April 2, 2002

Joyce G. Somsak, Program Director
State Planning Grants Program Office
HRSA Grants Application Center
Attention: HAB Grants Management Office CFDA 93.256
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

Dear Ms. Somsak:

I am pleased to forward to you the State of Maine's application for a State Planning Grant under the HRSA solicitation. This proposal builds on Maine's long history of legislative and executive agency efforts aimed at reducing medical indigence and improving access to care for Maine people. Current executive department initiatives and legislative proposals reflect the high priority health reform has on Maine's policy agenda. We have made progress in the health of our people. We've gone from one of the highest to one of the lowest teen pregnancy rates in the country and have driven youth smoking down 36 percent since we began our attack on this plague almost exactly four years ago. We have created the Healthy Maine Prescriptions Program, one of the most effective discount initiatives in the country. While these are achievements where we can be proud, Maine, like the rest of the country still faces substantial challenges in assuring access to appropriate care for all our citizens. This planning grant will allow us to move significantly forward in our policy development efforts. There is no simple answer to this problem, but solid information and a process to engage stakeholders are critical to resolving this complex task.

I have designated the Department of Human Services as the lead agency to help build consensus around a reform strategy that will provide access to healthcare for the people of Maine. The Department of Human Services has the authority to oversee and coordinate all aspects of this plan. I am confident that with this leadership and with the active participation of executive, legislative and other stakeholders, the goals outlined in this application will result in meaningful change.

Sincerely,

Angus S. King, Jr.
Governor

Enc.

cc: Kevin W. Concannon, Commissioner
Department of Human Services

April 3, 2002

Joyce G. Somsak, Program Director
State Planning Grants Program Office
HRSA Grants Application Center
Attention: HAB Grants Management Office CFDA 93.256
901 Russell Avenue, Suite 450
Gaithersburg, MD 20879

Dear Ms. Somsak:

The Department of Human Services is pleased to submit an application for a State Planning Grant in the amount of $1,683,426 under the HRSA solicitation. This planning grant will provide the technical, analytic, and organizational support needed to decide how best to design a comprehensive strategy for universal access to health care for Maine residents.

Maine is favorably poised to solve this problem. Where partnership with the federal government has been possible – through the Medicaid and SCHIP programs – Maine has been quick to maximize the opportunities to expand access to its residents. In addition, the State has attempted a number of State-sponsored initiatives intended both to expand access and to reform the health insurance market. Like many other states, Maine has found these incremental efforts insufficient to alleviate the problem. Recent executive department initiatives and legislative proposals offer approaches to closing the access gap. While none of the current proposals taken alone will guarantee universal coverage, they will, if taken together, result in substantial reductions in the number of people without insurance or with inadequate coverage and may provide a blueprint for a strategy that will achieve the ultimate goal -- universal coverage.

This project's workplan is built around analyzing, evaluating, coordinating, and building consensus around several promising new reform initiatives emanating from the legislature and the Department of Human Services. As the lead agency in health care, the Department of Human Services will assume the role of convening the parties and overseeing the work of the projects' technical advisory group, the Muskie School of Public Service. A broad-based Task Force bringing together representatives of key government agencies with legislative leaders and community stakeholders will be used to develop consensus on a bi-partisan reform strategy that meets all or most of our reform objectives.

Eugene Gessow, Director of the Bureau of Medical Services within the Department of Human Services will serve as the Principal Investigator on this project and is the principal contact person for information regarding the proposed planning program. The Institute for Health Policy in the Muskie School of the University of Southern Maine will participate in this project as a Technical Analysis and Resource Group. The project Task Force will include representatives from the Governor's Office, the Legislature, the Departments of Commerce, Professional and Financial Regulation, Labor, and Behavioral and Developmental Services, and the Bureaus of Health, Elder and Adult Services, and Child and Family Services within the Department of Human Services.

I am confident that, along with our executive, legislative, and community partners, this project will move us substantially forward in our goal of providing quality health care to all residents of Maine.

Sincerely,

Kevin W. Concannon
Commissioner

Enclosure

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Project Abstract

The Department of Human Services of the State of Maine (the Department), proposes to lead a broad-based Task Force in an effort to assess, evaluate, coordinate and merge four already identified reform initiatives into a comprehensive strategy to expand access to health care to all Maine citizens. The proposal has two major components. First, the Department will oversee a technical analysis of Maine data allowing the development of business plans, cost estimates, and impact assessments of four reform proposals. Second, the Department will convene a Task Force that brings together key Executive Agency leadership, legislative leadership, and community stakeholders for the development of a comprehensive reform plan to expand access in Maine. The Task Force work will start with an evaluation of the four reform initiatives, with a view toward coordinating and merging proposed strategies that show the potential to work in a complementary fashion to address the problems of access to care. The Task Force will also consider the four insurance-based initiatives in the broader context of access needs in Maine. The Task Force will evaluate the State's public health infrastructure and the contribution of provider shortages to access problems, and embed the approved and adopted reform initiatives into a comprehensive plan that addresses these broader problems, as well as coverage issues.

Maine has a long history of legislative and executive agency efforts to improve access to care for Maine residents. Maine's Department of Human Services, with legislative support, has aggressively pursued options under the Medicaid program and SCHIP to expand coverage to as many low-income state residents as possible. These efforts include waiver initiatives targeted to particularly vulnerable populations, like individuals with HIV or AIDS, and broad-based initiatives to low-income families not traditionally eligible for Medicaid. Maine's government has also aggressively pursued options to assist low-income Mainers with the purchase of life saving and life enhancing medications. Over the past decade, the Legislature and the Department of Human Services have both tried to address cost barriers in the small group and individual market -- the former through reform of insurance regulation, curbing the worst abuses of carriers in this market, the latter through testing initiatives to subsidize the coverage of low-income workers in businesses not previously offering coverage.

