⁴⁷ STAFF OF S. DEMOCRATIC POLICY COMM., 111th CONG., SPECIAL REPORT, THE BENEFITS OF HEALTH REFORM IN HAWAII I (Comm. Print 2010), http://dpc.senate.gov/docs/sr-111-2-41_states/hi.pdf.

⁴⁸ *Id.* at 3.

⁴⁹ *Id.*

⁵⁰ *Id.* at 2.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ Patient Protection and Affordable Care Act § 1513.

⁵⁵ Health Care Education and Reconciliation Act of 2010 § 1003(a).

⁵⁶ Patient Protection and Affordable Care Act § 1560(b).

Accordingly, taking the Reform Law employer mandate into consideration, Hawaii's unique and stringent employer mandate should result in Hawaii having a greater employer-based coverage rate compared to any other state.

Even though the Hawaiian carve-out is likely to lead to higher coverage rates, Hawaiian employers, concerned about bearing higher health insurance costs than other states under the Reform Law, may creatively challenge the federal Reform Law in court under an Equal Protection argument. Though they are unlikely to succeed, small employers, with 50 employees or less, may claim that they are being singled out as not exempt from the federal employer mandate when compared to small employers in other states. Moreover, all Hawaiian employers may claim that they are being unfairly burdened to provide costly coverage to employees, whereas employers in other states have the choice to pay a tax penalty instead.

Although the Reform Law's PHCA exemption is likely to result in higher employer-based coverage rates than other states, the Reform Law will yield mixed results in terms of solving some of the problems associated with the PHCA's employer mandate. On the positive side, the Reform Law provides a tax credit to small employers who provide health coverage and who have 25 or fewer employees and average annual wages of less than \$50,000.⁵⁷ This will add to the premium supplement that some Hawaiian employers already receive under the PHCA and may encourage more small employers to provide coverage to their employees and avoid searching for ways around the Hawaii employer mandate. That said, the tax credit phases out as firm size and average wages increase and, starting in 2014, only applies to a small business for the first two years that it offers coverage purchased through the health insurance exchange.⁵⁸

Mostly, the Reform Law does little to solve the PHCA's employer mandate problems. First, there is no federal fix for the problem of Hawaiian businesses hiring part-time workers or laying off workers for a few days every four weeks to avoid the state employer mandate.⁵⁹ Second, the Reform Law does not change the fact that Hawaiian employers may choose not to offer dependent care coverage. However, those plans that choose to provide dependent coverage, must allow children to remain on their parents' plans until the age of 26.⁶⁰ Third, Hawaiian employees may still waive the Hawaiian employer mandate, although they would probably be subject to the Reform Law's individual insurance mandate, discussed *infra*. Fourth, the Reform Law does nothing to remedy Hawaii's "low [employer mandate] compliance rate and poor enforcement of the employer mandate."⁶¹ Fifth, the Reform Law does not alter Hawaii's ERISA waiver to allow the state to alter and adapt the PHCA to meet changes in health care, especially rising health care costs to employers.⁶²

While the Reform Law is likely to have little direct impact on Hawaii's employer-based coverage, the Reform Law's Medicaid changes and state-based

⁵⁷ *Id.* § 1421.

⁵⁸ *Id.* § 1421(e)(2).

⁵⁹ Law, *supra* note 20, at 212.

⁶⁰ Patient Protection and Affordable Care Act § 2714(a-).

⁶¹ Jacobson & Braun, *supra* note 11, at 1177; Law, *supra* note 20, at 212-13.

⁶² Jacobson & Braun, *supra* note 11, at 1177; Burge, *supra* note 42, at 686.

Basic Health Plan option should benefit the QUEST program. Shortly after implementation, QUEST developed financial problems as enrollment was much higher than expected, state policy makers failed to increase funding for the program, and Hawaii had to cut back on QUEST eligibility and benefits packages in the 1990s, thereby excluding many low-income families from coverage.⁶³ At first glance, the Reform Law may appear to make state financial matters worse as it increases Hawaii's financial Medicaid burden by expanding Medicaid coverage to all individuals earning up to 133% of the FPL, whereas Hawaii's present Medicaid program is presently more limited and only covers childless adults, parents, the aged, blind and the disabled up to 100% of the FPL.⁶⁴ However, the cost increase concerns are offset as the Reform Law increases Hawaii's Federal Medicaid Assistance Percentage ("FMAP") to 90% by 2020 for those who become newly eligible for Medicaid under the Reform Law's Medicaid expansion.⁶⁵ This is more than 20% above the FY 2010 FMAP for Hawaii for currently eligible Medicaid recipients.⁶⁶ This increased federal funding should cover the costs of Medicaid expansion and free up state funds for Hawaii to use in sustaining QUEST and reopening QUEST enrollment for groups for which it has been closed.

More directly, QUEST may receive new federal funding under the Reform Law's Basic Health Plan option, which allows states to create a Basic Health Plan for uninsured individuals between the new Medicaid level, 133% of FPL, and 200% of the FPL.⁶⁷ The federal government will pay the states 95% of the funds that it would have paid in federal premium and cost-sharing subsidies for these Basic Health Plan enrollees, if those individuals had purchased insurance through the health insurance exchanges contemplated under the Reform Law.⁶⁸ Accordingly, if Hawaii chooses to keep QUEST as its Basic Health Plan under the Reform Law, then the state will receive an influx of federal funding for QUEST, except for QUEST enrollees between 200% and 300% of the FPL. At the same time, in compliance with the Basic Health Plan option, Hawaii must ensure that QUEST complies with the Reform Law mandates of providing coverage for certain essential health benefits, as well as ensuring that eligible individuals do not pay more in premiums than they would have paid in the exchanges or pay more than the income-based cost-sharing maximums permitted under the Reform Law.⁶⁹

⁶³ Law, *supra* note 20, at 208-09 (discussing the history of the QUEST program).

⁶⁴ Patient Protection and Affordable Care Act § 2001; KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 22; *Income Eligibility Requirements*, KAISER COMM'N ON MEDICAID AND THE UNINSURED (2009), <http://www.statehealthfacts.org/comparereport.jsp?rep=59&cat=4>.

⁶⁵ Health Care Education and Reconciliation Act of 2010 § 1201.

⁶⁶ Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2009 Through September 30, 2010, 73 Fed. Reg. 72051, 72052 (Nov. 26, 2008) (setting Hawaii's FMAP for FY 2010 at 67.97%).

⁶⁷ Patient Protection and Affordable Care Act § 1331(e)(1)(B).

⁶⁸ *Id.* § 1331(d)(3)(A)(i).

⁶⁹ *Id.* § 1331(a)(2)(A)(i).

If Hawaii is able to increase its funding of QUEST and if there is new federal funding of QUEST, then new federal funding to states under the Reform Law may also resolve critics' concerns that QUEST threatens the fiscal health of Hawaii's community health centers.⁷⁰ Ever since the implementation of QUEST, community health centers caring for QUEST patients no longer receive payment on a generous fee-for-service basis, have received curtailed state subsidies, and have faced unreasonably low capitated payments.⁷¹ The increased federal Medicaid funding may free up state funds to provide greater state subsidies, as well as fee-for-service payments to community health centers. The Reform Law also directly benefits Hawaii's community health centers by increasing federal funding to those health centers by \$11 billion from 2011 through 2015.⁷²

Also outside of the interplay between the PHCA and the Reform Law is the impact of the new federal law on HMSA in Hawaii. While HMSA has provided a number of benefits to the Hawaiian health care system, its monopsony power has also resulted in negative effects, including claims of inadequate payment to providers through the absolute power to set payment rights and the right to exclude providers from HMSA, as well as claims of HMSA's interference with providers' professional judgment through "medically necessary" provisions in insurance contracts.⁷³ There is also a concern that low hospital reimbursement from HMSA is hurting hospitals that serve rural and underserved Hawaiians.⁷⁴

Under the Reform Law, the monopsony power of HMSA will likely change with the creation, by 2014, of state-based non-profit or state run American Health Benefit Exchanges ("AHBE") for the individual purchase of insurance, and Small Business Health Options Program ("SHOP") Exchanges for small businesses with 100 employees or less to purchase insurance.⁷⁵ Starting in 2017, the Reform Law also authorizes states to allow businesses with more than 100 employees to purchase coverage through the SHOP Exchanges.⁷⁶ Moreover, the Reform Law funds a Consumer Operated and Oriented Plan ("CO-OP") program to encourage the creation of non-profit, member-run health insurance companies in each state.⁷⁷ Both the exchange-based initiatives and CO-OP program introduce buyer-side competition in Hawaii, where little currently exists in light of HMSA. With increased buyer-side competition, health care providers on the supply side will gain more bargaining power, and as a result, should be more successful in bargaining for more adequate payment rates and avoiding exclusion from insurance plans.

