Maine Continuation State Planning Grant

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Final Report

Submitted by:
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Maine State Government

And

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MAINE STATE PLANNING GRANT
Executive Summary

Maine's State Planning Grant, awarded in 2004, superceded an initial State Planning Grant (2002) and a supplemental planning grant (2003). The 2004 grant provided research support for Maine's ongoing reform effort building on legislation passed by the Maine legislature in 2003. The Dirigo Health Reform Act includes reforms targeting expanded access to health coverage for the uninsured and under-insured, cost containment, and improvements in health care quality. While the initial grant supported the planning for the foundation of Governor Baldacci's major health reform initiative, the 2004 grant underwrote post-legislative planning efforts, including research to support the development of a state health plan, research to provide baseline information and tracking capacity to monitor health care spending in the state, and the development of materials for a major campaign to educate and elicit health system preferences from Maine's citizenry. In keeping with the reporting format required for the State Planning Grants, this report describes Maine's reform activities and accomplishments from the entire planning period supported by the HRSA State Planning Grant program, and encompasses information based on research conducted throughout this three year period.

Among the key findings and actions in Maine supported by the State Planning Grants are the following:

Scope of the Problem in Maine According to Maine's household survey and more recent Current Population Survey data, between 12 and 13 percent of Maine's population is uninsured. Twenty-three percent of young adults (below age 30) and 38 percent of very small business employees (10 or fewer workers) were uninsured at least part of the year of our survey.

The stability of the uninsured rate over the past several years masks sizeable changes taking place in the insurance market. Between 2002 and 2004, the proportion of Maine's adult population with employer provided health coverage dropped from 66 percent to 60 percent. The drop among children was from 60 percent to 49 percent. Losses in employer coverage were made up through slight increases in individual insurance coverage and substantial increases in public coverage.

The shift toward increased public coverage in Maine is not a phenomenon of "crowd-out" of employment-based coverage, but a reflection of the substantial uptake in Maine's Medicaid Program of the lowest income, mostly non-working adults. In 2003, Maine's Medicaid HIFA Waiver program for childless adults served 26,000 individuals with incomes below the federal poverty level, dramatically reducing the proportion of uninsured in this income group. During this same period (between 2001 and 2003), average premiums in Maine's small group market rose 78 percent to become the highest in the nation for single policies and 3rd highest among states for family policies (across all sizes of business). Enrollment in Maine's commercial small group insurance market shrank by 19 percent between 2001 and 2003. Most of the fall-out from the commercial insurance market is from the working uninsured who are ineligible for MaineCare programs. Both premium prices and coverage rates in the small group market stabilized in 2003, possibly in response to the reform activities underway in the State.

Political Climate The response of employers of both large and small businesses to insurance cost increases has been to move toward higher deductible health plans and shift a greater portion of premium costs to workers. In focus groups and interviews, employers almost uniformly saw the health care system as in crisis and needing intervention. While there was no consensus on the appropriate reforms, most employers in focus groups and interviews agreed that market competition was a failed strategy in the health care sector in Maine. Many pointed to the small number of insurance companies in the state and the consolidation of hospitals and physicians into a small number of groups for contracting purposes as evidence that healthy competition could not be achieved under current market arrangements.

Development of the Dirigo Health Reform Act The development of the proposed reform strategy was led by the Governor's Office of Health Policy and Finance, working in consultation with a committee of stakeholders, called the Health Action Team. The bill was heard by a special select committee of the legislature with representatives from the Committees of Health and Human Services, Banking and Insurance, and Appropriations and was reported out of committee with a unanimous recommendation of "ought to pass." It passed with strong support in both houses.

The major features of the Dirigo Health Reform Act are:

Access:

Creation of the DirigoChoice Plan, an insurance program for small businesses (50 or fewer full-time employees) with sliding scale subsidies for families with incomes below 300 percent of the federal poverty level (implemented).

Expansion of income eligibility for parents in the SCHIP program (implemented) and childless adults (on hold).

Cost Containment:

A twelve month moratorium on CON reviews and approvals followed by a permanent change in the CON law to limit annual approvals to amounts specified in a capital expenditure fund and expand review to non-hospital sites such as physician offices.

Mandate for a biennial State Health Plan to establish priorities for developments in Maine's health care system and develop strategies for improving the health of Mainers.

Establishment of a minimum 78 percent loss ratio in the commercial small group insurance market and new reporting requirements for insurers across all lines of business.

Voluntary targets for reduced rates of cost increase and consolidated operating margins for hospitals; and voluntary targets for maximum underwriting gains for insurers.

Quality:

Establishment of the Maine Quality Forum with responsibilities for the collection and dissemination of research findings related to quality of care, patient safety, best practices, and evidence based medicine.

Funding:

Program operations and subsidy costs were funded for the first year with a one time appropriation of $53 million. Subsequent funding derives from a Savings Offset Payment – an assessment of not more than 4 percent on health insurers and ASOs and TPAs serving self-insured businesses. The assessment is levied only if the Dirigo Health Agency can demonstrate offsetting savings to the health care system derived from reduced bad debt and charity care as health coverage is expanded, and from the Dirigo Reform's cost containment measures. After the first year of operations, the Superintendent of Insurance, at the conclusion of an adjudicatory hearing, ruled that reforms had resulted in $43 million in savings, allowing an assessment of approximately 2.5 percent.

Current Status of Reforms The DirigoChoice Plan has been operational since January 1st, 2005 and had, as of September 1st, over 8,100 enrollees representing 650 businesses and 1,300 sole proprietors. The plan is the fastest growing small business insurance product in Maine and has stimulated the return of a private insurer that had abandoned the Maine market and is now marketing a product to compete with the DirigoChoice Plan.

The Quality Forum is operational, is disseminating information on health service area differences in rates of elective procedures and quality measures. It has established a committee to plan for the development of a statewide, linked medical record system to allow seamless transmission of patient data to follow patients wherever they access care.

The first biennial State Health Plan has been developed and commented on during public hearings held in December, 2005. In preparation for plan development, the Governor's Office of Health Policy and Finance sponsored a "Tough Choices" campaign culminating in a day-long public participatory forum led by AmericaSpeaks. In addition, the Governor's Office of Health Policy commissioned a population and community health needs assessment organized by three major regions within the State.

Lessons Learned Tying access expansions to cost containment measures and quality enhancements was critical to the political acceptability of the reform proposal and is critical to its sustainability. There is political consensus in Maine that the rate of recent cost increases in the health sector is not sustainable. New coverage expansions have historically fueled utilization and cost increases, as individuals gain improved access and new resources pour into the system. The political will to fund subsidies for low-income citizens quickly dissipates as cost pressures rise. Maine, by trying to levy the resources to pay for access expansions through measured savings to payers, hopes to hold current payers harmless while maintaining the resources to bridge the gap between coverage costs and income availability of low to moderate income Mainers.

Another lesson from Maine's experience is the importance of including the public in a meaningful way in the reform debate and on-going reform efforts. Health financing has become very complex and health reform, an "insiders" game where stakeholder representatives and public officials argue over options. Without public engagement, negotiations frequently break down over payment issues. Educated and activated consumers can maintain pressure on stakeholders to keep the public interest foremost.

Maine State Planning Grant
Final Report

Introduction

In July, 2002, Maine's Department of Human Services was awarded a twelve month grant through the State Planning Grant Program of the Health Resources and Services Administration, U.S. Department of Health and Human Services. This grant was supplemented with two additional awards and the grant period extended to August 31, 2005.

In January, 2003, Maine inaugurated a new Governor who, as the first act of his governorship, created an Office of Health Policy and Finance (GOHPF) charged with leading an effort to reform Maine's health system with the goal of achieving universal health care coverage. The role of Principal Investigator of the Maine State Planning Grant and oversight of grant activities were transferred to the GOHPF.

In May of 2003, Maine's legislature passed the Dirigo Health Reform Act with bi-partisan support, marking the launch of a new initiative to provide coverage to many of Maine's uninsured, and the beginning of a period of intensive planning and negotiation for extensive changes to the organization and financing of health care in Maine so that the State could achieve universal coverage. The access initiatives encompassed within the Dirigo Reform – both Medicaid expansions and the creation of a new, state-sponsored and subsidized health plan – have been implemented. Planning efforts to insure the continued viability of the DirigoChoice Plan and to develop additional strategies to improve access are underway. Maine's first biennial State Health Plan has gone to public hearing. A year's experience with various cost containment measures has been measured and assessed. The Maine State Planning Grants have been instrumental in initiating and supporting the research and planning for these policy initiatives. This report from the Governor's Office of Health Policy and Finance is the final report of activities and findings resulting from the sponsorship of the Maine State Planning Grants, 2002 through 2004.

Section 1. Summary of Findings: Uninsured Individuals and Families

In October through December of 2002, as part of Maine's initial State Planning grant, the Governor's Office of Health Policy and Finance (GOHPF) sponsored a random telephone survey of Maine individuals of all ages to ascertain insurance status and related socio-demographic and health characteristics. Mathematica Policy Research, Inc., conducted the survey under contract to the Project, and delivered the survey data to the Maine Project staff at the Health Policy Institute of the Muskie School of Public Service in January, 2003. The findings from this survey are summarized below. Where more recent data from the Current Population Survey or other sources are available, the findings from the survey are updated to reflect the more recent findings. In addition, as part of Maine's supplemental State Planning Grant, the Governor's Office of Health Poicy and Finance commissioned a population health needs assessment for Maine, organized into three regions for the purposes of population and resource analyses. A summary of the findings from this needs assessment is reported in section 1.4, below.

1.1 Prevalence of Uninsurance In Maine

At the time of Maine's survey in 2002/2003 – of approximately 1.27 million Maine residents, an estimated 136,000 lacked health insurance coverage at the time they were surveyed. Across the total population, the proportion uninsured was 10.7 percent; among persons under age 65, the proportion uninsured was 12.5 percent. Surveyed individuals also reported whether they had been uninsured at any point in the past 12 months. When those with uninsured spells are added to those currently uninsured the number rises to 189,000 individuals – 15 percent of the total population and 17.3 percent of the under age 65 population. Based on more recent Current Population Survey (CPS) data, the aggregate percent of the under 65 population that is uninsured has held steady at between 12 and 13 percent.

The Maine survey showed coverage differences between adults and children. Among adults between the ages of 18 and 64, 66.3 percent had employer provided health benefits. Six percent have individually purchased health coverage policies, and 13 percent have some kind of public coverage. More recent CPS data indicate that Maine has experienced a shift with reductions in employer-based coverage and increases in Medicaid coverage. Among adults in Maine, in 2004, private employer coverage had dropped to 60 percent and public coverage increased to 19 percent. The proportion uninsured increased, slightly, to 14.5. These changes reflect changes in Maine's economy (loss of manufacturing jobs), insurance market (steep insurance increases), and eligibility expansions for adults in MaineCare – Maine's Medicaid program.

Maine children are less likely to be uninsured or have private health insurance than adults are. At the time of the survey, 59.5 percent of children (through age 17) had employer-based coverage and 5 percent were covered through individually purchased policies. Twenty-eight percent had public coverage, primarily Medicaid coverage. The rate of lack of coverage among children was 7.6 percent. In 2004, employer coverage had dropped even more dramatically among children than it had among adults. According to CPS survey findings, only 49.4 percent of Maine children were covered through employer benefit plans. Public coverage for children rose to 39 percent and uninsurance rates dropped slightly to 6.8 percent.

1.2 Characteristics of the Uninsured

Income

At the time of Maine's survey, Maine residents with incomes between one and two times the federal poverty level made up almost a third of the uninsured, even though they represented only 17 percent of Maine's population (*Table 1*). Maine has a larger proportion of uninsured with incomes above 200 percent of the federal poverty level than the country as a whole. (*Table 2*).

Table 1
Income Distribution of Maine's Non-Elderly Uninsured Population[1]

Income	Percent Distribution of Uninsured Persons	Percent Distribution of total Maine Population
< federal poverty level	16.0	12.0
100 - 199% FPL	31.8	17.7
200 - 299% FPL	22.9	20.5
≥ 300% FPL	23.2	45.1

The relative skewing of Maine's uninsured population toward higher incomes than the country as a whole, we believe, is due both to Maine's generous eligibility criteria for Medicaid coverage which provides coverage to proportionately more of the low-income population, and the very high costs of private health insurance relative to many other states which creates financial barriers to coverage for moderate income families. The characteristics of Maine's insurance market are discussed in greater detail in Section 2.

Table 2
Income Distribution of Maine's Non-elderly Uninsured Compared to National Average[2]

Income	Percent Distribution of Maine Uninsured	Percent Distribution of U.S. Uninsured
< federal poverty level	16.0	36.0
100% - 199% FPL	31.8	29.0
≥ 200% FPL	46.1	35.0

Coverage penetration rates of health benefits programs by income category can also be assessed by measuring the relative burden of uninsurance born by different income segments within the population as a whole. The most vulnerable group for lack of coverage in the state is the population with incomes between 100 percent and 200 percent of the federal poverty level (*Table 3*). In this group, over 22 percent were without coverage at the time of the survey. The lowest income population had a somewhat lower rate of uninsurance. Those between 200

percent and 300 percent of the federal poverty level also experienced substantial coverage gaps, with about 14 percent in this group uninsured.

Maine's rates of uninsurance are lower among the poor and near poor and slightly higher among middle and higher income groups than the national average. These differences may reflect Maine's relatively generous eligibility for public coverage for low income groups. In addition, higher than average premium costs and lower than average household income may contribute to increasing uninsurance among moderate income families in Maine.

Table 3
Percent of Non-elderly Maine Residents Uninsured by Income

Income	Maine Percent Uninsured	United States Percent Uninsured
< federal poverty level	17.7	36.5
100 - 199% FPL	22.5	27.5
200 - 299% FPL	13.9	15.8
≥ 300% FPL	6.0	6.2

Age

Table 4 shows the age distribution of Maine's uninsured. Although about 28 percent of Maine residents are children, they make up only 17 percent of Maine's uninsured. Adults aged 18 through 44 are over-represented among the uninsured, comprising about 61 percent of the total. Pre-Medicare-eligible older adults (aged 45 through 64) make up the remaining 22 percent of the uninsured, although they represent about 29 percent of Maine's population overall. Adults aged 18 through 29 are at the highest risk of being uninsured, with an uninsurance rate in this population age group of 32 percent (over the course of a year).

Table 4
Age Distribution of Maine's Non-elderly Uninsured

Age	Percent Distribution
0 – 17	16.8
18 – 29	28.2
30 – 44	32.6
45 – 64	22.4

Gender

Among adults, men comprise roughly half of Maine's entire non-elderly population (49 percent). However, Maine's men are overrepresented among the uninsured so that 58 percent of those without health insurance coverage at the time of the survey were male.

Family Composition

Maine residents are less likely to be uninsured if they are married or, in the case of children, live in a family where the head-of-household is married. Only 8 percent of Maine residents in married families were uninsured at the time of the survey. Being single or living with a domestic partner are characteristics associated with a higher rate of uninsurance. Slightly over 20 percent in each of these categories was uninsured at the time of the survey. The rate of uninsurance among separated, divorced or widowed persons or their family members was 16.7 percent.

Although at lowest risk of being uninsured, members of married families comprise 44 percent of the total uninsured population. This is because two-thirds of all non-elderly households in Maine are headed by married couples. While individuals living in households headed by non-married domestic partners represent 8 percent of Maine's population, they comprise 13 percent of the State's uninsured. Maine residents living in families headed by a single adult make up 16 percent of the population but are 29 percent of the uninsured.

Health Status and Access to Care

The uninsured in Maine report poorer health status than insured persons. Almost one in five uninsured (19.4 percent) survey respondents characterize their health as fair or poor, compared to 12.4 percent of insured respondents. Conversely, 30 percent of the insured rate their health as excellent, compared to 22 percent of the uninsured.

The overwhelming majority of non-elderly Maine residents (90 percent of adults and 97 percent of children) obtain their medical care from one regular provider. However, they are less likely to have a provider if they are uninsured. Among uninsured adults, 33.5 percent report not having a regular source of care. Among children, 16.3 percent are reported to lack a regular provider.

Although most Maine residents believe they can get needed health services regardless of insurance status, uninsured children are seven times more likely than insured children to have a delay in getting needed health care services because of cost (42 percent compared to 6 percent of insured children). Sixty-three percent of uninsured adults in Maine report delaying needed care compared to 21 percent of those with health insurance. These reported barriers are reflected in differences in rates of health service utilization. Fifty percent of uninsured adults report receiving an ambulatory care visit in the six months prior to the survey, compared to 79 percent of insured adults. Insured children were about 15 percent more likely to have had an ambulatory visit than uninsured children over the previous 6 months.

Employment Status

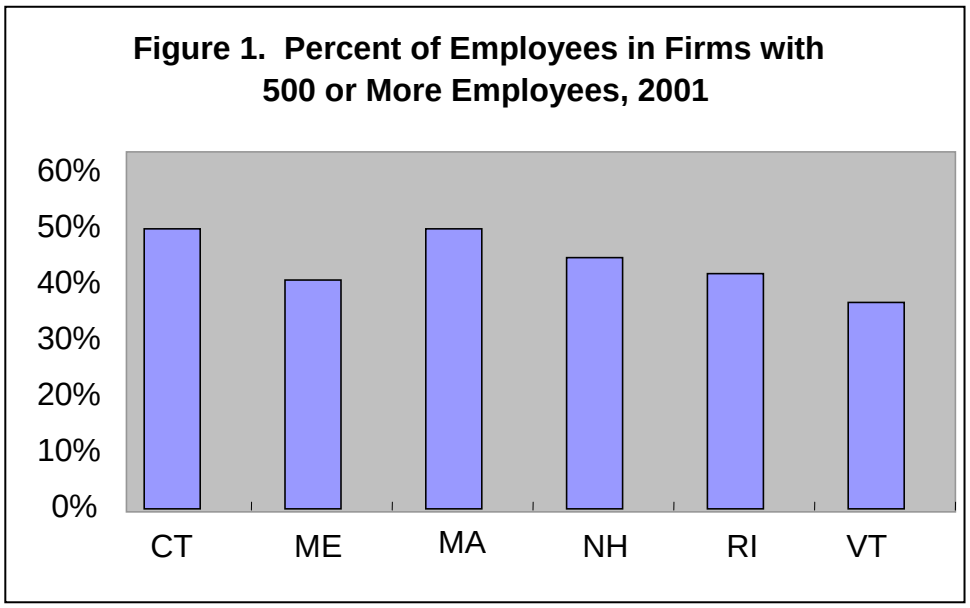
Maine residents who work for themselves are at highest risk of being uninsured. Twenty-seven percent of self-employed residents were uninsured at the time of the survey and these self-employed individuals comprise 28 percent of the total population of the uninsured in the State. While only 12.3 percent of employees are uninsured, this group comprises more than half (51.6 percent) of the uninsured population. The rate of uninsurance among the unemployed is 17.6 percent and this group represents about 17 percent of the uninsured population. Less than 4 percent of Maine's uninsured population is out of the labor force and this group also has the lowest uninsured rate (6.4 percent) presumably because they have higher rates of public insurance coverage.[3]

Part-time workers (uninsured rate, 22 percent) are about twice as likely to be uninsured as full-time workers (uninsured rate, 9.2 percent). Maine workers are nearly three times as likely to be uninsured if they work at a temporary or seasonal job, compared to those who have permanent jobs. Thirty-seven percent of seasonal and temporarily employed workers were uninsured at the time of the survey, compared to 12.7 percent of those with permanent employment. Overall, among the population of uninsured persons in Maine, 30 percent work full-time or are the dependent of a full-time worker, 17 percent work part-time, and 15 percent work in temporary or seasonal jobs.[4]

Being employed by a small business places Maine workers at high risk of being uninsured. Thirty-one percent of those working for a business of 10 or less were uninsured at the time of the survey compared to 13 percent for those in businesses of 11 to 50 workers, and 6.8 percent for those in businesses greater than 50. While 29 percent of Maine residents work for a business with less than 50 employees, this sector contributes 52 percent of Maine's uninsured population. Nineteen percent of the uninsured are working in businesses of 50 or more workers.

Maine has a high rate of self-employment and employment in small firms in comparison to the rest of New England and the nation as a whole. This characteristic became more prominent in the 1990s and continues to grow, as Maine loses the industries that had sustained many communities. Maine has experienced a sharp reduction in manufacturing jobs – usually associated with large firms and good benefits – and now has about 65 percent of the manufacturing employment it had in 1960, while the U.S. as a whole retains 95 percent.[5] In 2001, the proportion of workers in Maine in firms with 500 or more employees was 41 percent, lower than all New England states except Vermont (***Figure 1)***.

Figure 1
Percent of Employees in Firms with 500 or more Employees, 2001



Availability of Private Coverage

According to Maine's survey, just under half of Maine's uninsured work for a business that does not offer health insurance coverage, including those who are self-employed and do not provide coverage to themselves or their workers. Twenty-four percent of the uninsured, about 34,000 work for employers who offer health insurance to at least some of their workers. Nineteen percent of the uninsured, approximately 27,000 individuals, are eligible for coverage through their employer or a spouse's or parent's employer. Seventy-six percent of the eligible uninsured declined to enroll because they find the cost prohibitive. Another 13 percent stated that they had held other insurance, such as Medicaid, at the time they declined their employer's coverage plan or that they expected to get coverage through another source in the near future. About six percent were in probationary periods before becoming eligible for their employer's plan. About five percent did not want health insurance coverage.

Availability of Public Coverage

Like most New England states, Maine has generous income eligibility thresholds for almost all categorical programs within Medicaid. In addition, Maine has a HIFA waiver program to extend eligibility to non-categorical adults with incomes below 125 percent of FPL (See *Table 5* for a description of Maine Medicaid eligibility groups and benefits). All children in Maine in households with incomes at or below 200 percent of the poverty level are eligible for public coverage through MaineCare (Maine's Medicaid and SCHIP programs). Forty-two percent of

children in Maine fall within these income guidelines. Among children in poverty in Maine, one in four was uninsured at the time of the survey. Among those in households between poverty and 200 percent of the poverty level, 17 percent were uninsured. Although Maine compares well with other states in outreach efforts to eligible children,[6] there remain approximately 6,800 children without coverage who are eligible for enrollment in currently available health coverage programs.

At the time of the survey, Maine's eligibility for SCHIP parents was at 150 percent of the federal poverty level and, through a federal waiver program, the State had extended coverage to non-categorical adults with income below the poverty line. The survey determined, at this time, that there were approximately 150,000 adults between the ages of 18 and 65 who were uninsured or had been uninsured during the past year. Of these, 18 percent, or approximately 27,000 individuals had incomes below the federal poverty level indicating that they were eligible for public coverage regardless of family status.

Table 5

Major MaineCare Eligibility Groups

Group	Benefit Level	Income Limit	Asset Limit	Notes
Children 0 - 18	MaineCare Full Benefits	200% of FPL (federal poverty level)	None	Children with income up to 150% of FPL and infants under 1 with income up to 185% of FPL pay no premium. Children between 150% and 200% of FPL are eligible for Maine's SCHIP program and pay between $8 and $64 per month per family. Children who have a serious medical condition are served under the Katie Beckett option where only the income of the child who has the disabling condition (not the parents' income) is counted. There is an asset limit of $2,000. Families who lose coverage due to increased income can buy into MaineCare at cost for 18 months.
Young adults age 19 – 20	MaineCare Full Benefits	150% of FPL	$2000 (Many assets are excluded)	Income of parents in the household is counted in some circumstances.
Parents with children under 19 at home	MaineCare Full Benefits	200% of FPL	$2,000 (Many assets are excluded)	
Pregnant Women	MaineCare Full Benefits	200% of FPL	None	For the mother, coverage continues 2 months beyond pregnancy. Coverage will continue longer, if the mother meets criteria above for parents. If the mother had full benefit MaineCare when the baby was born, MaineCare covers the baby for one year.
Disabled Adults and Persons 65 and Over	MaineCare Full Benefits	100% of FPL (For disabled only, this will expand to 125% of FPL on 4/1/05)	$2,000 ($3,000 for a couple) For working disabled – $8,000 ($12,000 for a couple) (Many assets are excluded)	Full benefit MaineCare 'wraps around' Medicare. It covers Medicare deductibles and co-payments.Medicare beneficiaries who are not eligible for MaineCare full benefits may be eligible for the MaineCare Medicare Buy In benefit which may pay for Medicare Part B premium, co-pays and deductibles. The Working Disabled Benefit: People with disabilities who work may be eligible for full benefit MaineCare if their unearned income is under 100% FPL and their total income, including earnings, is under 250% FPL. Some people may have to pay small monthly premiums
HIV Positive Adults	MaineCare Prescriptions and other limited coverage	250% of FPL	None	Individual must be HIV-positive (with or without diagnosis of AIDS); coverage includes prescriptions, physician and hospital services, there are some limitations on services; co-pays are higher ($10 per prescription and office visit) than for full benefit MaineCare; there is a limit on the number of individuals who can participate in the program
Women who have Breast or Cervical Cancer (or pre-cancerous condition)	MaineCare Full Benefits	250% of FPL	None	Women must be without insurance; age 40 to 64 (or over 64 if they only get Part A Medicare, not Part B); and have a positive screening by the Bureau of Health Program
Adults medically eligible for nursing care	MaineCare Full Benefits	$1,692/mo	$2,000 ($3,000 for couple)[2] (Many assets are excluded)	Condition must be so severe that they would be nursing home eligible, but they are living in the community. Adults are served under the home-based care waiver program.
"Non-categoricals"	MaineCare Full Benefits	100% of FPL	$2,000 ($3,000 for couple) (Many assets are excluded)	Adults who do not fit in another MaineCare category are eligible for MaineCare if their income is below 100% of poverty and are under the asset limit.

Source: Maine Equal Justice Partners. "Maine's Medical Assistance Programs: Who's Covered and Who's Not?" http://www.mejp.org/medicalprograms.htm (accessed 12/20/04)

State Fiscal Year 2004 was Maine's first full year of experience with its non-categorical adult waiver program. Over the course of the year, approximately 26,000 new members received services through this program. This number exceeds survey estimates of the total population meeting eligibility criteria (childless adults with incomes below the federal poverty level). This experience illustrates some of the limitations of survey data for policy planning purposes. We believe the survey underestimated this population because many very low income childless adults have transient residency or lack phones. In addition, except in an unusually massive and costly survey, the sample size within a small state of persons meeting all eligibility criteria is very small creating a large margin of error for state-level estimates.

Maine has authorization from the DHHS and the Maine legislature to expand eligibility under Medicaid for non-categorical adults with incomes up to 125 percent of FPL and SCHIP parents with incomes up to 200 percent FPL. Maine survey estimates project 7,500 adults with incomes between the poverty level and 125 percent of the poverty level who would become eligible for public coverage under the new criteria. Another 26 percent of uninsured adults, or about 39,000 persons, have incomes above 125 percent of the FPL but below 200 percent FPL. Among this group, those who are parents became eligible for public coverage under new eligibility criteria that Maine's Department of Human Services implemented in May, 2005. Enrollment in Maine's non-categorical adult program is currently frozen and no expansion of this program is contemplated in the short-term.

According to survey estimates, twenty-five percent of Maine's uninsured adults, or approximately 33,500 persons, have incomes between 200 percent and 300 percent of the federal poverty level. Among this income group, those who work for small businesses, are self-employed or unemployed, are eligible to enroll in Maine's new state-sponsored health coverage initiative with sliding scale payment discounts based on income (see discussion, Section 4). In future years, individuals in this income group, working for large employers, may also be eligible to participate or for assistance with premium payment for coverage in a qualified employer-sponsored health benefits plan.

Twenty-six percent of Maine's uninsured adults have incomes above 300 percent of the federal poverty level. This fact points to the high cost of health insurance in the state and the continued erosion of employer-based coverage. Among the policy efforts under development in the State are strategies to contain premium costs in the private insurance sector and to encourage voluntary participation in coverage initiatives at full cost.

Race/Ethnicity

An estimated 3.4 percent of Maine's non-elderly population belongs to a racial or ethnic minority group. The proportion of this population who were uninsured at the time of the survey was 17.2 percent, compared to 12.2 percent for the white, non-Hispanic population – a heightened risk of uninsurance of about 40 percent.

Geographic Location

The Maine household survey sample was stratified to allow comparison of urban and rural populations. For sampling purposes, the State was divided into five regions: the three metropolitan areas – Portland, Bangor and Lewiston – and a northern non-metropolitan area and a southern non-metropolitan area. For the purpose of analyzing urban/rural differences, the samples from the three metro areas are combined and the two non-metropolitan samples are combined.

Maine's rural residents are more likely to be uninsured than its urban residents (*Table 6)*. This difference is particularly pronounced among adults, where rates of uninsurance at the time of the survey were 12 percent for urban dwellers and 16 percent for rural dwellers. In the urban adult population, 16 percent had been uninsured for some part of the past year, compared to 21 percent of the rural population.

Among children, differences point-in-time estimates of uninsurance were not as large. Eight percent of rural children were uninsured at the time of the survey, compared to 6.5 percent of urban children. However, more dramatic differences are apparent in measurements of children who had a spell of uninsurance over the prior 12 months. Fifteen percent of rural children report being uninsured at some point in the prior 12 months, compared to 9 percent of urban children.

The differences between adults and children, and the differences among children between point-in-time estimates and uninsured spells can largely be attributed to the greater availability of public coverage for children. Among adults, a similar proportion of urban and rural dwellers have public coverage (10 percent and 11.6 percent, respectively) and non-group coverage (5 percent and 7 percent, respectively), while urban adults are more likely to have employer-based coverage than rural adults (73 percent compared to 65 percent). Thus, the lower employer coverage among adults results in higher rates of uninsurance among rural residents.

Among children, public coverage is higher among rural residents than among urban residents (28 percent compared to 21 percent). Rural children are also more likely than urban children to have individual coverage (6 percent compared to 3.8 percent). These differences help to off-set the lower rates of coverage through employer benefit plans among rural children, compared to urban children (57 percent compared to 68 percent).

Table 6
Urban/Rural Differences in Coverage Among Adults and Children

	Uninsured	Public Coverage	Employer Coverage	Individual Coverage
Urban Adults	11.8%	10.2%	72.8%	5.2%
Rural Adults	16.1	11.6	65.4	6.9
Urban Children	6.5	21.4	68.3	3.8
Rural Children	8.3	28.0	57.5	6.3

1.3 Summary of Population Survey Findings

According to survey data, one in eight non-elderly Maine residents is without health insurance on any given day. One in six went without coverage at least part of the last year. The problem is particularly acute among young adults. Twenty-three percent (below age 30) and 14 percent of those between the ages of 30 and 44 are uninsured. The highest proportion of the uninsured is in the "near poor" income categories. However, the financial strain imposed by the upward creep in health and insurance costs is reflected in the fact that, now, almost a quarter of the uninsured in the State have incomes more than 3 times the federal poverty level.