Despite the ongoing efforts within the State to combat medical indigence, lack of coverage continues as a problem. Maine's overall uninusurance rate is 11.9 percent. Low-income adults between the ages of 19 and 64 are particularly at risk of lacking health coverage. Turmoil in the health insurance and managed care industry, and rapidly rising premiums point to a worsening of the problem if it is not addressed through a coordinated, comprehensive strategy.

A second area where both the Governor, and his designees, and the Legislature have been active is in convening experts and stakeholders to conduct careful assessments of the dynamics in the health care market in Maine and to begin a long-term planning process for major reforms. The Governor's Year 2000 Blue Ribbon Commission to Study Health Care Costs produced a comprehensive and thoroughly researched report that provides a solid foundation for the planning efforts proposed under this grant program. The legislature, last year convened a Health Services and Health Security Board charged with developing a plan for universal coverage. This group is in the early stages of deliberations.

The proposed project will channel the building momentum for reform in Maine into a coordinated reform effort. Four proposed reform initiatives are currently "on the table" in Maine. The first of these is the charge to the Health Security Board, mentioned above, to develop a plan for and to assess the feasibility of a universal coverage, single payer system for Maine.

Two reform proposals targeted to the employer benefits market have emerged from the current legislative session. One of these proposals calls for the development of a publicly sponsored insurance plan available to all businesses of 50 or fewer employees and charges the Department of Human Services with the responsibility of maximizing, to the extent possible, the contribution of Medicaid dollars for eligible individuals enrolled in the new insurance plan. The plan would be designed and overseen by a publicly appointed Board that would determine the benefit package, provider reimbursement schedules, and minimum loss ratios for the contracting plan administrator.

The second legislative initiative calls for the creation of a purchasing pool to negotiate benefits on behalf of large and small employers in the state. The pool, which would be administered by publicly appointed officials, would be required to offer a range of enrollment plan options and would have the flexibility to negotiate a Basic Plan that omitted some benefits mandated under Maine law.

Finally, a proposal emanating from the Year 2000 Blue Ribbon Commission has been targeted by the Departments of Human Services for further study and analysis. This proposal calls for the creation of a mandatory participation, universal, catastrophic coverage plan. The intent of the proposed reform would be to broadly distribute the medical expenses associated with high cost cases across the total population in Maine and to stimulate the restructuring of the private insurance market to offer low-cost products that were automatically "reinsured" against catastrophic losses.

Each of these four proposed reform initiatives authorizes the creation of a Board to oversee planning, development, and, ultimately, operations. These Boards will have broad representation from providers, consumers, employers, and health system administrators. In the absence of the proposed planning grant, each of these Boards will conduct their planning activities and deliberations in isolation from one another. The activities proposed under this HRSA initiative provides an opportunity to turn these promising initiatives into something that is greater than the sum of their parts.

Under this grant, the Department proposes to initiate and coordinate a major data collection and analysis process that can aid each of the reform initiatives. The data collection plan includes a statewide household survey to develop a detailed profile of the uninsured and underinsured population in Maine; a statewide survey of businesses that will provide data to project trends in the health coverage market and allow modeling of the impact of the proposed reforms; focus groups of consumers to gain a greater understanding of the complexity of issues contributing to access barriers; and research on the experiences of other states. The Department also proposes to contract for actuarial analyses to assess the cost and impact of proposed reforms, once the individual reform initiatives have been consolidated into a coordinated plan.

A long-standing cooperative agreement between the Department and the Institute for Health Policy within the Muskie School of the University of Southern Maine will provide the Department with a Technical Assistance Group that can oversee and carry out the analytic work associated with the proposed project. Four senior researchers from the Institute for Health Policy, with varying areas of expertise, will provide technical support to the Department, the Task Force, and the reform initiative Boards. These individuals will be supported by a team of research and data analysts within the Institute. The Institute for Health Policy will also take responsibility for contracting for the survey work and actuarial analyses.

The Department will also contract with the Maine Development Foundation, a long-standing public/private enterprise that will serve a convening function for the Project Task Force during the process of consensus development.

In summary, the proposed project has two goals. The first is to provide the technical and analytic resources to support the planning efforts of four reform initiatives already underway and to assess the combined effects and interaction of these reforms, should they be implemented. The second goal is to bring policymakers and stakeholders together, under the auspices of the Department of Human Services, to review the analyses of the reform efforts and to develop a consensus for a comprehensive reform strategy that merges the individual initiatives into coordinated and staged plan for addressing access problems in Maine. The expected results from this effort are a significant reduction in the number of uninsured persons in the State of Maine, and the creation of a blueprint of steps leading to universal coverage.

The interim and final findings from the planning process will be reported to the Secretary. The Technical Assistance Group will prepare interim reports on the survey findings, results of the focus groups, and the analysis of other state initiatives. The final Report to the Secretary will summarize these findings, present the findings from the actuarial assessments, include the recommendations of the Task Force for reform implementation and funding, and include estimates on the projected impact of the reforms on access and on the health care market.

Current Status of Health Care Insurance Coverage

Among Maine's population of 1.27 million people, an estimated 11.9 percent have no health insurance coverage.[1] This percent, while among the highest rates in New England, is substantially below the national estimated average of 15.5 percent.

