Maine State Planning Grant
Interim Report

Section 1. Summary of Findings: Uninsured Individuals and Families

In October through December of 2002, the Maine State Planning Project conducted 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 in January, 2003. The findings from this survey are summarized below. A complete survey report inclusive of a description of the methodology and a copy of the survey instrument are appended in *Appendix III.*

1.1 Prevalence of Uninsurance In Maine

Of Maine's approximately 1.27 million 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.

Among the insured population, type of coverage differs between adults and children. Among adults between the ages of 18 and 64, 66.3 percent have employer provided health benefits. Six percent have individually purchased health coverage policies, and 13 percent have some kind of public coverage.

Maine children are less likely to 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 have public coverage, primarily Medicaid coverage.

1.2 Characteristics of the Uninsured

Income

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

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

Income	Percent Distribution of Uninsured Persons	Percent Distribution of total Maine Population
Below federal poverty level	16.0	12.0
100% to 199% FPL	31.8	17.7
200 to 299% FPL	22.9	20.5
300% or more FPL	23.2	45.1

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
Below federal poverty level	16.0	36
100% to 199% FPL	31.8	29
200% or above	46.1	35

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.

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. As Table 3, below shows, 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. 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.

[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

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
Below federal poverty level	17.7	36.5
100 to 199% FPL	22.5	27.5
200 to 299% FPL	13.9	15.8
300% or above FPB	6.0	6.2

Age

Table 4, below, 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 overrepresented 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). The next highest rate is found among 30 to 44 year-olds, where 19.2 percent spent some time uninsured over the past 12 months. Older adults (age 45 through 64) and children (age 17 and below) have similar rates of uninsurance – 13 percent for children and 12 percent for the adult group.

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 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.

Availability of Private Coverage

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

[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.

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

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 CHIP 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. While outreach and enrollment campaigns in Maine have been relatively successful, 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 CHIP 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.[5] 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. Another five percent, 7,500 persons, had incomes between the poverty level and 125 percent of the poverty level and would become automatically eligible for public coverage under new eligibility 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 that are parents will be eligible for public coverage under new eligibility criteria.

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, will be eligible to enroll in Maine's new state-sponsored health coverage initiative with premium subsidies on a sliding scale based on income (see discussion, Section 4). Individuals working for large employers in this income group may also be eligible for assistance with premium payment for coverage in a qualified employer-sponsored health benefits plan.

[5] In September 2003, eligibility for MaineCare rose to 200 percent of FPL for parents and to 125 percent of FPL for non-categorical adults.

Of significance is the fact that 26 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 encourage voluntary participation in coverage initiatives at full cost by uninsured persons who can afford the payments as well as initiatives to contain costs in the health care sector.

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. 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 is off-set by 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 5
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

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. In addition, although the small business sector was identified as having the most pressing need for policy intervention, the Governor concluded that a comprehensive reform strategy that extended coverage to all State residents was needed. 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.

Section 2. Employer-Based Coverage

As part of the Maine State Planning grant, Maine's Department of Human Services contracted with the Institute for Health Policy at the Muskie School to conduct 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. 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 ten 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 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 full report on the findings from the focus groups and key informant interviews will be submitted under separate cover.

2.1 Quantitative Analysis

Not applicable.

2.2 Decision to Offer or Not

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 are really bright software engineers and 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 can't work for me. If she can't get her kids to the hospital, she can't get them medicine – 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, an 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 wish my product could go up 50 percent biannually. So 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.

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. Interestingly, the major concern expressed toward limited networks was not with regard to barriers to favored local providers, but 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. On the other

side, some participants 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 no or few 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 incented or 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 reflected prior utilization. One worker 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, Ivan, 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, "We can't do that, unfortunately, we can't say stop smoking and we will insure you, and have your wife stop smoking. But 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."

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.

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 Dirigo Health 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.

2.6 Impact on Employers of Expansion Strategies

The range of reform options under consideration by the administration in Maine did not include tax incentives or purchasing alliances. Therefore these strategies were not explored during the focus groups or employer interviews.

Mathematica Policy Research, Inc. together with Watson Wyatt is currently modeling expected price sensitivities applicable to premium subsidies, at the individual –not the employer level – based on a constructed model of Maine's population, and changes in coverage with price changes over recent years. The results of this analysis will be included in the final report.

2.7 Strategies to Motivate Non-insuring Employers to Provide Coverage

The Governor's Office of Health Policy and Finance applied for and 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. In addition to offering group coverage through the Dirigo Health Plan (see Section 4), the demonstration will develop a package of services, targeted to employers, to incent them to participate and 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 target population is an estimated 150 agencies employing approximately 5,000 workers who provide Medicaid and state-funded services statewide. 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 Dirigo Health Plan by other small employers who do not currently provide coverage.