Small business employees and seasonal workers face particular difficulties. Thirty-eight percent of employees of very small businesses (10 or fewer workers) in Maine were uninsured at least part of the last year, compared to about 10 percent of workers in large businesses. Because Maine has so many small businesses, this means that workers and their families in businesses of fewer than 50 make up more than half of uninsured Maine residents. Fifteen percent of the uninsured are working in temporary or seasonal jobs, and 17 percent work part-time.

Even among businesses that have health benefit plans, cost constraints can create barriers to coverage. One fifth of Maine's uninsured – about 27,000 people – are eligible for coverage through their employer or a spouse's employer benefit plan. Three quarters of these eligible individuals indicate that they remain uninsured because they cannot afford the premium costs. Only 2 percent decline the offer of insurance coverage believing that they do not need coverage because they are rarely sick.

Based on these survey findings, as well as direct commentary from business owners (reported in Section 2), policymakers in Maine concluded that eroding health coverage is directly linked to rapidly rising health care costs and that access and cost issues must be addressed simultaneously. Only an all-encompassing system that eliminates the substantial burden of bad debt and charity care, that controls cost shifting between payers, and that infuses new premium contribution dollars from moderate income individuals and businesses was viewed as having the capacity to reverse the current upward trend in costs and downward trend in coverage. In addition, although the Governor concluded that a comprehensive reform strategy was needed to achieve the goal of universal access, his Administration identified the small business sector, part-time workers and the self-employed as having the most pressing need for policy intervention, and targeted this group for immediate programmatic assistance.

1.4 The State of Maine's Health, Regional Differences and National Comparisons

One of the activities undertaken with resources from Maine's Continuation State Planning Grant was an epidemiologic analysis of regional differences in population characteristics within Maine, for the purposes of supporting Maine's State Health Plan development. For the purposes of the analysis, Maine was divided into three areas, each with approximately the same number of people residing therein. These regions – the Northeast region, the Central region and the Southern region also roughly correspond to the service areas of the three hospitals in Maine providing all or some tertiary level care. The study, in addition to analyzing regional differences,

compared statewide Maine statistics with national averages. Some of the key findings are presented below.

Maine Health Statistics in Comparison with National Averages

Demographics

Compared to the nation as a whole, Maine's population is skewed toward demographic and socio-economic characteristics often associated with poorer health. Maine has a higher than average age, a lower than average household income, and a higher average age than the US population at large. However, the proportion of Maine's population living below the poverty line is lower than is seen, on average, across the country.

Disease Prevalence

The rate of smoking-related deaths is significantly higher in Maine than for the US population, for both men and women. Although it has now come down to the national average, for many years, the smoking rate in Maine was higher than the nation as a whole. Maine will likely continue to see the health effects from prior high smoking rates, for some years to come. The overall rate of cancer of all kinds is higher in Maine than in the US. Mainers have higher incidence of lung cancer, prostate cancer, and colorectal cancer. Mainers, however, have lower incidence of breast cancer than the US average. The overall death rate from cancer is also significantly higher in Maine than in the US. Most of the excess death is attributable to mortality associated with lung cancer. Maine also has significantly higher rates of asthma among adults than is found in the nation, as a whole.

On some other diseases, Maine compares well to or is on a par with the nation as a whole. The prevalence of high cholesterol is the same in Maine as in the US. The prevalence of diabetes in Maine is the same as for the US. Death from heart disease is significantly lower in Maine than the national rate. Maine women receive health care earlier in their pregnancy than do American women, generally, and the State has lower rates of infant mortality and premature birth – although the rate of low birth weight babies is slightly elevated compared to the national average. The teen birth rate is significantly lower in Maine than in the US. A significantly lower proportion of Maine's population is obese than is true of Americans, generally. However, a significantly higher percentage of Mainers are overweight than is true nationally.

Regional Variation in Maine

Demographics

Currently, the age distribution across the three regions in Maine differs only slightly. The Northeast region (the most rural) is slightly older than the rest of the state (15.2 percent age 65 and older, compared to 13.7 percent in the southern region). However, the rates of change in population differ quite dramatically. The southern region, which has higher average income, employment and education levels than the rest of the state, has seen most of the population growth. As such, it is the only region in the State that saw a net increase in children in the decade

between 1990 and 2000. The other two regions experienced a net loss in persons under age 45 over the last decade.

Health Status

People living in central and northeastern Maine generally report their health as being poorer than do persons living in southern Maine. A greater proportion of people living in the central and northeastern regions have three or more chronic medical conditions. Similarly, more people in central and northeastern Maine report their health as being either "fair" or "poor." The differences between southern Maine and the other two regions are statistically significant.

Health Behaviors

Smoking is significantly more prevalent in central and northeastern Maine than in southern Maine. Obesity is greatest in the central region. More Mainers in the southern region report regular vigorous exercise.

Disease Prevalence

Several chronic diseases vary in prevalence by region in Maine. In most instances, prevalence is lowest in the southern region. Among the diseases more prevalent in the northern and central regions are diabetes, Chronic Obstructive Pulmonary Disease, and all cancers. However, cancer mortality does not differ by region. Prostate cancer, where the incidence is 40 percent higher in central Maine and 28 percent higher in nrtheast Maine than in the southern region has statistically significant differences in rates of diagnosis. Other regional differences in incidence of specific cancers do not reach the level of statistical significance.

By contrast, the overall incidence of stroke (as measured by hospitalizations) is highest in the southern region of the State. The difference is limited to the elderly population. The rate of death due to stroke, however, is higher in the northeastern region of the state.

Some chronic illnesses do not show regional variation. Asthma prevalence is similar across the State. Coronary heart disease and related conditions such as high blood pressure and high cholesterol is evenly distributed. However, the incidence of acute myocardial infarction does vary significantly, with the highest hospitalization rate in the northeastern region. In addition, the rate of CABG procedures is highest in the northeast region and lowest in the southern region. Mortality due to heart disease and heart attacks across all age groups is significantly lower in the southern region than the in the northeastern region.

While the incidence of AIDS is similar across all three regions, the rate of other STDs are lowest in the northeastern region.

Occupational Health

Southern Maine has the highest rate of workers' compensation injury cases, followed by the central region, with the lowest rate in the northeast. Central Maine, however, has the highest

medical cost per workers' compensation case, followed by the northeast, with the lowest rate in southern Maine. These differences may reflect differences in the industry mix across the regions, with higher concentrations of physically dangerous jobs such as logging and construction that can generate serious injuries in the northeast, while the southern part of the state may have higher concentrations of office-based occupations that contribute to repetitive motion injuries that may be lower cost per case.

Use of preventive health services

Rates of use of screening services also varies by region. The rate of adults receiving a colonoscopy/sigmoidoscopy is significantly lower in the northeastern region of Maine. In particular, the rate for persons over age 50 shows substantial differences. PSA screening tests for prostate cancer are highest in central Maine, which also has the highest diagnosis rate for prostate cancer. Among women, the proportion having mammograms, clinical breast exams, and Pap smears does not vary significantly by region. People living in the southern region were more likely to see a dentist during the past year than in other regions of the state. A smaller proportion of southern Maine's population suffers from gum disease than the rest of the state.

Mortality Rates

The mortality rate attributable to alcohol use is much higher in central Maine than it is in either of the two other regions. In the case of drug-induced deaths, the mortality rate is considerably higher in southern Maine than the other two regions. The death rate due to motor vehicle accidents is highest in central Maine, influenced by a particularly large disparity among teenagers and young adults. Since central Maine also has the highest alcohol-related deaths, drunk driving may be a factor in the motor vehicle accident rate.

Overall suicide mortality rates are higher in the northeastern region of Maine than in southern or central Maine. Suicide among teens ages 15 through 19 is highest in the northeastern region. That region's rate is 84 percent higher than the comparable rate for the central region and 38 percent higher than the southern region. The rate of suicide among persons age 45 and older is also highest in northeastern Maine.

Over 40 percent of homicide deaths in Maine are associated with domestic violence. The proportion of all homicides that are attributable to domestic violence varies across areas, with the highest proportion occurring in the northeastern region.

Deaths from pneumonia and flu are highest in the southern Maine region.

Quality of Care Indicators

Our analyses included two markers of quality of hospital care: the rate of adverse events following a hospital discharge and the rate of hospital acquired wound infections. When the data are adjusted for difference in severity of hospital admissions, there are no statistically significant differences in the rates of these two indicators.

Measures of Regional Differences in Access

Residents (both adults and children) of the southern Maine region have the highest percentage of the population with health insurance – with an uninsurance rate of 10 percent. The central region averages 11.6 percent uninsured, and the northeast region, 16.5 percent uninsured. The difference in coverage rates between the northern and southern regions of the state is statistically significant.

Among children 0 through 17, the rate of health insurance coverage in central Maine is 10 percent lower than in the southern or northeaster regions of the state. This difference may reflect a greater use of the MaineCare program in the north and south than in central Maine. A recent national study found that 20 percent of Maine children without insurance in 2003, received no medical care during the year.[7]

The hospital uncompensated care burden is greatest among hospitals in the central region of Maine. This may indicate greater concentrations of uninsured citizens with serious medical conditions in this part of the state. However, the rates of uninsurance and of poverty are highest in the northeast region of the state. The uncompensated care difference may be attributable to differing hospital policies with regard to the provision of uncompensated care, to different cultural attitudes regarding seeking medical care and paying medical bills among citizens, and/or differences in the cost of care.

Significantly more Mainers in the northeast region report difficultly affording physician visits when needed than Mainers in the southern region. The rate varies from about 14 percent in the northern part of the state to about 7 percent in the southern region, with the central region falling half-way between.

Use of hospital emergency departments can be an indicator of barriers to appropriate ambulatory care access – particularly for persons seeking medical attention for ambulatory sensitive conditions. The central and northeast regions of Maine have almost twice the utilization rate of ED visits as the southern region. Differences occur across all age groups. Emergency department visits for substance abuse and asthma are highest in central Maine.

A similar pattern is seen with hospitalizations for ambulatory sensitive conditions. The admission rate is highest in northeast Maine, followed by central Maine, and lowest in Southern Maine.

Access can be affected by provider supply issues, as well as by citizen characteristics and insurance status. The supply of primary care physicians varies by region, with the highest concentration found in the southern part of the state. Differences in the distribution of dentists, which follow the same pattern, are statistically significant. The supply of registered nurses and licensed practical nurses per population is lowest in central Maine.

Health Care Resources

For some health care services, capacity varies by region. The availability of physicians, inclusive of both primary care doctors and specialists, is about the same in the central and northeast

regions, with 230 physicians per 100,000 population in the central region and 239 in the northeast region. The southern region, however, has a greater concentration, at 306 physicians per 100,000 population. Both dentists and dental hygienists are more available in the southern region of Maine than in either the central or the northeast region. Physical therapists and occupational therapists are also more concentrated in the southern region than in the other two regions.

The central region has lower concentrations than the other two regions of pharmacists, psychologists, and licensed social workers. The central region, however, has the highest concentration of radiology technicians, with 131 providers per 100,000 population compared to 125 in the northeast region and 117 in the southern region.

Conclusions

These analyses show that Maine has considerable geographic variation with regard to population characteristics, the burden of disease, and the availability of health care resources. The more rural parts of Maine have older populations, lower average income, lower rates of insurance coverage, and greater disease burdens for some chronic illnesses than is found in the more densely populated and economically robust region in the southern part of the State. While these findings point to a greater need for health care services in rural areas, many of the states's health service resources are more concentrated in the southern region, when adjusted for population density.

These findings pose special challenges to state policymakers, as they develop the State Health Plan and prioritize initiatives in the strategic planning process.

Section 2. Employer-Based Coverage

Maine State Planning Grant activities did not include an employer survey. Some information from Maine's household survey from which information about employer coverage can be deduced is reported in section 2.1, below. As part of the Maine State Planning grant, the Institute for Health Policy at the Muskie School conducted focus groups with small employers and key informant interviews with representatives of large employers, to gain insight into the state of the employer health insurance market and the attitudes of employers toward various strategies for change in the market. Findings from this qualitative data collection effort are reported in sections 2.2 through 2.7. A link to a full report on focus group findings is provided in *Appendix 2.*

2.1 Quantitative Analysis

Characteristics of Firms Offering Coverage, compared to Firms that Do Not

Based on Maine's household survey, Maine workers and their dependents in firms of 10 or fewer workers have a probability of being uninsured that is four and one-half times as great as Maine workers in firms of 50 or more workers. Slightly over 50 percent of the uninsured in Maine are

linked to employment in firms of 50 or fewer workers (including the self-employed). Based on these data, one can conclude that Maine does not differ from other areas of the country where small size of firm is strongly associated with a lower rate of offers and take-up of health insurance than is found in large firms. Small firm coverage trends are particularly important in Maine where the economy relies on small businesses and self-employment more than most of the New England region (*Figure 1).* Market trends are described in Section 3.

2.2 Decision to Offer or Not

Sections 2.2 through 2.7 report findings from Maine's focus groups with employers in the small business sector

Institute for Health Policy researchers conducted four focus groups, two with employers currently offering insurance to their employees and two with non-insuring employers. The two insuring employer focus groups were held in Portland (urban) and Presque Isle (rural), and the two non-insuring employer focus groups were held in Bangor (urban) and Oxford Hills/South Paris (rural). The two lead researchers on the project from the Muskie School completed nine key informant interviews. Most of these interviews were with health benefits officers or company presidents of large companies in the private sector (e.g., Bath Iron Works, banks, etc.). Branches of national companies, where benefit decisions are made elsewhere were excluded. Two interviews were with large employers in the not-for-profit sector (a private college and the Maine University System). Finally, the Superintendent of Maine's Bureau of Insurance also provided information from the perspective of a regulator.

These focus groups and interviews supported the conclusion, gained from the household survey, that the small business sector is particularly stressed with regard to health benefits in the current market situation in Maine. However, they also revealed significant concerns among many (but not all) large businesses and provided insight into a political climate among businesses in Maine that had shifted considerably since the early '90s. Specific findings are discussed, below, in Sections 2.2 through 2.7.

The stress in Maine's employer coverage market, evidenced from aggregate trends in coverage and costs, was affirmed in a series of focus groups with small business employers and interviews with representatives of large businesses.

Among the small employers we interviewed who currently offer coverage, the most frequently provided reason for providing health benefits was competition in the labor market. We heard this response in both the rural and urban markets. Typical responses were: 1) "I offer insurance to compete." 2) "I need the loyalty of my workers." 3) "I think it is really instrumental in keeping our employees. They could go elsewhere….I think the health insurance has kept them around."

A second response we heard frequently related to an awareness of trade-off costs in absenteeism or workers' compensation costs. One rural employer said, "When we didn't have [health insurance], worker's comp rates went up because people would use it as health insurance." Another said, "Employees take more sick time when they don't have insurance. They take better

care of themselves when they have insurance." A Portland-based employer, explaining why he contributes to family coverage as well as employee coverage (a rarity) painted a graphic picture for us: "I have a young mother with two children who is single. If I say, your kids are your problem and if you can't pay for it (family coverage) – too bad…It might be egalitarian, but if her kids are sick, – she's useless to me. I can bring her in and sit her at a desk, but if her kids are sick at home and they are not getting treatment, I am not going to get a day's work. I want everybody to be equal [but] I want everybody to be emotionally capable of coming to work and doing the job."

Finally, a number of employers responded that providing coverage was "the right thing to do," or a moral obligation.

Among employers who do not offer coverage, the overwhelming reason given was cost. A substantial number of the employers participating in our focus groups who currently do not provide coverage had done so in the past, but gave it up because they could no longer afford it. Their responses reflect the current volatility in Maine's small group and individual insurance markets. A typical response was: "I had coverage until last October, when my premiums went up 50 percent. I had to make a decision that at this point, I don't have any coverage." Another employer put it this way: "You might as well be paying for another house…I was paying $930 [a month] with the National Association for the Self-Employed….They went up to $1,500 a month."

Other reasons offered for not providing coverage relate to the volatility of the workforce and uneven demand. One employer whose business requires hard physical labor said, "Mine is a filthy, nasty, hard business to be in….If I keep an employee for six months to nine months, it is a wonderful thing." Many spoke of having some employees who got coverage through a spouse and only a few who needed coverage.

The predominant attitude among the employers from large businesses was also that health insurance is a prerequisite for competitive recruitment and retention of employees. Employees expect the benefit and many would consider employment absent health benefits unacceptable. Many large employers indicated that they recruit nationally for management and professional positions. The labor market in which they compete is national, and benefits available through similarly situated employers around the country are the standard of comparison.

2.3 Factors Affecting Decisions Regarding Benefit Package and Premium Contributions

Because of steep increases in prices in the small group and individual insurance markets in Maine in the past several years, employers participating in our focus groups uniformly reported shifts toward more employee premium cost sharing and/or higher deductible policies. Many employers who previously covered 100% of an individual employee's premium reported now contributing 50% or 60%. Others reported increasing the deductible from $500 to $1,000. A few reported strategies where they increased the deductible to $2,000, or more, and "self-insured" the deductible amount by setting aside firm funds that employees could spend down for medical costs. A portion of each employee's unspent monies was shared with the employees at the end of the year to create incentives for reduced utilization.

The focus groups were structured to asked participants to respond to a series of trade-off questions, with regard to benefit structure, so we might systematically determine popular and less popular options. The trade-offs were the following:

> Holding benefits constant (and assuming a comprehensive benefit package) asking participants to choose between lower copayments and deductibles with higher premiums or higher out-of-pocket costs with lower premiums.
>
> Holding benefits *and* out-of-pocket payments constant, asking participants to choose between lower premiums with a limited provider network or unrestricted choice with higher premiums.
>
> Holding premium costs and benefits constant, asking participants to choose between unrestricted choice with high out-of-pocket cost sharing or a restricted network with lower out-of-pocket costs.
>
> Holding premium costs constant, asking participants to choose between a catastrophic health plan with high front end cost sharing, or coverage for preventive and routine health care costs with a limited hospital benefit and a cap on total benefits.

Across the four focus groups, the response to the trade-off between premiums copayments and deductibles was in favor of lowering the premium. This expressed choice is reflected in actual market behavior in Maine, where the small group and individual markets are shifting dramatically to high deductible policies.

Sentiment among focus group participants was very mixed with regard to limited provider networks in both rural and urban areas. The major concern expressed toward limited networks was with restricted choice of specialists in the event of a major illness. Even in Presque Isle (a 7 to 8 hour drive from the southern Maine border) some participants expressed dismay at the idea of not having access to specialists in Boston. Some participants, however, expressed indifference to the concept of limited networks, pointing out that preferred provider organization plans in Maine currently contract with all providers willing to participate.

Presented with a choice between catastrophic coverage and routine and primary care coverage, most participants expressed a preference for catastrophic coverage (again, reflecting current market dynamics), commenting that their highest concern was protecting their assets. Some respondents pointed out, however, that among employees, preference was likely to be affected by age and income. One respondent referred to the idea of very high deductible plans as "class war," stating that for individuals with the discretionary income to pay the deductible out-of-pocket, such a plan was clearly preferable, but many low wage workers would face substantial hardship in paying their bills, in the face of a serious illness. Another commented that for the young and healthy, who expected to use few or no health care services, lower premiums in exchange for higher deductibles was a preferred choice, but for older workers who routinely use more medical care, a high deductible policy was less attractive.

Many employers, in all four focus groups, expressed considerable interest in strategies that encouraged preventive behaviors on the part of employees. In the most conservative group, this perspective translated into a desire to dismantle small group market reforms and revert to insurance pricing strategies where premiums reflect health status and prior utilization. One employer made an analogy with automobile insurance stating, "If you are a good driver, your car insurance is lower." Even when pressed, by the facilitator on coverage for illnesses which are not influenced by personal behaviors, this group maintained a preference for experience-rated premiums. As one said, "Right now, we are all being penalized, so to give the benefit to the majority of people, it would be best to get [a premium break] for not using health services."

In other groups, the interest in prevention translated into two types of suggestions. The first was a desire to see preventive services, such as "check-ups" and screening exams covered, even under high deductible policies. (Plan riders for a schedule of preventive services are currently being marketed along with catastrophic coverage policies by Anthem Blue Cross, which controls 90 percent of the non-group market in Maine.) Second, a number of employers suggested increasing premiums for smokers. One employer suggested he would like to be able to say to his employees, "Look, Joe, you are too fat. You smoke. You drink too much. We are not going to insure you. You have to start taking care of yourself better – then we will start taking care of you." He added, "That is something we are going to have to take a look at. We are going to have to throw something back onto the employee that says, if you want it, here it is, here is what *you* have to do."

Similar to the small business employers, large employer representatives identified rising health care costs as the biggest challenge confronting their companies. There was little consensus, however, on strategic responses. Many were in the process of assessing future options. Several predicted a move to more employee cost sharing both of monthly premium expenses and deductibles. One company had introduced a high deductible plan at no monthly premium cost for employees as a strategy for attracting younger and healthier workers to the company. A number of interviewees mentioned consumer driven health plans, under Section 105 of the IRS code, as an increasingly attractive approach to cost sharing with employees. Other companies, however, felt that any diminution in benefit coverage would reflect poorly on the company and generate employee hostility. These companies were currently more interested in alternative cost management strategies such as disease management programs.

The broader range of opinion among large companies was reflected in interviewees' responses to benefit tradeoffs. When asked to prioritize among lower premiums, comprehensive benefits and free provider access, there were significant differences in opinion that reflected both corporate philosophy as well a conditions specific to a company's workforce.

When compared to small businesses, the larger companies clearly demonstrated familiarity with a broader array of tools and expertise to evaluate and implement different management strategies for health benefits. Most were self-insured, allowing company flexibility with regard to coverage of state mandated benefits. Medical savings accounts, flexible benefit plans, more effective management of pharmacy benefits, and closer attention to plan administration were all mentioned as strategies companies recently have used to better manage their medical plans.

2.4 Employer Response to Economic Downturn or Cost Increases

Maine has experienced both an economic downturn and substantial insurance cost increases over the past three years. The response in the small group market has been dropped coverage, increased employee cost sharing, and an increase in the number of uninsured. A majority of the non-insuring employers who participated in our focus groups reported either having dropped individual coverage for themselves and their family or group coverage in the recent past. Several of the employers who continued to provide coverage, but who had increased employee cost-sharing, reported that their young employees had dropped from the plan.

Some of the large company representatives interviewed indicated an interest in their company in non-insurance-based approaches to managing benefit costs. These included fitness and wellness programs, employee assistance plans, case management and disease management. Consumer education programs were also described; both traditional programs, like smoking cessation, as well as educational programs aimed at helping employees and their families to better and more effectively use the benefit plan provided. Health education services extended to on-site preventive and acute care. One employer had found that the introduction of on-site physical therapists had been very effective in reducing utilization for certain musculo-skeletal conditions.

A number of respondents emphasized that the effectiveness of these interventions were very data driven. Without good information, it was impossible to make the business case for initiating a program or to appropriately evaluate the results. Many of the employers attempting health improvement innovations are members of the Maine Health Management Coalition where they contract for analyses of their company's claims data and have the opportunity to compare the experience of their own company to other member company's data reports.

2.5 Susceptibility to Crowd-out

We did not include questions in our focus groups related directly to crowd-out. However, we did query employers about their view of the role for government in health reform. In three of the four focus groups, opinions – although mixed – reflected a decided shift toward a seeing a greater need for a government response to a non-functional market. Several employers stated a preference for a state-sponsored, universal, single payer system. Others cited the example of the Maine Mutual Employers Insurance Company – a legislatively created, non-profit entity that provides workers' compensation coverage and competes with private insurers. Others said that although they did not like government-run services and distrusted bureaucracies, there was a role for state government in controlling costs.

In one of the four groups, the opinion of most participants was decidedly anti-regulatory. They perceived regulations requiring guaranteed issue and renewal, limiting pre-existing condition limitations, and modified community rating as driving the cost increases in the small group and individual market. As one participant said, "The legislature should admit they made a mistake and undo the regulation to see what happens."

The openness to an expanded government role on the part of a significant section of the small employer community indicates that many small employers may be willing to participate in the

DirigoChoice Plan sponsored by the State (see section 4) – something the plan is designed to accommodate. For plan design features intended to prevent crowd-out – as defined by Maine policymakers – see section 4.13.

As indicated in Sections 2.3 and 2.4, above, those large employers in Maine who were interviewed as part of the research for this project see health benefits as essential to their ability to attract and retain good employees. Since many of them view similar companies around the country as their competitors for top level employees, they are less inclined to respond to changes in public coverage options locally. The exceptions to this market dynamic are the big national companies such as the "big box" stores that have many low wage, low skill, jobs and that expect high employee turn-over. As discussed in Section 4.13, Maine's strategy, so far, with regard to a potential "crowd-out" with such employees is to limit access for new initiatives to employees of small businesses.

2.6 Impact of Expansion Strategies on Employers

Both market evidence (discussed in section 3) and commentary from employers in focus groups and interviews supported a view that the primary deterrent to employer-based coverage in Maine is related to the cost of coverage. The strategies identified in Maine for expanding health insurance and moving toward universal coverage (described in Section 4) target this problem in two ways: direct subsidies and regulatory and voluntary strategies to bring down health insurance costs.

Maine policymakers have chosen to direct subsidy dollars to the employee share of program participation costs (and employers' personal share – if their household income is below 300 percent of the federal poverty level) rather than to the employer share of benefits costs. Participating employers are required to contribute a minimum of 60 percent of the total enrollment cost for employees. This choice was taken, in part, because it offers greater assurance that the public dollars used for coverage subsidies go directly to the purpose for which they are intended – expanded access – rather than substituting for money employers would otherwise have spent on health benefits and allowing greater expenditures elsewhere or increased profit margins.

While explicit subsidies are provided to individual members, important steps have been taken to hold down the overall program costs, providing an indirect subsidy that benefits employers, as well. Under the terms of the contract with the partnering insurance carrier (Anthem), an Experience Modification Program – or "EMP" – is established. The EMP is essentially a risk sharing mechanism that limits Anthem's exposure for the DirigoChoice group. Although the EMP phases down over time, the protection it provides to Anthem results in rates that are lower than they otherwise would have been willing to contract for, which acts as an across the board subsidy for all subscribers.

While expected up-take of the DirigoChoice Plan was modeled by Mathematica Policy Research and Watson Wyatt (under contract to the Maine State Planning Grant), based on individual price sensitivity information derived from their proprietary database this theoretical model was used for planning purposes only. Lacking adequate data, either local or national, on small employer

response to similar programmatic initiatives, the consultant models assumed a uniform probability of an employer offer, and modeled likely employee response to an offer. The market reality of a program offered as a small group product is that the interaction of employer response and employee response figure into uptake rates and cannot, based on current data sources, be adequately predicted.

Information obtained primarily through employer focus groups, supplemented with research reports on other state initiatives targeted to small businesses has guided Maine policymakers' expectations regarding employer response. We expect that the availability of employee subsidies will affect the behavior of small employers, particularly those with low wage workers. A number of employers reported difficulty in establishing the minimum participation levels required by insurers because of the reluctance of many workers to participate in insurance programs. The availability of discounts for low wage workers provides employers and interested employees with an additional tool in persuading recalcitrant colleagues to participate. Further, insurers in the small group market in Maine vary premiums by group size, with a steep increase in cost for very small groups. Even for currently insuring employers, the availability of a discounted insurance product may increase the size of their covered group to a threshold level which reduces the cost per covered person – an added incentive for group participation. This dynamic has already been documented in some of the initial groups participating in the DirigoChoice Plan

2.7 Strategies to Motivate Non-insuring Employers to Provide Coverage

In addition to the expected effect of available discounts, the Dirigo Agency staff are using a television, radio, and newspaper marketing campaign to assure wide-spread dissemination of information about the DirigoChoice Plan. While employers and individuals can obtain information and application materials from the Dirigo Agency website and apply directly through the agency, the agency is relying primarily on the insurance partner's network of brokers for outreach and enrollment. Because the DirigoChoice product is different from anything previously sold by brokers, is complex to explain, and requires a lengthier and more complex application and review process, successful marketing requires broker training and added incentives. These activities are in place and are currently undergoing review and revision.

The Governor's Office of Health Policy and Finance has also received a Direct Service Workforce grant from the federal Centers for Medicare and Medicaid Services which it will use to test and implement strategies to improve the recruitment and retention of community-based direct service workers who provide support to people with disabilities and elders. This demonstration grant provides an opportunity to research and test additional incentive strategies for employers to encourage them to offer health benefits. Under the Workforce Grant, agencies employing direct service workers will be offered group coverage through the DirigoChoice Plan (see Section 4). In addition, the demonstration will develop a package of services for employers, to increase incentives for them to participate and to make the required employer contribution toward the health coverage. The package of services will be developed based on data collection from employers to determine what services would be most needed and attractive. The information gained through this demonstration project may have broader applicability for the Dirigo Program in learning what strategies will improve voluntary participation in the DirigoChoice Plan by other small employers who do not currently provide coverage.

Section 3. Maine's Healthcare Marketplace

Over the decade of the '90s, per capita personal health care spending in Maine rose at an average annual rate of 7.3 percent, faster than any state in the nation.[8] Regional health care costs reflect the interaction of population health characteristics, local prices for services, geography that contributes to local monopoly provider markets, and utilization which in turn can be affected by consumer demand and provider practice patterns. State Planning Grant research staff undertook a series of analyses to try to determine, to the extent possible, the factors underlying Maine's status as one of the top states in premium costs and in personal health care spending. These analyses included the development of a chart book in which Maine population characteristics, health system characteristics and spending are compared to national data and to five benchmark states selected based on their similarity to Maine's economy and rural status. On-line access is provided to The Chart Book in *Appendix 2.* In addition, project staff used claims data to analyze six year trends in cost and utilization for employees of large employer groups belonging to Maine's Health Care Management Coalition (approximately 200,000 lives). We conducted the trend analysis to differentiate trends in utilization, service intensity, and cost, and examine trends by specific sectors within the delivery system. Maine trends are compared to the national experience. The six year trend analysis is summarized below. The full report is attached in *Appendix 3,* with on-line access provided in *Appendix 2*.

Trends in Health Service Costs and Utilization

Among the characteristics of Maine's health care marketplace are low levels of competition among providers and low penetration of tightly managed managed care systems. As a largely rural state, most hospitals in Maine have minimally overlapping service areas with other inpatient facilities. Moreover, in the past 10 years, a large number of Maine's community hospitals have organized, through mergers or affiliation agreements, into one of four large hospital systems. Physicians, too, have consolidated, vertically and horizontally. Almost all radiologists and anesthesiologists in the State are employed by a single organization. Office-based specialists are concentrated in the State's largest cities and into single and multi-specialty group practices.

These delivery system characteristics, as well as the insurance market characteristics, influence rates of health care spending in Maine. Maine's State Planning Grant project analysts conducted an analysis of six years of private insurance claims data in order to better understand the cost and utilization dynamics that have driven insurance premiums and made Maine one of the highest per capita spending states in the country.