Health Coverage Among Maine Children

In addition to the national estimates, state government and private organizations in Maine have sponsored a number of studies that provide a more detailed picture of the insurance status of specific sub-populations. In 1997, Maine's Department of Human Services contracted for a statewide survey of households with children as part of the planning process for implementation of Maine's State Children's Health Insurance program (SCHIP).[2] This survey ascertained that, prior to the implementation of SCHIP, approximately 10 percent, or 30,000 children (through age 18 plus full-time students through age 22) did not have health insurance coverage. Lack of coverage was most pronounced in families with incomes between 125 percent of the federal poverty level (FPL) and 180 percent FPL. Among children in households below 125 percent of the poverty level, 60 percent received health coverage through the Medicaid program. However, an estimated 7,500 children in this income group remained uninsured, despite eligibility for Medicaid. This survey also ascertained that 85 percent of uninsured children were in households with at least one working adult. Over half of the uninsured families surveyed worked for an employer that offered health benefits. In 37 percent of these cases, the families were not eligible to participate. The majority of eligible families did not participate because of an inability to meet the cost sharing requirements.

In year 2000, The Department of Human Services again sponsored a statewide survey of households with children in order to measure the change in coverage status over the intervening 3 years and, specifically, to measure the impact of the implementation of the SCHIP program.[3] This survey estimated an uninsurance rate among children of 6 percent, or 18,950 children. The survey findings indicated that both public and private insurance coverage of children had increased since 1997. Among the population of children participating in the SCHIP program, fewer than 1 in 5 (18 percent) had had prior private insurance coverage. While the vast majority of children participating in the SCHIP program were in households with working parents, the adults were far more likely to be self-employed, seasonally employed, or working in firms with fewer than 25 employees, than the parents of children with private insurance coverage.

Health Coverage Among Maine Adults

The problem of uninsurance remains substantial among low-income adults in Maine. According to Current Population Survey (CPS) data, among persons living below 200 percent of the poverty line in Maine, the proportion without insurance is approximately 21 percent (2000 report). In this income group, however, the proportion without insurance rises to 49 percent among persons age 19 through 24, and 31 percent among persons age 25 through 64. The low rate of coverage among low and moderate income working adults in Maine may reflect its economic base with relatively few large employers. Companies with 50 or fewer employees make up more than 90 percent of Maine businesses. In 1998, when on average across the country, 55 percent of private sector business establishments provided health insurance to employees, only 49 percent of Maine businesses offered employer-based coverage.[4] Further, there is evidence that the employer-based

system of health coverage is becoming more frayed over time. Maine's unemployment rate fell from 5.1 percent to 3.9 percent between 1996 and 1999, yet the proportion of the population with employer coverage remained unchanged over this period.[5]

Regional Variation in Coverage in Maine

A further source of information on the health insurance status of Maine's population comes from a survey conducted in three Maine counties in planning a demonstration project designed to increase access to care for medically indigent adults.[6] This survey, conducted in 2000, demonstrates that the severity of the problem of uninsurance varies widely, regionally, within Maine.[7] Cumberland County, located in the southern and most populous part of the state, encompasses the city of Portland, the state's largest city, and enjoys a stronger economy than many other regions. The proportion of adults under age 65 without insurance in Cumberland County is 10 percent. By contrast, the proportion of uninsured adults in Lincoln County is 18 percent. Lincoln County is coastal, rural, and has an economy that is almost exclusively small business and seasonal. The third county surveyed -- Kennebec County -- falls between the other two in economic vitality and in the rate of uninsurance. Kennebec County, which includes the city of Augusta, the seat of State government, has an uninsurance rate of 14 percent. Across the three counties, this survey found that 71 percent of the uninsured adults are employed on a full or part-time basis. Most are employed by small firms with 25 or fewer employees. The majority (56 percent) of the uninsured adults with incomes below 300 percent of poverty have been without health insurance for at least five years.

Under-insurance in Maine

Inadequate insurance coverage creates access barriers that extend beyond the population without any form of health insurance. Under-insurance, a growing problem in Maine, arises when the out-of-pocket cost-sharing requirements of an insurance policy extend beyond a family's capacity to pay and discourage the use of appropriate care. On average, persons in Maine with private insurance pay 37.5 percent of their health care costs out-of-pocket.[8] The problem of under-insurance looms as an increasingly prevalent problem, as insurance costs go up. The recent experience of Blue Cross and Blue Shield of Maine (now Anthem) illustrates this point. Between 1995 and December of 2001, Blue Cross's book of business in the individual policy market grew by 22 percent. In 1995, over one-quarter of the policies sold in the non-group market had a deductible of $150. Less than one percent of purchasers bought policies with a $5,000 deductible. In 2001, the proportion in the non-group market with $150 deductibles had dropped to 2 percent. Conversely, the proportion with $5,000 deductibles rose to 66 percent. Another 30 percent of policyholders had policies with a $5,000 deductible, but first dollar coverage of a package of preventive services.[9]

Another population in Maine that suffers from under-insurance is persons covered by Medicare. Maine has a larger than average elder population with below average household income. A very large proportion in this population cannot afford Medigap policies and experience significant out-of-pocket expenses when they receive health care services. Persons with chronic conditions who need regular expensive medications are a particularly vulnerable group.