Section 3. Maine's Healthcare Marketplace

The Governor's Office of Health Policy and Finance has sponsored a variety of activities related to understanding Maine's healthcare marketplace, most of which are ongoing at this time. Included among these activities are:

- A trend analysis of health care utilization and spending over the past 6 years based on analysis of comprehensive claims data from the state Medicaid program and private employer health benefits plans covering approximately 100,000 lives. This analysis is being conducted by the Institute for Health Policy at the Muskie School.

- An analysis of changes in insurance prices, enrollment and disenrollment trends, administrative costs, and loss ratios, based on reports from licensed insurers in the State filed with the Bureau of Insurance. This analysis is being conducted by Mathematica Policy Research, Inc. under sub-contract to the Muskie School.

- A trend analysis of Maine hospital admissions, occupancy rates, revenues, operating margins and total margins, capital expenditures, and ratios of financial health based on data from the Medicare Cost reports from the past six years. This study includes a comparison with benchmark hospitals in 6 other states. This analysis is being conducted by the Institute for Health Policy at the Muskie School.

- A resource distribution analysis of hospital-based services by hospital service area and population density, based on service inventories provided by Maine's Hospital Association. This analysis is being conducted by the Institute for Health

Policy.

Findings from these analyses will be included in the final report submitted at the termination of the grant.

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 II).* Included in the law (known familiarly as the Dirigo Health Plan) 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 MaineCare for non-categorical adults from the federal poverty level up to 125 percent of the federal poverty level;[6]

- Authorization of a state-sponsored health coverage program that will provide premium 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.

4.2 Program Eligibility

Medicaid Expansions

In 1998, Maine elected to participate in the State Children's Health Insurance Program (CHIP) through both a Medicaid expansion and state-sponsored program. Medicaid coverage was extended to children to 150 percent of the Federal Poverty Level and a new program, CubCare, provided coverage for children from families with incomes between 150 and 200 percent of the FPL. Health benefits in the CubCare program are identical to the State's Medicaid benefits, but families pay a small premium for participation.

[6] Maine has prior 1115 Waiver authority for coverage of non-categorical adults at this income level, but had previously selected to extend eligibility only to 100% of the federal poverty level.

In 2000, Maine extended eligibility under the CHIP program to parents of eligible and enrolled children.

In 2002, Maine received federal 1115 waiver authority to extend Medicaid eligibility to impoverished childless, non-disabled adults (non-categoricals). Although the waiver authorizes eligibility up to 125 percent of FPL, the State chose, in 2002, to limit eligibility for this group to persons with incomes below poverty. Also, in 2002, the Maine legislature consolidated SCHIP and Medicaid programs in Maine under the name MaineCare.

As part of the Dirigo Health Reform package enacted in 2003, Maine has extended eligibility for parents from 150 percent to 200 percent of FPL, and from 100 percent to 125 percent FPL for non-categorical adults.

Dirigo Health

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.

? The level of the required employer contribution toward premium costs of employees and their dependents will be determined by the Dirigo Board but cannot exceed 60 percent of aggregate membership costs.

? Other individuals who are residents of Maine, except those working in businesses that offer health benefits and that have more than 50 employees, may purchase non-group coverage through Dirigo Health. 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.

? Dirigo enrollees who are eligible for MaineCare coverage will receive benefits through the Dirigo Plan carrier in a manner similar to other Dirigo enrollees, and will be eligible for wrap-around benefits administered by MaineCare to the extent of their entitlement through 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 sponsored subsidies to their membership costs on a sliding scale.

- Non-group enrollees with incomes below 300 percent of poverty and not otherwise eligible for MaineCare will be eligible for membership payment subsidies. However, the maximum subsidy amount cannot exceed the maximum subsidy available to enrollees whose employers contribute a portion of the costs.

- Otherwise eligible individuals, employees and employers whose incomes exceed 300 percent of FPL may enroll in Dirigo Health at full membership cost.

- Uninsured individuals and their dependents with incomes below 300 percent of FPL who work for employers that offer health benefits and that have more than 50 employees may be eligible for a sliding scale subsidy toward the purchase of coverage through their employer-sponsored health benefits program.

- At its discretion, the Dirigo Board may set a requirement that eligible individuals certify that all their dependents are enrolled in Dirigo or are covered by another credible plan.

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.

Dirigo Health

Under the Dirigo Health Act, Dirigo Health is established as an independent executive agency to arrange for the provision of comprehensive health coverage to eligible small employers and individuals on a voluntary basis. Dirigo Health will operate 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 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.

The Dirigo Board has overall responsibility for the oversight of the administration of the Dirigo Health Plan including powers to hire an Executive Director for the program,

determine the benefit plans for Dirigo Health offerings, arrange for the provision of Dirigo health benefit coverage through contracts with one or more qualified bidders, and collect the savings offset payments used to fund program administration and premium subsidies. In addition, the Board has authorization and responsibility to establish and operate the Maine Quality Forum, 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 Dirigo Health 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, premiums earned and claims incurred.