The analysis relied on de-identified claims data from the health benefit plans of some of the employers participating in the Maine Health Management Coalition, a consortium of about 40 Maine employers including public sector and private entities. Overall, the Maine Health Management Coalition employees and their dependents include about 200,000 Maine residents (approximately 25 percent of the privately insured population in the State). The analysis was limited to member organizations that were part of the Coalition throughout the six year study period, 1995 through 2001. This group encompassed about 106,000 health plan beneficiaries.

The purpose of the analysis was to examine changes in health service utilization and costs over time. Expenditures analyzed included both empoyer and employee share of covered benefit costs and capitation payments so that observed differences from year to year reflect changes in total cost, not benefit variation. The analysis excluded pharmaceutical costs because of incomplete data. The units of analysis were average, per-person cost per member per month (PMPM) and measures of average utilization. Where possible, the Maine Health Management Coalition experience was contrasted with national data from privately insured populations for the same time period.

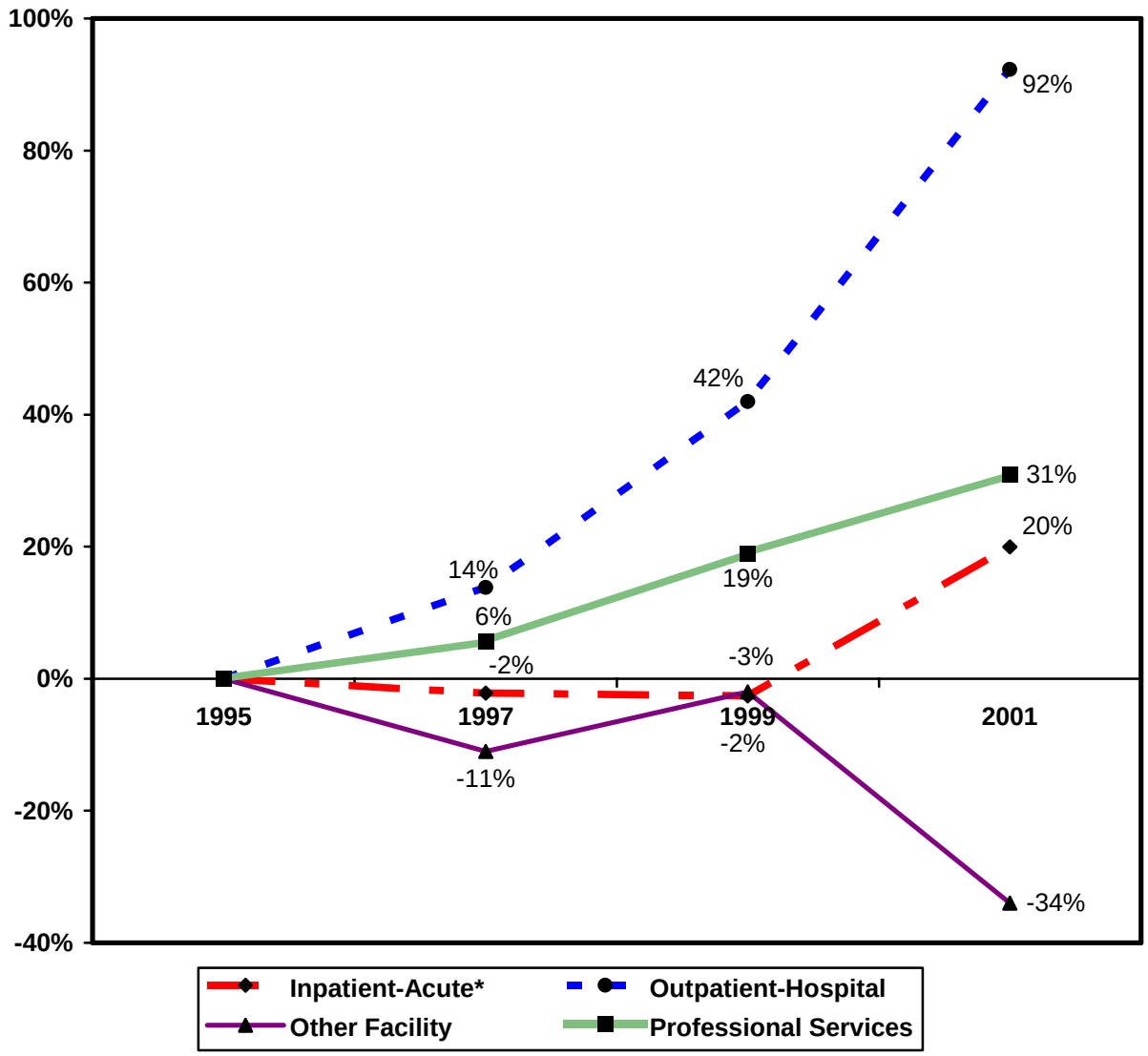
Trends by Category of Service – Summary of Findings

While age-adjusted PMPM costs across all categories of covered services (exclusive of pharmaceutical costs) increased 34 percent between 1995 and 2001, the percent increase differs dramatically for specific services. Figure 2 depicts the cumulative six-year change in PMPM costs for select categories of service: acute-care inpatient, hospital outpatient, professional services, and other facility services.

Hospital outpatient services rose at the most rapid rate during the study period, increasing 92 percent in per person cost over the six years. General acute care inpatient PMPM costs increased 20 percent and professional services increase 31 percent. The PMPM costs of other facility services declined by 34 percent. This category represents a very small proportion of total costs.

Figure 2

Cumulative Percent Increase in Per Person Cost by Category of Service 1995 – 2001



Trends in Inpatient Costs and Utilization

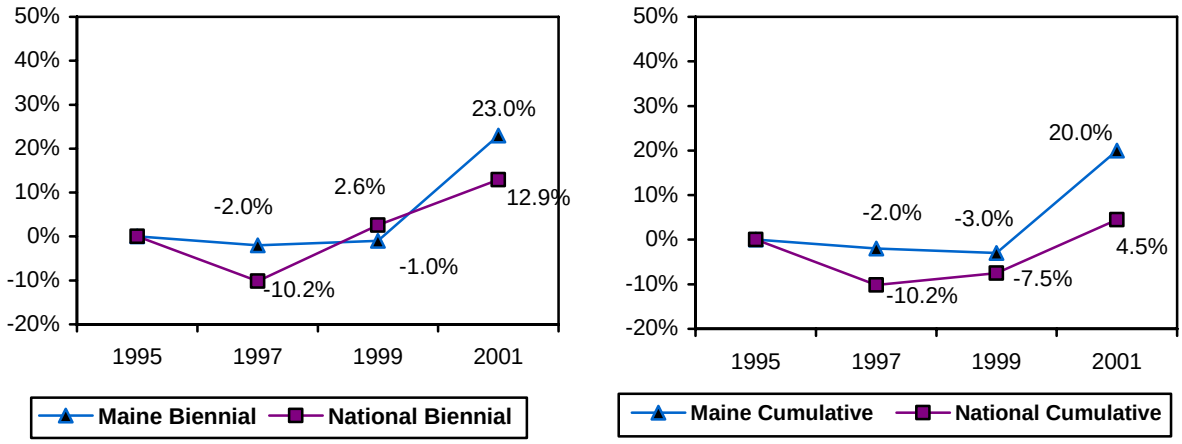
The Maine Health Management Coalition rate of inpatient use declined between 1995 and 2001 – with a 12.6 percent decline in the discharge rate per 1000 and a 5.8 percent decline in patient days per 1000. During this same period, average expenditures per discharge increased by 40 percent (18 percent when adjusted for case-mix). The net effect of declining utilization and increasing unit costs was a 20 percent increase in per member per month costs for inpatient care.

The MHMC experience with inpatient cost increases between 1995 and 2001 differed

markedly from the experience of private insurers nationwide (Figure 3). Based on data from the Milliman USA Health Cost Index, private insurer hospital costs on a per capita basis declined 10 percent between 1995 and 1997, stayed flat in 1998, rose less than 3 percent in 1999, and rose about 13 percent between 1999 and 2001. Using 1995 as a base year, this drop and subsequent increase put per capita costs only 5 percent higher in 2001 than they had been in 1995.[9] These costs, derived from both publicly available and proprietary data, are based upon a $0 deductible policy[10] to control for the effect of increased employee cost sharing in measuring expenditures. In this respect, the measurements are comparable to the MHMC costs used for this study, which include both employer and employee costs associated with hospital expenditures. During this same time period, the MHMC employers included in this study saw much smaller decreases in the mid-'90s and steeper rises at the end of the decade. As a consequence, their per capita inpatient costs were 20 percent higher in 2001 compared to 1995.

Figure 3

Biennial and Cumulative Changes in Inpatient Per Capita Costs, Maine and National 1995-2001

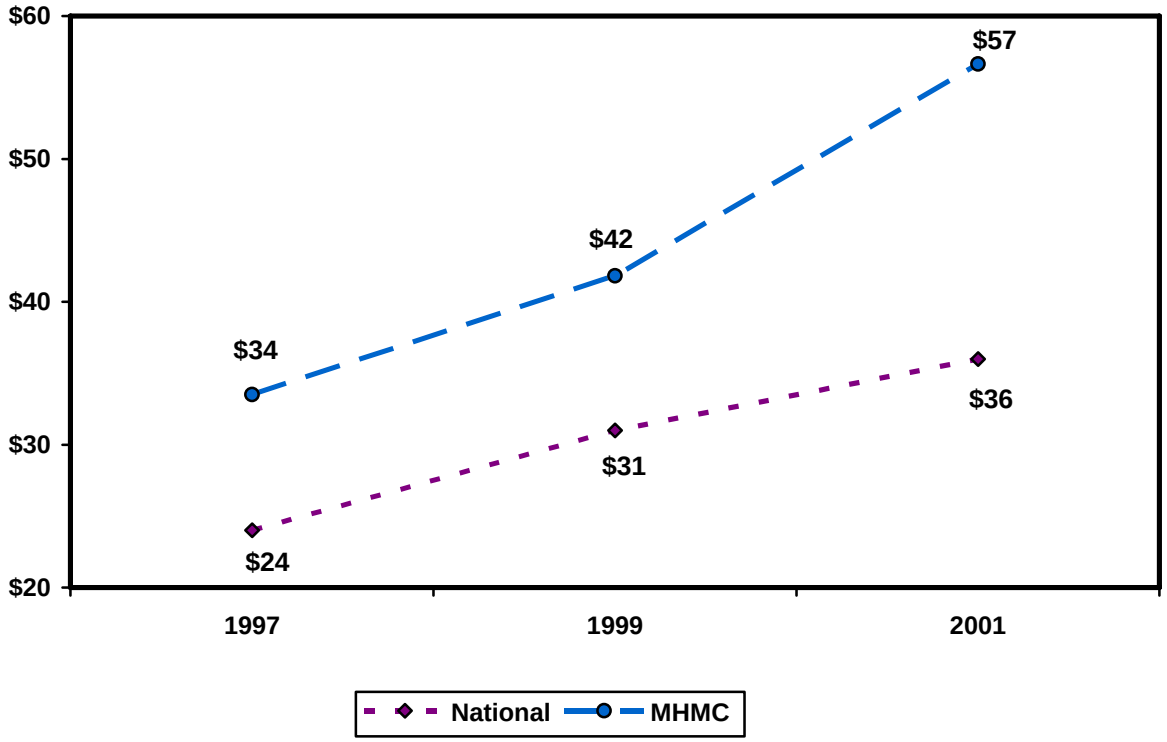


Trends in Hospital Outpatient Costs

Figure 4 compares the MHMC increases in PMPM for outpatient services to the average experience of "loosely managed" commercial health plans nationally. The national data are excerpted from a report by Milliman-USA.[11] The Milliman report demonstrates that national hospital outpatient PMPM costs increased substantially between 1997 and 2001, from $24 to $36. However, this increase of 50 percent over three years remained less than the MHMC increase of 68 percent over the same time frame.

Figure 4

Estimated National Average Commercial Plan PMPM Cost for Hospital Outpatient Services Compared to Maine Health Management Coalition Experience 1995 - 2001



Source for National Data: Milliman Health Cost Guidelines, as cited in, Pyenson, BS, Zenner, PA, Chye, P. (2002). *Silver Bullets for Outpatient Cost Increases?* Milliman, May 2002: p. 4. Data were extrapolated from a bar chart so dollar amounts are approximate.

Procedure Trends

Table 7 presents the change in the use rates of selected procedures from 1995 – 2001 for the MHMC study population. These procedures, while frequently provided on an outpatient basis, are not limited to hospital outpatient departments, but encompass all settings including physician offices, ambulatory surgical centers, nursing facilities and health center.

Table 7 reveals very substantial increases in the rate of use of some tests and procedures. CAT and MRI imaging, for example, rose 143 percent and 149 percent respectively. Colonoscopies per 1000 covered persons increased 262 percent. It is unlikely that a major change in disease or trauma could explain an increase of more than 100 percent in utilization in a study population of working families drawn from the same group of businesses throughout the period of observation. The very substantial increases in imaging tests may have been driven in part by increased capacity in the State, both within hospital outpatient departments and in free-standing facilities. A published report indicates, for example, that the number of free-standing MRI units within Maine increased 1200 percent between 1999 and 2001, and that the current capacity relative to population density in Maine is more than double that of demographically similar states and about eight time the capacity in New Hampshire.

Table 7:
Change in Rates of Procedures per 1000 Covered Persons, Maine Health Management Coalition, 1995 - 2001

Procedure Rates per 1000 Covered Persons:	1995	1997	1999	2001	% Change 1995 - 2001
Standard Imaging – Chest	109.0	111.6	130.3	133.9	23%
Standard Imaging – Skeletal	176.0	202.7	240.8	263.3	50%
Standard Imaging – Breast	93.1	114.6	141.0	153.8	65%
CAT Scan	28.7	38.7	51.7	69.8	143%
MRI	18.7	24.1	36.6	46.6	149%
Cardiac Imaging	17.1	21.0	22.9	25.9	52%
Other Imaging	93.4	105.5	135.1	157.6	69%
EKG, Treadmill, Other Cardiac Testing	94.4	110.8	122.3	139.4	48%
Endoscopy – Arthroscopy	4.0	5.3	6.4	6.4	59%
Endoscopy - Upper Gastrointestinal	8.2	9.4	11.5	14.1	72%
Endoscopy - Sigmoidoscopy	7.5	9.8	12.7	11.3	52%
Endoscopy - Colonoscopy	8.1	11.7	16.9	29.2	262%

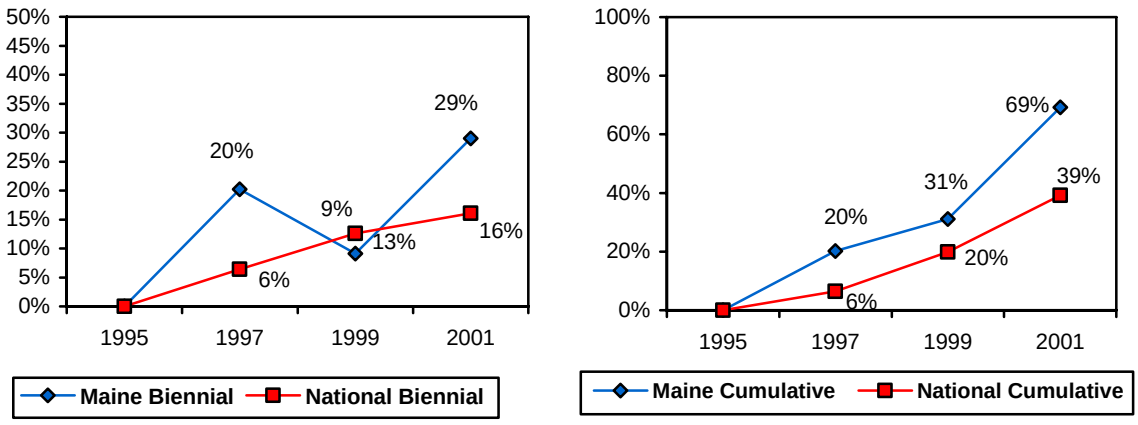
Trends in use and Cost of Physician Services

During the six years of the study, the physician visit rate among study participants increased from 2.6 to 3.2 vists per person per year – a 24 percent increase. At the same time, the average paid per visit increased from $54 to $74 – a 36 percent increase. The net impact in per member per month costs was a 69 percent increase. Per person costs for primary care visits increased slightly faster than specialty care visits, due to a steeper rise in the amount paid per visit.

Maine per capita costs for physician services increased over the study period at a more rapid rate than did per capita costs for private insurers, nationally. Figure 5 shows that Maine costs rose more steeply than national costs throughout the six years except for the period between 1997 and 1999. The cumulative effect over the six years was a 69 percent increase in Maine compared to a 39 percent increase, nationally.[12] Physician visits are a component of professional services and costs for this category of services rose only by 31 percent during the study period, possibly indicating a substitution of physician visits for other professional services. Despite the growth in PMPM costs for physician visits, professional services as a whole composed a smaller portion of total health care spending in the study population in 2001 than in 1996.

Figure 5

Comparison of Biennial and Cumulative Changes in Per Person Physician Costs for MHMC and Privately Insured Persons, Nationally, 1995 - 2001



Conclusions Regarding Trends in Expenditures

These analyses from a privately insured population in Maine shed light on some of the factors contributing to the rapid growth in per capita health care spending in Maine. Growth in per capita spending varied substantially by type of service during the time studied. The high growth sectors in Maine – hospital outpatient services and, to a lesser extent physician services, were also high growth sectors nationally, as indicated by the experience of privately insured populations nationwide. However, the growth rates in Maine exceeded the national experience in

each of these areas. Similarly, the rate of increase in Maine's inpatient costs declined less steeply than the national experience in the mid 1990s and rose more steeply than national per capita costs at the end of the decade.

The factors responsible for increasing per capita expenditures differed by type of service. Inpatient care expenditures increased as a result of unit cost increases. Utilization rates actually declined while costs per discharge rose steeply. The rate of increase in utilization of specific diagnostic services frequently provided on an outpatient basis no doubt contributed to the inflation of average per capita outpatient costs. It was not possible with the data available, to determine the relative contribution of changes in unit price to increasing outpatient expenditures. Both increased visit rates and increases in unit costs contributed to the increase in per capita spending for physician care. However, the increase in utilization for physician visits brought the rate to a level that was below national utilization rates for similar populations and to a level considered appropriate for a population with adequate access to care.

3.1 Adequacy of Existing Insurance Products

An important measure of the adequacy of insurance products is the extent to which available options leave gaps in coverage due to excluded benefits or cost-sharing requirements that leave beneficiaries exposed to substantial financial hardship, should they accumulate major medical claims (under-insurance). A second measure of adequacy is affordability.

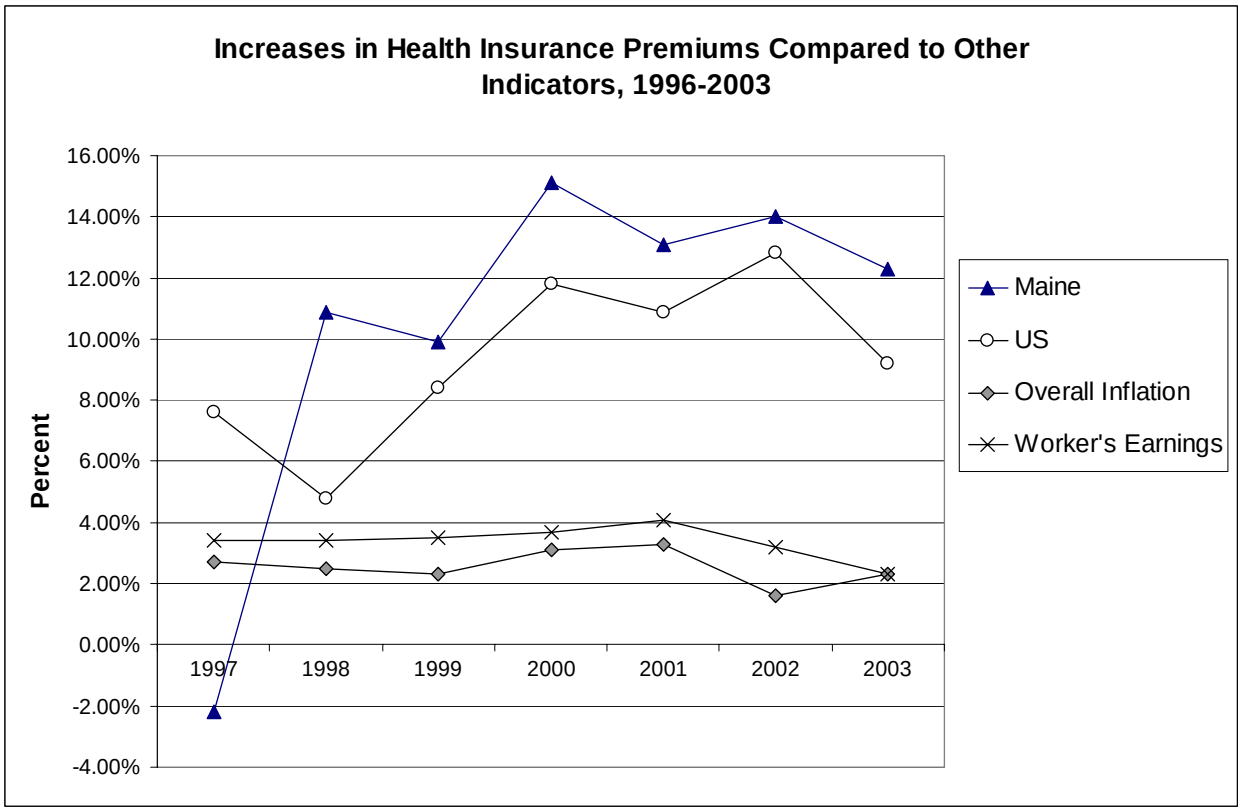
Maine State Planning Grant project staff analyzed information from a variety of secondary data sources to develop an assessment of Maine's insurance marketplace in relation to national trends and trends in New England. Included in these analyses was a review of trends in Maine's commercial insurance market based on data from the National Medical Expenditure Panel Survey – Insurance Component, and data from Maine's Bureau of Insurance. Summaries of the findings from all these analyses are reported below.

Maine Premium Trends in Relation to National Trends

Premiums have been rising dramatically across the country, at a rate that far exceeds wage growth or general inflation. However, premiums rose faster in Maine than in the nation, as a whole (*Figure 6*). In 2002, Maine's average employer-based premium across all sizes of business was among the highest across all states.[13] In 2004, the year that the Maine legislature implemented major health reform, premium increases in the small group market were considerably constrained. The market response was immediate with the first aggregate growth (2 percent) in covered lives in the small group market in four years.

Figure 6

Comparison of Rate of Annual Increase in Total Family Premium, Employers of All Sizes, Maine and the US



Source: Premium data from National Medical Expenditure Panel Survey – Insurance Component, 1997-2002. For overall inflation and workers' earnings, Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation and Seasonally Adjusted Data from the Current Employment Statistics Survey, '88-2002, as reported in the Kaiser Family Foundation and Health Research and Educational Trust 2003 Employer Health Benefits Survey Annual Report.

Because Maine is 39nd among states in median household income[14] these high premiums are a particularly formidable barrier to stable or expanded employment based coverage. Employees are disadvantaged, compared to national average experience, across all sizes of businesses (*Figure 7*). However, small business workers are particularly stressed. Family premiums in Maine's small group market in 2003 were almost 26 percent of median household income, compared to the national average premium rate which was 21 percent of US median income (*Figure 8*).[15]

Figure 7

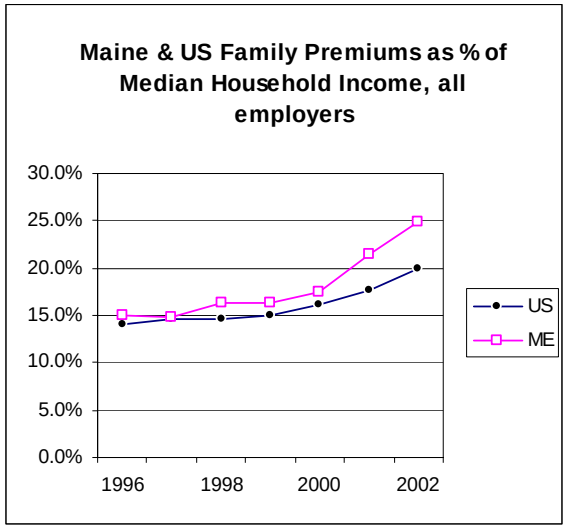
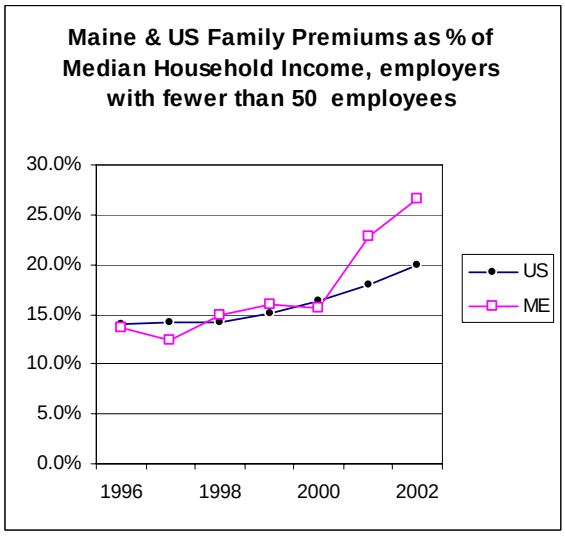


Figure 8



Cost of Employer Benefit Plan Policies in Maine

Table 8, below, presents summary information on premium costs (single and family) by size of business in Maine compared to other New England States. On average, across businesses of all sizes, premiums in Maine are 11 percent above the US mean and rank among the top five states in cost. In the small business sector, Maine family premiums compare more favorably with other states (Maine ranks 21st in cost of family premiums for businesses less than 10 employees). Maine has maintained relatively strict community rating standards in the small group market which results in an even distribution of cost across singles and families. In states with less regulated markets, insurers may load more cost onto couples and family premiums, in the hopes of attracting young (healthy) single subscribers. Thus, Maine compares badly when looking at single premiums, but much better when looking at family premiums. These patterns do not hold for the large employer market, where employers are experience rated.

These rankings do not adjust for scope of benefits so it is not possible to know how product selection differs from state to state or the effect of these differing products on average costs. The market trend in Maine has been toward reduced comprehensiveness of benefits primarily through the use of high deductible policies, particularly in the non-group and small group markets.

Table 8

Average Total Single and Family Premium Per Enrolled Employee in Private Businesses, by Size of Business

	Average, all Employers	Rank	Less than 10 Employees	Rank	Less than 50 employees	Rank	100-999 employees	Rank	1000+ employees	Rank
US Single	$3,481		$3,834		$3,623		$3,430		$3,430	
US Family	$9,249		$9,340		$9,321		$9,038		$9,286	
ME Single	3,852	3	4,534	2	4,093	3	3,809	10	3,666	8
ME Family	10,308	4	9,386	21	10,066	14	10,140	7	10,492	2
CT Single	3,676	12	3,969	14	3,944	8	3,961	6	3,435	23
CT family	10,119	6	9,801	13	10,086	13	11,603	3	9,838	8
MA Single	3,496	25	4,194	3	3,678	21	3,444	25	3,435	24
MA family	9,867	8	10,378	3	10,129	11	9,482	16	9,982	6
NH Single	3,563	21	4,052	11	3,831	13	3,815	10	3,047	47
NH Family	9,776	9	11,188	2	11,078	2	10,477	4	8,515	35

Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Costs Trends. 2003 Medical Expenditure Panel Survey-Insurance Component.

Enrollment Trends in Maine's Commercial Insurance Market

In the small group market, the number of covered lives dropped from 147,784 to 131,138 – and 11 percent decline in 2002. In 2003, the small group market lost another 8 percent, dropping to 120,657 covered lives for a cumulative two year loss of 18 percent (*Table 9)*. The individual market in this same time period grew by 2 percent in 2002 and 10 percent in 2003, rising over the two years from 30,757 to 34,431.[16] Taken together, these figures show a decline in coverage in the small employer market that is only slightly countered by growth in the individual insurance. The number who lost coverage in the small group market is more than four times as large as the number who gained coverage in the individual market.

In 2004, in conjunction with a moderation in the rate of increase of premiums, the small group market made a slight recovery, ending the year at 121,643, for a three year net loss of 17.7 percent. The non-group market continued to grow in 2004, ending the year at 37,597, for a net three year gain of 28 percent. This moderation may reflect the market's response to the legislative attention to health reform in 2004 in Maine, the year the Dirigo Reform Act was passed. It may also or alternatively reflect the transition to a different phase within the insurance underwriting cycle as is suggested by a national trend showing moderation in price increases (*Figure 6)*.

Table 9

Enrollment Changes in Small Group and Individual Coverage in Maine, 2001-2004

	Small Group Number Insured	Percent Change	Individual Coverage Number Insured	Percent Change
Small Group2001	147,784		30,757	
Individual2002	131,138	-11.3%	31,383	2.0%
2003	120,657	-8.0%	34,431	9.7%
2004	121,643	0.8%	39,347	14.3%

Table 10

Average Rate Increases across Maine's Small Group Insurance Market, by Calendar Year

Year	Average Premium Increase
2001	33%
2002	29%
2003	16%
2004	6%

Source: Market Snapshot – Small Group, Maine Bureau of Insurance, March, 2005.

We do not have data that can tell us how many of those who lost coverage in the small group market gained coverage by moving to employment in large firms. However, this shift is likely to be small. Maine has been losing traditional manufacturing jobs that often include health benefits at a rate that far exceeds the national average. Maine, which lost 2,000 manufacturing jobs between December 2003 and August 2004 alone, now has 65 percent of the manufacturing employment it had in 1960. The US, as a whole, retains 95 percent.[17] Lost manufacturing jobs have been replaced largely with service sector jobs that are less likely to provide health benefits. Nationally in 2003 the uninsurance rate in the manufacturing sector was 16.6 percent compared to 35.7 percent in the service sector.[18]

Information on insurance coverage among Maine's large employers is limited both because self-funded ERISA plans are not required to report to the Bureau of Insurance and because Maine's Bureau of Insurance only began tracking enrollment in the commercial large group market in 2004. Nevertheless, there is evidence that suggests that the large group insurance market in Maine also experienced a contraction in 2003.

In 2003, the number with coverage through large commercial insurance groups in Maine was approximately 208,000. Between 2000 and 2001, earned premium in the large group market grew by 56 percent. In the next year, growth slowed to 3.7 percent. And in 2003, earned premiums fell by 10 percent.[19] Since there is no evidence that insurers reduced prices, the loss of premium revenue must be associated with down-sizing in the market. Several large groups in Maine (the State employee benefit plan, for example) transferred from fully insured products to self-funded plans in this year. Most of the loss to the commercial large group market is likely to be associated with the growth of ERISA plans in the State.