⁷⁰ Law, *supra* note 20, at 210 (describing the negative impact of QUEST on Hawaii's community health centers).

⁷¹ Jacobson & Braun, *supra* note 11, at 1177 (discussing cutbacks in funding and services to community health centers as a result of QUEST); Law, *supra* note 20, at 210.

⁷² Patient Protection and Affordable Care Act § 10503(b)(2).

⁷³ Law, *supra* note 20, at 211 (evaluating the positive and negative effects of HMSA on the Hawaiian health care system).

⁷⁴ *Id.* at 212.

⁷⁵ Patient Protection and Affordable Care Act §§ 1304(b)(2), 1311.

⁷⁶ *Id.* § 1312.

⁷⁷ *Id.* § 1322.

Despite the overall benefits of increased insurance provider competition, there may be negative effects as a result of the creation of exchanges in Hawaii. First, the low health care costs associated with HMSA's monopsony power may increase as health care providers gain the power to raise rates with more buyers in the system; the buyer-side rate setting monopsony power will be gone. Second, HMSA has such a stranglehold on the buyer-side of the Hawaiian health care market that it may be difficult to encourage other insurers to join the Hawaiian exchanges and encourage the creation of CO-OP plans. Potential entrants may be concerned about the difficulties of entering a market where a single competitor controls fifty percent of the market share. Matters are only made worse by Hawaii's geographic isolation. The cost of opening shop in Hawaii and moving personnel to Hawaii is likely to be much more expensive than a situation where an insurance company in Maryland decides it wants to expand operations and join Virginia's health care insurance exchanges.

Finally, in assessing the impact of the Reform Law on Hawaii's health care system, it is important to examine the option for states, starting in 2017, to apply for a five-year waiver from the Reform Law's requirements regarding qualified health plans, exchanges, cost-sharing reductions, tax credits, the individual mandate and the employer mandate.⁷⁸ States applying for a waiver must implement an alternative coverage plan that is at least as comprehensive and affordable as the minimum plan contemplated under the Reform Law, and covers as many residents as would be covered under the Reform Law.⁷⁹ For those states with high uninsured rates or those states with unaffordable health care, the waiver option might not be viable. However, Hawaii's 2008 uninsured rate of 7.8%⁸⁰ is relatively close to the 5% national uninsured rate, as predicted by the CBO under the PPACA.⁸¹ Moreover, Hawaii's health care costs are currently reasonably low compared to other states.⁸² Accordingly, Hawaii may choose to waive out of certain aspects of the Reform Law. For example, Hawaii may prefer HMSA's monopsony situation over the health exchange idea, and may decide to waive that Reform Law provision. Nonetheless, the waiver may not be as attractive as it would seem because the waiver does not

⁷⁸ *Id.* § 1332.

⁷⁹ *Id.*

⁸⁰ U.S. Census Bureau, *Health Insurance Coverage Status by State for All People: 2008*, Current Population Survey (2009), http://www.census.gov/hhes/www/cpstables/032009/health/h06_000.htm.

⁸¹ STAFF OF H. COMMS. ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUC. AND LABOR, 111th CONG., REPORT ON AFFORDABLE HEALTH CARE FOR AMERICA 1, (Comm. Print 2010), <http://docs.house.gov/energycommerce/SUMMARY.pdf>.

⁸² Kaiser Family Foundation, *Health Care Expenditures Per Capita by State of Residence, 2004*, WWW.STATEHEALTHFACTS.ORG (Sept. 2007), <http://www.statehealthfacts.org/comparemaptable.jsp?ind=596&cat=5>; Kaiser Family Foundation, *Distribution of State General Fund Expenditures (In Millions), SFY2008*, WWW.STATEHEALTHFACTS.ORG (2009), <http://www.statehealthfacts.org/comparetable.jsp?typ=2&ind=33&cat=1&sub=10>.

begin until after almost all of the Reform Law elements are already required to be implemented and it only lasts for five years.⁸³

III. MAINE

A. *The Dirigo Health Reform Act*

In the 21st century, Maine has been the trailblazer for universal health care among the states. In June 2003, Maine enacted the Dirigo Health Reform Act (the “Dirigo Act”).⁸⁴ Among the goals of the Dirigo Act was the aim to cover Maine’s 130,000 uninsured residents by 2009 through a new health plan.⁸⁵ Under the Dirigo Act, the central vehicle for achieving universal coverage is a voluntary “state-sponsored health plan administered by . . . [a single] private insurer” (“DirigoChoice”).⁸⁶ DirigoChoice is primarily directed toward encouraging small businesses to provide insurance coverage to their employees, but it also offers coverage to those who are self-employed, unemployed, or employed by a small business that does not offer health insurance.⁸⁷

DirigoChoice was originally funded through individual and employer insurance contributions, as well as an upfront payment by Maine of fifty-three million dollars.⁸⁸ The program was designed to be sustained through a savings offset payment (“SOP”) from insurers, which is “a two percent surcharge to all health care insurance gross premium revenues that exceed four percent.”⁸⁹ However, on October 1, 2009, the state legislature repealed the SOP.⁹⁰

Turning to DirigoChoice’s participation requirements, the state’s contracting insurer must qualify under Medicaid and must meet minimum coverage requirements, including ensuring that providers “do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, [or] previous

⁸³ Should a state choose to waive out of certain Reform Law provisions and be able to demonstrate comprehensive and affordable coverage results, it seems unlikely that the federal government would not allow that state to renew its waiver program after five years.

⁸⁴ ME. REV. STAT. ANN. tit. 24-A, §§ 6901-6981 (2007); Mark E. Douglas, *Finally Moving Beyond the Fiction: An Overview of the Recent State Rally for Health Care Reform*, 5 Ind. Health L. Rev. 277, 293 (2008) (outlining and evaluating Maine’s health care reform plan).

⁸⁵ Douglas, *supra* note 84, at 293.

⁸⁶ Douglas, *supra* note 84, at 293; *See also* ME. REV. STAT. ANN. tit. 24-A, §§ 6902, 6910(1) (2003); *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, 2 (2009), <http://www.dirigohealth.maine.gov/Documents/SFY%202008%20Annual%20Report%20012009.pdf>.

⁸⁷ ME. REV. STAT. ANN. tit. 24-A, § 6903(7) (2007); Jonathan M. Kucskar, *Laboratories of Democracy: Why State Health Care Experimentation Offers the Best Chance to Enact Effective Federal Health Care Reform*, 11 J. Health Care L. & Pol’y 377, 378 (2008) (describing the focus of Maine’s health insurance reform plan); Douglas, *supra* note 84, at 293.

⁸⁸ Douglas, *supra* note 84, at 293 (discussing the funding of DirigoChoice).

⁸⁹ Douglas, *supra* note 84, at 293.

⁹⁰ ME. REV. STAT. ANN. tit. 24-A, § 6913 (repealed 2009).

insurance status.”⁹¹ For small businesses enrolling in DirigoChoice, eligibility is limited to those who employ between two and fifty employees, and participating employers must “certify that at least 75% of their employees that work 30 hours or more per week and who do not have other creditable coverage are enrolled in the Dirigo Health Program.”⁹²

DirigoChoice for employers operates by small businesses choosing one of three plans to offer employees with deductibles ranging from \$1,250 to \$2,500, corresponding decreasing monthly individual premiums from \$364 to \$331 and out of pocket annual maximums of between \$3,500 and \$5,600.⁹³ Participating employers must pay at least 60% of their employees’ premium costs and the legislation authorizes Dirigo Health, the executive agency overseeing the program, to require mandatory minimum employer contributions toward coverage for dependents.⁹⁴

Similar to employers, individual and the self-employed DirigoChoice enrollees choose one of two health plans with out of pocket maximums ranging from \$3,500 to \$5,600 and one plan with a deductible of \$1,750 and a \$458 individual monthly premium and a second plan with a deductible of \$2,500 and a \$451 individual monthly premium.⁹⁵ This means, without accounting for state subsidies for low income individuals, that an individual who purchases the cheapest DirigoChoice plan and makes as little as \$30,000 annually could end up paying almost \$8,000 per year in health care costs or more than one-third of their income, if you add the premiums and deductible together.

Focusing on the lowest income Mainers, the Dirigo Act expands Medicaid “to cover all adults below 100 percent of the FPL and parents below 200 percent of the FPL.”⁹⁶ Even those who are ineligible for Medicaid, but earn less than 300% of the FPL receive lower sliding scale deductibles and premiums under DirigoChoice.⁹⁷ For example, individuals enrolling in the high deductible \$2,500 deductible plan and who fall between 100% and 149% of the FPL receive a subsidy of 80% of their monthly premiums, pay a \$500 deductible, and are subject to a \$700 annual out-of-pocket maximum.⁹⁸ This means that a person making a little under \$15,000 annually may have to pay approximately \$1,600 in annual health care costs, adding the premiums and deductible together. These subsidies phase out as income rises. However, compared with individuals making \$30,000 or more per year, these low

⁹¹ ME. REV. STAT. ANN, tit. 24-A, § 6910(3).