The Executive Director will hire staff as appropriate to carry out the duties of the Dirigo Health Agency as directed by the Board. These duties may include, selection of insurance carriers on a competitive bid basis, program enrollment, determination of eligibility for premium subsidies, premium collection and program marketing.

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.

Advisory Council on Health Systems Development

The Dirigo Law establishes 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.

The Advisory Council is also charged with advising the Governor on the establishment and adjustments to the Capital Investment Fund and State Health Plan.

The public purchasers in the State, including the Medicaid Program, the State employees health benefits plan, the Municipal Association, the State university system, the Maine Educational Association, and others, are charged with submitting to the Council a consolidated public purchasers expenditure report outlining all funds expended in the most recently completed state fiscal year for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health, and other services. The Council is also charged with encouraging private purchasers to develop and submit similar reports.

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.

4.4 Outreach and Enrollment

The outreach and enrollment processes for the Dirigo Health Program will be directed by the Dirigo Agency. The Agency and the Governor's Office of Health Policy and Finance are working together to develop two campaigns. The first is an initiative to educate the public about the health reform initiative, generally, and the role of citizens in promoting cost containment, quality, and access. This campaign will entail the use of public service announcements and paid placements in radio, television and print media. Dissemination outlets will also include libraries, town halls, community agencies, schools, etc.

Dirigo Health and GOHPF, in conjunction with any partnering organizations such as a collaborating insurer, a disease management vendor or fitness/wellness vendors will jointly develop informational and marketing materials for distribution to those persons – employers and individuals – expressing an interest in joining the Dirigo Health Program. This campaign will dovetail with the general educational campaign, described above, ensuring consistency in message and branding.

Community based advocates will 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 reform plan and Dirigo Health Agency, as well as to the spirit of the law that was enacted in June. They are in an excellent position to educate the community about reform efforts and are equipped to assist the public in becoming engaged in the reform initiative and in the Dirigo Health Program.

The actual process of enrollment in the Dirigo Health Program has yet to be defined.

4.5 Premiums

When a business or individual joins the Dirigo Health Program, 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. The membership payment will be predicated upon the package of services, which is not divisible. Therefore, members do not pay a premium; they make membership payments.

Employers, employees and individual members of the Dirigo Health Program will be expected to make contributions toward the membership payment. Expected contribution levels will be established by the Dirigo Health Board of Directors, through a public rulemaking process. By law, the employer's minimum contribution requirement may not exceed 60% of the membership payment. Employee and individual contributions will be based on a sliding scale of subsidies. Persons over 300% of poverty will be expected to pay their full share of the membership payment. Between 300% of poverty and MaineCare eligibility limits, members will be responsible for a portion of the payment,

with the balance met by public subsidy monies. The very poorest people will be enrolled in the MaineCare program, Maine's Medicaid program.

4.6 Benefits Structure

The benefits structure – including provisions for cost sharing – for the Dirigo Health Program has not yet been finalized. However, some level of cost sharing is contemplated, both for non-coverage related services as well as those services provided through the collaborating carrier. The cost sharing design is being developed with a high degree of sensitivity for the challenges lower income Mainers face in accessing health and wellness services. The final design will represent a balance between the practical reality of programmatic costs, the potential benefits offered by the introduction of some level of cost sharing, and the very real financial limitations of many potential members.

4.7 Projected Costs

As part of the early phases of the planning process for reform, a considerable investment was made in the development of financial modeling for the Dirigo Health Program. Modeling was a collaborative undertaking between Mathematica Policy Research, Inc. and the Health Policy Institute of the Muskie School of Public Service, both under contract through the HRSA State Planning Grant.

The population data from the Maine household survey was used to estimate enrollment by category (income, current coverage status, employment status, age, and household status). A target per member per month cost of enrollment was developed for modeling purposes by Watson Wyatt, Inc., under sub-contract to Mathematica. These per person cost estimates were derived from claims data for years 2000 and 2001 for approximately 100,000 privately insured Maine residents and claims data from Maine's Medicaid program. Revenue streams were calculated based on different enrollment assumptions from employer membership contributions, enrollee membership contributions, federal matching dollars on expanded Medicaid enrollment, and funding through a savings off-set payment generated through an assessment on health insurance premiums and TPA business. Table 5 shows the approach and framework used in modeling costs and revenues under different program assumptions. Modeling encompassed only subsidized and MaineCare eligible enrollees since enrollment by those paying full membership costs is expected to be self-sustaining.

The Program has been designed to be self-sustaining, with the above-mentioned revenue sources and with little or no need for an on-going infusion of state dollars.