We do not have the capacity to measure, through insurance data, the extent to which down-sizing in the large group market results in growth of the uninsured. Maine's commercial insurance premiums for businesses are among the highest in the nation (*Table 9*).[20] At the time of Maine's household survey, fewer than 8 percent of Mainers working or dependent on a worker in a business larger than 50 were uninsured. It is likely in the period since the survey that more workers are declining offers as premiums rise. A national study covering this time period revealed that almost all the decline in employer health coverage from 1988 to 2000 was explained by a decline in uptake among employees offered coverage, and that every $10 increase in employee cost toward coverage is associated with a decline of 0.4 percentage points coverage rates.[21]

Trends in Underinsurance in Maine

There is growing evidence of under-insurance in Maine related to cost-sharing requirements. This phenomenon is particularly pronounced in the individual insurance market. As noted earlier, Maine's Household Survey obtained reports of median insurance deductibles of $4,200 for individually insured respondents compared to $375 for group covered respondents.[22]

Findings from Maine's household survey are corroborated by data from Anthem Blue Cross and Blue Shield, the carrier with more than 90 percent of the non-group insurance business in Maine. Anthem is aggressively promoting high deductible policies. Its advertised products include policies with $5,000 deductibles per individual ($10,000 per family), and $10,000 individual deductible policies. Policies with a minimum $5,000 family deductible rose from less than 1 percent of Anthem's non-group business in 1995, to 90 percent in 2004. Standard indemnity policies are still available but unaffordable. Prices for a $500 deductible policy, for example, range from $8,000 to $9,800 per year for a single policy and $21,390 to $24,047 for a family policy (for non-smokers only).[23] Anthem has filed for a rate increase in 2006 that would raise prices for a $500 deductible policy to $10,727 for a single individual and $28,427 for a family.

Although quantitative data are not available for the small group market, the information obtained through focus groups with small employers in four locations throughout the State indicate that insurers are also promoting high deductible policies among small business employers as a response to rising premiums.

Evidence of under-insurance in both the non-group and small group markets is further corroborated by a survey conducted among enrollees of the DirigoChoice Plan after the first six months of operation. This survey found that about 60 percent of subscribers with incomes below 125 percent of the federal poverty level who had prior health insurance, had policies with deductibles of at least $2500 per individual and $5,000 per family. Similarly, about 52 percent of subscribers with incomes between 125 and 150 percent of FPL who had prior coverage had high deductible policies.[24]

3.2 Variation in benefits among non-group, small group, large group, and self-insured plans

Insurance benefit plans are filed with the Maine Bureau of Insurance on a "file and use" basis, and the Bureau does not keep systematic information on differences in benefit. Given this absence of data and because we did not conduct an employer survey, we have no systematic information on the scope or variation in benefits across the different market sectors in Maine.

3.3 Prevalence of self-insured firms

Information is not available on an employer-specific basis regarding firm status as fully insured or self-insured. An indication of the division of the market can be determined by looking at numbers of carriers and third-party administrators (TPAs) operating in the State and at claims volume. In 2003, 4 insurance companies in Maine accounted for 92 percent of the large group market and 87.6 percent of the small group market, based on premium volume.[25] Maine's largest insurer controlled 65 percent of the large group market, 64.5 percent of the small group market, and 95 percent of the individual coverage market. The next largest insurer in the large group market had a 16 percent share with only a 3 percent share of the small group market. A third carrier had a 20 percent share in the small group market and a 10 percent share in the large group market.

By contrast, in 2003, there were 130 ASOs and TPAs administering health benefits in Maine. These companies paid claims on behalf of self-funded employer plans in aggregate in the amount of $680.3 million. Total claims information is not available for the commercial insurance market, however, a rough calculation of market share can be made based on premium information. Based on an assumption that, on average, 20 percent of premiums collected is retained for administrative costs and profit, an estimate of claims payment by the commercial insurers in the group market in 2003 is $932.1 million. Although average cost per covered life may not be the same between the group insurance business and the self-insured firms, the difference in claims volume gives a sense of the magnitude of the division between self-funded benefit plans and insured plans. Based on this estimate, the TPA/ASO business represented almost 53 percent of large group and dental insurance claims and 42 percent of total group claims volume in 2003 (*Table 11*).

Table 11

Premiums, Estimated Claims, and Market Share by Commercial Insurers and Self-Funded Plans in Maine, 2003

	Fully Insured Premium Revenue	Fully insured medical claims paid[a]	TPA/ASO medical claims payout	TPA/ASO Percent Share of Medical claims
Large group (> 50)	$697,673,648	$558,138,918		
Dental	68,705,450	54,964,360		
Subtotal	766,379,098	613,103,278	$680,289,888	52.6%
Small Group	398,748,555	318,998,844	$0[b]	
Total	$1,165,127,653	$932,102,122	$680,289,888	42.2%

a Estimated at 80% of premiums

b Estimated

Source: TPA/ASO claims data from Maine Health Data Organization. Premium Revenue data from Maine Bureau of Insurance

The commercial insurance industry apparently continues to lose share to ERISA plans over time. In 2004, for example, the Maine State Employee Benefit plan, one of the largest groups in Maine, moved to self-insured status for the first time.

3.4 Impact of State as Purchaser

Maine has established a Public Purchasers' Steering Committee to investigate strategies where collective action can contribute to improving quality and costs of health care services. Entities participating in this group include: the State of Maine Employee Benefit Plan, Maine's Medicaid Program, the University of Maine System, the Maine School Management Association, the Maine Educational Association Benefits Trust, the Maine Municipal Employees Health Trust, the Maine Department of Corrections, and the City of Portland (2005 Members listed in *Appendix 3*).

Taken together, these purchasers represent a very significant portion of Maine's health insurance market. Service payment exclusive of administrative costs and administrator retention (and exclusive of the Medicaid Program) came to approximately 35 percent of total group insurance claims paid in the State 2003 – 2004 (*Table 12*).[26]

Table 12
Distribution of Medical Claims by Public and Private Purchaser Groups

	Medical Claims, 2003 (in $ millions)	Percent of Total Exclusive of MaineCare	Percent of Total
Public Purchasers, Exclusive of MaineCare	$558.5	35%	15.8%
MaineCare	1,926.7		54.4%
Sub-Total	2,485.2		70.2%
All Private Groups	1,053.9	65%	29.8
Total Exclusive of MaineCare	1,612.4		
Total	**3,539.1**	**100%**	100%

Source: Public Purchaser claims data from 2004 Annual Report of the Public Purchasers' Steering Group. Private Group claims data derived by summing ASO/TPA 2003 claims data and insurance claims data (table 9) and subtracting public purchasers' from the total.

The Maine Medicaid program spending is than more triple the total claims experience of Maine's other public purchasers combined (*Table 12*). Taken together, then, these purchasers represent approximately 70 percent of health services purchased in the State exclusive of Medicare, individual insurance, and out-of-pocket payments. The Medicaid Program, alone, represents 54 percent of group purchasing. However, the distribution of MaineCare payments across services is very different from public and private employer plans. While hospital services represent over 39 percent of total expenditures for the public employer plans, for example, they represent only about 12 percent of MaineCare expenditures (*Table 13*). This is because MaineCare spends proportionately much more on long-term care services and mental health and substance abuse services. Nevertheless, because MaineCare is, in aggregate, such a large purchaser of services, it is the largest purchaser in absolute dollars for all service categories except physician and other professional services.

The Public Purchasers' Steering Group was created by Executive Order in August, 2003. It has been meeting for over a year and has issued its first annual report to the Governor (*Appendix 3*). Over the course of the first full year of operations, the Group developed a report on member organization health expenditures, adopted hospital performance measure metrics, participated as individual members in a demonstration of a model "pay for performance" reimbursement strategy, analyzed the impact of adopting a DRG payment system, and reviewed options for collective purchasing of pharmaceuticals. Many of the member entities also participate in the Maine Health Management Coalition, a private organization of businesses, insurers and hospitals that work together on issues of health quality and cost.

Table 13

Total Public Purchasing Claims Experience

Total Costs (year ending 6/30/04) By Service Type

	Non-MaineCare[1] Total	*Percent*	MaineCare[2] Total	*Percent*	Total Total	*Percent*
Hospital Facility						
Inpatient	$ 99,429,303	*16.2%*	$ 148,640,103	*7.7%*	$ 248,069,406	*9.8%*
Outpatient	$ 141,960,767	*23.2%*	$ 98,072,296	*5.1%*	$ 240,033,063	*9.5%*
Professional except MHSA[3]	$ 139,453,243	*22.8%*	$ 75,207,576	*3.9%*	$ 214,660,820	*8.5%*
Mental Health/Substance Abuse[4]	$ 16,419,777	*2.7%*	$ 484,811,922	*25.2%*	$ 501,231,699	*19.7%*
Prescription	$ 131,436,979	*21.5%*	$ 189,318,670	*9.8%*	$ 320,755,649	*12.6%*
Outpatient Facility (non-hospital)[5]	$ 18,322,485	*3.0%*	$ 29,287,292	*1.5%*	$ 47,609,777	*1.9%*
Other medical/health care services	$ 11,485,651	*1.9%*	$ 901,368,717	*46.8%*	$ 912,854,369	*36.0%*
Administration/Retention[6]	$ 53,472,755	*8.7%*	n/r	*n/a*	$ 53,472,755	*2.1%*
Total	$ 611,980,961	*100.0%*	$1,926,706,576	*100.0%*	$ 2,538,687,537	*100.0%*

Notes:

1 Inflation applied to University of Maine Systems, ME Municipal and City of Portland to standardize reporting period.
Maine School Management Association member incurred costs distributed proportionally across service types.

2 MaineCare allocation based on sfy 2004 annual report expenditure data applied to sfy 2004 claims experience.

3 Includes mental health/substance abuse costs for Maine School Management Association

4 Includes both facility and professional expenditures

5 Includes other medical services for Maine School Management Association.
For MEA Benefits Trust, these costs were distributed in other categories.

6 Does not include costs from Maine School Management Association

Rounding errors and applied inflation may contribute to slight variance in totals when compared to earlier schedules. 2/25/2004

Source: Public Purchasers' Steering Group Annual Report to the Governor, 2004.

3.5 Impact of market trends and regulatory environment on models of universal coverage

Provider Regulation

Between 1983 and 1996, the Maine Health Care Finance Commission (MHCFC) regulated hospital revenues and oversaw the negotiation of hospital pricing in Maine. During this period, the rate of growth in hospital spending slowed relative to Maine's historic rate. The Maine legislature dismantled the MHCFC at the urging of Maine's Hospital Association, which argued that market competition would more effectively drive improvements in quality and efficiency. With the exception of Certificate of Need review for large hospital capital projects and licensing laws, Maine's providers have operated in an unregulated environment for the past decade.

Maine has seen substantial consolidation in its delivery system over the past decade. All but four of Maine's 39 hospitals are affiliated with one of four hospital groups in the State. Maine has two urban centers where specialty and tertiary care are concentrated – Portland and Bangor. In each of these cities, most medical specialties are represented by a single group practice. Almost all anesthesiologists, radiologists and pathologists in the State belong to a single organization.

Hospital data from Medicare Cost Reports indicate that health care costs in Maine rose faster than the nation and the northeast region over the past decade. Specifically, average values for total cost per case mix and wage adjusted discharges in Maine averaged 20 percent higher than the national average cost per adjusted discharge and 25 percent higher than the northeast region between 1999 and 2003.[27] (See full discussion of health service costs and utilization in section 3.0.)

Maine's Certificate of Need law (CON), prior to the Dirigo Health Reform Act of 2003, applied only to hospital facilities. Between 2001 and 2003, an average of $65 million in capital projects subject to CON review were approved annually. CON-reviewed projects represented only 40 percent of hospital capital expenditures during this period. A comparison of trends on average plant age between Maine hospitals, the northeast region, and the US, indicates that Maine tracks the experience of most neighboring states and of rural hospitals across the country, and has a slightly higher rate of replacement than the Northeast region, as a whole (*Table 14*).

Table 14:
Average Age of Plant for Maine Hospitals, Comparison States, Hospitals, and Regions

State	Avg Age of Plant, 1998	Avg Age of Plant, 1999	Avg Age of Plant, 2000	Avg Age of Plant, 2001	Avg Age of Plant, 2002
Maine	8.68	9.50	9.71	9.77	9.85
New Hampshire	9.25	7.55	8.28	8.21	7.89
Vermont	8.75	8.92	9.62	9.73	9.92
Massachusetts	10.34	10.34	9.6	9.58	9.67
Northeast	9.85	9.95	9.82	10.18	10.83
Rural Hospitals	9.45	9.45	9.71	9.87	9.98
All	**9.26**	**9.22**	**9.39**	**9.56**	**9.77**

Insurance Industry Regulation

Maine's insurance market has also gone through regulatory changes and structural transformation over the past 15 years. Premium rates in Maine's individual health insurance market (both comprehensive coverage policies and Medicare companion plans) have been subject to regulatory review and approval for more than 25 years. The group commercial market, until 1990, was regulated only with regard to mandated benefits, contractual language, and risk reserve requirements. Policies sold in Maine were approved on a "file and use" basis and insurers were free to determine underwriting guidelines, waiting periods, pricing, and terms of contract renewal. During the 1980s and early '90s in Maine, as in most markets, most insurers in the small group and individual insurance market competed on risk avoidance, and medical underwriting, health screening and denial were standard practices among commercial insurers. Blue Cross and Blue Shield of Maine (BCBS) was Maine's only not-for-profit carrier and was a major player in both the large group and small group markets. In addition, as a tax-exempt entity, BCBS was considered "insurer of last resort" with an obligation to offer coverage to all applicants, regardless of health status or claims history.[28] BCBS's individual and small group products were community-rated.

In 1990, Maine's legislature turned its attention to the operations of the commercial small group market in a quest to improve access. Several years prior to the federal passage of the HIPAA legislation, Maine mandated insurance portability and guaranteed renewal in the small group and non-group insurance markets. In addition, in 1992, the Maine legislature attempted to address cost barriers in the small group and individual market through regulatory reform of medical underwriting and actuarial pricing. Rating bands were established that set boundaries around price differentials based on underwriting criteria. Current regulations allow a 20 percent variance from a carrier's community rate for the factors of: age, industry, and geographic location. In addition, insurers can adjust rates based on group size, without regard to the community rate.

The early '90s was a period of significant turmoil and ultimate consolidation in Maine's health insurance market, as national and regional managed care companies entered new markets and aggressively sought market share. The Tufts Health Plan, Harvard Pilgrim, CIGNA, New York Life (NYLCare), and Aetna, among others, developed provider networks and established operations in Maine. In addition, several newly formed integrated provider entities including major hospitals and physician-hospital organizations, entered into joint ventures with managed care companies to offer locally "branded" managed care products. In July 1999, Blue Cross and Blue Shield of Maine was sold to Anthem Blue Cross and Blue Shield, a for-profit plan. By 2000, Aetna had purchased NYLCare, CIGNA had purchased Healthsource Maine, Tufts had left the market, and Harvard Pilgrim had ceased marketing for additional business. As indicated in Section 3.3, above, one insurer, Anthem Blue Cross and Blue Shield, dominates the commercial market, with two other significant players.

The consolidation in both the provider and insurance sectors has meant that there is no price competition in the health sector in Maine. Competition among providers, rather, is reflected through up-grading and expanding services in efforts to expand market share – a practice that exacerbates the already troublesome problem of health cost inflation in the State. Insurers have

minimal capacity and little incentive to contract selectively and respond to price pressures from providers by passing the costs to consumers in rate increases. *Figure 3* shows the net impact on premiums of the era of "competition" in Maine.

As part of Maine's State Planning Grant activities, the Governor's Office of Health Policy and Finance reviewed the cost trends from the current period of comparatively low levels of regulation and determined that universal access could not be achieved and sustained if cost trends were not moderated. A return to the price and revenue regulatory strategies of the 1980s was not viewed as advisable or feasible. The development of a mix of regulatory and voluntary measures that rely on public transparency and reporting is still under development. The changes in regulation that were adopted by Maine's legislature as a part of the Dirigo Health Reform Act reflect the consensus for change, to date, and include the following:

A one-year moratorium on Certificate of Need Review and Approval Process (in effect from July, 2004 through June, 2005).

An expansion of CON review to all capital projects meeting dollar threshold and service criteria, regardless of location or sponsorship. This change expands CON review to ambulatory surgical centers, physician practices, and other non-hospital settings.

Establishment of a Capital Investment Fund that establishes an annual cap on the dollar value of CON projects that may be approved in a given year.

Establishment of a competitive CON review process that batches all large requests and all small requests, reviews the merits and establishes priorities for funding based on amounts available in the Capital Development Fund and State needs according to the State Health Plan.

Establishment of a minimum, 3 year rolling average 78 percent loss ratio for health insurers in their small group lines of business. Insurers can choose between submitting proposed rate increases for review and approval by Maine's Bureau of Insurance, or complying with the 78 percent loss ratio by returning retained premium in excess of 22 percent to policyholders.

New reporting requirements for insurers including membership growth or decline, premium revenue, claims experience, and retention (or loss), by line of business.

Requirements on providers to publicly post prices for their most frequent services and procedures.

Additional provisions of the Dirigo Health Reform Act reflect the efforts of Maine policymakers to develop collaborative and non-regulatory strategies to rationalize Maine's health care system in a way that is supportive of coverage expansions and the goal of universal access. These provisions and their current status are summarized below:

The establishment of a State Health Plan, revised on a biennial basis, which establishes goals and priorities for the health care system based on an analysis of underlying health and disease problems in the State and the current availability of resources. The first State Plan has been completed. Its location on-line is provided in *Appendix 2*).

Establishment of one-year voluntary targets for hospitals that limit growth in case-mix adjusted cost per patient discharge to 3.5 percent and total consolidated margins to 3 percent. Measurement of the impact of these voluntary measures has been completed and is reported in section 4.9.

Establishment of a one-year voluntary cap of 3 percent on underwriting gains for the health insurance industry. Measurement of the impact of this voluntary measure has been completed and is reported in section 4.9.

Establishment of a study to review Maine Medicaid provider reimbursement rates, in comparison to other states and the fiscal impact of potential rate increases. The study has been completed. On-line access is provided in *Appendix 2*.

Establishment of a Commission to Study Maine Hospitals to review long-term options for planning, growth, and improved efficiency. The Commission has completed its work. The Commission Report to the Governor is available on-line (see *Appendix 2.*)

Voluntary limits on cost growth and operating margins for all additional health care providers.

There is consensus among consumers, employers, providers, insurers and policymakers in Maine, that current growth rates in the health care sector are unsustainable. To date, despite measured savings from several of the voluntary constraints enumerated above, insurers and payers claim little relief and have not successfully negotiated reductions in the expected rates of increase from providers. More stringent regulatory strategies may be considered in the near future.

3.6 Impact of Universal Coverage on Financial Status of Health Plans and Providers

Impact on Providers

The options for reform designed to attain universal coverage that have been adopted in Maine can potentially affect service volume, reimbursement rates, and bad debt and charity care. National research based on year 2000 MEPS data shows that persons uninsured for a full year use, on average, about 55 percent of the volume (as measured by cost) of health care services as fully insured individuals.[29] Individuals uninsured for part of a year use 83 percent of an average insured person's level of services. Based on these estimates, we expect that extension of health insurance coverage to Maine's uninsured population will increase volume for most health services and may decrease volume for use of hospital emergency departments.

Maine's Medicaid program generally reimburses providers at rates lower than those paid by private payers and, in some cases, below cost. (An exception is mental health care services, where the MaineCare Program reimburses at higher rates than private payers.) As a consequence, providers increase negotiated rates with private payers to compensate for "under-payment" by the MaineCare Program. While the extent to which Maine's high costs to private payers can be attributed to "the cost shift" is under study, the existence of the phenomenon is not in dispute. An analysis by Milliman Consultants and Actuaries on behalf of the Maine Association of Health Plans compared average allowed charges for common DRG/CPT codes for Maine, New Hampshire and Massachusetts, based on claims data submitted by most large insurers doing business in the three states. Participating insurers included Blue Cross and Blue Shield of Massachusetts, CIGNA, Anthem Blue Cross and Blue Shield of New Hampshire, Anthem Blue Cross and Blue Shield of Maine, and Harvard Community Health Plan. Comparison by DRG allowed control for case-mix and severity. This analysis found allowed charges in Maine to be consistently higher than both New Hampshire and Massachusetts, with the exception of

physician office visits, neonatal stays with significant problems, and treatment for alcohol/substance abuse. Allowed charges for an uncomplicated appendectomy in Maine, for example, were 151 percent of allowed charges in Massachusetts and 131 percent of those in New Hampshire, per admission. A hospital stay for chest pain in Maine cost insurers 176 percent of the cost in Massachusetts and 124 percent of the cost in New Hampshire, per admission.[30]

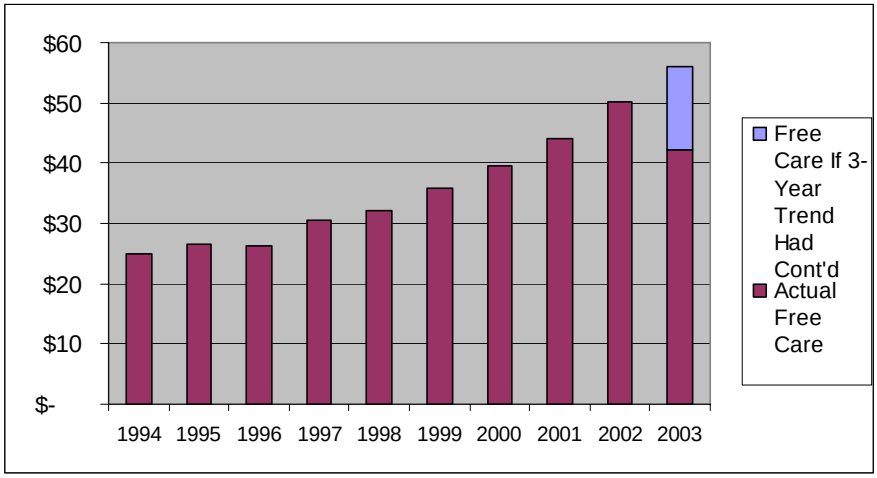
These very significant differentials are believed to result from several factors, including the non-competitive market environment described in Section 3.5. But because of lower average incomes, areas of economic depression, and generous Medicaid eligibility criteria, Maine's Medicaid Program is a proportionately larger payer of hospital services than are the Medicaid Programs of Massachusetts and New Hampshire. Maine's hospitals argue that the extent of the "cost shift" in Maine is therefore greater than in neighboring states and is a significant contributor higher rates charged to private payers. The extent to which public payer reimbursement rates contribute to higher allowed charges in Maine is under study. However, in the interest of avoiding any additional cost shift to private payers, Maine policymakers opted to use negotiated "market" reimbursement rates for new coverage programs funded under the Dirigo Health Reform Act, rather than Medicaid reimbursement rates. Thus, the impact of Maine's reform strategies on provider volume and reimbursement should be positive.

In 2002, Maine providers, hospital and non-hospital, provided an estimated $191.7 million in bad debt and charity care – a figure that dropped to $178.5 million in 2003.[31] Within the hospital sector, based on survey information, approximately 31 percent of the cumulative amount of uncompensated care is free care, and 69 percent is bad debt. Hospitals in Maine are required by law to offer services without billing to uninsured persons with household incomes below the federal poverty level. Many hospitals have policies that extend free care to higher income levels, such as 150 percent of FPL, or 200 percent FPL. Free care, then, by definition, is care provided to low-income uninsured. Results from a sample of 17 hospitals in Maine showed that 48 percent of their bad debt was generated by self-pay, or uninsured patients. Another 29 percent was generated by privately insured patients.[32]

Maine's access initiative, the DirigoChoice Plan, offers subsidized, comprehensive health coverage to low-income Maine individuals and families. To the extent that this program is enrolling previously uninsured persons, or low-income individuals who previously had high deductible policies, it reduces both the charity care and bad debt burden of providers. The potential impact as the program grows is illustrated by Maine's recent experience with a Medicaid expansion to non-categorical adults. This HIFA waiver program enrolled 26,000 individuals in 2003, a year in which Maine providers saw the first decline in hospital bad debt and charity care experience in a decade. The estimated savings represented by actual experience compared to expected levels of uncompensated care trended from prior years experience, was between $28 and $32 million dollars (*Figure 9*). Interestingly, this decline represents an almost one-for-one offset of the dollars spent on hospital care under the HIFA waiver program.

Figure 9

2003 Estimated Savings in Free Care in the First Year of Maine's HIFA Waiver Program



Based on measurement of current levels of bad debt and charity care and recent experience in reductions associated with access expansions, we expect Maine's access initiatives – which include both MaineCare eligibility expansions and State-funded and subsidized coverage programs to continue to reduce provision of uncompensated care. This change will serve both to decrease a financial stressor on providers and to modify allowed charges to private payers.

In sum, the expected impact of Maine's access initiatives on providers is an increase in their market-priced revenue stream, a decrease of uncompensated care, and an easing of emergency department use.

Impact on Health Plans

Maine policymakers have elected to pursue a mixed model approach to achieving universal coverage – one that relies on and expands the employer-based system and private health coverage while also expanding the safety net programs of MaineCare. As described in section 3.1, prior to Maine's reforms, the commercial insurance market was in a downward spiral of declining enrollment, rising risk segmentation, and rising premiums. The broad package of reforms adopted by Maine's legislature contains a number of provisions designed to help stabilize health care costs and premiums, particularly in the small group market (see Section 3.5). In addition, the DirigoChoice Plan offers new coverage opportunities for low income working families in a manner that builds the private insurance market. While the DirigoChoice Plan relies on public dollars and a partnership with the MaineCare program to reduce cost barriers to low and moderate income Mainers, it is a plan contracted to a private insurer (selected through a competitive bid process) for all insurance-related functions (except eligibility determination, enrollment fee collection, and subsidy allocation). The entry of the DirigoChoice Plan into the market is intended to stimulate competition and reverse the decline in small employer coverage.

Ultimately, policymakers hope that new insurers will enter Maine's market, increasing consumer choice and creating greater pressure on premium prices, and there is already evidence that the reforms are having a positive impact. After only four months of enrollment, the DirigoChoice Plan has stimulated the entry into the small group market of a carrier that had ceased marketing in Maine – Harvard Pilgrim. Executives of the health plan indicated that their return is a direct result of reforms in Maine – that the DirigoChoice Plan and other reforms had stimulated new competition in the insurance market in Maine.

3.7 Safety Net Providers

For the most part, Maine does not have safety net providers separate and apart from the main stream delivery system. There are no public, state, county or city hospitals. Maine relies on public funding (Medicaid), its network of not-for-profit hospitals, and private practice physicians to provide safety net services to medically indigent populations. This private sector infrastructure is supplemented with nine federally qualified rural health center organizations that offer free and sliding scale health care to eligible persons, publicly funded clinics operated by the City of Portland, and a small number of sites offering free or reduced cost care sponsored by hospitals or residency training programs.

Three aspects of Maine's planning process will have a direct impact on safety net providers. First, as part of Maine's access expansions, eligibility for MaineCare coverage has been expanded for adults. Increased Medicaid participation should proportionately increase reimbursable services and decrease free and sliding scale care for providers who serve indigent patients. Second, Maine has recently increased reimbursement rates to critical access facilities and settled more than a decade's worth of outstanding disputes with hositals over earlier Medicaid reimbursements. Third, the current Administration and legislature increased physician reimbursement rates under the MaineCare Program. These efforts should result in an increase in revenues for safety net providers.

Because Maine's universal coverage strategy relies, to date, on programs with voluntary participation, policymakers anticipate that enrollment will not be universal, and a subset of indigent patients will remain "outside the system." Among the populations that have historically had difficulty accessing appropriate care through insurance-based systems are homeless persons, migrant workers, and individuals with mental illness. Ambulatory care clinics remain an important resource for these populations. The planning process in Maine has not built upon or expanded the very modest infrastructure in the State for the delivery of care to these populations. However, the State continues to rely on existing safety net providers and has used rate increases to assure their viability.

3.8 Changes in Utilization with Universal Coverage

Pre-Reform Analyses

Maine's State Planning Grant project team contracted with Mathematica Policy Research, Inc. (MPR) and Watson Wyatt to model expected utilization and health service costs under Maine's proposed programs of expanded coverage for the uninsured. Two analyses were carried out.

While formulating the proposed access strategy prior to the submission of legislation, MPR and Watson Wyatt estimated state costs at different enrollment levels ranging from 25 percent of the estimated subsidy-eligible uninsured (below 300 percent of the federal poverty level) to 100 percent. Population numbers were drawn from Maine's Household survey and utilization assumptions from Maine employer and Medicaid claims data. During this phase of policy development, utilization assumptions included an adverse risk factor adjustment based on an assumption that early "takers" in a voluntary enrollment program would be more likely to be higher users of health care services than a typical large group health benefit plan enrollee. Employers' experience with COBRA plan enrollees was used to establish the adjustment.

Pre-Enrollment Analyses

Following the passage of reform legislation and prior to the competitive bidding process for an insurance partner for the DirigoChoice program, MPR and Watson Wyatt conducted a more refined analysis based on the legislative parameters for the program and first year assumptions regarding enrollment. The contractors estimated take-up based on multivariate analysis of the household survey, assuming that all employees in eligible groups had the same probability of an offer (with an assumed increase in offer rates over time). Watson Wyatt's Preview model then applied standard probabilities of service use based on 104 age/sex/family type categories and 7 family income categories (total of 728 cells). For this later phase of utilization estimates, an adjustment factor for adverse selection was not built into the estimates on the assumption that insurance company bidders would use their own actuarial adjustments. This omission assured that adverse selection assumptions were not built in twice to negotiated rates.

These modeling efforts were intended to predict the utilization experience within Maine's access initiative, not to estimate total changes in utilization across the population in Maine. Maine's model for access expansion is predicated on the assumption that providing coverage to the previously uninsured will reduce bad debt and charity care, substitute primary care, preventive care and chronic disease case management for crisis intervention medical care. The net impact of these changes has not been estimated. Based on national studies, there is some evidence that persons who are in long term uninsured spells use, on average, 50 percent of the level of health care services as an average fully insured individual.[33] This estimate would indicate that the net effect of increased insurance coverage would be increased utilization, but at a reduced rate since the health service use associated with membership growth would be offset by reductions in uncompensated care.

PostEnrollment Analyses

The Dirigo Agency receives regular quarterly reports from Anthem Blue Cross and Blue Shield on the utilization experience of enrollees in the DirigoChoice Plan. Benchmark data based on the experience of Anthem's large group enrolled population is provided as well. The experience of the DirigoChoice Plan, which has been operational less than a year, is too immature to draw conclusions about expected long-term utilization trends. To date, the experience of the plan compares favorably with the benchmark indicators.

3.9 Experience from Other States

Several state initiatives, both current and past, have served as models for components of Maine's access initiative. In particular, Maine project staff has studied:

- the Rhode Island RIte Share program as a case study in coordinating Medicaid funding with workplace benefits for eligible persons in the workforce.
- Maryland's experience with Certificate of Need and hospital rate regulation.
- The state of Washington's Basic Health Plan as a model for the development of a State-sponsored, subsidized coverage program for non-Medicaid eligible individuals.
- The experience of commercial carriers in assessing the feasibility and advisability of a reinsurance approach to access expansions.