⁹² ME. REV. STAT. ANN, tit. 24-A, §§ 6903(5), 6910(4)(B)(4); *see also Dirigo Health’s FAQ’s*, DIRIGO HEALTH AGENCY, <http://www.dirigohealth.maine.gov/Pages/faq.html> (last visited Sept. 28, 2010).

⁹³ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 25-28.

⁹⁴ ME. REV. STAT. ANN, tit. 24-A, § 6910(4)(B)(3).

⁹⁵ *Id.*

⁹⁶ Karen Davis & Christine Haran, *Innovative State and Federal Initiatives to Cover the Uninsured and Increase Access to Care*, 19 Health Law. 1, 3 (June, 2007) (describing Maine’s efforts to provide coverage for low income individuals).

⁹⁷ *Id.*

⁹⁸ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 25.

income individuals receive a better bargain, as the former pays more than one third of their income toward health care costs and the latter pays a little more than 10% of their income toward health care costs.

Since the initial enactment of the Dirigo Act, Maine has tweaked the legislation in three ways. First, in 2007, the Maine legislature amended the Dirigo Act to allow Dirigo Health to self-administer DirigoChoice, instead of contracting with a private insurance carrier.⁹⁹ Prior to this amendment, some had criticized the Dirigo Act for increasing government bureaucracy and administrative costs by having two layers to the program, a private insurer layer and a Dirigo Health layer.¹⁰⁰ Second, Maine enacted a requirement that insurance companies allow insureds to insure their dependent children up to the age of 25.¹⁰¹ Third, the Maine legislature amended the Dirigo Act to include a reinsurance program in order to lower premiums in the individual market.¹⁰²

B. Maine's Coverage Outcomes

Since the beginning of DirigoChoice in 2003, plan enrollment has been less than spectacular. As of February 2010, DirigoChoice had only enrolled a little under 31,000 of Maine's 130,000 uninsured residents.¹⁰³ Moreover, noting that one of the goals of DirigoChoice was to cover the previously uninsured, as of 2008, only 36% of DirigoChoice individual members were previously uninsured.¹⁰⁴

Though the voluntariness and high buyer-side costs of DirigoChoice contribute to low enrollment, as discussed *infra*, to some extent the tepid enrollment statistics are self-imposed by Maine to fight high costs. Since September 2007, Dirigo Health has capped enrollment in DirigoChoice as a way to manage the high costs of DirigoChoice to the state.¹⁰⁵ In fact, as of the last DirigoChoice annual report in 2008, there were 2,000 Maine residents on the waiting list to enroll.¹⁰⁶ The high costs to the state arise from the high level of DirigoChoice subsidies. As of February 2010, 83% of those enrolled in DirigoChoice were eligible for state subsidies, and 50% of enrollees fell below 150% of the FPL, thereby receiving state subsidies of 80% of their monthly premiums.¹⁰⁷ A robust small employer-based health coverage system has yet to materialize in Maine, and the state has been forced to bear the bulk

⁹⁹ ME. REV. STAT. ANN, tit. 24-A, § 6981.

¹⁰⁰ Kucskar, *supra* note 87, at 401 (describing negative side effects of Maine's state health care reform).

¹⁰¹ ME. REV. STAT. ANN, tit. 24-A, § 2742-B(2).

¹⁰² *States Moving Toward Comprehensive Health Care Reform*, KAISER COMM'N ON MEDICAID AND THE UNINSURED (2008), <http://www.kff.org/uninsured/statehealthreform/me.cfm>.

¹⁰³ *Dirigo Health Monthly Numbers February 2010*, DIRIGO HEALTH AGENCY, 1 (March 4, 2010), http://www.dirigohealth.maine.gov/Documents/Numbers_February10.pdf.

¹⁰⁴ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 32.

¹⁰⁵ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 2, 4.

¹⁰⁶ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 2.

¹⁰⁷ *Dirigo Health Monthly Numbers February 2010*, DIRIGO HEALTH AGENCY, *supra* note 103.

of the funding burden of health care reform through individual subsidies, which it simply cannot afford.

In terms of overall coverage statistics, in 2002, the last pre-DirigoChoice year, Maine's uninsured rate was 11.3%,¹⁰⁸ whereas in 2008 the uninsured rate had dropped to only 10.4%.¹⁰⁹ In six years, Maine had increased the total number of covered residents by a mere 57,000 people, not even halfway towards its goal of universal coverage.¹¹⁰ Nonetheless, in 2008, Maine's uninsured rate was impressively the 11th lowest in the country.¹¹¹

While Maine may be performing above average in terms of overall coverage rates, its employment-based coverage statistics are more troubling. In 2008, 71.2% of those who were uninsured were employed, which is the 11th worst rate in the nation.¹¹² In other words, almost three-quarters of Maine's uninsured population are employed. Given that the DirigoChoice program focuses on small employers providing coverage, the percentage of full-time working uninsured residents is not what would be expected if the program were a great success.

In light of the percentage of working uninsured Maine residents, it is no surprise that within the DirigoChoice program, as of February 2010, only 29% of the members purchasing DirigoChoice were small group employers, with 44% being individuals and 27% being sole proprietors.¹¹³ Only 46% of those DirigoChoice employer purchasers had previously offered no insurance to their employees.¹¹⁴ In other words, more than half of the employers purchasing DirigoChoice have been merely switching from another insurance provider to DirigoChoice.

Outside of DirigoChoice, small employer purchasers the story is similar. In 2009, only 41.8% of Maine employers with fewer than 50 employees provided insurance coverage to their employees.¹¹⁵ Moreover, among private sector employers of all sizes, from 2008 through 2009, the percentage of Vermont

¹⁰⁸ *Health Insurance Coverage Status by State for All People: 2002*, U.S. CENSUS BUREAU (2003), http://pubdb3.census.gov/macro/032003/health/h06_000.htm.

¹⁰⁹ *Health Insurance Coverage by Status by State for All People: 2008*, U.S. CENSUS BUREAU, *supra* note 36.

¹¹⁰ *Compare Health Insurance Coverage Status by State for All People: 2002*, U.S. CENSUS BUREAU (2003), http://pubdb3.census.gov/macro/032003/health/h06_000.htm with *Health Insurance Coverage by Status by State for All People: 2008*, U.S. CENSUS BUREAU, *supra* note 36.

¹¹¹ *Health Insurance Coverage by Status by State for All People: 2008*, U.S. CENSUS BUREAU, *supra* note 36.

¹¹² URBAN INST. AND KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 38.

¹¹³ *Dirigo Health Monthly Numbers February 2010*, DIRIGO HEALTH AGENCY, *supra* note 103.

¹¹⁴ *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 32.

¹¹⁵ Kaiser Family Foundation, *Percent of Private Sector Establishments That Offer Health Insurance To Employees, by Firm Size, 2009*, <http://www.statehealthfacts.kff.org/profileind.jsp?ind=176&cat=3&rgn=21> (last visited Sept. 29, 2010).

nonelderly adult residents receiving employment-based coverage actually decreased by 2.8%.¹¹⁶

Corresponding to Maine's relatively unimpressive employment-based coverage rates is Maine's ranking as the state with the 3rd highest rate of Medicaid enrollment, with 27% of Maine residents receiving Medicaid in 2007.¹¹⁷ Although this percentage merely verifies that Maine intentionally expanded its Medicaid program through the Dirigo Act to expand coverage to the poor, it also demonstrates that almost 1/5 of Maine's population has an income below 200% of the FPL, and that employers are not stepping up to the plate to provide insurance for those Medicaid residents who are employed.

C. *The Impact of the National Health Reform Law on Maine*

The DPC's report on the benefits of the Reform Law for Maine predicts that the new law will provide new coverage options for 135,000 presently uninsured Mainers.¹¹⁸ On the financial side of health care coverage, 99,100 Mainers will receive tax credits for health insurance premiums and average family health insurance premiums will be reduced by \$1,730 to \$2,470 a year.¹¹⁹ These coverage and financial predictions for Maine are somewhat similar to the predictions for Hawaii under the Reform Law, which is expected, given that Maine and Hawaii have very similar population sizes, with Maine being slightly larger in population.¹²⁰ Still, Maine's coverage scenario is likely to improve more than Hawaii's under the new federal law and Mainers' health care costs are predicted to decrease substantially more than Hawaiians' health care costs under the Reform Law. The greater improvement in coverage for Maine may be because Hawaii's existing uninsured rate is already fairly impressive compared to Maine's rate, so there is less room for improvement in Hawaii. Similarly, in terms of costs, Hawaii has already reaped whatever cost savings result from having an employer mandate, whereas the Reform Law's "pay or play" employer mandate is new to Maine. Moreover, some of Maine's predicted greater costs savings may be due to the fact that Hawaiians already enjoy substantial cost savings through HMSA's monopsony powers, whereas Maine does not have a similar monopsony situation.