Maine's Health Care Delivery System

The problems of access in Maine, as in the rest of the country, are exacerbated by the rapid changes underway in the health insurance market and health care delivery system. For example, in the 1980's Maine's hospital revenues were regulated by a state rate-setting commission which recognized each hospital's experience of bad debt and charity care and which provided, in hospital reimbursement formulas, for hospitals to recoup these losses. The rate-setting system was dismantled in 1992, at the same time that large employers and other payers, working through managed care organizations, substantially increased pressure on providers for reduced prices. This pressure on hospitals has made it more difficult for them to provide charity care at a level previously undertaken.

Maine's private insurance market has experienced very substantial change over the past decade. Traditionally, Maine's market was dominated by the local, not-for-profit, Blue Cross and Blue Shield organization while a large number of national companies maintained a presence in both the large employer and small employer markets. In the early 1990s, at least five, large regional and national managed care organizations began to compete vigorously for a larger share of the large employer market in Maine. Now, in less than 10 years, several regional plans have been purchased by large, national organizations, one plan suffered bankruptcy and left the state, and another is in the process of being consolidated into Anthem Blue Cross and Blue Shield. In year 2000, Maine Blue Cross and Blue Shield was purchased by Anthem Blue Cross and Blue Shield, a for-profit health insurer. Currently, there is little competition, indemnity insurance has a vastly reduced share of the market, and there are only four HMOs actively marketing in the state. Based on 2000 data, 76 percent of the commercial insurance market in Maine is enrolled in HMOs.[10] Premium increases in the large group, small group, and individual insurance markets have been very substantial in the past year, ranging from 30 to 50 percent.

The small group market has been substantially affected by Maine's Small Group Health Insurance Reform Act, passed in 1992. Maine's legislation, passed before the federal enactment of the Kennedy-Kassebaum bill, contained provisions that went beyond the federal reforms. Like the federal legislation, Maine law mandated guaranteed renewal and restricted waiting periods and pre-existing condition limitations for persons changing policies. Maine's legislation also restricted insurers' pricing policies with regard to medical underwriting and age/sex rating -- imposing gradually narrowing bands of allowed price differentials, with the goal of moving toward a community-rating pricing policy in the small group market. Although these pricing restrictions have since been reversed, a number of insurers left the small group market in Maine. Those that remain complain that the reforms discourage young, healthy individuals from purchasing, or staying in the insurance market and warn that the market is entering a "death spiral."

Maine "Safety-net" Providers

Although Maine has health care resources for medically indigent persons, these resources are inadequate to meet the volume and scope of care needs of the uninsured population. Maine has no city or county public hospitals and the State Public Health Agency does not support an infrastructure of direct service clinics or providers. Only in the city of Portland, does the city Health Department fund community and school-based clinics that provide free or sliding fee care

to uninsured patients. Nevertheless, a range of medical care services is available to uninsured and medically indigent persons at various locations throughout the state.

Maine has 24 federally qualified community and migrant health care centers (FQHC) that offer services on a sliding fee scale to low-income individuals. These centers provided some care to 16 percent of Maine's children living below the poverty level in 1998, and 18 percent of the adults in this income group. Additionally, the centers served 17 percent of children with household incomes between 100 percent and 200 percent of the poverty level, and 8 percent of adults with similar incomes.[11]

Maine currently has 49 health care providers from the National Health Service Corps providing health care in medically underserved areas. These providers include 26 physicians, 5 nurse practitioners, 5 mental health providers, and 4 dentists.

Free clinics staffed by voluntary providers offer care on a part-time basis in three Maine towns. Four of Maine's largest hospitals have family residency programs and associated outpatient clinics that serve as a resource to uninsured patients.

Impact of Insurance Status on Access to Care and Health Status

Despite the availability of resources for medically indigent persons in Maine such as the federally funded health centers, -- and the willingness of Maine providers to serve as an informal safety net -- there is ample evidence of adverse health consequences associated with lack of health coverage. The Maine surveys indicate, for example, that when compared with insured children in comparable low-income households, uninsured children are more likely to be in fair or poor health, are less likely to have a regular provider, and less likely to have had a dental visit in the prior year.[12] Although the majority of uninsured adults responding to the surveys reported that they were in good health (61 percent), the lowest income were at greatest risk of poor health. Those with incomes below the federal poverty level reported being in poor or fair health four times more frequently (21 percent) than uninsured persons with incomes between 200 percent and 300 percent of the poverty level (5 percent). Among the uninsured requiring prescription medications, more than half reported delaying purchasing or taking medications due to cost. Almost 70 percent reported not having received routine dental care within the prior 12 months.[13]

Earlier Efforts to Reduce the Number of Uninsured Residents

Maine has a long history of legislative and executive agency efforts to introduce incremental reforms aimed at reducing medical indigence and improving access to care for Maine residents.

Maximization of Medicaid and SCHIP

First and foremost, Maine has maximized the opportunities provided by the Medicaid program to expand coverage to medically indigent persons. Historically, Maine set high eligibility thresholds based on income criteria, relative to other states; it covers all optional benefits and has adopted optional eligibility categories as they have been authorized by Congress. In recent years, Maine has used both dollars from the Tobacco Settlement Fund and state general fund dollars to maximize the reach of Medicaid to medically indigent populations. Maine first expanded eligibility at higher income levels to pregnant women and infants. Through the new options available under the Balanced Budget Act, Maine extended coverage to persons with disabilities who participate in the workforce. Maine has taken advantage of a State plan option to provide breast and cervical screening and treatment services. Maine has a waiver for individuals diagnosed with HIV and AIDS that allows Medicaid eligibility up to 300 percent of the federal poverty level. In addition, Healthy Maine is a waiver program that allows Maine residents with incomes at or below 300 percent of the poverty level to purchase prescription drugs at discounted prices.