As Maine continues in its ongoing reform efforts to increase the availability of affordable coverage, analysts are reviewing possible strategies complementary to already implemented reforms. In particular, the reinsurance strategy exemplified by the Healthy NY program in New York State is under review.

In addition, several members of the Governor's Office of Health Policy and Finance's consultant team have extensive experience in state health policy and could bring their experience to bear on issues of Maine's reform design. These consultants include, Deborah Chollet of Mathematica Policy Research, Jean Lambrew of George Washington University, Cindy Mann of George Washington University, Nancy Kane of Harvard University, and Andy Schneiter.

Section 4. Maine Policy Choices for Expanding Coverage

4.1 Coverage Expansions

In May, 2003, the Maine Legislature passed H.P. 1187, An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs – a reform proposal submitted by Governor Baldacci (*web link provided in Appendix 2).* Included in the law (known as the Dirigo Health Reform Act) are four initiatives designed to expand access to health coverage. These specific measures are:

- An expansion of eligibility under MaineCare (Maine's Medicaid and SCHIP programs) for parents of eligible children from 150 percent of the federal poverty level up to 200 percent of FPL;

- An expansion of eligibility under Maine's HIFA waiver for non-categorical adults from the federal poverty level up to 125 percent of the federal poverty level;[34]

- Authorization of a state-sponsored health coverage program that will provide membership fee subsidies on a sliding scale for non-MaineCare eligible individuals and

families with incomes up to 300 percent FPL who meet program eligibility criteria (discussed below);

Premium assistance for uninsured persons working in large businesses toward the purchase of coverage in their employer's qualified health benefits plan. Persons with incomes below 300 percent of FPL are eligible.

The status of each of these initiatives is reported below.

Income Eligibility Expansion for SCHIP parents

The expansion of coverage for SCHIP parents went into effect May 1st, 2005. Current projections are that about 10,000 previously ineligible individuals will enroll, based on the expanded eligibility. The legislature approved incremental funding of about $7.7 million to accommodate the expanded program. As of September 30th 2005, there were more than 3,700 parents covered under MaineCare who had been previously ineligible.

Income Eligibility Expansion for non-Categorical Adults

State Fiscal Year 2004 was Maine's first full year of experience with its non-categorical adult waiver program (at an income eligibility threshold of 100 percent of the federal poverty level). Over the course of the year, approximately 26,000 new members received services through this program. This number exceeds the estimate based on the Maine household survey of the total population meeting program eligibility criteria (childless adults with incomes below the federal poverty level). We believe the survey underestimated this population because many very low income childless adults have transient residency or lack phones. In addition, except in an unusually massive and costly survey, the sample size within a small state of persons meeting all eligibility criteria is very small creating a large margin of error for state-level estimates. Moreover, enrollment of this population proceeds unusually rapidly because providers are motivated to assist in enrolling eligible persons who enter the health care system and who would otherwise be a charity care obligation for the provider.[35]

The conditions of a HIFA waiver require that federal Medicaid spending not exceed what would have been spent in the absence of the waiver program. Maine's costs for the non-categorical enrolled adults have hit the cap of available federal cost sharing. As a consequence, enrollment in Maine's non-categorical adult program is currently frozen and no expansion of this program is contemplated in the short-term.

The Dirigo Choice Plan – Publicly Sponsored and Subsidized Insurance Plan for Small Businesses, the Self-Employed, and Some Individuals

The DirigoChoice Plan commenced operations on January 1, 2005, has an enrollment of approximately 9,200 (covered lives) as of Februar 1st, 2006. Current enrollment includes 720 small businesses. Compared to growth rates of other small business insurance products,

enrollment rates are very successful. The DirigoChoice Plan is Anthem Blue Cross and Blue Shield's fastest growing line of business and the fastest growing small business insurance product in the State.

A telephone survey was completed in August, 2005, providing a profile of DirigoChoice enrollees from the first six months of operation. This survey found that the program is serving a largely low-income population; almost 40 percent, at the time of the survey were from households with incomes at or less than 150 percent of the federal poverty line and almost 60 percent less than 200 percent of FPL. About 35 percent of subscribers were uninsured or had been uninsured within the prior 12 months when they enrolled. Among those with prior coverage, over 40 percent had prior high deductible plans. Individuals in the lowest income categories were more likely to have had deductibles greater than $2,500 than the higher income enrollees. Approximately 28 percent of the previously insured enrollees reported not getting care when they needed it under their prior policies.[36] A copy of the survey report is included in *Appendix 3*.

Premium Assistance for Low-income Workers in Large Businesses

The option to provide sliding scale premium assistance to purchase employer provided health benefits to low-income workers in large businesses was authorized in the Dirigo Health Reform Act, but has not been implemented. This option is still under consideration for future implementation and will be weighed against an alternative strategy of opening the DirigoChoice Plan to large employer groups.

4.2 Program Eligibility

DirigoChoice

Maine's reform program includes enactment of a state-sponsored and subsidized health coverage initiative targeted to small businesses, the self-employed, and individuals not otherwise eligible for coverage. Eligibility for this program includes the following:

> Businesses with 50 or fewer full-time employees are eligible to purchase an employee health benefits plan through Dirigo Health. At least 75 percent of employees working 30 hours or more per week and who do not have other credible coverage must participate. Sole proprietors are considered businesses of one and are eligible to enroll. Currently insured businesses are not precluded from switching to the DirigoChoice Plan.
>
> The level of the required employer contribution toward premium costs of employees is determined by the Dirigo Board and is currently set at 60 percent of the employees' membership costs.
>
> Other Maine residents may purchase non-group coverage if they work 20 or fewer hours per week for any one employer, or if they work for a business of fewer than 50 that does not offer health insurance coverage, or if they are an employer of a small business who

tried to purchase DirigoChoice coverage but was unable to secure 75 percent participation from eligible employees. Employees working for employers who do not provide employer-sponsored health benefits will not be eligible until the period they have been without employer-sponsored coverage exceeds 12 months. Enrollment of non-group individuals is capped in the first year to determine the utilization experience of this group.

Dirigo enrollees who are eligible for MaineCare coverage will receive benefits through the DirigoChoice Plan carrier in a manner similar to other Dirigo enrollees, and will receive wrap-around benefits administered by MaineCare to the extent of their entitlement under the MaineCare program. Employers of MaineCare eligible DirigoChoice enrollees are obligated to contribute the 60 percent employer share of the membership cost. The enrollee's membership share is fully subsidized by the MaineCare Program.

Enrolled individuals and their dependents whose household income is below 300 percent of the federal poverty level but who are not eligible for any MaineCare programs will be eligible for state funded subsidies to their membership costs on a sliding scale. There are four tiers of subsidy: an 80 percent discount, 60 percent, 40 percent, and 20 percent. The discount applies to the employee's share of premium cost for both individuals and family membership. The employer's share of membership costs is not subsidized.

Employees and employers whose incomes exceed 300 percent of FPL may enroll in DirigoChoice at full membership cost.

Sole proprietors with incomes below 300 percent of the federal poverty level are eligible only for the "enrollee" level of subsidy. Their business is expected to pay the employer share of the premium. Non-group enrollees with incomes below 300 percent of poverty and not otherwise eligible for MaineCare receive subsidies against the entire premium. Thus, if an employee of a business is eligible for a 40 percent reduction in his/her share of the membership costs, a similarly situated individual would receive a 40 percent reduction in the full membership costs

4.3 Program Administration

The Dirigo Health Reform Act is complex legislation containing access initiatives, cost-containment provisions, and quality enhancement programs. A variety of administrative structures are authorized to oversee these new State responsibilities. In addition, the DirigoChoice program is jointly administered by a new state agency and an insurance partner selected through a competitive bid process (currently Anthem Blue Cross and Blue Shield of Maine). Each of these new administrative arrangements is described below.

Governor's Office of Health Policy and Finance

Overall responsibility for health policy development, coordination across the different health programs sponsored and administered by the State, and representing the Governor's positions on

health policy rests in the Governor's Office of Health Policy and Finance. This office works closely with all of the agencies, commissions, and advisory groups described below that have responsibilities for the implementation of the Dirigo Health Reform Act. In addition, the Governor's Office coordinates between these new health policy initiatives and the traditional health responsibilities of the State housed within the Department of Health and Human Services (MaineCare, the Public Health Department and services to the elderly), the Bureau of Insurance, and State Employee Health Benefit Plan.

Dirigo Health Agency

Under the Dirigo Health Reform Act, the Dirigo Health Agency was established as an independent executive agency of state government to arrange for the provision of comprehensive health coverage to eligible small employers and individuals on a voluntary basis. The Dirigo Health Agency operates under oversight of a Board consisting of 5 voting members and 3 *ex officio* members. The five voting members are appointed by the Governor, subject to the review of the joint standing committee of the Legislature having jurisdiction over health insurance matters and confirmation by the Senate. The voting members must be knowledgeable in one or more of the following areas: health care purchasing; health insurance; MaineCare; health policy and law; State management and budget; or health care financing. Board members may not be a representative of or an employee of an insurance carrier licensed in the State or a health care provider operating in the State and may not be affiliated with a health or health-related organization regulated by State government. The three *ex officio*, nonvoting members of the Board are: the Commissioner of Professional and Financial Regulation; the Director of the Governor's Office of Health Policy and Finance; and the Commissioner of Administrative and Financial Services. Current Board members are listed in *Appendix 3*.

The Dirigo Board has oversight responsibility for the activities of the Dirigo Health Agency and the administration of the DirigoChoice Plan, including powers to hire an Executive Director for the program, determine the benefit plans for DirigoChoice offerings, arrange for the provision of DirigoChoice coverage through contracts with one or more qualified bidders, and collect the savings offset payments used to fund program administration and membership subsidies. In addition, the Board has authorization and responsibility to establish and operate the Maine Quality Forum (discussed below) and establish and administer a revolving loan fund to assist health care practitioners and providers in the purchase of hardware and software necessary to implement electronic claims submission systems. The Board is obligated to submit an annual report to the legislature providing information on the impact of the DirigoChoice program on the small group and individual health insurance markets in Maine, and on the number of uninsured individuals in the State. The Board will also report on program experience, including enrollment levels, administrative costs, revenues earned, and claims incurred.

The duties of the Executive Director of the Dirigo Agency and her staff, under the direction of the Board, include selection of insurance carriers on a competitive bid basis, program enrollment, determination of eligibility for membership subsidies, membership fee collection, program marketing, and oversight of agency administrative responsibilities and budget.

The Dirigo Health Agency has been operational for more than a year. A Request for Proposal for an insurance carrier to partner with the State in administering the Dirigo Program was put out to bid in July, 2004, and a contract signed with Anthem Blue Cross and Blue Shield of Maine (Anthem) in September, 2004. The contract stipulates that Anthem will market and offer two benefit plans selected by the Dirigo Board. The Dirigo Agency receives application materials, has applications for program subsidies and Medicaid coverage processed by Maine's Bureau of Income and Family Assistance, and collects employer and participant payments. The Dirigo Agency also handles administration of subsidy refunds to enrollees. Anthem receives bundled payments of the full membership fee amount for enrolled groups.

Maine Quality Forum

The Maine Quality Forum is established by law and housed within the new Dirigo Health Agency. The Forum or MQF is intended to serve as an umbrella for the wide range of quality improvement and wellness initiatives being undertaken across the state to enhance opportunities for efficiency and cross-fertilization of ideas. Through the creation of a state-level coordinating function, Maine will realize a greater benefit than might be delivered by any single effort alone. The MQF is specifically charged with the following responsibilities:

> The collection and dissemination of research findings related to quality of care, patient safety, best practices and evidence based medicine;
>
> The identification of a set of measures to be used to evaluate and compare health care quality and provider performance;
>
> The coordination of statewide collection of health care quality data to minimize duplication of effort and the burden on providers;
>
> The production of annual reports on the quality of care in Maine;
>
> The conduct of consumer education campaigns promoting informed decision making and wellness;
>
> Technology assessment to guide recommendations under the state's Certificate of Need program;
>
> The development of recommendations for the State Health Plan; and
>
> The production and dissemination of an annual report.

The Forum is advised by a 17-member council, which has been named by the Governor and has begun to meet. The membership reflects the provider community, consumers, labor, employers, payers and Maine's Medicaid program. A list of current members is attached in *Appendix 3*.

The Maine Quality Forum established three work groups: a Technology Assessment Committee that is charged with assessing the feasibility and cost of adopting a statewide, coordinated

medical record system; a Performance Indicator Committee that is developing the first set of statewide measures to assess variation and quality of care; and a Provider Advisory Group.

Over the course of its first year of operations, the MQF undertook three broad initiatives. First, in an effort at public education and broad dissemination of information related to quality of health care, the MQF established a website and posted geographic variation data for a range of surgical procedures and categories of medical hospital admissions, highlighting substantial geographic variation. The MQF also completed a rulemaking procedure to establish criteria for "healthcare quality datasets." The new rule requires all health providers that treat patients with heart attack, congestive heart failure, pneumonia and surgical infection to submit data that will document their compliance with recognized and established best practices for these conditions. The MQF is also currently conducting an analysis of the use of advanced imaging in Maine and its impact on the healthcare system. A link to the Forum's website is included in *Appendix 2*.

Advisory Council on Health Systems Development

The Dirigo Health Reform Act established an Advisory Council on Health Systems Development with responsibilities to:

> Collect and coordinate data on health systems development in the State;
>
> Synthesize relevant research; and
>
> Conduct public hearings on the State Plan and the capital investment fund each biennium.
>
> Receive reports from the Public Purchasers' Steering Group.

The Advisory Council provided guidance in the initiation of the following activities over its first year:

> An analysis of Emergency Department use by persons experiencing a psychiatric crisis. This study was undertaken under the leadership of the Office of Adult Mental Health Services within the Maine Department of Human Services.
>
> The development of strategies to improve outcomes and reduce costs of treatment of substance abause and co-occurring disorders. This initiative was undertaken under the leadership of the Office of Substance Abuse within the Department of Health and Human Services.
>
> The convening of a Care Model Working Group to adapt a care model for Maine and a consortium of physicians, other providers and payers to disseminate the care model broadly within the State. This project was conducted under the leadership of the Governor's Office of Health Policy and Finance.
>
> Established criteria for prioritizing projects that are submitted for Certificate of Need (CON) review and approval. Provided guidance for determining the level of the Capital

Investment Fund which sets an annual limit on the aggregate dollar value of CON project approvals.

In the first year, the Capital Investment Fund was set at $6.6 million. Four applications were submitted under the first round of competitive review, all of which were approved.

Currently, work is underway to establish the Capital Investment Fund for the next calendar year. A public hearing on the proposed amount is $7.7 million has been held and public comments are currently being received.

In collaboration with the Governor's Office of Health Policy and Finance, issued the first proposed biennial State Health Plan. Regional public hearings are currently underway on the proposed plan. A link to the draft State Health Plan is provided in *Appendix 2.*

The Council is made of eleven members appointed by the Governor with approval by the joint standing committee of the Legislature with jurisdiction over health and human services. The Council members are selected to represent constituencies specified in the legislation including: two individuals with expertise in the health care delivery system; one expert in long-term care; one expert in mental health; one expert in public health care financing; one expert in private health care financing; one expert in health care quality; one expert in public health; and two consumer representatives. Also on the Council is one representative of the Department of Human Services, Bureau of Health. A listing of the current members of the Advisory Council is included in *Appendix 3*.

Public Purchasers' Steering Group

The Public Purchasers' Steering Group is composed of representatives of all of the State's major organizations and agencies that purchase health benefits on behalf of their employees or constitutents. Included in the group are representatives of the MaineCare Program, state employees health benefits plan, State University system, municipal employees, state teachers' association, the Department of Corrections, and the City of Portland. A list of current members is provided in *Appendix 3*.

The Public Purchasers' Steering Group submitted its first Annual Report including reports of health benefits expenditures of members in April, 2005. A copy of the Annual Report is included in *Appendix 3*.
An organizational chart showing the relationships of these administrative agencies, together with the Governor's Office of Health Policy and Finance is included in *Appendix 3*.

4.4 Outreach and Enrollment

The outreach and enrollment processes for the DirigoChoice Program are directed by the Dirigo Agency in conjunction with its insurance partner, Anthem Blue Cross and Blue Shield of Maine (Anthem) and the Governor's Office of Health Policy and Finance (GOHPF). An advertising and public education campaign with placements on television, radio and in newspapers has been sponsored and directed by GOHPF and the Dirigo Agency. The Dirigo Agency also has a

website that provides information on the DirigoChoice plan and subsidy program (link provided in *Appendix 2*.) Small business and sole proprietor outreach and enrollment application are the responsibility of Anthem's network of brokers and agents. Their activity has been supplemented with outreach by the Dirigo Agency staff members, who have made numerous presentations about the DirigoChoice Program to small business audiences.

Once an application has been made, the enrollment process is done jointly by the Dirigo Health Agency and Anthem. All applicants who choose to apply for a discount complete an application providing information about household income and assets. The Dirigo Health Agency forwards the subsidy applications to Maine's Bureau of Income Assistance for review and determination of eligibility and subsidy level. The applications for insurance coverage are processed by Anthem, where full monthly program costs per individual are determined based on factors of age, geographic location, business type, and the size of the enrollment group.[37] Once both the subsidy eligibility and the membership rates have been determined, employers are given a rate quote. Subsidy information is communicated directly to applicants and is treated confidentially (see Section 4.5, below).

In addition to DirigoChoice enrollment and outreach, the Dirigo Health Agency and the Governor's Office of Health Policy and Finance are working together to implement a public education campaign to inform the public about Maine's health reform strategies, generally, and the role of citizens in promoting cost containment, quality, and access. This campaign entails the use of public service announcements and paid placements in radio, television and print media. Dissemination outlets also include libraries, town halls, community agencies, schools, etc. This campaign dovetails with the DirigoChoice advertising campaign, ensuring consistency in message and branding.

Community based advocates also play a role in outreach and education. The advocacy organizations were staunch supporters of the Dirigo Reform legislation, a stance that was nurtured by the Governor's Office through close collaboration with these groups during the legislative process. As a result, the advocacy community is very much attuned to the "mechanics" of the DirigoChoice plan. They are in an excellent position to educate the community about reform efforts and are equipped to assist the public in understanding the DirigoChoice program and to encourage engagement in the larger health improvement and cost containment initiatives.

4.5 Premiums

When a business or individual joins DirigoChoice, they become members of a comprehensive program of services, ranging from health risk assessment and wellness and quality initiatives to support programs for shared decision making in arranging the provision of health care coverage. Membership payment is predicated upon the package of services, which is not divisible. Therefore, members do not pay a premium; they make membership payments.

The level of the required employer contribution toward membership costs of employees is determined by the Dirigo Board and is currently set at 60 percent of the employees' membership costs. Enrolled individuals and their dependents whose household income is below 300 percent

of the federal poverty level are eligible for state funded subsidies to their membership costs on a sliding scale. There are five tiers of subsidy spanning from 100 percent to 20 percent. The 100 percent subsidy applies to individuals who are eligible for MaineCare which pays a negotiated capitation rate to the insurance carrier on behalf of these individuals. The discount applies to the employee's share of premium cost for both individuals and family membership. The employer's share of premium is not subsidized. Employees and employers whose incomes exceed 300% of FPL may enroll in DirigoChoice at full membership cost.

Employers have an opportunity for a one time discount off their share of membership costs. If all employees in a participating business complete health risk assessments with their physician in the first year of enrollment, the employer receives a $1,000 rebate, or discount off their required payment. This offer is available in the first year only. In addition, as noted earlier, a negotiated risk sharing arrangement between the Dirigo Health Agency and Anthem Blue Cross and Blue Shield reduces the overall enrollment costs, benefiting employers.

Enrolled businesses and individuals make monthly membership payments to the Dirigo Health Agency. Employers collect employee contributions through payroll deductions. Because subsidy information is confidential, the full employee share is collected on behalf of all employees. Members with subsidies receive an electronic bank card from the Dirigo Health Agency and the dollar amount of the approved discount is transferred to the member on the day of the payroll deduction.

The Dirigo Health Agency makes bundled monthly payments on behalf of all DirigoChoice members to Anthem. DirigoChoice is considered a single large group by Anthem.

4.6 Benefits Structure

The DirigoChoice Plan offers two benefit options that differ with regard to deductible level. The benefit structure of the DirigoChoice Plan is unique in several regards. First, deductible levels and out-of-pocket limits (as well as membership contributions) are varied according to household income of members. Full deductible amounts are $1,250 for a single policy and $2,500 for a family policy in plan 1, and $1,750 for a single policy and $3,500 for a family policy in plan 2. These amounts are reduced by 80 percent, 60 percent, 40 percent or 20 percent in accordance with membership discounts for enrollees with incomes below 300 percent of the federal poverty level. Similarly, annual out-of-pocket limits are reduced from 80 percent to 20 percent. Members who apply for and who are determined to be MaineCare eligible pay no deductibles.

The decision to adopt a relatively high deductible benefit plan with sliding scale reductions in required out-of-pocket payments was driven by Maine's insurance market. As described in Section 3, premiums are very high in Maine relative to median household income and high deductible policies currently dominate the small group and individual insurance markets. Policymakers were concerned that a comprehensive health plan with low cost sharing would be uncompetitive in price and suffer severe adverse risk selection. Further, many low wage workers who would be eligible for discounted membership fees might be barred from participation by employers unwilling to pay the employer share of the membership fees and higher paid employees unwilling to enroll at full membership cost. On the other hand, high front end costs

for members could pose a barrier to appropriate health care utilization and create financial hardships for low income families. The adoption of sliding scale cost sharing was a compromise approach to keeping membership costs as low as possible.

Another innovative feature of the DirigoChoice Plan benefit structure is its emphasis on wellness and personal health responsibility. Both child and adult preventive physician visits, including associated diagnostic tests and x-rays are covered 100 percent with no copayments or deductibles applied. Smoking cessation treatment is covered in full, without cost-sharing. And the program offers an annual $100 reward to individuals who, with their primary care provider, develop a plan to improve health through changes in personal behavior – such as weight reduction, an exercise plan, or smoking cessation – and carry through on the plan.

4.7 Program Costs

The Dirigo Program is now operational and reported its financial experience to the Board and the legislature at the end of the State's fiscal year, June 30, 2005. This financial report reflects a year of operations of the Dirigo Agency during a start-up period, and six months of operations of the DirigoChoice plan, which began coverage on January 1st, 2005. The Fund Flow Report is shown in Table 15. As shown in the table, the program expenditures totaled $18.3 million in the first year. Of this, close to $14 million was DirigoChoice Program costs and the remainder was Agency start-up and administrative expenses. The program received a one-time appropriation of $52,179,223. In addition, over the first six months of DirigoChoice Program operations, the program generated $8,271,663 in fees from participating employers and employees and $11,447 in federal matching dollars for enrollees dually eligible for the MaineCare program, for total program revenues of $60,450,886. Unused funds from the first year will be applied to FY 06 program expenses.

Of the $14 million in program costs, $3.8 million went to direct subsidies – the sliding scale discounts and sliding scale deductibles. $3.2 million was set aside in a risk-sharing arrangement with the carrier. Depending on the claims experience of enrollees, some or all of the dollars associated with the "Experience Modification Program" will be returned to the Dirigo Agency for application to future program costs. Employer/employee contributions covered 77 percent of non-administrative program costs less the experience modification program.

With the recent resolution of the amount of the Savings Offset Payment assessment for FY 06 – which serves as a major revenue source for the Dirigo Agency – the Agency's proposed administrative and operations budget for the coming year is under development. See Section 4.8 for discussion of program financing.

Table 15
Dirigo Agency Fund Flow Report Fiscal Year, 2005

	Dirigo Agency Funds Flow FY 05 Actual
Revenues	
One-time State dollars	$52,179,223
Employer/employee contributions	8,271,663
Federal match – DirigoChoice/MaineCare	11,447
Total	**$60,450,886**
Expenditures	
Program	
Sliding Scale Discounts	$2,711,534
Sliding Scale Deductibles	1,098,219
Experience Modification Program – DirigoChoice	3,208,318
Experience Modification Program – MaineCare	41,206
Dirigo Carrier Payments	6,826,702
HealthyMaine Program	94,100
Sub-total	**$13,980,079**
Agency Administrative	
Salary and benefits	1,024,300
Purchased services from DHHS	$2,084,931
All other	1,196,923
Total	**4,306,154**
Expenditures Total	**$18,286,233**

4.8 Financing

Revenue Sources

The DirigoChoice Plan is financed by employer and employee contributions, Medicaid dollars for those individuals eligible for the program and, in Year 1 only, $53 million dollars of state general revenue funds.

Beginning in Year 2, state funds will be replaced by a savings offset payment assessed against insurers and third-party administrators. The State's initial outlay of $53 million and the savings offset payment in future years will cover membership subsidies and also the administrative costs of the Dirigo Health Agency and the Maine Quality Forum. The savings offset assessment can only be levied if and when the Dirigo Health Agency can document reductions in the growth of health care costs as evidenced by reductions in the cost of bad debt and charity care and the impact of overall cost containment initiatives

contained in the Dirigo Health Reform law. The assessment is also capped at 4 percent of premium revenues.

The ability to fund subsidies to make the Dirigo Health product affordable depends on the ability of Dirigo system reforms to generate savings in the system. Currently, the $200 million in bad debt and charity care services provided by Maine hospitals and doctors are borne as a hidden tax by the insured in Maine, who pay marked up service rates to cover these costs. To the extent that the DirigoChoice Plan enrolls previously uninsured individuals and individuals who would have lost coverage in the absence of the DirigoChoice option, uncompensated care burdens in the State will be mitigated. The potential impact is illustrated by Maine's recent experience with a Medicaid expansion to non-categorical adults. This HIFA waiver program enrolled 26,000 individuals in 2003. This year saw the first decline in hospital bad debt and charity care experience in a decade. The estimated savings represented by actual experience compared to expected levels of uncompensated care trended from prior years experience, was between $28 and $32 million dollars (Figure 7). Interestingly, this decline represents an almost one-for-one offset of the dollars spent on hospital care under the HIFA waiver program.

In addition, the Dirigo Health Reform Act encompasses a number of measures designed to reduce the rate of increase in health care spending in the State (described in detail, in Section 4.9, below). The savings offset payment recaptures some of the cost reductions both from averted bad debt and charity care and from these other spending reductions.

Savings Offset Payment Calculation and Administration

The measurement of health care savings, for the purpose of determining whether a savings offset payment may be assessed, and the amount of the assessment (within legislatively set parameters) is a responsibility of the Dirigo Board of Directors, with review and ultimate determination by the Superintendent of Insurance. The Board's proposal regarding the Savings Offset Payment is subject to public hearings. The initial estimates of savings attributable to the Dirigo reform initiatives, and the ruling of Maine's Superintendent of Insurance with regard to these savings is described in section 4.9, below.

4.9 Cost Containment

The Dirigo health reform initiative is comprised of three facets: cost, quality and access. Reform cannot be achieved nor sustained without each of these facets being adequately addressed – they are intimately interrelated. One of the most significant achievements of Maine's reform effort is the development of a program structure that makes sustained access expansion dependent upon demonstrable cost savings – a structure that increases public understanding of the interdependency of cost containment and access. This allows the state to advance cost containment initiatives that might otherwise enjoy little broad based support. This structure also recognizes that when new public funds are introduced into the health care system through access initiatives, the impact can be inflationary in the absence of explicit strategies for containing costs.

The cost containment provisions included in the Dirigo Health Reform Act, as described in Section 3.5, began with a call for voluntary restraint – asking hospitals and other providers to limit their cost growth to 3.5 percent and their operating margins to 3 percent in the first year following enactment. Insurers were asked to limit their operating margin to 3.5 percent as well. In addition, the Governor imposed a moratorium on Certificate of Need, freezing new authorization of costly new construction and other capital expenditures in the health system until May 2004 when an interim State Health Plan established a budget to guide investments in new health services statewide. The State Health Plan includes specified limits for a capital investment fund that establishes an annual ceiling on amounts that can be approved under the Certificate of Need program. Requests for new programs, services, and capital expansion that come under the purview of the Certificate of Need Program are reviewed competitively in two review cycles per year. Approvals above the amount of the Capital Investment Fund are not allowed, although amounts related to extraordinary projects – those over $2 million – may be spread over multiple years. Certificate of Need has been expanded to cover high cost out-patient services provided in physicians' offices and ambulatory surgical centers.
In addition, the Dirigo Health Reform Act requires providers to post prices of common procedures. Through the Maine Quality Forum, other information, such as variations in rates of elective surgical procedures and hospitalization for ambulatory sensitive conditions, is being made available to Maine citizens to help them better understand the costs and quality of health care in the State and be better informed consumers.
Voluntary limits have again been negotiated with the Maine Hospital Association for the second year post-enactment, and the Legislature is currently considering renewal of the statutory call for continued restraints. The effectiveness of the combination of voluntary constraints with greater transparency and public awareness will be monitored by the Governor's Office of Health Policy and Finance, the Dirigo Board, and the Health Advisory Council. A collaborative approach toward cost constraint is preferred by Maine policymakers. However, a more structured regulatory approach, including an assessment of a global spending constraint, will be considered if voluntary measures lose their effectiveness.

The Governor (or his designee) is charged with issuing a biennial State Health Plan which must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on stateside cost, quality and access goals and strategies to ensure access, maintain a rational system of health care and promote the development of the health care workforce. The Advisory Council on Health Systems Development and the Maine Quality Forum provides major input to the development of the State Health Plan. An interim, one-year State Health Plan was issued in 2004. The first biennial State Health Plan was released for public comment in November of 2005. A link to the State Plan is provided in *Appendix II*.

The Dirigo Health Reform Act also mandated a Commission to Study Maine's Hospitals charged with preparing recommendations for the Governor and legislature on strategies to enhance efficiency in Maine's hospital sector and to assure the economic health of Maine's network of voluntary, not-for-profit inpatient facilities. The Commission,

chaired by William Haggett, former CEO of Bath Iron Works, completed its work in January, 2005 (Commission members listed *in Appendix III;* a link to the Commission Final Report included in *Appendix II*). Dr. Nancy Kane, D.B.A., from Harvard School of Public Health, was brought in as a consultant to the Governor's Office of Health Policy and Finance to conduct an extensive study of Maine's hospitals to inform the Commission (funded through non-HRSA grant funds). Dr. Kane's work was used in measuring the impact of the voluntary hospital cost constraint measures, and the impact of the DirigoChoice Plan on bad debt and charity care. Dr. Kane completed her work in October, 2005.