¹¹⁶ Kaiser Family Foundation, *Percentage Point Change Amount Nonelderly Adults 19-64 by Coverage Type, 2008-2009*, <http://www.statehealthfacts.org/comparetable.jsp?ind=172&cat=3> (last visited Sept. 29, 2010).

¹¹⁷ Kaiser Family Foundation, *Medicaid Enrollment as a Percentage of Total Population, 2007*, <http://www.statehealthfacts.org/comparemtable.jsp?ind=199&cat=4> (last visited Sept. 29, 2010).

¹¹⁸ STAFF OF S. ON THE DEMOCRATIC POLICY COMM., 111TH CONG., REP. ON THE BENEFITS OF HEALTH REFORM IN MAINE 1 (Comm. Print 2010), http://dpc.senate.gov/docs/sr-111-2-41_states/me.pdf. Most likely, the difference between the number of uninsured Mainers identified by the DPC and the number of uninsured Mainers identified *infra* is the result of different dates or methods of measuring the number of uninsured Mainers.

¹¹⁹ *Id.* at 2.

¹²⁰ U.S. CENSUS BUREAU, ANNUAL ESTIMATES OF THE RESIDENT POPULATION FOR THE UNITED STATES, REGIONS, STATES, AND PUERTO RICO: APRIL 1, 2000 TO JULY 1, 2009 (2009), <http://www.census.gov/popest/states/NST-ann-est.html> (follow the "Excel" or the "CSV" hyperlink).

Turning to Maine's poor population, the DPC anticipates that the Reform Law will expand Medicaid to cover an additional 54,707 residents.¹²¹ This is less than half of the predicted new Medicaid eligible Hawaiians under the Reform Law. Most likely, this difference is due to the Dirigo Act's existing Medicaid reforms being more generous and expanding Medicaid coverage more than Hawaii's QUEST program, particularly given that Hawaii has closed off Medicaid enrollment to certain groups. Accordingly, Hawaii would be expected to experience greater Medicaid coverage expansion under the Reform Law.

Since DirigoChoice focuses on small business-based insurance coverage, it is important to look at the DPC's predictions regarding changes for Maine employer-based coverage under the Reform Law. Presently, only 45.6% of Maine small businesses are able to offer health insurance coverage to their employees, a statistic which does not shine favorably on the success of DirigoChoice in encouraging small businesses to provide coverage.¹²² Under the Reform Law, the DPC predicts that 25,804 Maine small businesses employing 92,600 Mainers will be eligible for tax credits to assist in paying for the employer's share of employee health insurance.¹²³ These new federal tax credits may improve the incentives for Maine small businesses to provide coverage to their employees.

Beyond the DPC's general predictions and honing in on the interplay between the provisions of the Reform Law and those of the Dirigo Act, one of the most striking differences between the two is the contrast between the Reform Law's health insurance exchange concept and the DirigoChoice single-payer government run insurer concept. The Reform Law does not provide for a public option plan, but instead primarily relies upon state-based insurance exchanges to offer coverage to individuals and small businesses.¹²⁴ The closest the Reform Law comes to a public option is the state-based Basic Health Plan option for low income individuals, discussed *supra*, and the requirement that the Office of Personnel Management contract with insurers to offer at least two multi-state plans in each exchange, one of which must be offered by a non-profit entity.¹²⁵ In other words, DirigoChoice and the Reform Law's respective approaches to providing coverage to individuals and small businesses are fundamentally different. Accordingly, Maine probably has two choices for DirigoChoice under the Reform Law: 1) alter DirigoChoice to fit the requirements of the Reform Law state-based Basic Health Plan option, or 2) alter DirigoChoice to fit within one or both of the state exchanges.

If DirigoChoice becomes Maine's Basic Health Plan, then it would receive an influx of federal funding under that option, but would also have to meet the essential benefit and the maximum cost requirements for insureds under the Reform Law's Basic Health Plan option, and would no longer provide coverage to those with incomes between 201% and 300% of the FPL. Under this scenario, DirigoChoice's financial situation should improve, but the scope of coverage would be restricted to

¹²¹ STAFF OF S. DEMOCRATIC POLICY COMM., *supra* note 118, at 3.

¹²² *See supra* note 117, at 2.

¹²³ *See supra* note 117, at 2.

¹²⁴ Patient Protection and Affordable Care Act §§ 1304, 1311.

¹²⁵ *Id.* at §§1331, 1334.

those earning less than 200% of the FPL, whereas DirigoChoice presently applies to those earning up to 300% of the FPL.

Alternatively, if DirigoChoice chooses to join the Maine exchanges, then it may be forced to make some modifications to meet the Reform Law exchange requirements. Most significantly, DirigoChoice would have to sell coverage to small businesses with up to 100 employees, whereas DirigoChoice presently only offers coverage to small businesses with between 2 and 50 employees.¹²⁶ Of course, this alteration expands the scope of coverage, but because of that expansion, it also increases the costs of DirigoChoice to the state.

Separate and apart from changes brought on by the Reform Law's insurance exchange concept, concerns arise regarding application of the Reform Law's "pay or play" employer mandate to Maine's voluntary DirigoChoice program. The Reform Law's employer mandate fails to remedy the problems posed by the interconnected issues of DirigoChoice's voluntariness and the perceived high buyer-side costs of DirigoChoice. Under Maine's current system, "small businesses and individuals have complained that the [DirigoChoice buyer-side] costs remain too high."¹²⁷ Many business owners claim that the cost to purchase DirigoChoice for employees is more expensive than purchasing private health insurance for their employees.¹²⁸ Moreover, the buyer-side costs continue to increase, as in January 2010, the small employer monthly premium rates were expected to increase by 8.4% from the previous year and the individual monthly premium rates were expected to increase by 8.1% from the previous year.¹²⁹

These high buyer-side costs combine with the voluntariness of DirigoChoice to create a problem of low enrollment and high dropout.¹³⁰ Dirigo Health projected, based on anticipated premium rate increases, that a number of DirigoChoice members will terminate their coverage in 2010.¹³¹ As recently as 2008, 15% of members were dropping coverage at the end of the year instead of renewing coverage.¹³² The high buyer-side costs have consistently proven to be a problem for Maine in voluntarily recruiting small businesses to participate in DirigoChoice.¹³³

Even though the Reform Law imposes a "pay or play" employer mandate with a tax penalty opt out, it exempts employers with 50 or fewer employees, the precise small employer target for DirigoChoice.¹³⁴ Accordingly, the Reform Law's "pay or

¹²⁶ *Id.* at §§ 1304, 1311.

¹²⁷ Douglas, *supra* note 84, at 294 (describing obstacles face by DirigoChoice since its implementation).

¹²⁸ Kucskar, *supra* note 87, at 399 (discussing the negative impacts of DirigoChoice as a voluntary health care reform system).

¹²⁹ DIRIGO HEALTH AGENCY, BD. OF TRS., MEETING MINUTES 1 (2009), http://www.dirigo.health.maine.gov/Documents/DHA%20Final%20BOT%20meeting%20minutes%20for%2011-16-09%20_2_.pdf.

¹³⁰ Jacobson & Braun, *supra* note 11, at 1187 (summarizing Maine's legislative health care reform effort).

¹³¹ DIRIGO HEALTH AGENCY, BD. OF TRS., MEETING MINUTES 1, *supra* note 129, at 1.

¹³² *Annual Report State Fiscal Year 2008*, DIRIGO HEALTH AGENCY, *supra* note 86, at 32.

¹³³ Douglas, *supra* note 84, at 294; Kucskar, *supra* note 87, at 379.

¹³⁴ Patient Protection and Affordable Care Act §1513.

play” employer mandate does not solve the DirigoChoice voluntariness problems with regard to improving small business enrollment.

Unlike the Reform Law’s employer mandate, its “pay or play” individual mandate should remedy enrollment problems with regard to DirigoChoice individual purchasers. The Reform Law’s individual mandate requires all United States citizens to either obtain coverage, or pay a tax penalty of the greater of \$695 per year up to a maximum of three times that amount per family or 2.5% of the individual’s household income.¹³⁵ Some individuals are exempt from the mandate; most notably those with financial hardships, those for whom the lowest cost plan option exceeds 8% of an individual’s income and those with incomes below the tax filing threshold.¹³⁶ However, these exemptions are limited to a small population and most Maine individual purchasers without employer-based, Medicaid or Medicare insurance will have to choose between paying a penalty and receiving no health insurance, or obtaining health insurance. Under the Reform Law, no longer will most Maine individual purchasers be able to avoid purchasing coverage because costs are too high or because they would “rather risk it.” Therefore, the Reform Law’s individual mandate will most definitely increase enrollment in a program like DirigoChoice.