Maine implemented a SCHIP program with two parts in 1998. A Medicaid expansion offers coverage to children in families with incomes up to 150 percent of the federal poverty level, and a companion Cub Care Program, which requires some cost sharing in the form of sliding scale premiums, is available to children in families up to 200 percent of poverty. Maine has been among the most successful states in its efforts at enrolling eligible children in SCHIP. In year 2000, it ranked fifth among states in increasing coverage for children through its SCHIP program, and sixth, in increasing coverage through a combination of Medicaid enrollment and SCHIP enrollment.[14] In 2000, 18 percent of the children in Maine were enrolled in Medicaid or SCHIP.[15]

In 1999, Maine expanded eligibility to parents of children enrolled in Medicaid and SCHIP. With authorization from the Maine legislature, the Department of Human has submitted an application for a Medicaid waiver which would allow expansion of eligibility to non-categorical adults at or below 125 percent of the federal poverty level. The State's goal is to implement this program expansion in the fall of 2002.

Maine works closely with a Medicaid Advisory Group made up of consumers and providers, who consult with the Department on proposed policy changes to the Medicaid program. This group has been active in researching options for expansion and working closely with the Department to maximize the potential of the Medicaid program in Maine.

State Sponsored Access Initiatives

State sponsored efforts at addressing access problems go all the way back to the 1970s when the legislature implemented a catastrophic health insurance program, phased out in 1986 in deference to other approaches to improving access and coverage. In 1987, the legislature passed

a law, still in place, requiring hospitals to provide urgent care, upon demand, to individuals with incomes below the federal poverty level, without billing for these services. Many hospitals, voluntarily, extend their charity care policy to medically indigent persons who are still low income, but whose incomes are above the poverty level. In the late 1980s, the legislature also tested a variety of initiatives aimed at improving access to care: a high risk insurance program for persons denied coverage due to pre-existing conditions; and a demonstration project, MaineCare, designed to test a public/private collaboration for expanding affordable insurance coverage among small businesses in Maine.

In 1989, the legislature again acted to expand access to care through state-funded initiatives. The Maine Health Program, included expansion of eligibility to a Medicaid-like program for adults with incomes up to 95 percent of the federal poverty level, and children in households with incomes up to 125 percent of the poverty level. The program offered the same benefits as Medicaid, reimbursed providers at Medicaid rates, used Medicaid's claims processing and review process -- but was funded with state dollars. This program has, in the intervening years, been subsumed by federally authorized Medicaid expansions.

Another area where Maine has vigorously worked to meet the health care needs of its population is in accessing necessary prescription medications. Drugs for the Elderly has been in place for many years. This program provides payment for drugs for eligible persons for treatment of specific chronic health conditions including: diabetes, heart disease, Chronic Lung Disease, arthritis, osteoporosis, Parkinson's Disease, multiple sclerosis, and others.

Recently, the program has been expanded to add coverage of all generic prescription drugs. For eligible persons, the Department will pay 80 percent of the cost and the consumer pays 20 percent. A second change to the program is the addition of catastrophic coverage. For persons who spend $1,000 for program-covered prescription drugs within a year, the Department will pay 80 percent of the cost of subsequent drug purchases for the remainder of the year.

As indicated earlier, Maine has used its waiver authority to expand eligibility to persons with incomes below 300 percent of the federal poverty level to discounted medications. This program currently serves 100,000 people.

Regulatory Strategies to Expand Access

In 1990, Maine's legislature turned its attention to the operations of the commercial small group market in a quest to improve access. Two laws were passed. The first mandated that individuals enrolled in any group health insurance policy would have 30 days to transition to a different policy -- group or non-group -- without the imposition of new waiting periods for services or exclusions based on pre-existing conditions. The law also mandated guaranteed renewal of group policies. Insurers could not refuse to renew a policy at the end of a contract period for reasons other than non-payment or fraud. The second law attempted to address cost barriers in the small group and individual market through regulatory reform of medical under-writing and actuarial pricing. Rating bands were established that set boundaries around price differentials based on under-writing criteria. While the guaranteed issue and pre-existing condition limitations are still in place, the regulation of pricing as been over-turned.

Analysis of Comprehensive Reform Options
Maine State Government has sponsored several in-depth analyses of the State health care system and broad strategies for reform -- analyses that provide a foundation upon which the proposed planning effort can build. In 1994 the Maine Legislature established the Maine Health Care Reform Commission with the charge of designing and evaluating the feasibility of attaining universal coverage in Maine.

The Commission recommended a package of incremental reforms. Among the reforms recommended was an expansion of Medicaid coverage to children up to 250 percent of the federal poverty level -- a recommendation that has been accomplished, in part, through the implementation of Maine's SCHIP program. The Commission also recommended the creation of a Maine Health Data Organization as in independent state agency governed by a board composed of public and private sector stakeholders. This recommendation, enacted into law, created an organization that collects data on utilization, costs and charges from all providers.[16] Finally, the Commission stimulated the drafting and passage of a law allowing the formation of purchasing alliances.

In year 2000, the Governor appointed a Blue Ribbon Commission on Health Care with the charge of identifying the cost elements of Maine's health care system, identifying the factors driving up health care costs, examining cost shifting, and recommending strategies for stabilizing health care costs. Five individuals who were not stakeholders in the health care system were appointed to the Blue Ribbon Commission. Staff support was provided by the Maine Development Foundation and by the Edmund S. Muskie School of Public Service.