The insurance market for small groups and individuals has changed considerably since the discussions around health reform began early last year. This year has already seen the introduction of several new products aimed at these market segments, very likely in response to the pending introduction of the Dirigo Health Program. As mentioned elsewhere in this report, the benefits offered to members of this Program will be wide ranging; only one piece of the benefit package relates to arranging for coverage. The

price of Dirigo membership, though, must be competitive with the simple coverage options available in the broader market. Therefore, we continue to work to shape a comprehensive benefits package to meet the needs and expectations of Maine's businesses, employees and individuals. Ultimately the total package of benefits will impact on program costs, subsidy needs, and expected voluntary enrollment levels among non-subsidized businesses and individuals.

4.8 Financing

Dirigo health will be 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 made available as a result of one-time federal fiscal relief.

Beginning in Year 2, state funds will be replaced by a savings offset payment assessed on gross revenues of insurers and third-party administrators. This assessment can only be levied if and when Dirigo 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 new law.

The ability to fund subsidies to make the Dirigo Health product affordable depends on the ability to bring savings in the system. Currently, insured Mainers spends over $275 million a year in a hidden tax to cover the costs of uninsured people who require health services. Those costs are now passed on as higher rates from providers and higher premiums from insurers. The savings offset payment recaptures some of those costs already in the system.

Table 5

Cost and Revenue Worksheet: Dirigo Health Plan (based on 2002): Assumption 75% Participation

				NON-MEDICAID SUBSIDIES				
	Individual	Small Group	**SUBTOTAL**	Individual	Small Group	Large Group	**SUBTOTAL**	**TOTAL**
COSTS / USES OF FUNDS								
Total Eligible Population	13,886	63,931	77,817	25,722	83,032	2,930	111,684	189,501
Take up Rate	75%	75%		75%	75%	75%		
Enrolled Population	10,415	47,948	58,363	19,292	62,274	2,198	83,763	142,126
Premium (person/year)	$xxx	$xxx		$xxx	$xxx	$xxx		
Selection Adjustment	1.00	1.07		1.07	1.07	1.07		
Cost, adj for selection	$xxx	$xxx		$xxx	$xxx	$xxx		
Gross Costs (Enrolled x Cost adj for selection)	**($xxx,xxx)**	**($xxx,xxx)**		**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**		
Individual/Family Payments	n/a	n/a		$xxx,xxx	$xxx,xxx	$xxx,xxx		
Employer Payments	n/a	n/a*		n/a	$xxx,xxx	$xxx,xxx		
Retained Employer Payments					$xxx,xxx			
Current Medicaid Spending	n/a	n/a		n/a	n/a	n/a		
New Federal Spending	$xxx,xxx	$xxx,xxx		n/a	n/a	n/a		
Net State Costs	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**	**($xxx,xxx)**
REVENUES/SOURCES OF FUNDS								
Dirigo buy in								$xxx,xxx
BDC Recovery								$xxx,xxx
Net State Revenue								**$xxx,xxx**
NET EFFECT ON STATE								**$xxx,xxx**

NOTES:

Bad Debt/Charity (BDC) Recovery

Total BDC Available to Recover	$164,000,000
Recovery	$ 87,781,974
Pop for which recovery is realized:	142,126
Total Private Premiums	$2,194,549,354
Recovery as Pct of Pvt Prem	4.00%

Individual Medicaid	$ 2,155	Actual per capita Medicaid expenditures.
Adult Parents	$ 2,055	
Childless Adults	$ 5,532	
Individual Non Medicaid	$ XXXX	"3A" option with additional cost sharing to reach this premium level.
Selection Adjust Factor	0.25	Controls nonlinear function of the estimated take up rate, as a multiple of premium cost
Small-Group Employer Contribution	55%	
NonMedicaid Employee Contribution	20%	
Non-Medicaid Individual/Family Contribution	48%	

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 the reform effort, in our view, is the "marrying" cost containment to access and quality in the minds of the public. This allows the state to advance cost containment initiatives that might otherwise enjoy little broad based support.

The cost containment provisions included in the Reform Act begin with a call for voluntary restraint asking hospitals and other providers to limit their cost growth to 3% and their operating margins to 3.5% over the coming year. Insurers are asked to limit their operating margin to 3.5% as well. In addition, the Governor has imposed a moratorium on Certificate of Need, limiting costly new construction and other capital expenditures in the health system until at least May 2004 when a state health plan with a budget will be established to guide investments in new health services statewide. The State Health Plan will include specified limits on 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 comes under the purview of the Certificate of Need Program, will be reviewed competitively in two review cycles per year. Approvals above the amount of the Capital Investment Fund will not be allowed. Certificate of Need has been expanded to cover high cost out-patient services provided in physicians' offices and ambulatory surgical centers.