Having demonstrated that the Reform Law yields mixed results on the voluntariness problems of DirigoChoice, the next issue is how the Reform Law deals with the high buyer-side costs for individuals and small businesses under DirigoChoice. The DirigoChoice buyer-side costs or premiums are high for small businesses because of the “high rate of [state] subsidies for low-income individuals.”¹³⁷ As a result of the subsidy costs to the state, DirigoChoice has been unable to offer lower premium rates to small businesses.¹³⁸ Ironically, if more small businesses enrolled in DirigoChoice, then the premiums would actually decrease.¹³⁹

The Reform Law assists small employers with high buyer-side costs by providing a tax credit to the employer tied to the employer’s contribution toward employees’ premiums.¹⁴⁰ Subject to the caveats discussed *supra* under the Hawaii experience, the structure of the tax credit varies over time, is temporary and phases out as firm size and average annual wages for the firm increase.¹⁴¹ However, until the temporary tax credit period ends, the tax credit increases over time, starting at 35% of the employer’s contribution toward the premium and maxing out at 50% of the employer’s contribution.¹⁴²

In the short term, for small employers with 25 employees or less, the Reform Law is a boon. Under DirigoChoice, Maine does not provide these employers with any sort of benefit or assistance to provide coverage. The Reform Law, at least

¹³⁵ Patient Protection and Affordable Care Act §5000a (2010).

¹³⁶ *Id.*

¹³⁷ Kucskar, *supra* note 87, at 399.

¹³⁸ *See supra* note 87, at 399.

¹³⁹ *See supra* note 87, at 399.

¹⁴⁰ The Patient Protection and Affordable Care Act § 1421.

¹⁴¹ *Id.*

¹⁴² *Id.*

temporarily, provides these employers with a substantial tax credit, creating a greater incentive for them to purchase coverage for their employees. However, these small employers may not choose to remain in the market after the tax credit disappears. Still, as discussed *supra*, once more employers enter into the insurance market, the costs of purchasing go down, as a result of risk spreading. Accordingly, even after the tax credits expire, small business may find it financially acceptable to remain in a market with such decreased costs.

Moving from the employer purchasers to individual purchasers, a major buyer-side cost saving provision is that the Reform Law requires that out of pocket limits be no higher than the federal limits on Health Savings Accounts,¹⁴³ which are currently \$5,950 for individuals and \$11,900 for families.¹⁴⁴ Moreover, under the Reform Law low income individuals with incomes between 100% and 400% of the FPL will have annual out of pocket limits between \$1,983 and \$3,987 depending on where they stand in relation to the FPL.¹⁴⁵ They will also receive sliding scale cost-sharing subsidies, such that those with incomes of 100% to 150% of the FPL will pay no more than 6% of their health care costs and those with incomes of 250% to 400% of the FPL will pay no more than 30% of their health care costs.¹⁴⁶ Individuals and families with incomes between 100% and 400% of the FPL will also receive premium credits to purchase insurance through the exchanges.¹⁴⁷ The premium tax credits will be tied to the second cheapest plan in the exchange, the Silver plan, and will be set on a sliding scale such that those with incomes from 100% to 150% of the FPL will pay no more than 2% to 4% of their income toward premiums and individuals with incomes from 300% to 400% of the FPL will pay no more than 9.5% of their income toward premiums.¹⁴⁸

Looking at individual purchasers regardless of income, the Reform Law maximum individual deductible is slightly smaller than that of DirigoChoice, while the Reform Law individual out of pocket limits are slightly larger than those of DirigoChoice; the two cancel each other out. At this stage it is unknown what the premiums will be like under the Reform Law in Maine versus what they are now under DirigoChoice, so it is impossible to compare the two in terms of cost savings. Therefore, taking into account only the known cost savings, the Reform Law does not bring about significant health care cost reductions for Maine individual purchasers. Nonetheless, as a result of the improved risk spreading under the federal individual mandate, individual insurance costs should become more attractive to purchasers anyway.

Compared with individual purchasers in general, lower income Maine individual purchasers benefit more from the Reform Law. First, the various Reform Law

¹⁴³ *Id.* §1302(c); IRC § 223(c)(2)(A)(ii).

¹⁴⁴ IRS Publication 969.

¹⁴⁵ PPACA §1402. *See also* The Lewin Group, Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers, June 8, 2010 at 13(calculating the actual out-of-pocket limits using the percentage reductions contained within §1402).

¹⁴⁶ PPACA §1402; HCEARA §1001(b).

¹⁴⁷ PPACA §1401.

¹⁴⁸ *Id.*; HCEARA §1001(a).

buyer-side subsidies extend to those making up to 400% of the FPL, whereas the DirigoChoice subsidies only extend to those making up to 300% of the FPL. Second, the cost sharing subsidy under the federal law is drastically more generous than the one under DirigoChoice. On the downside, the Reform Law does not treat maximum deductibles for low income individual purchasers any different than deductibles for higher income individual purchasers. In fact, compared to DirigoChoice maximum deductibles for the wealthiest of low income individual purchasers, the Reform Law allows maximum deductibles \$1,000 higher. Moreover, there is little difference between the out of pocket limits for lower income individual purchasers under DirigoChoice and lower income individual purchasers under the Reform Law. Still, the fact that more low income Mainers receive various subsidies under the Reform Law and receive better cost sharing subsidies makes the Reform Law an overall improvement for lower income Maine individual purchasers.

IV. VERMONT

A. *The Health Care Affordability Act*

In May 2006, Vermont enacted the Health Care Affordability Act (“HCAA”) and began its journey toward universal coverage.¹⁴⁹ Following Maine and joining Massachusetts, Vermont’s HCAA is one of only three existing state statutes, which fully commits the state to universal health care access. The HCAA expressly provides that “[i]t is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.”¹⁵⁰ More specifically, the HCAA aims to achieve universal coverage by guaranteeing a minimum level of preventive service to Vermont residents and by reducing chronic care costs and applying those savings towards covering the state’s uninsured residents.¹⁵¹

There are three major provisions of the HCAA that promote the goal of universal coverage: 1) A standard health care plan available to all uninsured residents; 2) Premium assistance to poor employed residents to purchase employer-sponsored health insurance; and 3) A “pay or play” provision requiring employers to provide health insurance coverage to employees or pay a state assessment.¹⁵² Of the provisions, the primary vehicle for HCAA’s universal coverage goal is Catamount Health (“Catamount”), “a voluntary universal plan to control rising costs and help cover 69,000 uninsured citizens.”¹⁵³ Although participation in Catamount is presently voluntary, if more than 4% of Vermont residents remain uninsured by the end of 2010, Vermont will consider mandating enrollment in Catamount.¹⁵⁴

¹⁴⁹ Vermont Health Care Affordability Act, No. 191 (2006).

¹⁵⁰ *Id.*

¹⁵¹ Kucskar, *supra* note 87, at 392 (describing the legislative objectives of the HCAA).

¹⁵² Kaiser Family Foundation, *Vermont Health Care Reform Plan*, 1 (Dec. 2007) <http://www.kff.org/uninsured/upload/7723.pdf>.

¹⁵³ Douglas, *supra* note 84, at 294 (describing the structure of Catamount).

¹⁵⁴ VT. STAT. ANN. tit. 2, § 902(a)(3)(D) (2006).