This Commission determined that Maine citizens spend almost five billion dollars a year on personal health care, an amount representing nearly 14 percent of the state's gross domestic product. They concluded that the factors driving costs are complex and not easily addressed. They include: high demand, an aging population, price insensitivity, rising prescription drug costs, system complexity, and government mandates. The Commission further determined that providers write off $163 million in bad debt and charity care annually, and that Medicare reimbursement, which provides about 80 cents on each dollar spent gives rise to a shortfall of approximately $100 million that is shifted to other populations for payment.[17] The careful analytic work of this Commission provides a blueprint for the proposed project for the collection and analysis of comprehensive costs data in the State, necessary to develop cost and impact estimates for proposed reforms.

Voluntary, Private Sector Initiatives to Expand Access
Because Maine does not have an infrastructure of publicly funded direct service programs, Maine providers are acutely aware that they are the only safety-net available to medically indigent patients. Charity care has always been broadly distributed both geographically, and among providers. In the past few years, however, provider organizations have stepped forward to improve access to care for medically indigent populations, rationalize the provision of charity care, and expand the delivery of primary and preventive care, as well as acute care. Most notably, MaineHealth, a health system encompassing a network of hospitals, a physician-hospital organization, and a managed care system, has developed a program, Community Partners, based on formalized voluntary free care provided through its network. The project obtained

development funds from the Robert Wood Johnson Foundation's Communities in Charge initiative, and started as a demonstration in three Maine counties. Uninsured individuals with incomes below 150 percent of the poverty level who are not eligible for benefits through other programs are eligible to participate. Those who enroll are assigned a case manager and a primary care physician. They have access to a full range of specialty care and hospital care, as needed. The program also provides enrollees with free prescription drugs. Prevention is emphasized and enrolled individuals are asked to take responsibility in managing their health. The project is currently being expanded to two new counties.

Other, similar hospital and community sponsored voluntary initiatives are under development in several other communities in Maine. The hospital in Farmington, Maine, is developing a program very much like the MaineHealth model. Free clinics, organized by providers and reliant on the volunteered professional services of providers, are operational in three Maine communities. Some hospitals are sponsoring and financing school-based health clinics to broaden the availability of primary care to underserved children.

Summary Conclusions on Prior Efforts to Reduce the Number of Uninsured

Maine has a long history of State government and legislative activism around the issue of access to care. Where partnership with the federal government has been possible -- through the Medicaid and SCHIP programs -- Maine has been quick to maximize the opportunities to expand access to its citizens. In addition, the state has attempted a number of state-sponsored initiatives intended both to expand access and to reform the health insurance market.

Like many other states, Maine has found these incremental efforts, to date, insufficient to alleviate the problem. State funded programs, especially those targeted to a small portion of the population, are vulnerable to loss of funds during periods of economic instability. Further, the private insurance market, which has always been the primary anchor of the health coverage system in the United States, is deteriorating rapidly in Maine. After a brief period of relatively stable costs, premiums again are rising at a rate that is causing great consternation in Maine's business community, among consumers, and in the legislature.

There is substantial interest, by all stakeholders in Maine, to work collaboratively toward a solution to the twin problems of health care access and rising health care costs. The initiatives discussed in Sections 8 and 9 speak to the level of interest and to the frameworks that have been put in place to facilitate dialogue and planning.

Requesting Preferences

Maine's Department of Human Services requests that this application be given preference because Maine has a relatively low rate of uninsured among its population. The most recent Current Population statistics indicate that Maine's overall rate of uninsurance is 11.9 percent, as compared to a national average of 15.5 percent, and a state high of 24 percent in New Mexico.

State sponsored surveys in Maine, although not as comprehensive as the Current Population Survey, provide support that the uninsured rate in the state is about 12 percent (see discussion in Section 5). In addition, state surveys indicate that among children, where Maine has been most aggressive in expanding access options, the uninsurance rate is 6 percent -- a drop from 10 percent prior to the implementation of the SCHIP program. This drop indicates that the problem in Maine is responsive to policy initiatives and that public sector expansions do not result in a corresponding decline in level of effort in the private sector.

The relatively low number of uninsured residents increases the likelihood that initiatives targeted to attaining universal coverage will be financially and operationally feasible, and that political support can be gained for the approval and implementation of such initiatives.

For the reasons specified above, Maine's Department of Human Services requests review preference under the criterion of being a state with a low level of uninsured population.

Statement of Project Goals

The overriding goal of the State and the parties collaborating on this proposal reflects the general consensus of Maine people: to work toward universal access to health care for our residents. Initiatives over the past decade are a testament to a commitment among our elected officials and the staff of the Executive Branch to reach this goal. More importantly, current Executive Department initiatives and Legislative proposals reflect the high priority health reform has on Maine's policy agenda. However, we have not reached consensus regarding a single path to follow toward our mutual goal. This planning grant represents an opportunity to ground the policy explorations in sound data and analysis, to bring policymakers in all branches of government and community stakeholders together to coordinate initiatives, and to move toward a comprehensive plan for health reform.

Maine's Department of Human Services, which will serve as the lead agency in this initiative, will provide a convening function for a variety of planning efforts that are currently underway. The Executive branch, the Legislature and community-based stakeholders are all already engaged in a number of health planning and policy development efforts that will be informed by the data analysis proposed under this initiative, and that will be brought into a comprehensive planning process. This planning effort will support three legislative initiatives for major reform, and one initiative under development through a collaboration between the Department of Human Services and the Health Policy Institute of the Muskie School of Public Service. Coordination between and among these initiatives will be achieved through a Task Force convened by the Department of Human Services and including representatives of major government agencies, legislative leadership, representatives of the individual reform efforts, and community stakeholders.