In addition, providers will be asked to post prices of common procedures and other information will be made available to Maine citizens to help them better understand the costs of health care in the State and be better informed consumers. These voluntary efforts will be assessed at the end of the year to determine 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 will provide major input to the development of the State Health Plan. The plan is expected to develop global health care spending budget recommendations for the State.

A study of hospital costs and hospital services is now getting underway with the guidance of a Hospital Study Commission chaired by William Haggett, former CEO of Bath Iron Works. Dr. Nancy Kane, D.B.A., from Harvard School of Public Health, will conduct an extensive study of Maine's hospitals to inform that advisory group. In addition, an Advisory Council on Health System Development has been appointed, will seek extensive public input and develop a state health plan to more rationally distribute health care services and costs across Maine.

4.10 Service Delivery

As noted elsewhere in this document, the Dirigo Health Program comprises a comprehensive range of services. Many of these services will be provided to members through contracted vendors; others will be delivered by the Dirigo Health Agency directly.

Health care services delivery will be provided through the provider network of the collaborating carrier or carriers. This network will be statewide, ensuring access to services to members in all regions of Maine.

4.11 Quality Assurance

The Dirigo Health Agency will be responsible for overseeing the quality of services provided by vendors to Program members. Guarantees will be used to enforce contractually prescribed performance expectations. In addition, the Agency will establish internal due process mechanisms, ensuring that members have an effective avenue of recourse should they be dissatisfied with the services they receive under the Program.

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

4.13 Coordination with existing programs

The Dirigo reform effort is run out of 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 have anything to do with the purchase or delivery of health services; these include Education, Corrections, State Employee Health Insurance, and so on. This level of consolidation helps to ensure consistent policy across all of state government.

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

The Dirigo Reform Act incorporates a provision for the establishment of a "virtual" high risk pool within the Dirigo 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 Dirigo Health Program will be managed under a high cost 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 Dirigo Program members must meet all applicable insurance regulations; the Program receives no preferred treatment. Consequently, all reforms applicable to the insurance carriers will impact Program members.

As noted elsewhere, Dirigo Health will compete in the marketplace alongside other commercially available benefits products. However, an employer choosing to enroll his/her business in Dirigo will have to agree to offer only Dirigo Health – 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 enabling the Dirigo Health Program specifies that eligibility for Program 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 the volatility in the private market that is making it more and more difficult for small employers to find affordable coverage. However, employees of a business that dropped coverage within the 12 month period preceding an employee's attempt to enroll in the Program, 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. Another provision of the Dirigo program sets out 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.

A tracking system to monitor crowd-out has not yet been developed.

4.14 Data Collection

When discussing the issue of data collection it is again important to bear in mind that this reform initiative encompasses a broad collection of efforts focusing on cost, quality and access. Data will be collected as part of each of these various focus areas.

The Dirigo Health Program will collect data from each member. At the time of enrollment, information on age, gender, residence, occupation, household size, and prior insurance status will be collected from the application form. Dirigo will also obtain information on household income from those applicants seeking membership subsidies. Each new member will 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 will provide census data including hours worked by employee and prior insurance status as part of the master membership application.

Dirigo Health will track the use of Program services either directly or through affiliated vendors. Duplicate claims data will be analyzed by the Program to gain insight into utilization patterns, develop predictive models for early intervention and assess the effectiveness of intensive case management for high risk members. It is also conceivable that outcomes data may be collected as part of the quality improvement initiatives undertaken by the Maine Quality Forum.

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 carry out the population-based tracking practice-wide.

In order that the savings offset payment be calculated each year, system wide data will need to be gathered regarding the number of previously uninsured individuals who gained coverage through the Dirigo Program, and their utilization experience. This will allow the state to develop an estimate of bad debt/charity care averted by expansions in coverage. We will also track aggregate actual health care spending against the expected trajectory of spending, based on recent trends, to evaluate the impact of the reform initiative's cost containment impact.

Each year, beginning in 2004, the Governor's Office is required to issue a State Health Plan. Part of this process is establishing a limit on the awards allowed under Maine's Certificate of Need Program. In order to set this limit, data must be collected on the average age of plant, the estimated impact of new technology and the rate of increase in the cost of health care services. These data will be collated with information on the ability of Maine residents to support changes in the cost of the health care system arising from investment in new 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 an expenditures target. The budget will provide parameters for investment under the provisions of the State Health Plan.

4.15 Program Evaluation

The Dirigo law 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.

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.

In addition to on-going internal evaluation for the purpose of informing the Maine people and the legislature of program progress, the Governor's Office of Health Policy and Finance will seek external funding for a program evaluation to be conducted by an objective third party.