Catamount is administered by three private insurers and available to any uninsured state resident.¹⁵⁵ For those Vermont residents with incomes at or below 300% of the FPL, Catamount provides sliding-scale insurance subsidies based on income level.¹⁵⁶ For example, in the year 2008, the individual contribution for the lowest cost Catamount plan was capped at \$60 per month for those at 200% of the FPL or less and \$135 per month for those at 300% of the FPL or less.¹⁵⁷ The individual contribution changes from year to year based on the growth in overall spending per Catamount enrollee.¹⁵⁸ Even uninsured residents whose income is above 300% FPL can participate in Catamount by paying the actual cost of the plan, which is a monthly premium of \$393 per individual or \$1,100 per family.¹⁵⁹

Along with premium costs, other costs to Catamount enrollees include: 1) A \$250.00 in-network individual deductible, a \$500.00 in-network family deductible, a \$500.00 out-of-network individual deductible and a \$1,000.00 out-of-network family deductible; 2) 20% co-insurance payments; 3) \$10 office co-payments; 4) Prescription drug coverage without a deductible, \$10 co-payments for generic drugs, \$30 co-payments for preferred drugs and \$50 co-payments for nonpreferred drugs; and 5) \$800 individual in-network out-of-pocket maximums, \$1,600 family in-network out-of-pocket maximums, \$1,500 individual out-of-network out-of-pocket maximums and \$3,000 family out-of-network out-of-pocket maximums.¹⁶⁰ Notably, Catamount enrollees do not pay any deductible for chronic care or preventive care.¹⁶¹

Unlike commercial insurers, Catamount insurers are prohibited from limiting or altering coverage on the basis of a number of risk factors, including age, gender, geographic area, and experience rating.¹⁶² Moreover, Catamount insurers must use a community rating method to determine premiums.¹⁶³ However, the HCAA imposes other limits on coverage. First, the definition of “uninsured” under the HCAA does not include those who are eligible for Medicare, Medicaid, or two other state medical insurance programs.¹⁶⁴ Second, the term “uninsured” also excludes those who have had private or employer-sponsored insurance within the 12 month period before the date of application for Catamount.¹⁶⁵ Third, the HCAA also contains a specific eligibility exclusion for applicants who are eligible for employer-sponsored

¹⁵⁵ *Id.* at tit. 8, § 4080f (b), (d)(1). *See also* Brent R. Trame, *Going Dutch: Can Holland Solve the U.S. Insurance Problem?*, 16 *Elder L.J.* 445, 469 (2009) (discussing how Catamount assists the elderly).

¹⁵⁶ VT. STAT. ANN. tit. 33, § 1984 (2006).

¹⁵⁷ *Id.* § 1984(c).

¹⁵⁸ *Id.* § 1984(b).

¹⁵⁹ *Id.* § 1984(c)(1)(G); Kaiser Family Foundation, *supra* note 152, at 1.

¹⁶⁰ VT. STAT. ANN. tit. 8, § 4080f (c)(1) (2006).

¹⁶¹ *Id.* § 4080f (c)(1)(F).

¹⁶² *Id.* § 4080f (j).

¹⁶³ *Id.*

¹⁶⁴ *Id.* § 4080f (a)(9).

¹⁶⁵ *Id.*

insurance, except for certain circumstances involving individuals who are eligible for employer-sponsored insurance and have an income of 300% of the FPL or less.¹⁶⁶

Beyond the statutory Catamount coverage limitations, Catamount insurers may also apply preexisting condition limitations on coverage.¹⁶⁷ For those without proof of creditable coverage, insurers may limit coverage of preexisting conditions, which existed during the 12-month period prior to the application date, with the exception of enrollees in a chronic care management program and pregnant women (“12-month exclusion”).¹⁶⁸ Additional exceptions to preexisting condition exclusions include subscribers who applied to Catamount before November 1, 2008, and applicants who were previously “insured in the nongroup market, lost his or her employment, terminated insurance coverage, and had no other private insurance or employer-sponsored coverage . . . for the 12 months preceding his or her application.”¹⁶⁹

Despite the option for Catamount insurers to impose certain coverage limitations, Catamount insurers are required to cover a broad array of health care services. The HCAA expressly provides that “Catamount Health shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services.”¹⁷⁰ Focusing specifically on chronic care, the HCAA requires Catamount insurers to provide a chronic care management program that focuses on coordinating care for patients with chronic conditions, increasing communications between health care providers and patients, and patient self-management, education, wellness, and follow-up.¹⁷¹

Along with Catamount, there are two other HCAA provisions directed toward universal coverage. First, the HCAA provides premium subsidies to employed individuals with incomes less than 300% of the poverty level to purchase employer-sponsored insurance, if it is more cost-effective than having those individuals enroll in Catamount or Vermont’s Medicaid program.¹⁷² Under this provision, if the employee is eligible for the Vermont Health Access Plan, then his or her maximum premium is limited to no more than \$49 per month, depending on the person’s income.¹⁷³ Otherwise, the premium level ranges from \$60 per month to \$185 per month, depending on the person’s income.¹⁷⁴ Second, the HCAA contains a “pay or play” provision, which requires employers with five or more employees to either provide coverage to their full-time employees or pay a contribution per year per

¹⁶⁶ *Id.* § 4080f (d)(1)-(2).

¹⁶⁷ *Id.* § 4080f(e).

¹⁶⁸ *Id.* § 4080f(e)(1).

¹⁶⁹ *Id.* § 4080f(e)(2)-(3).

¹⁷⁰ *Id.* § 4080f(c)(1).

¹⁷¹ *Id.* § 4080f (c)(2); VT. STAT. ANN. tit. 33, § 1903a(c) (2010).

¹⁷² VT. STAT. ANN. tit. 33, § 1974(a)-(b) (2010).

¹⁷³ GREEN MOUNTAIN CARE, GREEN MOUNTAIN CARE PROGRAMS, http://www.greenmountaincare.org/about/green_mountain_care_programs.html.

¹⁷⁴ VT. STAT. ANN. tit. 33, § 1974(j); GREEN MOUNTAIN CARE, GREEN MOUNTAIN CARE PROGRAMS, http://www.greenmountaincare.org/about/green_mountain_care_programs.html.

uncovered employee to the state.¹⁷⁵ The state assessment increases annually at a rate corresponding to Catamount's premium growth.¹⁷⁶

B. Vermont's Coverage Outcomes

Catamount went into effect on October 1, 2007.¹⁷⁷ Following implementation of Catamount, Vermont's coverage results are mixed. However, Catamount has only had a little over two years to produce increased health care coverage results, and is therefore, still in its infancy. Moreover, big changes may not be expected, as at the time of Catamount's implementation, Vermont already had a low rate of uninsured residents, low rate of uninsured children, and one of the lowest poverty rates in the nation.¹⁷⁸

Catamount's enrollment numbers started out slow, as approximately only 700 individuals enrolled during the first year.¹⁷⁹ However, by July 2009, around 9,500 had enrolled in Catamount, and enrollment in all of Vermont's various state sponsored health care coverage programs had increased by over 23,000.¹⁸⁰ Though a 23,000 increase is promising, there must also be a significant increase in employment-based coverage for Vermont to meet its future goal of a 96% coverage rate and coverage for an additional 69,000 residents by the end of 2010. This may in fact be what is happening. In 2007, which was mostly a pre-Catamount year, 88.8% of Vermont residents had some sort of health insurance coverage, whereas in 2008, that percentage had increased to 90.8%.¹⁸¹ Assuming this rate of increase rises in 2009 and 2010, Vermont is on target to achieve its goal of 96% coverage by the end of 2010. This is hardly an impossible goal, as in 2008, Vermont already had the fourth highest percentage of residents with health insurance coverage in the country.¹⁸²

Turning to coverage statistics for employment-based coverage, Vermont, through its "pay or play" provision, encourages employers to share the burden of providing coverage to Vermonters, most likely with the hope that the state budget does not bear the full brunt of coverage costs. Unfortunately, the statistics on employer-based coverage do not reflect such success. In 2007 and 2008, 74.3% of uninsured

¹⁷⁵ See VT. STAT. ANN. tit. 21, § 2003(a)-(b) (2010).

¹⁷⁶ *Id.* § 2003(b).

¹⁷⁷ VT. STAT. ANN. tit. 8, § 4080f(1) (2010).

¹⁷⁸ David Pratt, *The Past, Present, and Future of Health Care Reform: Can It Happen?*, 40 J. MARSHALL L. REV. 767, 802 (2007) (predicting ease of success for Catamount's reforms).

¹⁷⁹ Douglas, *supra* note 84, at 295 (describing the early coverage results of Catamount).

¹⁸⁰ Susan Besio, *Update on Vermont Health Care Reform*, STATE COVERAGE INITIATIVES, slide 4 (July 2009), <http://www.statecoverage.org/node/1962> (follow the "Update on Vermont Health Care Reform" hyperlink).

¹⁸¹ Insurance Coverage Status by State for All People in 2007. The correct citation is: *Compare Current Population Survey: Health Insurance Coverage Status by State for All People in 2007*, U.S. CENSUS BUREAU, 2008 ANN. AND SOC. ECON. SUPPLEMENT (2008), Table H106, available at http://www.census.gov/hhes/www/macro/032008/health/h06_000.htm, with U.S. CENSUS BUREAU, *supra* note 36.

¹⁸² U.S. CENSUS BUREAU, *supra* note 36.