Determination of Savings after the first year of Dirigo Health Reform Initiatives

The Dirigo Board made a determination of savings resulting from the various reform initiatives of the Dirigo Health Reform Act in September, 2005. In October, the Board presented a case for these measured savings and a proposed Savings Offset Payment to fund the DirigoChoice Program and the Maine Quality Forum in the coming fiscal year. The Board's proposal was presented at an adjudicatory hearing before Maine's Superintendent of Insurance and a final determination of reasonably supported savings was made by the Superintendent in November. The components of the measured savings determined by the Superintendent are summarized in Table 16 and described below.

Table 16:
Summary of First Year Savings Due to Dirigo Health Reform Initiatives

Savings Initiative	Savings
Hospital Savings Initiatives	$33.7 million
Reduction in uninsured bad debt and charity care	$1.6 million
Reduction in under-insured bad debt & charity care	$1.1 million
Hosp. Certificate of Need and Capital Invest. Fund	None in first year
Non-hosp. CON and Capital Investment Fund	None in first year
MaineCare physician fee increases	$7.3 million
Total	**$43.7 million**

Analyses to measure the savings attributable to the Dirigo reform initiatives were carried out by Mercer Government Human Services Consulting (Mercer) and by Nancy Kane, DBA, Harvard School of Public Health. A link to the ruling by the Superintendent of Insurance is provided in *Appendix 2*.

1) Savings Associated with voluntary hospital limits on consolidated operating margins to 3 percent in 2004.

The Dirigo Health Reform Act includes the following language: "Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than 3% for the hospital's fiscal year beginning July 1, 2003 and ending June 30, 2004."

To calculate savings related to this voluntary activity, Dr. Kane undertook the following analysis: A baseline operating margin for each hospital was constructed using the average operating margin over the prior three years (2001 – 2003). A savings was calculated if 1) a hospital's baseline margin was above 3 percent; 2) the 2004 operating marging was below the baseline margin. The savings was calculated as the difference in operating income between the baseline margin applied to 2004 operating revenue, and the actual operating income in 2004.

[(Baseline Margin * 2004 Total Operating Revenue) – 2004 Operating Income]

Since many Maine hospitals' fiscal years did not comport with the state fiscal year, hospital operating revenue, expense, and income were weighted by hospital fiscal year to achieve compliance with the required measurement period. Investment income, gifts, and equity investments were excluded from the calculations in order to standardize the definition of operating income across hospitals in Maine.

Table 17 shows an example of the measurement method.

Table 17
Example of Calculation of Savings Associated with Voluntary Limits on Hospital Consolidated Operating Margins

2004 Total Operating Revenue Hospital X	Baseline Margin[a]	Expected Income[b]	2004 Actual Operating Income	**Savings**
$75,000,000	4.3%	$3,225,000	$2,250,000	$975,000

[a] Calculated as mean of operating margin rates for years 2001 through 2003
b Calculated as 4.3 percent of 2004 total operating revenues

When this analysis was applied to the 2004 experience of Maine's 36 general hospitals, 3 were found to have met the criteria for claimed savings. When the changes in operating margin across all hospitals, including those with increased margins, were taken into account, the Superintendant ruled that there were no net savings to the system in the first year of this voluntary measure.

2) Savings Associated with Voluntary Limits on Growth in Cost per Case-mix Adjusted Discharge to 3.5 Percent

The Dirigo Act specifies, "each hospital…is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than 3.5% for the hospital fiscal year beginning July 1,2003 and ending June 30, 2004.

The analysis of savings resulting from decreasing rates of growth in hospital costs per case-mix adjusted discharge relied on the development of baseline information from

which to establish a trend of each hospital's prior rate of growth in costs. Dr. Kane used Medicare Case mix indices and discharge data on each hospital, provided by the Maine Health Data Organization, for the years 2000 through 2004. Inpatient discharges (including newborns) were multiplied by the Case Mix Index using the CMS case weights applied to all payer discharges. Outpatient-adjusted discharges were calculated by dividing outpatient gross patient service revenue for each hospital by inpatient gross patient service revenue per inpatient discharge (a methodology advocated by the Maine Hospital Association). The cost data were adapted from each hospital's fiscal year to the state fiscal year (the required measurement period, as specified in the law) using the same weighting methodology as described for the Operating Margin analysis, above.

The three year trend data were adjusted to take into account national hospital cost inflation as measured by the Hospital Market Basket Inflation (HMBI) developed by CMS for the purposes of determining updates to the Medicare Prospective Payment System. The HMBI, which is based on the federal fiscal year of October 1 through September 30th, was weighted to correspond to the measurement year called for in the Dirigo law (July 1 through June 30). This resulted in annual HMBI for Maine of 4.2 percent in 2001, 3.1 percent in 2002, 3.5 percent in 2003, and 3.8 percent in 2004. The growth rate of each Maine hospital *after* accounting for HMBI was then calculated.

A second adjustment to the trend line was the application of compound growth rates rather than average growth rates over the baseline period. Thus, after inflation was taken out of cost growth over the baseline period, the baseline growth rate was the compound growth rate (CGR). The CGR was slightly lower than the average growth rate over the 3 years. An example is provided below.

Hospital x: cost per case-mix adjusted discharge (CMAD) in 2000 = $4000
CMAD 2003 = $4700 after taking out inflation-related growth

Average Growth Rate = 5.83% (4700 – 4000)/3
Compound growth rate = 5.52% 4000*1.0552*1.0552*1.0552=$4700

To determine whether the voluntary constraints had generated any savings, the inflation adjusted compounded rate of growth determined for each hospital for the three years prior to the Dirigo reforms was applied to the 2003 average adjusted cost per discharge, to determine what would have been expected as an average cost per discharge in 2004, absent the voluntary constraints. This amount was then compared to the inflation adjusted actual average cost per discharge of each hospital in 2004, to determine whether each hospital had reduced its rate of increase. The difference between the expected cost per discharge and the actual was taken as a savings to the system. The per-discharge savings amount was then multiplied by the number of casemix and outpatient adjusted discharges to calculate total savings per hospital. *Table 18* shows a simplified example (without illustration of inflation adjustments or compound rate increase adjustments) of a calculation for a hospital whose cost per case mix adjusted patient discharge rose at an average annual rate of 5.08 percent between 2001 and 2003.

Table 18
Example of Calculation of Savings from Voluntary Constraints on CMAD

2003 Cost per Pt.	Adjusted Base-line Growth Rate	Expected 2004 Cost per Pt.[a]	Actual 2004 Cost per Pt.	Savings in Cost per discharge.	Number of Discharges, 2004	**Total Savings**
$5125	5.35%	$5399[a]	$5110[a]	$289	7,000	$2,023,000

[a] After HMBI removed.

The Dirigo Agency's consultant, Dr. Kane, determined, after analyzing each hospital's experience over the four years required for this assessment, that 22 of the 36 acute care hospitals in Maine reduced their expected cost per discharge in response to the voluntary constraint effort, for a total estimated savings of $55.2 million. The Superintendant determined that, after taking into account the increases in costs associated with hospitals that did not meet the target, the net savings were $33.7 million.

3) Savings Associated with Insuring the Uninsured and Under-Insured

The Dirigo law includes the following provision: "Savings offset payments must reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State, as the result of the operation of Dirigo Health and any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004."

The estimate of savings associated with insuring the uninsured requires estimating what *would have* been spent in uncompensated care for uninsured and underinsured individuals that was averted by providing full coverage. Simply measuring changes in hospitals' and other providers' experience of bad debt and charity care is insufficient since more individuals may become uninsured or underinsured simultaneously to the initiatives that provide new sources of coverage. In these circumstances, the providers' experience of bad debt and charity care would have been more extensive, in the absence of the access initiatives, but the absolute level may not have dropped – or may have dropped less precipitously than would be indicated by enrollment levels in the access expansion programs.

The approach used to estimate averted uncompensated care relied on analyses conducted by the Muskie School under the HRSA state planning grant and analyses by the Dirigo Agency consultants, Mercer and Dr. Kane. Estimates were developed of average, per member per month costs (PMPM) in uncompensated care generated by uninsured and under-insured persons in the State. The Kane analysis of hospital 2003 audited financial statements indicated that hospitals provided $150 million in bad debt and charity care in 2003. Another $28.6 million in uncompensated care was identified provided by other providers (physician practices whose bad debt and charity care was reported on hospital financial statements, non-profit practices that report their uncompensated care experience, and Maine's two psychiatric specialty hospitals.) Kane's analysis found that 90 percent of hospital charity care was allocated to uninsured patients, and that 50 percent of bad debt was generated by uninsured patients. Based on these

allocations, $109 million in bad debt and charity care was provided to uninsured patients in 2003, from these hospitals and other providers. This figure, trended forward, using the Hospital Market Basket Index, results in an estimated $114.9 million in uncompensated care costs in 2004. Using the Maine Household Survey point in time estimate of 136,000 uninsured, this yields an average PMPM of $70.39. Mercer used a claims probability distribution table to calculate the increased risk of those enrolling in the DirigoChoice Plan and, based on these standard actuarial assumptions, estimated a DirigoChoice enrollee PMPM for previously uninsured plan participants of $95.88. This figure was applied to the total enrolled months of DirigoChoice enrollees who had been uninsured at the time they enrolled, to generate an estimated savings in bad debt and charity care of $1.6 million.

For estimating savings related to under-insured enrollees in the DirigoChoice plan, the following definition of under-insured was used:

> Persons in households with incomes below 200 percent of the federal poverty level with private insurance with deductibles greater than 5 percent of household income; and
> Persons in households with incomes between 200 and 299 percent of the federal poverty level with private insurance with deductibles greater than 10 percent of household income.

To estimate an average PMPM in experienced bad debt for under-insured populations in Maine, Mercer used an assumed figure of 20 percent of hospital bad debt as generated by the under-insured. Based on the Kane study of cumulative bad debt in the State in 2003, this assumption yielded an estimate of $26 million in bad debt generated by under-insured persons. Trended forward to 2004, the total was estimated at $27.4 million.
Based on household income and insurance deductible information collected during the Maine Household survey, the number of under-insured in the state was estimated at 34,475. Together, these data provided an estimate of $66.18 PMPM in bad debt that can be attributed to the under-insured in Maine in 2004. Mercer used a claims probability distribution table to calculate the increased risk of those enrolling in the DirigoChoice Plan and, based on these standard actuarial assumptions, estimated a DirigoChoice enrollee PMPM for previously under-insured plan participants of $78.16. Mulitplied by the total enrolled member months of DirigoChoice enrollees who had been previously under-insured, the estimated savings came to $1.1 million.

3) Savings Associated with One Year Moratorium on Certificate of Need Review and Capital Investment Fund

As part of the Dirigo Reform Act, the State of Maine imposed a year-long moratorium, starting May 1, 2003, on spending for new buildings and equipment that would have been subject to Certificate of Need review. Following the moratorium, the Capital Investment Fund (CIF), enacted as part of the Dirigo law, imposes a limit on all subsequent new spending to an annually adjusted amount determined through the state planning process.

The Superintendant ruled that if the present value of operating costs resulting from approved projects is applied to the year of approval, no savings can yet be measured from the new restrictions on capital development.

4) Savings Associated with Changes in MaineCare Reimbursement Approved as Part of Maine's FY 06 – 07 State Budget

During the course of the first year of the Dirigo Reform Act, Maine's Department of Human Services entered into a settlement agreement with hospitals of claims for past un-reimbursed Medicaid costs. In addition, the Legislature included in the budget for SFY 05 and SFY 06, Medicaid settlement amounts for SFY 03 through SFY 05 and increases in the Periodic Interim Payments (PIP) by which the Department makes payments to hospitals. The amount of the historic settlement of past claims was $96.4 million, the budgeted amount for settlements for the SFY 03 to SFY 05 period was $35 million, and the PIP increases were budgeted at $68.5 million.

In addition to these hospital payment initiatives, the Department of Human services also agreed to an increase in fees for physician services under the MaineCare program, and the Legislature approved budgetary amounts to accommodate this increase.

Except for the physician pay increase, these moneys do not reflect an increase in *rate* of MaineCare payment, but rather, a payment at current reimbursement rates for previously disputed amounts as well as reduction in the lag time which hospitals have experienced in the past, between provision of services and final payment. Therefore, system savings were not claimed for the full dollar amount, but rather for the time value of money reflected in the decreased lag time in payment. The Superintendant found that the settlement with the hospitals resulted in $1.5 million in savings based on the accelerated payment schedule. He found that the increased PIP payments prior to 2006 had resulted in $1.7 million in savings. He found that the increase in reimbursement rates to physicians had resulted in a reduced cost shift of $4.1 million in 2005, for a total $7.3 million in savings Maine's Medicaid fee initiatives.

4.10 Service Delivery

As noted elsewhere in this document, the Dirigo Health Program comprises a comprehensive range of services. A traditional comprehensive insurance benefit plan is provided to members through Anthem's network of providers in the State; other services are delivered by the Dirigo Health Agency directly. Anthem's network is statewide, assuring access to services to members in all regions of Maine.

Among the non-traditional services that are encompassed within the DirigoChoice member program are workplace wellness support and personal health responsibility initiatives including coverage of and financial incentives for receiving comprehensive health assessments and personal care plans. The services of the Maine Quality Forum are an additional benefit unavailable through insurance products.

4.11 Quality Assurance

As an agency that administers the Department of Health and Human Services' Medicaid managed care contract for Dirigo enrollees who are Medicaid-eligible, and the DirigoChoice program for small group and individual insurance contract holders, the Dirigo Health Agency is in compliance both with Maine's regulations governing the private insurance market and with Medicaid regulatory requirements. This dual role assures that quality oversight of the agency and its programs is extensive.

The Dirigo Health Agency is responsible for overseeing the quality of services provided by Anthem Blue Cross and Blue Shield to DirigoChoice members. Contractual guarantees establish and are used to enforce prescribed performance expectations. In addition, the Dirigo Health Agency is establishing internal due process mechanisms, ensuring that members have an effective avenue of appeal should they be dissatisfied with the services they receive under the DirigoChoice program. Rulemaking is underway on these safeguards. The Dirigo agency also has established rigorous quality controls for the administrative functions that are internal to the agency. Quality checks are built into all operating systems. The Agency staff includes a position whose sole function is quality oversight of operating systems.

Dirigo Health also incorporates the Maine Quality Forum (MQF), which is specifically designed to advance quality improvement in the delivery of health care services. Please see the description of the MQF, in Section 4.3.

The MQF is engaged in a wide spectrum of activities. In addition to providing advice and guidance on the State Health Plan and providing information and education to consumers on health care quality, the Forum is helping lead the *Maine Health Information Network Technology* initiative, aimed at building and implementing a statewide system for the electronic sharing of clinical information between un-allied health providers. Encouraging and supporting the development of computerized medical records technology and the systems to support real time interchange of patient information is viewed as one of the top priorities of the Quality Forum.

Among the Forum's other priorities is the development of Maine's own version of The Care Model. As noted elsewhere in this paper, Maine's population is the oldest in the country and carries a substantial burden of chronic illness. Our delivery system (as is true elsewhere in the nation), however, remains firmly fixed on acute illness interventions and rehabilitation, rendering it far from effective in meeting the needs of many Mainers. The Maine Quality Forum, in tandem with the Governor's Office of Health Policy and Finance, are spearheading an effort to disseminate the care model in this state, as called for in the current State Health Plan.

Finally, the Maine Quality Forum has initiated the Safety Star Initiative which encompasses safety standard and protocols for Maine hospitals. Hospitals that meet the standards established the Forum are awarded a Safety Star rating. This information, which is being widely disseminated, is intended to assist the public in selecting providers based on quality and safety measures.

4.12 Coordination with existing programs

The Dirigo reform effort is directed by the Governor's Office of Health Policy and Finance, which is responsible for coordinating all health policy for Maine. This sphere of influence extends past the Dirigo Health Agency, to the MaineCare program, Mental Health and Developmental Services and the Bureau of Health, as well as across all programs within state agencies that purchase or deliver health services. These include: the Departments of Education, Corrections, the State Employee Health Benefit Plan, and so on. This level of consolidation helps to ensure consistent policy across all of state government.

The DirigoChoice Plan is highly coordinated with MaineCare, Maine's Medicaid and SCHIP programs. Applicants, whether entering through a group or as individuals, upon request, are screened for eligibility to MaineCare or for sliding scale subsidies. Those who are eligible for MaineCare, including business employees, are enrolled in the MaineCare program although they receive a DirigoChoice Health Plan card and receive benefits in a manner similar to other non-MaineCare eligible enrollees. MaineCare wraps around DirigoChoice benefits for uncovered services including any co-payments and deductibles that require out-of-pocket payments beyond current MaineCare cost sharing requirements. All members receive the full range of DirigoChoice membership benefits, extending from arranging for the provision of coverage and subsidies, to wellness initiatives, care management, and fitness benefits.

The Dirigo Health Reform Act incorporates a provision for the establishment of a "virtual" high risk pool within the DirigoChoice Program. The objective of this statutory provision is to allow us to study the potential impact a high risk pool might have for Maine's insurance market, without actually establishing a free standing, independent pool. High risk and/or high cost members of the DirigoChoice Program will be managed under a case management protocol; their utilization, claims, and outcomes experience will be tracked carefully. The findings of this demonstration will be reported back to the Legislature after several years of experience are gained.

The statute clearly specifies that any health benefits coverage accessed by DirigoChoice members must meet all applicable insurance regulations; the Program receives no preferred regulatory treatment. Consequently, all reforms applicable to the insurance carriers will impact DirigoChoice members.

As noted elsewhere, the DirigoChoice plan competes in the marketplace alongside other commercially available benefits products. However, an employer choosing to enroll his/her business must agree to offer only DirigoChoice – the Program may not be offered as one of multiple options. This provision will assist Dirigo in avoiding severe adverse selection.

4.13 Crowd Out

The statute authorizing the DirigoChoice Plan specifies that eligibility for membership is open to all employers with fewer than 50 employees, regardless of whether or not they currently offer a benefits program. This provision maintains equity between currently insuring and non-insuring employers in the small group market and recognizes that the volatility in the private market is making it increasingly difficult for small employers to find and keep affordable coverage. However, employees of a business that dropped coverage within the 12 month period preceding an employee's attempt to enroll in DirigoChoice, are not eligible for membership as individuals. This provision discourages small employers from dropping coverage with the intent that their employees enroll as individuals without an employer contribution.

Further, the number of persons who can enroll as individuals is capped on an annual basis to provide an opportunity for the plan to assess experience with this group and to prevent incentives for small employers to encourage their employees to apply as individuals. In the first year of program operations, enrollment of individuals closed at the end of April and a waiting list was established. Enrollment from the waiting list was taken as places opened due to disenrollments. At year end, there were approximately 2,500 persons on waiting lists. Open enrollment of individuals re-commenced on January 1st, 2006. As of February 1st, more than 2,100 new participants will be added to the plan, with 55 percent of these enrolling as individuals, and 45 percent through employer groups or sole proprietors. Another provision of the DirigoChoice Plan requires that employees (other than part-time and seasonal workers) of small businesses that offer coverage can *only* enroll through their employer plan. They cannot enroll as individuals. This provision discourages individuals who have coverage available from an employer from dropping coverage (where they may have substantial cost-sharing) to enroll as individuals.

To date, information on the prior insurance status of enrollees is available for the first six months of program enrollment experience. This information indicates that first responders to the DirigoChoice plan (first quarter enrollees) were likely to be small businesses and sole proprietors with low to moderate incomes who switched from high deductible policies. In this quarter, 28 percent of enrollees were uninsured at the time of enrollment and another 7 percent had been uninsured within the prior 12 months. Second quarter data indicate that the plan attracted an increased number of previously uninsured as time went on. In the second quarter, 42 percent of individual enrollees and 30 percent of small business enrollees were uninsured when they enrolled. Over half of individual enrollees and 37 percent of small business enrollees had been uninsured within the past 12 months. In addition, 16 percent of individual enrollees were

obtaining insurance through COBRA provisions at the time they enrolled and a little over 3 percent switched to the DirigoChoice plan from Medicaid.

4.14 Data Collection

Data collection is a routine part of Dirigo program operations. The DirigoChoice Plan collects data from each member at the time of enrollment, including information on age, gender, residence, occupation, household size, and prior insurance status. The Dirigo Health Agency also obtains information on household income from those applicants seeking membership subsidies. Each new member is encouraged to complete a health risk assessment, allowing the Program to identify persons with chronic and/or acute conditions requiring care management, or risk factors that merit early intervention. Finally, employers enrolling a business group in the Program provide census data including hours worked by employees as part of the master membership application.

As part of the terms of the contract between the Dirigo Health Agency and Anthem Blue Cross and Blue Shield, Anthem is required to provide the Agency with regular reports on utilization and claims data files. These reports provide the Dirigo Agency with information on enrollee utilization patterns benchmarked against the experience of Anthem large group enrollees.

We intend to develop internal registries of members with certain chronic conditions, to enable the Program and the member's primary care provider to identify gaps in needed services. These registries will be developed at the Program level, as many providers have not developed the capacity to create such tools. Gap reports both on an aggregate/practice level and on an individual patient level will be fed back to the primary provider. Following these data over time will allow both the provider and the Program (and perhaps the member, as well) to monitor compliance with best practices. At the same time, the Program will be modeling best office practices for the providers, and assisting them in developing the internal systems required to implement population-based tracking practice-wide.

In order that the savings offset payment can be calculated each year, the number of previously uninsured individuals who gained coverage through the DirigoChoice Plan is continually monitored. This will allow the state to develop an estimate of bad debt/charity care averted by expansions in coverage. As discussed in 4.13 above, the Muskie School conducted surveys of all households that enrolled members in the DirigoChoice plan within the first six months of plan operations. The survey captured information on prior insurance coverage, if any, held by the subscriber and his/her dependents. Information collected included type of coverage and size of deductibles and co-pays so that estimates could be developed on the extent of "underinsurance" as well as un-insurance.

Other measures of changes in aggregate health care spending and utilization in Maine are captured through hospital cost reports and from claims data reported to the Maine Health Data Organization. These data collection and monitoring activities are discussed in detail in section 4.9.

Each biennium, beginning in 2004, the Governor's Office is required to issue a State Health Plan. The Plan sets limits for Maine's Certificate of Need Program. The determination of the limit (measured as expected third year operating costs of the proposed capital projects) is based on a statewide and region-specific assessment of factors such as: the average age of plant; the estimated impact of new technology; extent of unmet need; potential for duplication of services; and the expected rate of increase in the cost of health care services. These data are being collated with information on the demographic, socioeconomic, and health status characteristics of Maine residents to prioritize new system development and determine the capacity of Maine's population to support changes in the cost of the health care system arising from investment in projects involving the substantial capital funding and/or operating costs.

Additionally, the statute requires the Governor to establish an annual state health expenditures budget. This budget is to encompass all expenditures for health care, not just those purchased with state dollars, and will, for the time being, serve as a voluntary expenditures target. The budget will provide parameters for investment under the provisions of the State Health Plan.

4.15 Program Evaluation

The Dirigo Health Reform Act includes many ongoing evaluative reporting requirements. The Dirigo Board is required to report, annually, on program experience to the joint standing committee of the Legislature with jurisdiction. The report must include an assessment of the impact of the program on the small group and individual health insurance markets in the State and on reductions in the number of uninsured persons in the State. The Board is also required to report on membership, administrative expenses, scope of coverage, revenues, and claims incurred.

The Board is also required to report annually on cost savings attributable to the Dirigo Program. This report will be used both to assess performance of the program and also to establish the level of the Savings Offset Payment on an annual basis.

The Maine Quality Forum also has an annual reporting requirement on annual activities.

The Governor, or his designee, is required to report annually on progress toward the goals set out in the State Health Plan, and issue an annual statewide health expenditure budget report that will serve as the basis for establishing priorities in the State Plan.

Insurers operating in Maine's health insurance market have new reporting requirements covering all lines of health business. These reports, submitted to the Maine Bureau of Insurance, will provide the public with information, for each line of business, on premiums earned, claims paid out, and administrative retention. Maine's Hospital Study Commission has also recommended a reporting format for Maine hospitals that would provide annual information on a timely basis on the financial status and experience of each hospital.

In addition to on-going internal evaluation for the purpose of informing the Maine people and the legislature of program progress, the Commonwealth Fund has funded Mathematica Policy Research, Inc. to conduct an external evaluation of the early Dirigo reform experience.

4.16 Political Considerations and the Path to Consensus

When Governor Baldacci, who took office in January 2003, the environment was ripe for reform. Small business premiums had increased 78 percent between 2001 and 2004 (*Table 10*); individuals and large businesses experienced similar rate increases. Over the past decade, Maine led the United States in growth in personal per capita health spending and now ranked 11th in per capita spending, but 42nd in median household income. Employers were rolling back benefits, shifting premiums to employees, or dropping coverage altogether. These factors contributed to a very real sense of crisis about the future of Maine's health care system.

The Baldacci administration came into office at a time when, for the first time in 16 years, the same party controlled the Executive Office and the Legislature, providing a necessary – but not sufficient – ingredient for the passage of major reform legislation.

The Governor and his staff, thus, began consideration of reform options in an environment with broad consensus that the health care system was in crisis and that the small business community was particularly handicapped by health care costs. Many in Maine's business community recognized that market mechanisms had failed to rationalize the health care system or drive efficiencies and – although there was no consensus about the appropriate role for state government – many business leaders were more open to a public-sector led initiative than had been the case in prior years.

The Governor engaged stakeholders in early policy formation through a 27-member advisory group, the Health Action Team. Members spanned a wide spectrum of views, from single payer advocates, to proponents of incremental reforms, to outspoken advocates for a market-based system without governmental intervention. This advisory team was not charged with reaching consensus but, rather, responded to and provided advice on shaping a strategy within parameters set out by the Governor. Non-negotiable points established by the Governor included a requirement that the strategy provide a means to attain universal coverage within a short timeframe and that cost, quality and access all be addressed simultaneously. Specifically excluded from the range of options available for consideration were: a single payer system and employer or individual mandates. The Governor felt that a single payer system would require participation by Medicare and Medicaid in order to be financially feasible and that such participation was unlikely to be forthcoming or would take too long to achieve. He opposed mandates in a situation where health care costs were uncontrolled. The possibility of considering a mandatory participation system, in the future, when participation was affordable, was not ruled out.

The Health Action Team worked for two months, providing valuable feedback to the Governor's Office of Health Policy and Finance (GOHPF), and driving substantive redesigns to the basic reform proposal. At the end of the Team's tenure (in March), there was not unanimity across the group regarding the reform proposal, but every constituency understood the proposal and its evolution.

When the Governor formally introduced the proposal and accompanying legislation in May 2003, it was in the wake of a successful effort, working with the legislature, to close a substantial gap in the state budget without raising taxes. His approval ratings with the Maine public were very high, and his party controlled both houses of the Legislature. The Legislature established a Special Select Committee to hear and work the Dirigo Reform legislation and set aside all other health related bills until the Committee reported out the Governor's bill.

The bill had both strong proponents and opponents. The public hearing on the bill lasted for nine hours and was characterized in the press as "The People Versus the Powerful." Many individual citizens spoke, with riveting and distressing stories of personal hardship related to lack of health coverage and access. Supporting the bill were the Maine State Chamber of Commerce, the Maine State Nurses Association, unions, and the Alliance for Small Business. The Maine chapter of the National Federation of Independent Businesses and local chambers – usually strong opponents of public sector interference in the insurance market – testified neither for nor against the bill. Opposing the legislation were the hospitals, physicians' organizations, and insurers. Many of the opposing stakeholders announced that they liked and supported most of the bill but had specific objections to parts of it.

As the bill was worked during the legislative session, organized opposition to the plan, on the whole, was restrained – except among hospitals. Most stakeholder groups targeted specific elements for modification or removal. Insurers were concerned primarily about the proposed assessment and new regulatory requirements affecting their industry. The physician associations were concerned with the proposal to extend of Certificate of Need review to non-hospital settings. Hospitals rejected proposed cost containment provisions, in particular, language that referenced a proposed global expenditure target. The global expenditure target was initially proposed as part of voluntary planning process where hospitals would be protected from anti-trust challenge while they engaged in collaborative planning to share services and create efficiencies in the hospital delivery system in order to reduce aggregate health care spending. Maine's Hospital Association took the position that budget targets without adjustments for growth in utilization were unacceptable and maintained that Maine's hospitals were unwilling to participate in system-level planning through a publicly transparent forum. The hospitals organized community forums, wrote editorials in local newspapers, and distributed materials to their employees, Boards, and communities, warning of hospital closures and massive layoffs in the event of passage of the bill. A letter writing and e-mail campaign to Maine legislators was launched that was aggressive and unrelenting.

The legislative committee hearing the bill instructed the Governor's Office of Health Policy and Finance to negotiate differences with the key stakeholders and to return to the committee with a compromise bill. Long hours of "shuttle diplomacy" succeeded in finding sufficient compromises so that a revised bill was brought to the legislative committee with a commitment of support from insurers, hospitals, and physicians.

The proposed voluntary hospital planning provision and the hospital global expenditure target were eliminated. However, the Act retained the state health plan which includes a global spending target and a capital investment fund which will limit future system growth. In addition, a commission to study Maine's hospitals was created.

The 4 percent assessment on insurers' gross revenues proposed to fund the Dirigo reforms was replaced by the Savings Offset Payment. This revision retained the assessment, but required the Dirigo Board to demonstrate reductions of bad debt and charity care and/or reductions in health care cost growth in an amount equivalent or greater than the proposed assessment.

Finally, the Governor's Office agreed to fund the first year costs of the DirigoChoice Plan with funds made available through Federal fiscal relief. These funds "primed the pump" and helped resolve a serious problem. An assessment on insurance premiums prior to realizing any savings from reduced bad debt and charity care would have required the insurance industry either to fund the subsidy costs for the program from their reserves or to pass the assessments on to policyholders in premium increases. Under the final language of the bill, because the assessment is linked to demonstrated savings, insurers are expected to recoup the assessment costs through contract negotiations with providers rather than through increased premiums.

After the successful negotiation of compromise language, the bill received a unanimous, bipartisan committee report and two-thirds support in each house. An extraordinary amount of press attention followed enactment. *The LA Times, the International Herald Tribune, the New York Times* editorial page, and Ellen Goodman all wrote about the Dirigo Health Reform Act. That level of press scrutiny after a difficult fight also helped to unite Mainers around what was seen nationwide as a bold and creative solution to health reform.

In the first year of program operations and, in particular, the first test of the Savings Offset Payment determination, the bipartisan nature of support for the Dirigo Health program has eroded. While the subsidized, DirigoChoice plan is very popular with participants and the public at large, advocates for a market dominated health care system have maintained a systematic public relations campaign hostile to the program throughout the year and have gained support among Republican legislators. In addition, the determination of the first year savings offset payment raised opposition and concern among insurers and the Chamber of Commerce. It is clear that in the passage of the Dirigo Reform Act, Maine's legislature diffused significant political opposition by leaving to a later day, the ultimate determination of ongoing program funding. The delay, however, did nothing to reduce political friction when payment came due. The program has made it through this first hurdle and it gains strength in public support as enrollment grows. Maintaining and growing support in the business community may ultimately hinge on the success of the reform package's systemwide efforts at slowing aggregate health spending rates.