4.16 Political Considerations, the Path to Consensus and Implementation

Health reform in Maine gained tremendous impetus with the election of John E. Baldacci as Governor, who took office in January 2003. Governor Baldacci had made reform one of the major planks of his campaign platform, thereby pushing the issue to the top of the policy agenda. 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 environment was ripe for reform. Our small businesses were reeling under premium increases that had averaged 58 percent a year; individuals and even large businesses were experiencing 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 36th in personal income. Employers were rolling back benefits, contributions to coverage or dropping coverage altogether. These factors contributed to a very real sense

of crisis about the future of our health care system which, in turn, contributed to the conditions necessary to achieve comprehensive reform.

Work began on the formulation of the proposal in early January, with the formation of a 27-member advisory group dubbed the Governor's Health Action Team. Members of that group spanned a wide spectrum of views, from single payer advocates to those lobbying for incremental reforms to outspoken advocates for a market-based system without any governmental intervention. This advisory team was deliberately not charged with reaching consensus but, rather, responded to and provided advice on developing a strategy for implementing the Governor's vision of reform. This vision included addressing cost, quality and access simultaneously, with a goal of universal access to quality, comprehensive coverage for every man, woman and child in Maine. It did not include a single payer system, nor did it include mandates.

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 that proposal and its evolution.

The Governor formally introduced the proposal and accompanying legislation in May, after successfully closing a substantial gap in the state budget without raising taxes. The Legislature established a Special Select Committee to hear and work the legislation, which set to work on a very fast track.

As soon as the plan was presented, both campaigns of support and opposition began. The public hearing on the bill set the tone. The hearing lasted for nine hours and was characterized in the press as "The People Versus the Powerful." Supporting the bill were individuals from all over the state – many with riveting and distressing stories of personal hardship related to lack of health coverage and access – the Maine State Chamber of Commerce, the Maine State Nurses Association, unions, and the Alliance for Small Business. We felt it significant that the National Federation of Independent Businesses and local chambers testified neither for nor against. Opposing the bill were the hospitals, physicians' organizations, and insurers. Much of the opposition announced that they liked and supported most of the bill but had specific objections to parts of it.

Because the bill was so complex and public support for reform so strong, organized opposition to the plan, except among hospitals, on the whole was restrained. The stakeholders instead targeted specific elements for modification or removal. Insurers were concerned primarily about the cost of the assessment and the new regulations. Hospitals rejected cost containment provisions and launched a significant attack against the global budget. While we had proposed the budget for hospitals as a part of voluntary planning to reorganize and restructure hospital delivery in the state free from anti-trust challenge, hospitals made clear that the budget limits were simply too rigid to allow hospital services to be sustained and made clear their objections to meeting as a group to

divide up the pie. The hospitals helped organize community forums all over the state. A letter writing and e-mail campaign was launched that was aggressive and unrelenting.

The legislative committee hearing the bill instructed the Governor's Office of Health Policy and Finance to meet with opponents and see if compromises could be developed. Long hours of "shuttle diplomacy" were held, negotiating compromises with opponents only to incense proponents. The Governor and Committee leadership were persistent and insisted that the parties stay at the table. After extensive negotiations, each constituency had its primary objections addressed. As a result, the original proposal remains largely intact; the details of how the reform objectives will be realized are changed.

Specifically, voluntary hospital planning and the hospital global budget were eliminated. The hospitals made clear that with or without a budget they were not interested in a hospital-only discussion to realign hospital services statewide. However, the Act retains the state health plan which includes a global budget and a capital investment fund which will limit future system growth. And a commission to study Maine's hospitals was added.

The four percent assessment on insurers' gross revenues was replaced by savings offset payments. Dirigo Health must show reduction of bad debt and charity care and/or reductions in health care cost growth in order to assess up to four percent fees on insurers and third party administrators. We also agreed to negotiate further with third-party administrators about how the payment will be assessed to them. The savings offset payment will provide the necessary revenues for the employee and individual subsidies for individuals up to 300 percent of the Federal Poverty Level. By linking cost containment goals directly to access, we have generated broader support for cost restraints. Unless and until cost containment goals are met, funding for the subsidies will not be available.

Finally, we extended the phase-in for five years to cover all Maine's uninsured and agreed to fund the first year with funds made available through Federal fiscal relief. These funds will "prime the pump" and helped us resolve a very 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 "front" the subsidy costs for the program or to pass the assessments on to policyholders in premium increases. Under the current arrangements, 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.

As a result of all the negotiations and discussions, the bill received a unanimous, bipartisan committee report and two-thirds support in each house. The surprise for us was the extraordinary press attention that followed enactment. *The LA Times, The International Herald Tribune, The New York Times* editorial page, and Ellen Goodman all wrote about Dirigo Health. 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.