Vermont residents were employed full-time, which is the fifth worst rate in the country.¹⁸³

The private sector in Vermont is clearly not taking an active role in providing health care coverage. In 2009, only 56.4% of firms in Vermont offered health insurance to their employees, the 16th highest rate of employment-based coverage in the United States.¹⁸⁴ Moreover, employment-based coverage for Vermont nonelderly adult residents increased by only 1.1% from 2007 to 2008.¹⁸⁵ Looking at the issue from a different angle, in the first year of the “pay or play” program, 1,000 employers chose to pay the assessment fee instead of providing coverage.¹⁸⁶ On the public sector side of the scale, from 2007 to 2008, 19.2% of Vermont’s population was enrolled in Medicaid, the fifth highest in the country.¹⁸⁷ Given these statistics, the HCAA has yet to demonstrate much success in encouraging employers to provide more coverage to employees.

C. *The Impact of the National Health Reform Law on Vermont*

The DPC’s report on the benefits of the Reform Law for Vermont predicts that the Reform Law will provide new coverage options for 74,000 presently uninsured Vermont residents.¹⁸⁸ This number is a little more than half of the number for Maine and Hawaii’s similar statistical category, which makes sense given that Vermont is about half of the population size of Maine and Hawaii.¹⁸⁹ In terms of health care financial assistance, the Reform Law will provide 52,800 Vermonters with tax credits for health insurance premiums and will reduce the average Vermont family health insurance premiums by \$1,690 to \$2,410 a year.¹⁹⁰ Given their respective population sizes, the former statistic is proportionally in line with Maine’s numbers and the latter statistic represents similar savings for the two states.

Focusing on Vermont’s poor, the DPC does not provide statistics for the anticipated number of new Vermont Medicaid enrollees under the Reform Law, but the report states that Vermont’s Medicaid program will receive \$420 million in new federal funding.¹⁹¹ Given that Vermont has the fifth highest percentage population

¹⁸³ URBAN INST. AND KAISER COMM’N ON MEDICAID AND THE UNINSURED, *supra* note 38.

¹⁸⁴ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, *supra* note 41.

¹⁸⁵ URBAN INST. AND KAISER COMM’N ON MEDICAID AND THE UNINSURED, *supra* note 116.

¹⁸⁶ Patricia A. Butler, *Including Employer Financing in State Health Reform Initiatives: Implications of Recent Court Decisions*, NAT’L ACAD. FOR STATE HEALTH POLICY, 3 (Jan. 2009), <http://www.nashp.org/sites/default/files/Jan%202009%20ERISA%20Update%20FINAL.pdf>.

¹⁸⁷ URBAN INST. AND KAISER COMM’N ON MEDICAID AND THE UNINSURED, *supra* note 45.

¹⁸⁸ DEMOCRATIC POLICY COMM., *The Benefits of Health Reform in Vermont*, 1 (June 22, 2010), http://dpc.senate.gov/docs/sr-111-2-41_states/vt.pdf. Most likely, the difference between the number of uninsured Vermonters identified by the DPC and the number of uninsured Vermonters identified *infra* is the result of different dates or methods of measuring the number of uninsured Vermonters.

¹⁸⁹ U.S. CENSUS BUREAU, *supra* note 120.

¹⁹⁰ DEMOCRATIC POLICY COMM., *supra* note 188, at 2.

¹⁹¹ DEMOCRATIC POLICY COMM., *supra* note 188, at 2.

of Medicaid enrollees in the country, this influx of new funding will help Vermont to sustain the program and decrease the state's Medicaid financial burden.

Transitioning to Reform Law's benefits to Vermont small businesses, the DPC report notes that presently, only 45.8% of Vermont small businesses can offer health insurance coverage to their employees, and 81% of Vermont businesses are small businesses.¹⁹² Astonishingly, together these statistics mean that almost one half of all employers in Vermont do not offer health insurance to their employees. However, under the Reform Law, the DPC predicts that 14,441 Vermont small businesses will be eligible for tax credits to assist in paying for the employer's share of employee health insurance.¹⁹³ Moreover, these small businesses employ 52,324 Vermonters.¹⁹⁴ These tax credits, if substantial enough, may provide a much needed incentive for Vermont small businesses to provide coverage.

Juxtaposing Catamount onto the Reform Law, in some ways Catamount represents a mini-version of the reforms contemplated by the Reform Law. Despite these similarities, Vermont will have to substantially expand parts of the Catamount program and modify or eliminate other requirements and restrictions in order to transition smoothly into the system contemplated under the Reform Law. For example, one of the similarities between Catamount and the Reform Law is Catamount's administration by three different competing private insurers and the Reform Law's insurance exchange idea with multiple insurers competing to sell coverage. Although the multi-seller idea is common to both, for Catamount to join Vermont's insurance exchanges under the Reform Law, Catamount must expand its scope of coverage beyond a program to sell coverage to individuals, and must also sell coverage to small businesses with up to 100 employees.¹⁹⁵ This would be quite a sizeable expansion and cost increase to Catamount.

Another similarity between the two programs is Catamount's embodiment of the Reform Law's two general concepts of a standard health care plan with a minimum level of mandated benefits along with specific market restrictions and regulations. In terms of benefit levels, the Reform Law mandates minimum standard benefits in two ways: 1) Requiring the state-based Basic Health Plan option for uninsured individuals between 133% and 200% of the FPL to provide defined essential health benefits; and 2) Requiring all insurers within the individual and small group markets to provide comprehensive coverage or essential health benefits in one of four benefit categories, as defined by the Secretary of Health and Human Services ("Secretary").¹⁹⁶ As to the former, although Catamount already resembles the Basic Health Plan option and although Vermont could transform Catamount into its Basic Health Plan option, Vermont would also have to meet the requirements of the Basic Health Plan option, including, most notably, restricting the scope of Catamount to

¹⁹² DEMOCRATIC POLICY COMM., *supra* note 188, at 2.

¹⁹³ DEMOCRATIC POLICY COMM., *supra* note 188, at 2.

¹⁹⁴ DEMOCRATIC POLICY COMM., *supra* note 188, at 2.

¹⁹⁵ *See* Patient Protection and Affordable Care Act §§ 1304(a)-(b), 1311(b)(1)(B).

¹⁹⁶ *See generally id.* §§ 1301-1302, 1331, 2707 (providing background information on essential benefits, the level of coverage, and the Secretary's role).

individuals between 133% and 200% of the FPL, whereas Catamount currently serves almost all Vermonters.¹⁹⁷

As to the Reform Law's minimum mandated benefits for the individual and small group markets, the statute expressly requires coverage for general categories of benefits, including hospitalization, maternity and newborn care, as well as prescription drugs, and ambulatory, emergency, mental health, rehabilitative, laboratory, preventive, chronic care management and pediatric services.¹⁹⁸ Comparatively, Catamount mandates minimum benefits of coverage for primary, preventive, acute episodic and chronic care, as well as a chronic care management program and hospital services.¹⁹⁹ There are obvious similarities between the two programs, but the specific federal minimum benefits have yet to be announced by the Secretary. Nonetheless, looking at the language of the federal statute, the federal benefit mandates are likely to be at least, if not more, comprehensive than those of Catamount, and it is likely Vermont will have to adjust its mandated benefit requirements accordingly.

Moving from mandated benefit levels to market restrictions and eligibility restrictions, Vermont will have to make substantial changes to Catamount to meet the Reform Law requirements. For premium determination within the individual, small group market and exchanges, the Reform Law allows rating variation based only on age, geographic area, actuarial value, family composition and tobacco use, and limits the rating variation to a three to one ratio.²⁰⁰ By prohibiting all ratings except for community rating, Catamount takes the exact opposite approach as the Reform Law.²⁰¹ Arguably, Vermont's community rating system is a better system because it avoids wide premium cost disparity between younger and older people and consequently heavier financial burdens on older people, as will likely occur under the age rating system authorized under the Reform Law. However, Vermont will have to change its rating requirements to fit the Reform Law because the Reform Law's state innovation waiver provision does not apply with regard to insurance premium ratings.²⁰²

In terms of eligibility provisions, the Reform Law includes guaranteed availability of coverage, guaranteed renewability of coverage, elimination of preexisting condition exclusions, and prohibition of group coverage waiting periods beyond 90 days.²⁰³ Catamount does not include any of these provisions, and even allows for limited preexisting condition exclusions and exclusions for those who were insured within the 12 month period before they applied for Catamount.²⁰⁴ Critics have argued that these eligibility limiting provisions adversely impact

¹⁹⁷ Compare Patient Protection and Affordable Care Act § 1331(e)(1)(B) with Douglas, *supra* note 84, at 294 (describing Catamount as a voluntary universal coverage plan).

¹⁹⁸ Patient Protection and Affordable Care Act § 1302(b)(1).

¹⁹⁹ VT. STAT. ANN. tit. 8, § 4080f(c)(1).

²⁰⁰ Patient Protection and Affordable Care Act § 2701(a)(1).