4.17 Actions Taken and Remaining Challenges

As described above, reform legislation was introduced in May, 2003, and passed the legislature with a two-thirds vote in each house. All legislatively authorized Advisory Boards, and Councils are in place and all study commissions have completed their mandates. The Dirigo Health Agency is operational and the Agency has established a contractual relationship with Anthem Blue Cross and Blue Shield of Maine. The DirigoChoice insurance plan has been operational since January 1st, 2005 and current enrollment stands at around 9200 encompassing 720 small businesses.

The Governor's Office of Health Policy and Finance continues to coordinate and lead the policy implementation efforts. The team of experts established by the GOHPF during the policy development phase has been expanded. The Health Policy Institute of the Muskie School of Public Service continues to be engaged in research supporting program development, evaluation and new pilot project planning. Experts from the Harvard School of Public Health (Professor Nancy Kane, DBA), George Washington University (Jean Lambrew and Cindy Mann) and the Medicaid Policy Institute (Andrew Schneider), along with consultants from Mercer were contracted to assist in the development of the Anthem contract specifications and in the development of savings estimates for the Savings Offset Payment.

There are a number of challenges facing Maine in the next phase of health reform. First, continued operations and growth of the DirigoChoice Plan requires assessment of on-going program modifications and revised marketing strategies. Strategies are currently being developed by the Dirigo Agency staff to increase training of brokers and provide additional incentives for enrolling businesses in the DirigoChoice plan.

A second challenge facing Maine is a major public education campaign to increase Maine citizens' active participation in maintaining their own health and their understanding of the trade-offs and constraints needed in the health care system in order to assure that coverage is affordable for all.

A third challenge facing the Dirigo Reform staff is preparation for the end of the two year contract with Anthem. Staff must assess alternative contract arrangements, options for the development of inhouse program operation capacity, and options for a renewed competitive bid process.

Finally, the effort to assure a collaborative reform environment with Maine providers, insurers and other stakeholders, rather than an adversarial environment, remains a challenge.

4.18 Policy Options Not Selected

As indicated in our original proposal to the State Planning Grant program, the Maine legislature passed three health reform initiatives in 2001, prior to the election of Governor Baldacci. These initiatives included: the creation of a study commission to evaluate the feasibility of a universal, single payer health system for Maine; a small group coverage initiative that called for the development of a state sponsored program to offer coverage to small businesses and to expand Medicaid eligibility to cover low-income workers; and a small business initiative that would create a purchasing cooperative and consumer choice health program.

The Health Security Board, tasked with evaluating the feasibility of a Single Payer Health System, hired Mathematica Policy Research, Inc. (MPR), to model the costs of such a system and to compare the costs with projected costs under current coverage arrangements. MPR obtained Medicaid claims and comprehensive claims from over 100,000 lives covered through employer benefit plans in Maine to construct their model. The work of the Health Security Board and its consultant was completed prior to the election of Governor Baldacci and the Board

issued a report indicating that the estimates showed that a single payer system would generate savings within three years of implementation.

Governor Baldacci and his health policy staff did not pursue further investigation of a single payer health system for several reasons. First, the Governor felt that the likelihood of participation in such a system by the federal Medicare and Medicaid programs was unlikely, particularly in the short term, and he was interested in reform strategies that would relieve access and cost problems in Maine quickly. Second, he felt that an effort to implement a single payer health system would be too politically divisive and would lack sufficient public support. This estimate was reinforced by findings from the focus groups among small employers conducted under the State Planning Grant that showed wide-spread support for reform and an increased role for state government, but little support for a state-run health care system.

The reforms specified in the Act to Address the Health Care Crisis for Small Business and Individuals – the second piece of reform legislation passed prior to the initiation of Maine's State Planning Grant – have largely been encompassed within the Dirigo Health Law. The third reform legislation, the Consumer Choice Act was not pursued by Governor Baldacci because in his staff's assessment, the proposed strategies were insufficient to meet the crisis in Maine's health care system. The legislation relied on increased consumer price sensitivity as the sole mechanism for reducing the rate of increase in health care spending in the State. Analyses of Maine's health care market conducted as part of the State Planning grant showed that health care costs rose faster in Maine than in any other State over the past decade. Further, the managed care market largely collapsed in Maine due to an inability of managed care companies to negotiate discount rates with providers. As a largely rural state, and one where providers have consolidated into horizontally and vertically integrated entities, the opportunities for stimulating competition among providers are practically non-existent. With no discipline on pricing through market competition, and no discipline on utilization from managed care entities, reliance on consumer choice as a mechanism to control costs was deemed inadequate. Further, this proposal offered no immediate relief for the working poor and moderate income populations currently priced out of the market.

The Governor's Office of Health Policy and Finance initially explored the concept of a statewide public reinsurance mechanism with the goal of stimulating a restructuring of products and costs in the small group and individual insurance markets. This concept was discussed by the Governor's Health Action Team and met with strong opposition from both insurers and the business community. The opposition rested on the view that national insurers, such as those that dominate this state's market, obtain reinsurance coverage on a national basis and have a "deeper pocket" than the State. Thus, it was argued that the state's assumption of risk at a low attachment point would merely shift costs from one organization to another, but not lead to any savings. This argument, and the energy with which it was argued, led us to rethink our initial position.

The Governor also was interested in exploring the concept of instituting a publicly-sponsored, not-for-profit insurance company. This concept derives from Maine's successful experience of reform in the workers' compensation insurance market. When commercial coverage in that market collapsed due to uncontrolled costs and lack of competition, the Maine legislature instituted a number of reforms, including the creation of the Maine Employers Mutual Insurance

Company (MEMIC). In addition to providing insurance coverage, MEMIC has been successful at working with employers to introduce more aggressive workplace safety features and strategies to get injured workers back to work under modified work conditions. The package of reforms that were introduced together with MEMIC's performance has revived the worker's compensation insurance market. Commercial insurers now compete in the market, although MEMIC retains sixty percent.

After a review of this option, the Governor's Office of Health Policy and Finance decided to build the Dirigo Health Program as a public/private collaboration – contracting with commercial insurers on a full risk basis for the health insurance component of the program. However, the legislation contains language that reserves the right of State Government to proceed with the development of a public insurance entity, should private insurers refuse to participate. As the conclusion of Anthem's two year contract for the administration of the DirigoChoice plan draws near, the Governor's Office is assessing the feasibility of transferring the program to a public, not-for-profit entity.

4.19 Addressing the Eligible but not Enrolled

In 2000, Maine was among the top five states in the country in the proportion of eligible children enrolled in Medicaid and SCHIP, according to a report from the Children's Defense Fund.[38] As indicated in Section 1 of this report, close to 1 in 3 children in Maine (28 percent) have public coverage. These successes stemmed in part from aggressive outreach through schools and public service announcements, in part through simplified and streamlined application procedures, and in part from State TANF policy that reduced welfare roles more gradually than in some states. Nevertheless, Maine had 23,000 children uninsured at the time of its household survey, about half of whom were in households with incomes below 200 percent of the federal poverty level, making them eligible for enrollment in MaineCare.

The survey queried respondents about their attitudes toward participation in a publicly sponsored health coverage program. Eighty-seven percent of Maine's uninsured indicated that they would be willing to enroll in MaineCare or another public insurance program. Ninety-three percent of the uninsured with incomes below 200 percent of the federal poverty level were willing to enroll. The proportion of parents with uninsured children who would enroll their children in a public program was almost universal, according to our survey.

These findings indicate that attitudes are favorable in the populations targeted by the DirigoChoice Plan. The major challenge for enrollment in the DirigoChoice plan is persuading employers who have not provided health benefits in the past to undertake this commitment. As a new program and a policy initiative of a new administration, employers must be persuaded that the program has a stable future and that the favorable discounted rates that may make such a decision possible will still be available in coming years. Experience in the first year has shown that enrollment patterns for the DirigoChoice Program differ markedly from expansions of MaineCare. As a new product with a different target market, aggressive marketing and information dissemination are necessary to "get the word out," and to assist employers with decisionmaking and application processes. The Dirigo Agency staff are continuing to refine strategies to reach the eligible but not yet enrolled populations.

5. Consensus Building Strategy

5.1 Governance Structure Used in Planning Process

Governor Baldacci's first act as Governor was an Executive Order creating the Governor's Office of Health Policy and Finance (GOHPF), with oversight responsibility for health reform initiatives and health policy under his administration. The creation of this office sent a clear message to the public and stakeholders that the Governor gave health reform a very high priority and that he would be personally involved in the reform effort. Locating the initiative in the Governor's office also ensured that the entire Cabinet was apprised of policy strategies as they developed and that key government agencies were involved from the outset of the effort.

A second planning structure convened by the Governor was the Health Action Team (HAT) made up of key constituents and stakeholders. As mentioned elsewhere, this group comprised representatives of a broad range of policy views and included consumers, business representatives, insurers, providers and legislators. Individuals were appointed to the Health Action Team by the Governor. Most were recognized spokespersons for their interest group. For example, the Executive Directors of Maine's Hospital Association and the lead consumer advocacy group – Consumers for Affordable Health Care were both appointed to the HAT. In at least one case a trade association (insurance plans) was asked to select a member to serve as a representive of the Association on the HAT. Other key parties participating in the HAT deliberations were the President of the Maine Medical Association, the Director of the Maine State Employee benefit program and the head of the union representing State employees. The legislative representatives were the chairs of the standing legislative committees with a direct interest in health policy.

The HAT deliberations were not intended to result in consensus. Instead, the forum allowed all parties to voice their suggestions and concerns and to develop a sound understanding of the Governor's proposal and the rationale behind it. The meetings of the HAT were open to the public and were well attended. At least 30 minutes were reserved at the end of each meeting for public comment. The HAT also formed six subcommittees to develop recommendations on program features including benefit design, quality assurance, cost containment, finance, coordinated public purchasing, and the needs of special populations. The HAT deliberations led to some attenuation of later debate. It also allowed the Governor's proposal to be handled on an expedited basis by the Legislature, as much of the baseline educational work with the stakeholders and the public had been accomplished prior to the bill's introduction.

Key state officials were involved in the development of the Governor's proposal and in the legislative debate. The Superintendent of Insurance, for example, was consulted on features of the program that related to private insurance and insurance regulation, and he was also called to testify before the legislative committee of jurisdiction. Others who were engaged in the proposal development process included the head of the Bureau of Income and Family Assistance, the head of the Bureau of Medical Services (Medicaid administrative agency), and the head of the Bureau of Health.

5.2 Gaining Public Input

Pre-Legislative Action Public Input

Prior to the development of the Governor's proposal, public sentiment was explored in several ways. Focus groups were held with small employers in four different regions of the State. Among other subjects covered, participants were queried about their views on a variety of strategies for reform of the health care system. In addition, they were asked their opinion about the appropriate role for state government in overseeing and delivering health care services. Interviews were also conducted with representatives of large businesses who were queried on the same range of issues. Maine's household survey was used primarily to gather information on the number and characteristics of the uninsured in the State. However, the survey also included two questions about citizens' willingness to participate in a publicly sponsored health coverage program. These questions showed an overwhelmingly positive response.

The Health Action Team meetings held between January and March 2003 (see 5.1, above), were the primary vehicle for obtaining public input during the development of the proposal. All such meetings were open to the public and were regularly attended by anywhere from 25 to 100 people, in addition to the 27 Team members. The public was allowed to provide comment at these meetings, and many did so.

Additional input was received through direct correspondence by the public to the Governor's Office and through an invitation for input on the Governor's website. Finally, the Governor and GOHPF held a series of meetings with stakeholders to garner input and review concerns.

Once the Governor's proposal was introduced as legislation, it came under the purview of a Special Select Committee. That Committee held a nine-hour public hearing on the bill that provided valuable comments and suggestions, many of which were used to improve the bill before its enactment.

Post-Legislative Action Public Input

An important initiative encompassed within the Dirigo Reform Act is the establishment of a biennially-updated State Health Plan that is intended to serve as a blue print to guide resource allocation according to established priorities. The GOHPF has undertaken an extensive campaign to elicit public input for the development of the Plan.

The first stage in effort to engage Maine's populace in the planning effort was the Tough Choices Campaign. The GOHPF contracted with AmericaSpeaks, a Washington-based organization focused on participatory democracy, to assist in organizing and conducting two simultaneous and electronically linked day-long participatory meetings in which participants would discuss and prioritize among various health reform options. The meetings were structured around four sequenced discussions where participants considered different proposals for 1) improving citizen health status, 2) reducing health care costs, 3) expanding access to all citizens, and 4) improving quality of care. At the end of the day, participants had an opportunity to prioritize reform options across all areas that had been discussed.

Extensive research and planning went into meeting, including preparation of a 31 page participant guide designed to provide background information and set out five or six alternative reform strategies within each of the four topic areas (Discussion guide appended in Appendix 3). The options proposed represented a broad political spectrum and included "real world" "real time" reform proposals advocated by various stakeholder interest groups and under consideration by the Maine legislature. The draft guide was reviewed by a committee of stakeholders and extensively revised in response to concerns about a balanced presentation.

In order to assure that participants were broadly representative of Maine's citizenry, a recruitment process based on a random selection design was undertaken. The process was conducted by the Survey Research Center at the University of Southern Maine's Muskie School in collaboration with the University of Maine Margaret Chase Smith Policy Center and the National Academy for State Health Policy.

Letters were sent to randomly selected households chosen from a list made up of the telephone directory "white pages" from across the State. Those who received the mailing were asked to return a postage-paid card if they were interested in participating, and to complete a short demographic questionnaire about age, gender, place of employment, source of health care coverage and town of residence. Based on responses to the mailing, the Survey Center created a list of particants in a manner to best match US Census data for the state, and made telephone contact to confirm participation and make special arrangements, should participants need transportation or child care. Participants received the participant guide in the mail, prior to the meeting so that they would have an opportunity to study and consider the choices ahead of time.

At the meeting, participants sat at randomly assigned tables of 10, each staffed by a trained facilitator. Throughout the day, the table groups discussed each option and heard the points of view of the others at the table prior to voting on preferences, using wireless electronic keypad devices. In addition, each table selected a participant to record on a laptop computer, ideas and reactions that represented a consensus emerging from that table's discussants. The individual table recordings were transmitted, electronically to a central databank, where a "theme team" reviewed them in real time and identified repeated and emergent themes. The results of votes and emerging themes were periodically relayed back to the whole group through large screen broadcasts of bar charts and bulleted comments, and by the conference facilitator. The interactive nature of the discussions and votes, allowed participants to add new options for consideration and voting, when they felt that the choices offered through the participant guide did not adequately capture the group's preferences.

The participants rated the experience highly – 93 percent reporting that they learned new information, 61 percent reporting that the discussion led them to change their minds on some issues, and 86 percent ranking the overall meeting as good or excellent. They also used the opportunity to send clear and sometimes unexpected messages to the Administration.

Meeting Findings

Shown below are the outcomes of the policy choices expressed by the participants. For each policy option considered, participants could vote using a 6 scale ranking from strongly against to strongly in favor. Scores reported here were calculated by subtracting the percentages of those "strongly against" and "against" from the percentages that voted "strongly in favor" or "in favor." Thus, scores can rank anywhere from 100 if all participants vote in favor of an option to negative100 if all participants vote against an option. When participants are evenly divided, the score will be low (either positive or negative).

This group of randomly selected Mainers strongly favored public sector solutions to many health care problems. When considering options for expanding access to care for all Mainers, the option that received the highest ranking was the creation of a single payer system (Table 19). In a forced choice selection of the "best" of the five strategies considered, the single payer option received 54 percent of the vote.

Table 19
Scored Rankings of Strategies to Expand Access to Care

Choices for Expanding Access to Care for All Mainers	Score
Create a single payer system	26.1
Expand MaineCare (Medicaid)	25.8
Expand DirigoChoice	24.7
Require all Mainers to purchase health insurance	-44.2
Mandate employer contributions to health coverage for all employees	-61.1

When confronted with options for containing the rate of growth in health care costs, participants responded negatively to deregulated market strategies and were closely divided on regulatory strategies (Table 20). The group, by acclaim, requested an additional option put forward by some of the participants be included in the final vote. This option – "Get out of the for-profit insurance paradigm, altogether" – won overwhelmingly in the final, choice-among-options vote with 47.5 percent. An additional 27 percent of participants voted for "none-of-the-above," with all the options included in the participant guide receiving very little support.

Table 20
Scored Rankings of Strategies to Contain Costs

Choices for Reducing the Rate of Growth in Costs	Score
Regulate insurance premiums	11.0
Reduce or constrain the number of mandated benefits	-2.9
Cap the costs of health care providers and insurers	-29.1
Deregulate the insurance market	-40.3
Establish greater controls on access to some Rx, procedures and tests	-48.6
Establish a high risk pool	-65.2

Participants were enthusiastic about strategies for improving population health, except for the options using positive or negative financial incentives (Table21). Improving food and increasing opportunities for exercise in the school system was particularly well received. The issue of environmental health (reducing cancer-causing chemicals in the environment) was put forward by participants and received 12 percent of the final vote.

Table 21
Scored Rankings of Strategies to Improve Population Health

Choices for Improving the Health of Mainers	Score
Better food and exercise in schools	91.0
Mandate coverage of preventive care in insurance policies	47.2
Tougher seatbelt and helmet laws	26.7
Taxes on unhealthy habits	9.0
Premium discounts for healthy living	-ll.6

At the end of the day-long meetings, participants were asked to prioritize among the highly-scored options identified during the day. Strategies were divided into two categories – system-level change and incremental reforms. Among the system-level change options, single payer was the preferred option with 45 percent of participants listing it as their number one choice (Table 22). Interestingly, this choice was the top vote getter in every income category of participants and regardless of health coverage status or arrangement (employer coverage, individual coverage, public program, or uninsured).

Table 22
Ranked Preferences for System Level Change Options

Choice Rankings Among System-Level Change Options	Percent
Single payer system	45%
Expand Dirigo, MaineCare and Mandate	
Employer contribution to coverage	17.3%
Get out of the for-profit insurance paradigm	15.5%
None of the above	22.3%

Among incremental change strategies, the overwhelming favorite was one put forward from the floor earlier in the day – improving the public health infrastructure. This option, in a forced choice selection of the most important strategy, received 50.5 percent of the vote (Table 23).

Table 23
Ranked Preferences for Incremental Change Strategies

Choice Rankings Among Incremental Strategies	Percent
Improve the public health infrastructure	50.5%
Mandated benefit for preventive care	15.8%
Improve food and exercise in schools	13.4%
Cap costs of providers and insurers	6.4%
Regulate insurance premiums	5.9%

Summary

Overall, these choices reveal, among participants, significant support for public sector strategies to improve both access and health care delivery. Participants signaled a lack of confidence in the private insurance market, supported regulatory control of insurance premiums but not of providers,and in general, were less favorably inclined toward regulatory strategies than toward major system-level change. In addition, participants expressed strong opposition to mandates placed on employers. The group was enthusiastic about proposals to improve population health but disinclined to constrain choices and freedoms either through financial disincentives, mandated coverage, or restricted access.

While the number of participants was small in relation to the overall population in Maine, the random selection process lends additional weight to the opinions expressed. In addition, the uniformity of preference across income groups and insurance status groups provides additional evidence that the views expressed by participants may not be idiosyncratic or atypical.

Listening Tour

After the Tough Choices meetings, the Governor's Office of Health Policy and Finance undertook a second phase of soliciting public participation in the health policy debate – regional Listening Tours. In the summer of 2005, seven publicly announced and advertised open meetings

were held in: Brewer, Presque Isle, Calais, Lewiston, Augusta, Portland and Saco. At these meetings, the participants saw a presentation of findings on Maine health status excerpted from the Maine Healthcare System Assessment Report (See *Appendix 3*). The audience was then provided with an open microphone and asked for input on the pending State Health Plan – what the State's planning priorities should be. As would be expected in any forum such as this, a variety of frequently conflicting views and priorities were expressed. Nevertheless, some themes emerged across the 7 Meetings (see summary of themes in Table 24).

Table 24
Summaryof Major Themes from Listening Tour

Health, generally Personal responsibility important, but don't blame the victim Need to focus on whole person Prevention: Invest in public health infrastructure Use caution in shifting resources to prevention; some conditions are not preventable. Top Health Priorities Physical Fitness (exercise & diet) Dental/Oral Health Mental Health Behavioral Health (Substance & alcohol abuse) Other Health Priorities Tobacco Use Diabetes Healthy environments Suicide Lead exposure Teen pregnancy Asthma Cardiovascular disease/hypertension Access to Coverage Issues Single payer the way to go Single payer not the way to go Reduce barriers to MaineCare "Unhook" health insurance from employment	Dirigo Issues Dirigo is great Dirigo is communism Barriers to entry for Dirigo Access to Care Issues Mental and behavioral health services and treatment Prescription drugs Not enough school based health centers Dental health Cost Issues Variation in costs Defensive medicine Cost-shifting (especially to uninsured) Cross-Cutting Systems Issues Workforce: direct care EMR Employers: role in health promotion & access to coverage Community Coalitions: important but fragmented Integration of MH & medical system Integration of chronic care Need to regulate capital investment; open to public Rural hospitals threatened

5.3 Other Strategies to Build Awareness

During and after the legislative debate on the Dirigo Health Reform Act, both the Governor and the GOHPF staff spoke extensively at forums organized by public and private community agencies about the Dirigo reform effort. The GOHPF also prepared extensive briefing materials for the press. The Executive Director of the Dirigo Health Agency and GOHPF's Legislative and Constituent Liaison dedicate considerable time to speaking at meetings and forums to explain the Dirigo Reform components.

The Governor's website has incorporated a special section on the reform initiative. Substantial public comment is received through the website. Contacts through the website are added to an interested parties list for email communications and for initial marketing contacts.

Since the passage of the Dirigo Reform legislation, efforts to educate the public and key constituencies have continued.

The Maine Quality Forum, created through the Dirigo Health Reform Act, is another organization with a mission of public education. To date, working primarily through a website, the MQF is disseminating information on health care quality and utilization, using service area comparative data and standardized outcome measures.

5.4 The Impact on the Policy Environment

The Dirigo reform initiative has dominated all discussion of health care policy in the period since passage, both among proponents and opponents. During the legislative session in which the Governor's proposal was debated, all other bills related to health care introduced prior to the Dirigo proposal were held without hearing or discussion, pending consideration of the Governor's bill. The reform bill was comprehensive and, where appropriate, incorporated aspects of the other pending proposals, allowing the Legislature to dispose of most competing bills at the Committee level. Because the Dirigo Health Reform proposal came out of Committee with a unanimous "ought to pass" bipartisan vote, its passage on the floor was guaranteed.

In the period since the passage of legislation, public expectations have been high and the environment continues to be influenced by businesses' concerns with unsustainable cost increases. These two factors have militated against a return to "business as usual" among providers and insurers. One indication of the recognition of the need for a sustained reform effort is the response of hospitals in Maine to the voluntary cost containment measures included in the Dirigo Health Reform Act. Most hospitals met or made good faith efforts to meet legislatively set targets – including annual case-mix adjusted cost increases below 3.5 percent and consolidated margins below 3 percent – resulting in flat costs for purchasers for the first time in a decade. Small group market insurers, given a choice by legislation, between maintaining a minimum loss ration of 78 percent or submitting rate changes to regulatory review, have almost all chosen to comply with the 78 percent loss ratio requirement. The Dirigo law requires carriers to return earned premium in excess of the 22 percent retention allowance to policy holders in the form of premium rebates.

In the legislative session a year after enactment of the Dirigo Health Reform Act, legislators and policy advocates committed to free market strategies introduced legislation to create a high risk pool and deregulate the small group market. Most legislators, however, were inclined to monitor the impact of the Dirigo reform effort prior to making any further changes to the policy environment. These proposals have been revived for consideration in the current session.

With pending court challenges to the Savings Offset Payment authorized by the Superintendent of Insurance and the Dirigo Board, the major policy challenge facing the Baldacci administration is ongoing program funding. Because this payment is dependent upon a demonstration of system savings that requires complex measurement, it provides an opportunity for challenge by insurers and employers with self-funded benefit plans. The on-going generation of funds to pay for access expansions that require assessments on the private sector will be a challenge for policymakers, but one that will be substantially mitigated if the Dirigo reforms successfully reduce cost pressures on employers through reductions in system costs.

6. Lessons Learned

6.1 The Importance of State-Specific Data

State-specific data were very important to the development of a viable reform proposal. Population projections from the household survey were matched on key characteristics with the MEPS data to create a synthetic population, complete with utilization information, which was used to develop financing models and price the benefit package. In addition, the availability of two years of claims data from the MaineCare program and from large employer benefit plans allowed accurate trending of utilization and costs, and allowed the develop of actuarial models based on Maine-specific information.

The household survey confirmed suspicions that small businesses and the self-employed are should be a priority in addressing access issues.

Importantly, Maine-specific data averted time consuming and distracting debates about numbers. These data first allowed us to clearly communicate the extent of the crisis within our health care system with regard both to uncontrolled cost increases and barriers to access to appropriate care. Instead, discussion could be devoted to the substance of the policy issues at the heart of reform, which led to a more constructive process.

Focus groups and key informant interviews provided useful information on the likely reception to policy initiatives of various types. Among other things, these qualitative data gathering efforts indicated a far greater openness on the part of many segments of the business community – among both large and small employers – to comprehensive reform and an increased role for State government than has been true in the past. The perceptions garnered through data collection and analysis were confirmed during the legislative debate, when several organized business groups openly endorsed the Governor's proposal and others maintained a neutral stance.

Focus groups were also used to obtain information on employee and public response to different benefit designs for the Dirigo health plan.

6.2 Most Valuable Data Collection Activities

There were three data collection activities funded through the State Planning Grant that were of particular value in different stages of the planning process for health reform in Maine. These activities were: the household survey of insurance status; a trend analysis of cost and utilization among privately insured in Maine; and a regional health needs assessment of Maine people.

Although the household survey required considerable resources, it provided a sound foundation for the modeling necessary for proposal development, provided baseline data on coverage which can be used to monitor progress under the initiative when operational, and provided critical information on undersinsurance and barriers to access stemming from high deductibles which was used in determining the level of the savings offset payments.

A source of continuing debate among policymakers, employers and providers is the extent to which the high health care costs in Maine are driven by high prices and utilization rates, as opposed to cost shifts necessitated by bad debt, charity care and Medicare and Medicaid underpayments. The analysis of trends in per unit costs and utilization over a six year period provides important factual information to help inform this debate and to allow the development of policies appropriate to the particular dynamics of Maine's health care marketplace.

A central component of Maine's reform effort is the State Health Plan – a process that engages Maine's public and that helps establish a blueprint for future resource allocation. The regional needs assessment provided in depth information that highlighted differences between rural and urban, north and south communities and that supports the effort to engage Maine's citizenry in a meaningful discussion and decisionmaking process about the future of Maine's health system.

6.3 Data Collection Activities Proposed but not Undertaken

The Maine State Planning grant team considered a statewide employer survey, but decided against it on cost/benefit grounds. A number of concerns drove this decision. First, experience has shown that it is very hard and costly to get adequate response rates, particularly from small businesses. Second, the complexity of the information needed from business establishments does not lend itself well to a structured, forced choice survey instrument. Many businesses, for example have more than one coverage option. Third, it is hard to find one individual within a business establishment who has all the necessary information at hand to respond. Workforce information is needed on number of employees, age and sex, participation rates, and coverage of dependents. Other important variables are benefit design and cost information, including the employer contribution and required employee cost sharing. Based on assessments of the limits of the survey strategy, and the policy preference of Maine policymakers for publicly sponsored, as opposed to market-based reforms, the planning grant team decided not to pursue an employer survey.

6.4 Strategies Effective in Improving Data Collection

We preceded our random digit dial telephone survey with a mailed letter explaining the purpose of the survey, for all persons in the sample where mailing addresses could be obtained. The letter was sent out by Maine's Bureau of Public Health and signed by the Director of the Bureau of Public Health, a physician who has been highly visible in the State in association with youth anti-smoking campaigns and other public health measures. Our survey firm (Mathematica Policy Research) indicated that the letter was extraordinarily successful in increasing response rates, as indicated by comparing interview completion rates for those who received letters with those who did not. The survey firm had some individuals call them to make appointments to be interviewed.

Overall, the survey firm, which has conducted numerous state surveys on health topics, reported that the response rate in Maine was the highest they had experienced. We attribute this success in part to the personal popularity of the Director of the Bureau of Public Health and in part to the wide-spread sense of urgency in the Maine population about the availability and costs of health care.

For the small employer focus groups, we retained the services of an individual with prior work experience with the Greater Portland Chamber of Commerce to handle logistics. Her responsibilities included locating appropriate businesses (in two focus groups, *non*-insuring businesses of less than 50 employees and in two focus groups, *insuring* businesses of less than 50 employees) in each of 4 locations, securing commitments for participation, and confirming plans to attend close to the date of the focus group. This strategy proved quite effective. We had around 10 participating businesses in each of the sessions.

A third strategy that was effective was the use of comparative information from national databases and other states, particularly other New England states, to make the case for reform in Maine. The nation, as a whole, has experienced a period of rapid increases in insurance premiums and increases in underlying health care costs, particularly in hospital care and prescription drugs. Our ability to show that trends in Maine have been worse than elsewhere helped build consensus around the need for significant reform.

6.5 Additional Data Collection Activities Needed

There are a number of areas of on-going planning related to the Dirigo Health initiative where additional data collection is needed. Some of these data collection efforts are currently underway funded through sources other than the Maine State Planning grant.

A provision of the Dirigo legislation called for a Commission to Study Maine's Hospitals. The Maine hospital industry has undergone substantial change over the past 10 years. Many hospitals have integrated vertically and have complex ownership arrangements with entities such as home health agencies, nursing care facilities, medical practices, and other entities. In order to fully understand the cost drivers within the hospital sector and try to distinguish between appropriate or unavoidable growth and expansion of services or costs that can be curtailed, a detailed study of Maine's hospitals was undertaken. Critical to this analysis is institution-specific financial

information abstracted from audited financial statements and IRS Form 990 reports. In addition, comparable information from a sample of benchmark hospitals is necessary for comparative purposes. This data collection effort was undertaken under the direction of Nancy Kane, Professor, Harvard School of Public Health.

Under the new provisions for review of Certificate of Need, the Bureau of Insurance is charged with assessing proposals for their likely impact on premium costs in the State. A calculation of this impact requires an assessment of unmet need for the service, the substitution effect of the proposed service, the extent to which the new service is likely to generate new demand, and expected costs per service. The Bureau of Insurance is seeking assistance from consultants in developing a plan for data collection and analysis for this purpose.

The State Health Plan calls for tracking aggregate health spending on an annual basis. The Maine Health Data Organization currently receives and stores hospital cost reports from all hospitals in the State. In addition, MHDO is developing a linked database of claims data from all payers in the State. Aggregation of these data with cost information from direct service providers (public free clinics, etc.) the public health system, and other health spending that is not captured through claims (e.g., the prison system) will be necessary in order to track these costs. The systems and funding for this data collection and analysis effort are not yet in place.