The proposed project has two goals. The first is to provide the technical and analytic resources necessary to support of the planning efforts already initiated within the state. The tasks necessary to provide this support include:

- To develop a comprehensive database on the uninsured and underinsured in Maine;
- To refine our understanding of access barriers experienced by uninsured and underinsured Mainers;
- To develop a comprehensive database on the employer health benefit options and experience in Maine for both large and small employers;
- To review other state initiatives, synthesizing the experience, to date;
- To conduct actuarial analyses of the cost impact of the program designs developed under Maine's planning initiatives, using Maine-specific data on demographics and health costs.

The second goal is to bring policymakers and stakeholders together, under the auspices of the Department of Human Services, to assess and prioritize Maine's reform initiatives and build consensus for a comprehensive reform strategy that coordinates and builds upon the individual initiatives and that will provide access to health care for all Maine citizens.

Project Description

A. Narrative

The proposed project is designed to provide analytic support necessary to assess the feasibility and compatibility of several current proposals for major health system reforms that have already won approval in the Maine Legislature or are under consideration within the Executive agencies of government. In addition, the project will provide a forum where the government and stakeholders can work together to forge these independently conceived proposals into a consolidated, coordinated, and sequenced strategy, for moving Maine toward the goal of universal access.

Maine's Department of Human Services (hereafter, the Department) is the designated lead agency in this planning effort. The Department will serve a convening, coordinating, and information sharing function: assuring that data collection strategies are efficiently formulated to serve the needs of the specific reform initiatives, that analyses are shared across initiative work groups, and that parties come together to forge a consolidated plan.

The Department will convene a Project Task Force to bring expertise to the planning effort and to ensure that all state, legislative, and private stakeholder perspectives are engaged in the planning process and in the construction of the ultimate blue print for reform. The Project Task Force will include representation from the Governor's office, and the Executives, or their designees, from the following government agencies: the Departments of Commerce, Professional and Financial Regulation, Labor, and Behavioral and Developmental Services, and the Bureaus of Health, Medical Services, Elder and Adult Services, and Child and Family Services. The State Employee Health Commission will also be represented. The Leadership of the House and Senate will have seats and will make additional legislative appointments from the Joint Standing Committees of Health and Human Services, Appropriations, and Banking and Insurance. The Boards working on the individual reform initiatives will also have representatives on the Task Force. These Boards will assure stakeholder representation on the Task Force. Groups that have distinctive needs and separate governance bodies, such as Maine's Native American tribes, will also have representatives on the Task Force.

There are, currently, four reform initiatives -- three arising from the Legislature and one authorized for assessment and development by the Department of Human Services -- that are already in the early planning phases in Maine. Each of these initiatives calls for the formation of a planning and implementation Board with broad representation from community stakeholders, including representatives of large and small businesses, hospitals, physicians and other provider groups, consumer advocacy groups, and insurers. These reform initiatives, described in greater detail below, form the strategic core of the planning effort proposed for this grant initiative. The Boards, while engaged in the individual planning efforts, will also have representatives on the Statewide Task Force and will bring to the Task Force the perspective of the various private sector stakeholder groups. They will bring to the statewide group, the findings from their individual planning and assessment efforts, and will participate in the larger discussions on how to forge the individual planning efforts into a consolidated state plan for reform.

Some of the proposed reform initiatives (as described in greater detail below) explicitly call for close coordination with the state Medicaid Program and for determination of the maximum extent to which Medicaid can participate in the program initiatives under consideration. To accomplish this coordinating function, the Medicaid Advisory Group, a body of consumers and providers that works closely with the Medicaid Agency and which has a voice in the development of new Medicaid Policy, will serve as a fifth planning group in the overall planning effort described in this proposal.

The Department, the Task Force, and the individual reform initiative Boards will be supported by data collection and analysis and technical assistance provided and coordinated by the Institute for Health Policy of the Muskie School at the University of Southern Maine. Four senior research analysts from the Institute for Health Policy will constitute a Technical Assistance Group (TAG) that will coordinate the work of survey firms and hired consultants, and will take primary responsibility for conducting and overseeing analyses, and presenting findings in a manner supportive to the planning work of the reform initiatives and the Task Force. The TAG will be supported by a team of data analysts and research analysts within the Institute for Health policy. The TAG will have primary responsibility, under the guidance and instruction of the Department, for the preparation of interim and final reports emanating from the planning process.

Reform Options Under the Planning Project

Maine's Executive agencies and Legislature are already engaged in the early stages of assessing a number of major health reform options. Three of these proposals emanate from the State Legislature. The fourth proposed strategy was discussed by the prior Blue Ribbon Commission on Health Care Costs (see p.10) and has been further developed by senior staff at the Health Policy Institute of the Muskie School. It has been identified by the Department of Human Services as meriting further in depth analysis. While none of the current proposals taken alone will guarantee universal coverage, they may be complementary and, if taken together, result in substantial reductions in the numbers of people without insurance (or without adequate insurance) in our state and, perhaps, create a blueprint of steps for achieving universal coverage. These four reform initiatives are described, below.