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. Planning for implementation is currently underway, with a start-up date for program enrollment of July, 2004. The development and passage of the bill has proven to be the easiest aspect of reforming the system. The additional work that must be done to implement the provisions of the plan is extremely complex, and made more difficult by a shifting marketplace. With July 2004 as our deadline for implementation of the Dirigo Health Program, we are operating under tight time constraints. This, too, reflects a political decision; public expectations for the reform initiative are high and we must demonstrate progress in order to maintain the constituency for change.

Additional planning and implementation work is being conducted by the core project team – the staff of the GOHPF. This staff has been expanded by the hiring of four new positions, including the initial staff for the new Dirigo Health Agency. This team is augmented by the consultants who contributed so heavily to the initial planning process – the staff of the Muskie School of Public Service at the University of Southern Maine, Mathematica Policy Research and Watson, Wyatt. The consultant team has expanded to include experts from the Harvard School of Public Health (Kane), George Washington University (Lambrew and Mann) and Medicaid Policy (Schneider) as well as Mercer.

As we work to implement the plan, factors such as the public's preference for benefits configuration and price have grown even more important. Focus groups (discussed elsewhere in this report) have assisted the project team in gaining insight into how the Dirigo scope of services must be adapted to meet expectations and need. These changes must be balanced against price and ability to pay, while the soundness of the financial model is protected. Similarly, the administrative complexity of implementing a comprehensive program is high, forcing a variety of "make or buy" decisions that will shape the character of the new Dirigo Health Agency.

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.

4.19 Addressing the Eligible but not Enrolled

In 2000, Maine was among the top ten states in the country in the proportion of eligible children enrolled in Medicaid and CHIP, according to a report from the Children's Defense Fund.[7] 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 the 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 Dirigo Health Plan and that the challenge for enrollment in both MaineCare and Dirigo is

[7] *All Over the Map: A Progress Report on the State Children's Health Insurance Program.* Children's Defense Fund, Washington D.C., 2000.

making information available and providing assistance with application procedures. Early marketing and outreach efforts will be targeted at those geographic areas which demonstrate a proliferation of small businesses paying relatively low wage rates. Targeting data will be obtained using aggregate data on area wage rates from Maine's Department of Labor, indexed against a census of business, by size, by county and/or town code. Household survey data lead us to believe that many employees of such businesses are either uninsured, or have dependents who are uninsured. By targeting this market sector, we anticipate making early progress in enrolling the un- and underinsured.

Strategies for collaborating with entities at the county and municipal levels have not yet been devised. Maine has essentially no county government, so that level of interaction is not an issue.

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 made it very clear to the public and stakeholders that the Governor was committed and would be personally involved in the reform effort, giving it a very high priority. Locating the initiative in the Governor's office also ensured that the entire Cabinet was apprised of the initiative and that key 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 both "friends" and "foes" and included representatives of consumers, business, 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 – the association of insurance plans – the organization, itself, was asked to select a member to represent them on the HAT. Other key parties participating in the HAT deliberations were 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 mechanics of the 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 provided some diffusion of later debate. It also allowed the 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.

5.2 Gaining Public Input

The Health Action Team meetings that were held between January and March 2003, 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 did not shy away from doing 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 proposal was introduced as legislation, it became the purview of a Special Select Committee. That Committee held a public hearing on the bill, which ran for nine hours and which provided valuable comments and suggestions, many of which were used to improve the bill before its enactment.

5.3 Other Strategies to Build Awareness

Both the Governor and the GOHPF staff accepted almost as many invitations to speak about Dirigo as were offered, as a way to have conversations about the initiative and its objectives at the community level. We also cultivated relationships with a select group of press representatives, in whom we invested a good deal of time educating about the details of the proposal. This strategy served us in good stead, as we were not only able to identify "friends" in the media, but also to avoid the dissemination of misinformation through press channels.

The Governor's website was designed to incorporate a special section on the reform initiative. A great deal of public comment was received through the website. Contacts through the website also allowed us to build an interested parties list for email blasts and an initial marketing contact list.

5.4 The Impact on the Policy Environment

The Dirigo reform initiative dominated all discussion of health care during the past year and during the legislative session. All bills introduced prior to the Dirigo proposal were held, pending consideration of the Governor's bill. The reform bill was comprehensive and, where appropriate, incorporated the best of the other pending proposals, allowing the

Legislature to dispose of most competing bills at the Committee level. Because the Dirigo bill came out of Committee with a unanimous "ought to pass" bipartisan vote, its passage on the floor was guaranteed.

At the close of the session there were a number of health care bills remaining that had been tabled or held over during the session. Leadership has killed most of those bills, making it clear that it has little interest in revisiting this issue again during the short second session.

One indication of the current policy environment is the response of hospitals in the State to the voluntary cost containment measures included in the Dirigo Law. These asked hospitals to keep case-mix adjusted cost increases to below 3.5 percent and margins below 3 percent. Many hospitals in the State have announced their intention to meet these targets and have made statements to the press about the steps they have taken to comply.