The State would be substantially assisted in monitoring the impact and progress of Dirigo Health through follow-up household surveys that could monitor changes in insurance status both in response to the availability of coverage through the Dirigo Plan and through continuing changes in the private health insurance market. In addition, surveys of DirigoChoice enrollees and participating employers, as well as of eligible but not participating small employers would provide valuable information about the impact of the plan and opportunities to design modifications to improve enrollment and satisfaction. These surveys are currently underway funded thorugh a subsequent State Planning Grant.

6.6 Organizational and Operational Lessons

The development of DirigoChoice required the establishment of a new governmental agency – the Dirigo Health Agency – and close coordination between this agency and the Governor's Office of Health Policy and Finance, the Bureau of Insurance, and the Department of Human Services. Several considerations led to the decision to structure Maine's access initiative in this manner.

First, the Governor determined prior to taking office that succeeding with a major health reform initiative would require his personal involvement and close coordination from his office. The importance of his decision to create a Governor's Office of Health Policy and Finance has been demonstrated repeatedly. From the start of his administration, it signaled the priority he placed on health system reform – a factor that influenced the legislative leadership and brought stakeholders to the table and kept them there through difficult negotiations.

This office has also had the capacity to coordinate across state agencies to assure implementation of policies requiring inter-agency cooperation. An example of a key coordination strategy is the

eligibility determination process for the new DirigoChoice Plan. Most components of DirigoChoice administration have been outsourced to a private insurance partner. However, eligibility determination based on income criteria is not an activity of private insurers and undertaking this administrative function would have required major infrastructure development by the contractor. Under the leadership of the GOHPF, the Dirigo Agency was able to establish an agreement with Maine's Bureau of Income and Family Independence (BIFI) within the Department of Health and Human Services to carry out this function for the DirigoChoice Program. Since eligibility criteria are different from Maine's income assistance and Medicaid programs and because this activity increased workload, BIFI had to program new electronic protocols for eligibility determination, train workers, and increase staffing. The Dirigo Health Agency would not have been able to negotiate these arrangements without the coordination and assistance from the GOHPF.

A second important decision in terms of organizational arrangements was the establishment of the Dirigo Health Agency as a new, autonomous agency of state government. An alternative possibility that was considered was the establishment of a non-governmental agency such as the Maine Employers Mutual Insurance Company, created to provide workers' compensation coverage when Maine's commercial market collapsed. Alternatively, the oversight of the DirigoChoice Program could have been located within Maine's Department of Health and Human Services.

The new government agency structure is a model that is working well. The free standing agency has been able to recruit key staff quickly and attract talented individuals from both the private and public sectors. Staff was able to focus full attention, immediately, on the task at hand – getting the DirigoChoice program operational. The culture within the agency is similar to a start-up private sector enterprise, where competition with other private sector entities and consumer satisfaction are paramount. At the same time, key staff within the agency have worked closely with the Governor's Office of Health Policy and Finance and been instrumental in implementation of policies specified by the Dirigo Reform Law, such as operationalizing the savings offset payment. Finally, the establishment of the DirigoChoice Program outside the Department of Health and Human Services establishes a public image removed from the stigma of means tested programs.

Both the initial Dirigo Reform legislation and the Commission to Study Maine's Hospitals recommended the creation of a forum (consortium) where hospitals could come together to plan shared services, service expansions and other changes to the delivery system within a State Health Plan framework, protected from antitrust violations. The recommendation derives from the conclusion, by policymakers and Commission members, that competition among health care providers, particularly in a rural state, has not served the public well. In order for purchasers to have the ability to competitively bid prices and build a selective network requires substantial, and region-specific overcapacity in the system. In the absence of overcapacity, providers have monopoly power on price setting. Lack of adequate consumer knowledge to distinguish differential quality and reliance by consumers on their physicians for guidance on what tests, services, and institutions will meet their needs, all hamper the ability of a market for health care services to function efficiently. In this environment, providers compete by increasing capacity and adding new technology – strategies that attract physicians (who then bring their patients) and

that add high volume, high revenue services to facilities with traditionally high fixed costs and low margins. This competitive strategy increases costs and utilization in ways that may not improve population health.

The development of such a cooperative planning consortium would be a major shift from the market competition paradigm in the private sector. However, the hospital industry in the State has expressed opposition to the concept, preferring to form regional networks and plan services independently, without public scrutiny or oversight. To date, efforts to move toward a more transparent and publicly accountable planning process are stale-mated.

6.7 Key Lessons Regarding Insurers and Employers

Aside from the leadership of the Governor, probably the most important factor in determining Maine's initial success in legislating and implementing major reform was lack of organized opposition from the business community. As described earlier in the report, the Maine State Chamber of Commerce testified in favor the Dirigo Health Reform bill at the public hearing organized by the legislative committee of jurisdiction. The State Chamber represents businesses of all sizes in Maine, but most vocal and active members are large businesses. The Maine chapter of the National Federation of Independent Businesses, usually a vocal opponent of public sector initiatives in the health insurance arena, testified neither for nor against the bill. The Greater Portland Area Chamber, representing mostly smaller businesses in the southern Maine region, testified neither for nor against, and the Maine Small Business Alliance testified in favor.

There was and continues to be, of course, no unanimity of opinion in the business community about the appropriate measures to "fix" the problems in the health care system. There is, however, unanimity that costs are too high, are rising in an uncontrolled manner, and that significant and immediate intervention is needed. Many large employers in Maine are working independently and in consortiums to improve the experience of their own health benefit plans. Activities include cooperative ventures to purchase prescription medications, establishment of employee wellness programs and case management of chronic diseases, and experimentation with pay for performance initiatives. Some employers continue to view health coverage and management as a private sector activity and look with suspicion on new initiatives by state government.

The market situation, thus, created an environment where serious discussion and negotiation of health reform was possible. The Governor and his policy staff were careful, within the context of this environment, to craft a proposal that met the concerns of the employer community while minimizing disruptions of existing employer arrangements. DirigoChoice is structured to help promote and expand employer-based coverage. While the weight of opinion in the employer community shifted sufficiently to allow passage of the reform legislation, the debate over the ongoing funding needs of the Dirigo Program is eroding some of this support. The growing opposition is evidenced in the law suits against the Savings Offset assessment filed by the Chamber of Commerce. This increased political pressure makes paramount the state-led efforts to rein in the growth of health care spending in the State.

The key lesson with regard to working effectively with the employer community may well be that achieving support for access expansions must be linked explicitly to concrete actions taken to control increases in health care spending. Employers understand the burden uncompensated care places on payers, but if strategies to reduce the number of uninsured are not accompanied by mechanisms to reduce overall spending, employers will resist contributing to the costs to cover the uninsured.

The response from health plans in the State has also been one of caution and accommodation, rather than outright hostility. Maine's insurance market is dominated by Anthem Blue Cross and Blue Shield, which controls over 90 percent of the non-group market and 60 percent of the employer market. Anthem won the contract to partner with the Dirigo Health Agency in offering and administering the DirigoChoice program. With over 9200 individuals enrolled, the DirigoChoice Plan has become one of Anthem's largest "groups" and the insurer is invested in assuring the plan's on-going growth and success.

The entry of the DirigoChoice Plan into the market is already stimulating change and revitalizing the small group market in Maine. Harvard Pilgrim Health Care, which had ceased marketing in Maine, has developed a product to compete with the DirigoChoice Plan and is actively marketing, once again.

6.8 Key Recommendations

While every state is different and all politics is local, there are lessons that can be shared from our experience. We believe that firmly tying cost, quality and access together was critical to our success, to date. While promoting increased access and enhanced quality is usually a politically salient stance, cost containment initiatives are often resisted by providers and consumers. By making access enhancements reliant on achieving cost containment, we have been able to cultivate a new constituency among consumer advocates for controlling utilization and expenditures, where there once was little support.

A second factor that proved very important in Maine was the role of the business community. As discussed in 6.7, above, the attitudes of business toward the proposed reforms not only carried great weight with the legislature, but also with insurers and providers. Because of the difficult market environment, the Administration started the reform debate with the business community taking a "wait and see" attitude. Opposition would be quick to form against proposals viewed as harmful to business interests. By shaping a reform proposal that linked access initiatives to explicit efforts to control costs, creating a public/private partnership for program administration, and avoiding any disruption of existing employer benefit arrangements, the Administration maintained sufficient support to obtain passage of the legislation. A continued focus on cost containment and program adjustments will be necessary to assure that business support – critical to sustained success – does not erode.

A third lesson from the Maine experience is the importance of including the public in a meaningful way in the debate and on-going reform campaign. Health financing has become hugely complex and health reform has become an "insiders' game" where stakeholder representatives and public officials argue over options. With the enormous financial stakes, the

usual pattern is that negotiations break down over the issue of who pays for new coverage options.

Getting the public engaged in a meaningful way is difficult because of the complexity of issues. However, Maine's experience has shown that an extraordinary effort to educate and activate members of the public can create a constituency for necessary reforms. Maine has benefited for a decade from the work of grassroots organizations that have made health reform the center of their community-based activities. These organizations can rally citizen "lobbyists," provide testimony that puts a real face to the dilemmas faced by the uninsured, organize telephone and letter writing campaigns to counter the publicity garnered by stakeholder groups. But more than these traditional forms of political support, policymakers in Maine have found that creating transparency to the normally opaque activities of insurers and large health care organizations acts as an effective mechanism to reform behavior. The Dirigo Health Reform Act has many reporting requirements for both providers and insurers that will allow the public to monitor profit margins and other important measures that will help the public make informed judgments about cost, quality, and the proportion of state resources going to the health care sector. Finally, the Tough Choices Campaign and regional public hearings on the proposed State Health Plan provided forums for ordinary citizens to engage in a meaningful way with the complex issues of health policy and the sometimes even more complex proposals for reform.

6.9 Maine's Political and Economic Environment

The first change in the political environment occurred two months into Maine's planning grant when a new governor was elected. Governor Baldacci came into office with a commitment to major health reform with a goal of universal access to health care for all Maine citizens. His first act as governor was an executive order creating the Governor's Office of Health Policy and Finance to oversee all aspects of policy development related to health care and to lead the development and implementation of a reform initiative.

This development had a significant impact on the activities of the Maine planning grant which, developed under the prior administration, had proposed analyses and activities supportive of several initiatives under consideration in Maine's legislature.

Governor Baldacci took office during a period of economic stress in Maine, with an economy in recession, high unemployment, and subsequent downturn in state revenues. The economy continued to be a challenge during the grant period – in the first week of the new Administration, one of the state's largest paper mills announced its closure. At the outset of his term, the Governor had to address a 20 percent budget deficit. He did so without reducing eligibility for MaineCare, our state Medicaid program, and without raising taxes. However, the Administration faced the next session of the legislature with a substantial MaineCare deficit attributable in large measure to an increase in enrollment associated with the struggling economy. Again, the deficit issue was addressed without cutting program eligibility – although new enrollment into Maine's HIFA waiver program was stopped due to the unavailability of additional federal matching funds.

State deficits have caused some policymakers in the minority party to call for the repeal of the MaineCare eligibility expansions that were passed as part of the Dirigo Reform legislation. They also proposed using the $53 million Dirigo Reform appropriation to address the budget shortfall. The Administration has been successful in maintaining support for a budget that retains the Dirigo Reform funding and the previously authorized eligibility expansions for parents of SCHIP children.

The period of the grant also saw the development and growth of a better organized and funded opposition movement to Administration's approach to health reform. The voice of this movement comes from a new "think tank" that has identified the Dirigo reforms as a target of criticism. We are devoting a good deal of time and attention to managing this new challenge.

6.10 Changes in Project Goals

At the outset of the initial grant period, planning was being undertaken to support a feasibility study of a single payer system for Maine and two incremental reforms as discussed in section 4.18. When the Baldacci Administration came into office, the objective shifted to the development of a comprehensive reform strategy based on maintaining the current employer-based insurance system and addressing costs, quality and access, simultaneously.

With support from the resources of the planning grant, the Baldacci Administration considered several strategically different approaches before settling on the Dirigo Reform Strategy described extensively in this document. An option given considerable attention and discussed with the stakeholder advisory group – the Health Action Team – was a proposal for a state-sponsored reinsurance plan available to insurers in the small group market. This proposal was met with skepticism by the national health plans that dominate Maine's insurance market – who pointed out that their company reserves far exceed the amounts necessary for Maine's small insurance market and that an assessment strategy to fund the reinsurance program redistributes money within the insurance market but does not reduce insurance costs.

A second strategy that was considered was the development of a quasi-public insurance company modeled on Maine's successful experience with the workers' compensation insurance market. This strategy is viewed as compatible with the Dirigo Reform strategy that has been developed, to date, and may be reconsidered as a "next step" in the future – depending on the experience with the current public/private partnership arrangement.

6.11 Next Steps

We continue to work on the implementation of the Dirigo reforms and to plan modifications and next steps to meet new challenges as they arise. Major steps in our current work plan include:

> Accelerate the rate of covering Maine's uninsured by increasing the Dirigo Choice Plan's "close ratio," the proportion of applicants who enroll after obtaining a rate quote.

Based on a survey of states, assess the options for increasing employer financial incentives for providing health benefits.

Based on interviews and surveys with both participating and non-participating business owners, develop a range of benefit modifications to the DirigoChoice Plan for actuarial assessment.

Evaluate strategies to increase the productivity of brokers marketing the DirigoChoice product.

Identify and analyze alternative risk and administrative arrangements to for the DirigoChoice Plan to test as a pilot project.

7. Recommendations To The Federal Government

7.1 The Need for Waiver Authority

The Dirigo Reform Act does not require any federal waivers. The authority to expand MaineCare was obtained several years ago, when the authority to adopt eligibility for non-categorical adults and SCHIP parents was granted.

As is often the case with state health reform initiatives, efforts by the state would be facilitated by changes to the federal ERISA statute. However, the approach adopted by Maine in the Dirigo reforms is not substantially hampered by that Act.

7.2 Required Federal Participation for Coverage Expansions Not Selected

There is considerable public support in Maine for a single payer, publicly sponsored insurance program that would confer eligibility automatically to all Maine residents, assure uniformity of benefits, eliminate the need for duplicative and inefficient billing and utilization review systems, free employers from the increasingly burdensome costs of health benefit plans, and citizens from the gaps in coverage and administrative complexities associated with changing jobs and losing coverage. The level of interest is such that the Maine legislature, in 2002, established a study commission to assess the feasibility of such a system for Maine.

Governor Baldacci set single payer options outside the scope of reforms his Administration would consider in part because the infeasibility of such a system without participation from the Medicare and Medicaid programs. Willingness on the part of federal agencies to participate in a demonstration program at the state level of such a system would be necessary before a state could realistically contemplate a reform of this type. Because of the efficiencies inherent in the administration of such a system, the assurance of universal participation as compared to voluntary systems, and the superior ability of single payer to negotiate reasonable rates for health care services, the federal government should consider supporting a state in a trial of such a system.

Another health reform of concern to several states – particularly those with large numbers of low-wage workers – is creating seamless coverage systems between Medicaid and employer benefit plans. Under current Medicaid rules, states may not use employer contributions as state match in the provision of Medicaid benefits for eligible low-income workers. A reversal of this federal policy would not only allow coverage of more of the working uninsured, but would also allow states to integrate Medicaid coverage more easily and effectively with employer benefit plans.

7.3 Federal Support of Surveys

The Current Population Survey is an invaluable resource in tracking changes in health coverage and the uninsured on an annual basis. Since the sample size has been increased, its value has been enhanced, since the estimates are more reliable for small states like Maine. The National Medical Expenditure Panel Survey is also very useful in that it has longitudinal data that allows tracking changes in coverage status for individuals and families. The MEPS is also very useful for tracking insurance costs by employer size at the state level.

Both of these data resources would be more helpful for policymakers if state-specific data could be made available sooner after the surveys are conducted. Maine is required, under the Dirigo Health Reform Act, to report to the legislature on an annual basis, changes in the rates of insurance coverage and lack of coverage. The lag time in accessing information from the federal sources makes these surveys less useful for purposes such as these.

7.4 Additional Research

The trend reports on changes in health care costs and utilization that are reported out of the Office of the Actuary, National Health Statistics Group, CMS, are very useful for monitoring health care spending. Similar reports that break out the experience of employer benefit plans from the Medicare and Medicaid programs and from self-insured and uninsured populations would be very useful.

In addition to the broad-based data collection and analysis activities discussed in 7.3 and above, states could benefit from in-depth case studies and evaluations of different state approaches. Insight into program design, implementation hurdles, stakeholder response and costs associated with different models of access expansion would help states determine strategies and refine options.

Currently, the approaches states are taking to regulating the small group and individual insurance markets varies widely. Some states have moved toward adoption of high risk pools and deregulation of the market in the hopes that competition will stimulate the entry of innovative and lower cost coverage options that meet small employer needs. Other states have moved to limit the range of products in the small group market and to provide some reinsurance protection to insurers whose products meet certain specifications. In addition, federal legislation encouraging health savings accounts is stimulating change in the market. Federal funding for studies that offer uniform measurements of changes across different insurance markets would be

very welcome. Information on trends in average premium cost, market growth, decline, or shifts, as well as uninsurance rates would help determine the impact of these various strategies.

END NOTES

[1] Columns do not sum to 100% because of missing responses on this survey question.
[2] Source for national data on uninsured: Kaiser Family Foundation State Health Facts online. Calculations by the Urban Institute and Kaiser Commission on Medicaid and the Uninsured based on March 2002 Current Population survey. www.statehealthfacts.kff.org
[3] The survey did not ascertain the employment status of adults in the household other than the survey respondent except when the surveyed individual was a child. Thus, many of those who reported not being in the labor force may have had spouses or partners who were working and may have received health benefits as dependents.
[4] These categories are not mutually exclusive. See Appendix II for detailed distributions of Maine's uninsured population.
[5] Index of Maine and U.S. Manufacturing Employment, as reported by Laurie G. Lachance, Maine State Economist, at The Maine Heritage Policy Center's "Emergency Tax Summit," March 24, 2004.
[6] Edmunds, M., Teitelbaum, M., and Gleason, C., *All Over the Map: A Progress Report on the State Chilren's Health Insurance Program.* Children's Defense Fund: Washington, D.C. 2000: 4.
[7] State Health Access Data Assistance Center and the Urban Institute. *Going Without: American's Uninsured Children.* Covering Kids and Families; The Robert wood Johnson Foundation. 2005.
[8] Martin, Whittle, Levit, et al. (2002). Health Care Spending During 1991-1998: A Fifty-State Review. *Health Affairs* 21(4):114.
[9] Strunk B, Ginsburg, P. and Cookson, J. Tracking Health Care Costs: Declining Growth Trend Pauses in 2004. *Health Affairs – Web Exclusive*, 21 June: W5 – 288.
[10] Adjustments are made to the data to reflect a $0 deductible policy in order to control for changes in benefits and increases in cost sharing. Changes in utilization, however, reflect actual employer plan experience inclusive of employee cost sharing. Utilization is thus lower than would be the case if only actual $0 deductible policies were used to calculate average costs.
[11] Pyenson, BS, Zenner, PA, Chye, P. (2002). *Silver Bullets for Outpatient Cost Increases?* Milliman-USA, May 2002: p. 4.
[12] Cunningham P and May J (2003). Insured Americans Drive Surge in Emergency Department Visits. Center for Studying Health Systems Change Issue Brief No. 70: 2.
[13] MEPS data for 2002, accessed at: www.meps.ahrq.gov/MEPSDATA/ic/2002/Index202.htm
[14] Kaiser Family Foundation State Health Facts, based on data from U.S. Census Bureau, Current Population Survey, 2002 through 2004 Annual Social and Economic Supplements. Table 5: Money Income of Households by State Using 2- and 3-Year-Average Medians. Found at: www.statehealthfacts.kff.org Premium data from MEPS, 2003.
[15] Median income taken from US Census Bureau's 1998 through 2003 March Current Population Surveys, available through www.census.gov/hhes/www/previnc.html. Amounts used are two-year average medians in current year dollars. Premiums taken from Medical Expenditure Panel Survey (MEPS) Health Insurance Dataset, available through www.meps.ahrq.gov/Data_Pub/IC_Tables.htm. Amounts used are total cost (employee and employer share). MEPS did not provide Maine premiums for 1998 and 2000, so for these years we use the midpoint between the previous and successive year as an estimated amount.
[16] Source: Maine Bureau of Insurance report
[17] Index of Maine and U.S. Manufacturing Employment, as reported by Laurie Lachance, Maine State Economist, at The Maine Heritage Policy Center's "Emergency Tax Summit," March 24, 2004.
[18] Hoffman, Catherine, A. Carbaugh, and A. Cook. "Health Insurance Coverage in America: 2003 Data Update." Washington DC: Kaiser Commission on Medicaid and the Uninsured (November 2004).
[19] Data from the Maine Bureau of Insurance as reported by Deborah Chollet, Mathematica Policy Research, Inc., 2005.
[20] MEPS data for 2002, accessed at: www.meps.ahrq.gov/MEPSDATA/ic/2002/Index202.htm
[21] Cutler, D. (2002), "Employee Costs and the Decline in Health Insurance Coverage." NBER Working Paper 9036.
[22] Ziller and Kilbreth: 20-23.
[23] Source: Maine Bureau of Insurance web site at: www.state.me.us/pfr/ins/indhlth.htm
[24] Bowe, T. (2005). *DirigoChoice Member Survey: A Snapshot of the Program's Early Adopters.* Muskie School of Public Service, University of Souther Maine, Portland, ME.
[25] Source: Maine Bureau of Insurance, premium data for 2003.

[26] Data on Public Payer Expenditures from the First Annual Report of the Public Purchaser Steering Group, 2004. Estimates of total claims payment by private groups derived from Premium data from Maine's Bureau of Insurance (see table 9) and for ERISA groups, from the Maine Health Data Organization.
[27] *2005 Almanac of Hospital Financial and Operating Indicators* (Ingenix, 2004)
[28] BCBS, however, imposed waiting periods for pre-existing conditions.
[29] Hadley J. and Holahan, J., 2004. The Cost of Car for the Uninsured: What Do We Spend, Who Pays, and What would Full Coverage Add to Medical Spending? Prepared for the Kaiser Commission on Medicaid and the Uninsured. www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35965 (accessed March, 2005).
[30] Letter with attached exhibit from Jack Burke, F.S.A., Consulting Actuary, Milliman Consultants, to Katherine Pelletreau, Executive Director, Maine Association of Health Plans, November 19, 2004.
[31] Nancy Kane, *Bad Debt and Free Care Baseline Analysis,* Prepared for the Governor's Office of Health Policy and Finance, State of Maine, December, 2004. Calculation based on audited financial statements, IRS Form 990s, and a survey of Maine hospitals. Free care dropped in 2003 in large part because Maine expanded Medicaid coverage to non-categorical adults, thus reducing the population receiving charity services and increasing the paying patient population.
[32] Ibid.
[33] Hadley and Holahan, 2004.
[34] Maine has prior 1115 Waiver authority for coverage of non-categorical adults at this income level, but had previously elected to extend eligibility only to 100% of the federal poverty level.
[35] Maine law requires hospitals to provide care free of charge to uninsured individuals with incomes below the federal poverty level.
[36] Bowe, T., 2005. *DirigoChoice Member Survey: A Snapshot of the Program's Early Adopters.* Institute for Health Policy, Muskie School of Public Service, University of Southern Maine. Portland ME.
[37] Maine has a modified community-rating law that applies to the small group market. Up to a twenty percent variance on either side of the community rate is allowed for the following factors: age, geographic location, and business type. In addition, insurers are allowed rate adjustments for size of business. These adjustments are not constrained by the community rate. These regulatory rules apply to the DirigoChoice Program.
[38] *All Over the Map: A Progress Report on the State Children's Health Insurance Program.* Children's Defense Fund, Washington D.C., 2000.

APPENDIX 1: MAINE SUMMARY DATA

Maine Population, 2003 estimate	1,305,728
Number of Uninsured, 2004	135,298
Percent of Uninsured 2004 (under age 65) Percent Uninsured 2002 (under 65) Trend	12.4 12.5 Overall, rate of uninsured is steady. Employer coverage is declining and non-group coverage and public coverage is increasing
Median age of population	38.6
Percent of population age 65 and over	14.4
Percent of families living in Poverty	7.8
Percent of families with children under 18 living in poverty	11.9
Primary industries	Food services and drinking places Hospitals Ambulatory health care services Nursing and residential care facilities Administrative and support services Food and beverage stores Specialty trade contractors Educational services Social assistance Insurance carriers and related
Number and Percent of Employers offering coverage	N.A.
Number and Percent of self-insured firms	53% of large group and dental and 42% of overall insurance measured on a claims volume basis (est.)
Payer mix (on a claims volume basis)* * Excludes Medicare	Private payers 30% Public except Medicaid 16% Medicaid 54%

Provider Competition

Level of competition: low

34 of 38 community hospitals in Maine organized into one of 4 hospital networks

Physicians consolidated into group practices by specialty. Almost all radiologists and anesthesiologists in the State in organized into a single group.

Average values for total cost per case mix and wage adjusted discharges in Maine averaged 20% higher than the national average and 25% higher than the northeast region between 1999 and 2003.

Insurance Reforms

Guaranteed issue and mandated portability in small group and individual markets

Modified community rating, allowing 20% variance from community rate for age, industry and geographic location, in small group and individual markets

Minimum loss ratio of 78% (rolling 3 year average) in small group market

Insurance reporting requirements on premium revenues, claims payout, and retention in all lines of business

Regulatory oversight of managed care plans including grievance procedures and appeals and maximum travel times to providers

Eligibility to Existing Programs

Major MaineCare Eligibility Groups

Group	***Benefit Level***	***Income Limit***	***Asset Limit***	***Notes***
Children 0 - 18	MaineCare Full Benefits	200% of FPL (federal poverty level)	None	Children with income up to 150% of FPL and infants under 1 with income up to 185% of FPL pay no premium. Children between 150% and 200% of FPL are eligible for Maine's SCHIP program and pay between $8 and $64 per month per family. Children who have a serious medical condition are served under the Katie Beckett option where only the income of the child who has the disabling condition (not the parents' income) is counted. There is an asset limit of $2,000. Families who lose coverage due to increased income can buy into MaineCare at cost for 18 months.
Young adults age 19 - 20	MaineCare Full Benefits	150% of FPL	$2000 (Many assets are excluded)	Income of parents in the household is counted in some circumstances.
Parents with children under 19 at home	MaineCare Full Benefits	200% of FPL	$2,000 (Many assets are excluded)	
Pregnant Women	MaineCare Full Benefits	200% of FPL	None	For the mother, coverage continues 2 months beyond pregnancy. Coverage will continue longer, if the mother meets criteria above for parents. If the mother had full benefit MaineCare when the baby was born, MaineCare covers the baby for one year.
Disabled Adults and Persons 65 and Over	MaineCare Full Benefits	100% of FPL (For disabled only, this will expand to 125% of FPL on 4/1/05)	$2,000 ($3,000 for a couple) For working disabled – $8,000 ($12,000 for a couple) (Many assets are excluded)	Full benefit MaineCare 'wraps around' Medicare. It covers Medicare deductibles and co-payments.Medicare beneficiaries who are not eligible for MaineCare full benefits may be eligible for the MaineCare Medicare Buy In benefit which may pay for Medicare Part B premium, co-pays and deductibles. The Working Disabled Benefit: People with disabilities who work may be eligible for full benefit MaineCare if their unearned income is under 100% FPL and their total income, including earnings, is under 250% FPL. Some people may have to pay small monthly premiums
HIV Positive Adults	MaineCare Prescriptions and other limited coverage	250% of FPL	None	Individual must be HIV-positive (with or without diagnosis of AIDS); coverage includes prescriptions, physician and hospital services, there are some limitations on services; co-pays are higher ($10 per prescription and office visit) than for full benefit MaineCare; there is a limit on the number of individuals who can participate in the program
Women who have Breast or Cervical Cancer (or pre-cancerous condition)	MaineCare Full Benefits	250% of FPL	None	Women must be without insurance; age 40 to 64 (or over 64 if they only get Part A Medicare, not Part B); and have a positive screening by the Bureau of Health Program
Adults medically eligible for nursing care	MaineCare Full Benefits	$1,692/mo	$2,000 ($3,000 for couple)[2] (Many assets are excluded)	Condition must be so severe that they would be nursing home eligible, but they are living in the community. Adults are served under the home-based care waiver program.
"Non-categoricals"	MaineCare Full Benefits	100% of FPL	$2,000 ($3,000 for couple) (Many assets are excluded)	Adults who do not fit in another MaineCare category are eligible for MaineCare if their income is below 100% of poverty and are under the asset limit.

Federal Waivers

Maine has the following federal waivers:

Two 1115 demonstration waivers
- HIV waiver
- HIFA waiver (non-categorical enrollees)

Three 1915 home and community-based waivers
- Persons with mental retardation
- Adults with disabilities and the elderly (a single, combined waiver)
- Consumer-directed services for adults with disabilities

APPENDIX 2: Links To Reforms, Agencies, Reports, and Research Findings

1. Information regarding the Dirigo Reform Initiative may be accessed on line at:

   http://www.maine.gov/governor/baldacci/healthpolicy/index.html

2. A copy of the Dirigo legislation can be accessed on line at:

   http://www.state.me.us/governor/baldacci/healthpolicy/DH-Passed-Signed.pdf

3. The Dirigo Health Agency website:

   http://www.dirigohealth.maine.gov

4. Maine Quality Forum website

   www.dirigohealth.maine.gov/dhlp06.htm

5. DirigoChoice Coverage Information

   http://www.dirigohealth.maine.gov/dhlp02.html

6. Maine State Health Plan

   http://www.me.gov/governor/baldacci/healthpolicy/news/11_7_05.htm

7. Report of the Maine Commission to Study Maine's Hospitals

   http://www.me.gov/governor/baldacci/healthpolicy/reports/index.html#csmh_draft_report

8. Insurance Superintendent's Ruling on Measurable Savings Attributable to Dirigo Reforms

   http://www.state.me.us/pfr/ins/ins05700Dirigo.htm

9. Household Survey Report: Ziller, E. and Kilbreth, E., 2002. *Health Insurance Coverage Among Maine Residents: Results of a Household Survey.*

   http://muskie.usm.maine.edu/m_list_publications.jsp

10. Focus Groups Report: Nalli, G. and Kilbreth, E. 2004. *Maine Employer Experience and Perceptions Related to Providing Health Insurance.*

    http://muskie.usm.maine.edu/m_list_publications.jsp

11. Cost and Utilization Trend Analysis Report: Kilbreth, E., Ziller, E. and S. Payne 2005. *Trends in Health service Costs and Utilization 1995 – 2001.*

http://muskie.usm.maine.edu/m_list_publications.jsp

12. Maine Equal Justice Partners website:

http://www.mejp.org/medicalprograms.htm