²⁰¹ VT. STAT. ANN. tit. 8, § 4080f(j).

²⁰² Patient Protection and Affordable Care Act § 1332(a)(1).

²⁰³ *Id.* at §§ 2702-04, 2708.

²⁰⁴ VT. STAT. ANN. tit. 8, §§ 4080f (a)(9), 4080f(e)(1).

middle-aged or older residents, who would otherwise benefit extensively from Catamount, given Catamount's mandatory price caps on high health care costs, mandatory chronic care programs, and premiums based on community ratings.²⁰⁵ Fortunately, for these individuals, the Reform Law's state innovation waiver does not apply to the eligibility provisions of the Reform Law and Vermont will have to modify Catamount's eligibility requirements to expand coverage and eliminate the preexisting condition exclusion and 12-month exclusion.²⁰⁶

Refocusing on the interplay between cost and coverage in health care reform, a major concern of the Catamount program has been whether its costs will prove unaffordable for low and moderate income individuals and families, and whether those costs will negatively impact enrollment under Vermont's current voluntary individual market.²⁰⁷ For example, using the costs discussed *supra*, a currently uninsured Catamount individual purchaser with an income just above 300% of the FPL will pay almost \$5,000 per year in health insurance premiums, as well as the cost of other health care expenditures. The Reform Law's cost limitations on deductibles and out of pocket limits do not resolve the affordability problem under Catamount, and may in fact exacerbate the problem. The Reform Law's maximum individual deductible can be as high as \$2,000, and the out of pocket individual limits can be as high as \$6,000, numbers that are grossly higher than even the out of network individual deductibles and the out of network, out of pocket individual maximums under Catamount, both of which are under \$2,000.²⁰⁸ Fortunately, Vermont can apply for a state innovation waiver with regard to these federally imposed higher limits, and if approved, keep its more affordable deductible and out of pocket maximums, provided that it meets the other waiver requirements describe *supra*.²⁰⁹

In contrast to the impact of the Reform Law on Catamount affordability for all Vermonters, regardless of income, the Reform Law may improve affordability for Vermonters entitled to subsidies compared to the existing situation under Catamount. First, the Reform Law expands cost sharing subsidies to 400% of the FPL, whereas Catamount only provides subsidies to those who earn 300% of the FPL or less.²¹⁰ Second, the Reform Law provides premium tax credits, whereas Catamount does not.²¹¹

Despite these Reform Law affordability improvements for low income Vermonters, the subsidy levels for low income individuals under either Catamount or the Reform Law differ only slightly. For example, under the Reform Law, those between 250% and 400% of the FPL receive 70% of cost sharing subsidies, and

²⁰⁵ Trame, *supra* note 155, at 471-72.

²⁰⁶ See generally Patient Protection and Affordable Care Act § 1332 (demonstrating the provision's lack of a "preexisting condition exclusion" and a "12 month exclusion").

²⁰⁷ KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 152, at 2.

²⁰⁸ Patient Protection and Affordable Care Act §1302(c)(2); VT. STAT. ANN. tit. 8, § 4080f(c)(1).

²⁰⁹ See Patient Protection and Affordable Care Act § 1332(b)(1).

²¹⁰ *Id.* § 1402(b); VT. STAT. ANN. tit. 33, § 1974(a)-(b).

²¹¹ Compare Patient Protection and Affordable Care Act § 1401(a) with Vermont Health Care Affordability Act, No. 191 (2006).

under Catamount, those at 300% of the FPL pay a little more than one third of the premium cost that an individual earning above 300% of the FPL pays.²¹² Accordingly, for low income Vermonters, more people will get assistance and will get tax credits that they currently do not receive, but the level of cost-sharing subsidies will increase only slightly for low income individuals under the Reform Law.

From the state's perspective, the increase in federal funding through subsidies will be a big benefit to Vermont's coffers. Analysts have speculated that Vermont may not have the necessary long term state funding to support its current health care reform program.²¹³ Vermont already had to commit more funding to the program than initially planned because CMS denied Vermont's Medicaid waiver for federal funds "to finance Catamount Health Plan premium subsidies for individuals with incomes between 200-300 percent FPL."²¹⁴ The new federal funding subsidies alter the status quo and decrease the financial burden on Vermont.

Concluding with the federal individual and employer mandates, both provisions represent major changes to Catamount. For individuals, Vermont's HCAA law presently provides for individual voluntary compliance with the option for the Vermont legislature to consider mandating individual enrollment at the end of this year.²¹⁵ Conversely, the Reform Law affirmatively creates a "pay or play" individual mandate.²¹⁶ This federal individual mandate should increase coverage rates over Vermont's current voluntary system, for obvious reasons. Moreover, as a result of improved risk spreading under the federal individual mandate, Vermont's overall health insurance costs should decrease.

Although the Reform Law's creation of an individual "pay or play" mandate will improve overall coverage rates for Vermont, the Reform Law's employer "pay or play" mandate is only likely to improve employer-based coverage rates for larger employers compared to HCAA's employer "pay or play" mandate. Under the Reform Law, small employers with 50 or fewer employees are exempt from the "pay or play" employer mandate, whereas the HCAA's "pay or play" mandate applies to all employers, regardless of size.²¹⁷ Due to the greater expansiveness of Vermont's employer mandate, head-to-head with the Reform Law mandate, the Vermont employer mandate should result in a better rate of coverage. Unfortunately, the federal employer "pay or play" mandate is not subject to the waiver for state innovation and Vermont will have to adjust its employer mandate to comply with the federal law.²¹⁸

For larger employers, the Reform Law's "pay" provision of the employer "pay or play" mandate is much more substantial than Vermont's state provision, requiring a payment of \$3,000 or \$2,000 per employee depending on whether or not the

²¹² Patient Protection and Affordable Care Act § 1402(c); VT. STAT. ANN. tit. 33, § 1984(c).

²¹³ KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 152, at 2.

²¹⁴ KAISER COMM'N ON MEDICAID AND THE UNINSURED, *supra* note 152, at 2.

²¹⁵ VT. STAT. ANN. tit. 2, § 902(a)(3)(D).

²¹⁶ *See* Patient Protection and Affordable Care Act § 5000a(a).

²¹⁷ *Id.* § 1513(d)(2)(A); VT. STAT. ANN. tit. 21, § 2003(a)-(b).

²¹⁸ *See* Patient Protection and Affordable Care Act § 1332(a).

employee is receiving a premium tax credit.²¹⁹ In contrast, the HCAA's "pay" provision requires a payment of only \$91.25 per uncovered employee, as of 2008.²²⁰ Accordingly, the federal provision provides a substantially stronger incentive than Vermont's provision for larger employers to provide coverage to their employees, and therefore, should result in a higher employment-based insurance rate.

V. CONCLUSION

The Reform Law is no skeleton key. It does not unlock all of the solutions to all of the different problems posed by existing state health care systems and state reforms. At times, it appears as if Congress attempted to preserve the good of state health care reform efforts, while eliminating the bad. For example, Congress expressly preserved Hawaii's stringent employer mandate, thereby promoting better coverage rates than would exist if Hawaii adopted the federal "pay or play" employer mandate. On the flip side, Congress effectively eliminated Catamount's 12 month exclusion and authorization of preexisting condition exclusions, thereby extending coverage to more Vermonters than under the status quo.

While some of Congress' efforts appeared calculated to meet specific state concerns, other provisions of the Reform Law miss the mark and fail to remedy or make worse existing deficiencies in state systems. For example, the Reform Law does nothing to improve enforcement of Hawaii's employer mandate and does nothing to allow Hawaii to alter the PHCA to meet the new demands of a changing health care world. Similarly, in Vermont, the Reform Law forces the state to get rid of its community rating method for establishing premiums in favor of a rating system based in part on age, that results in inequity and heavier premium costs borne by older people. Moreover, the Reform Law allows for maximum deductibles and maximum out of pocket costs that are much higher and more unaffordable than the maximums allowed under Catamount.

Because Congress was late in enacting comprehensive health care reform, it did not work with a blank slate when it came to the states. Rather, Congress was faced with the impossible task of trying to design a federal system that addressed all of the health care idiosyncrasies of 50 states, including some with already significant health care reforms in place. Given that comprehensive federal health care reform at times seemed like a Sisyphean challenge doomed to fail, overall it is impressive that Congress comprehensively tailor-made the Reform Law for the states.

²¹⁹ *Id.* § 1513(c).

²²⁰ VT. STAT. ANN. tit. 21, § 2003(a)-(b). For 2010, the contribution is per employee in excess of four uncovered full-time employees and the amount of contribution is probably somewhat higher than \$91.25, as the amount is tied to the annual Catamount premium rate increase. Still, it is unlikely that the per employee contribution has risen to anywhere near \$2,000 or \$3,000.