Public expectations are high. The GOHPF receives calls on a regular basis from small business owners and individuals wanting to know when they will be able to enroll in the Dirigo Health Plan.

Although the development of the legislative proposal and its passage was challenging, it is certainly the easiest phase of reform. Much is left to do in terms of planning and development before the plan is fully implemented this coming July. However, the Governor remains firmly committed to implementation. Although there is some interest on the part of the minority party in the Legislature to enact alternative reforms of a far narrower scope, Leadership also remains committed to moving forward quickly. There is also a growing expectation on the part of the public to have Dirigo succeed. Therefore, it would be extraordinarily unlikely that this initiative would not move ahead.

6. Lessons Learned

6.1 The Importance of State-Specific Data

State-specific data was 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 are currently being 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

The conduct of the household survey was the most valuable data collection activity undertaken as part of the planning process to date. Although this effort 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 provides critical information for modeling changes in personal health care spending which will be needed to determine the level of the savings offset payments.

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 compared to 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 2 cases, non-insuring businesses of less than 50 employees and in 2 cases, 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.

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 calls 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 is underway. 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 is currently underway 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 the Dirigo Health Plan 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. Currently, there is no funding available for such surveys.

6.6 and 6.7

To be completed in the final report based on ongoing assessments.

6.8 Key Recommendations

While every state is different and all politics are local, there are lessons to be learned and shared from our experience. First, we believe that firmly tying cost, quality and access together was likely our most important achievement. While promoting increased access and enhance quality is usually a politically salient stance, the promotion of cost containment often is not broadly supported. By making access enhancements reliant on achieving cost containment, we were able to cultivate a new constituency for controlling expenditures and investments, where there once was little support. It is this strategy which differentiates this reform effort from those which came before it.

Running the reform effort as a campaign was also a strategically sound decision. This forced us to pay close attention to both supporters and detractors, which paid great dividends in the long run. We continue to view the process of working towards implementation as a campaign, which we believe will serve us well come July 2004, when the Dirigo Health Program is expected to go "live."

6.9 Maine's Political and Economic Environment

Maine's economic environment continued to experience hardship during the past year. As the Governor was signing the Executive Order establishing GOHPF on the first day of his Administration, one of the state's largest paper mills was announcing its closure.

At the outset of his term, the Governor had to address a 20% budget deficit; he did so without reducing eligibility for MaineCare, our state Medicaid program, and without raising taxes. However, we are coming into the new session with a substantial MaineCare deficit, attributable in large measure to an increase in enrollment associated with our struggling economy. Again, measures to address this issue are being taken without cutting eligibles. Still, this deficit has caused some in the minority party to call for the repeal of those provisions in the Dirigo Act that would expand MaineCare eligibility as a part of access reforms. They also are calling for using the $53 million appropriation from federal fiscal relief funds to be used for Dirigo start up to address the budget shortfall. The position of the Administration is that Dirigo is part of the answer to our health care crisis. To delay its implementation is short sighted and will do nothing to address the fundamental problems of our system. Instead, we need to invest in cost, access and quality initiatives in order to solve those challenges threatening our system today.

The past year has also witnessed the development and growth of a hard line right wing conservative movement in this state. The voice of this movement comes out of 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.

6.9 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.

6.10 Next Steps

We continue to work on the development of implementation plans for the Dirigo reforms. Major steps in this process include:

- Executing a contract with insurers and other vendors for major services specified as part of the Dirigo program. These services include: comprehensive health benefits; wellness programs; case management of chronic illnesses; and quality monitoring.

- Opening the Dirigo Plan for enrollment by July 1, 2004.

- Developing and implementing a plan of operations for the Maine Quality Forum.

- Development of a State Health Plan including the sizing of the Capital Investment Fund and a strategy for rationalizing the allocation of health services resources throughout the State.

- Development of information systems designed to provide ongoing and timely information on aggregate health care expenditures in the State.

- Development of a plan to move all providers in the State to a uniform and electronic claims submission system.

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. We will now simply implement the full extent of that granted authority.

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 through 7.4

Information will be provided in the final project report, based on continued experience with program development.

APPENDIX 1: MAINE SUMMARY DATA

To be submitted with final project report.

Data related to characteristics of Maine's Uninsured are available in Appendix 3, attached.

APPENDIX 2: LINKS TO 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) A copy of the Maine Household survey report can be accessed on line at:

http://muskie.usm.maine.edu/Publications/hpi/HealthInsuranceCoverageMaine2003.pdf

APPENDIX 3

Health Insurance Coverage Among Maine Residents
The Results of a Household Survey, 2000

And

Technical Report with Survey Instrument
From
Mathematica Policy Research, Inc.
Survey contractor