- LD 1784, *An Act to Address the Health Coverage Crisis for Maine's Small Businesses and Self-employed Persons*

The Speaker of the House has sponsored a bill in the current legislative session addressing the employer-sponsored private insurance market. As of the date of this writing, the Speaker's bill, which enjoys bipartisan support, has been enacted by the House and awaits final action by the Senate. It is expected to be enacted without controversy and the Governor has indicated he will sign the bill. The bill calls for the creation of a public/private program to offer affordable, comprehensive insurance coverage to small businesses (up to 50 employees) and self-employed individuals with a stipulation that benefits equal at least those offered to state employees.

The program is to be governed by an independent Board appointed by the Governor, the President of the Senate, and the Speaker of the House, with the Commissioner of Maine's Department of Human Services serving as an ex officio member. The Board will be empowered

to select an insurance program administrator from among qualified bidders, but also mandates that the Department of Human Services (which administers Maine's Medicaid Program) put forward a bid to act as administrator. It will negotiate rates with providers and will establish minimum loss ratios for participating carriers. Risk will be limited through the Board's purchase of reinsurance.

The legislative language specifies that Maine's Department of Human Services will act to maximize the use of federal funds available through the Medicaid Program to provide coverage through this program for enrollees who are or could become eligible for Medicaid. The bill also instructs the Department to coordinate, to the extent possible, with the Medicaid Medically Needy Program to reduce the program's catastrophic cost liability and reduce exposure that would be covered through purchase of reinsurance.

The legislation calls for the Board to develop a business plan, including actuarial and marketing analyses prior to implementation of the program. Among the analyses specified for this business plan are: an analysis of the potential pool of enrollees and estimates of utilization and costs associated with the enrollment pool; the development of potential provider rate schedules and premium schedules for the program, and determination of the levels of risk reserves or stop loss insurance coverage needed for the program.

- LD 2146, *An Act to Establish the Maine Consumer Choice Health Plan*

The Senate President has also sponsored a bill that is currently pending before the State Legislature; at this time, its passage appears to be assured. The bill is a response to the crisis in Maine's individual and small group health insurance markets, where premiums have been skyrocketing over the past two years. The legislation will establish the Maine Consumer Choice Health Plan as a new, independent State agency, to be governed by a five-member Board appointed by the Governor and confirmed by the Legislature. The Plan will act as a public purchasing pool, drawing enrollees from businesses of any size, including the self-employed as well as employees of governmental and municipal organizations. Individuals will be eligible to enroll so long as they do not have other health insurance. Individuals eligible for Medicaid are also eligible for enrollment to the extent allowed under federal and state law and/or in accordance with any applicable waiver programs.

The Plan will negotiate and contract with a number of competing carriers to offer a variety of health insurance products at a range of prices to Plan enrollees residing across the state. A range of products must be offered including a fee for service option, a managed care option, a point of service option and a basic plan. The bill specifies that the basic plan may, at the Board's discretion, exclude some or all of the benefits ordinarily mandated by Maine law. Finally, the coverage offered through the Plan must build in a range of deductible options, with at least one plan incorporating a high deductible. The Board is also allowed to offer medical savings accounts, if it elects to do so. Marketing of the Plan products will be carried out under the direction of the Board.

- *Health Security Board*

In 2001, the Maine Legislature established, through legislation, a Health Care System and Health Security Board with the specific purpose of developing recommendations to provide health care coverage to all citizens of Maine through a plan or plans that emphasize continuous access, quality, cost containment, choice of provider and preventive and long-term, as well as acute care. The Board is charged with developing a proposal for a single payer plan, assessing its feasibility and estimating costs. The Board is further charged with coming forward with a proposal for universal coverage that is projected to reduce overall health care spending in the state by at least 5 percent.

The Board is made up of 19 individuals including the Commissioner of the Department of Human Services, or his designee, the Executive Director of the State Employee Health Commission or his designee the State Tax Assessor, and legislative representatives from the Committees on Health and Human Services, Appropriations, and Banking and Insurance. The President of the Maine Senate and the Speaker of the House also were empowered to make committee appointments to represent physicians, small hospitals, large hospitals, health insurers, nurses, labor, the business community, consumer advocates, child rights advocates, and the self-employed. Finally, the Board designated a seat for a health economist -- currently held by a Senior Research Associate of the Health Policy Institute of the Muskie School who is also designated to serve as the technical director under the proposed project.

- *Universal Catastrophic Coverage*

Statewide, universal coverage for catastrophic health care costs represents another or possibly supplemental strategy for health system reform. The idea was discussed by Maine's Blue Ribbon Commission on Health Care Costs and was inspired by the experience of the Maine Employers Mutual Insurance Company -- a legislatively authorized, quasi-public company created to provide Workers' Compensation Insurance for Maine businesses when the private market collapsed in Maine.

The concept of the catastrophic coverage plan is that a mandatory participation, community-rated program would widely distribute the burden of high cost cases across the entire population of the state -- including persons and businesses not currently paying health insurance premiums. Further, the establishment of a single catastrophic plan would allow a restructuring of self-insured employer benefit plans and private insurance products in both the group and non-group markets, since products, automatically "reinsured" against catastrophic claims could be offered at lower cost.

Preliminary analyses also suggest that the implementation of such a model would reduce the charity care and bad debt costs experienced by providers that are currently shifted to private payers.

Preliminary analyses based on the 1999 estimates of personal health expenditures developed for the Year 2000 Blue Ribbon Commission on Health Care Costs indicate that such a program may

be feasible at politically acceptable costs. Further analyses, making use of professional actuarial consultants will be carried out under this project, as well as the development of proposals regarding program administrative structure, funding mechanisms, and coordination strategies with employers and the insurance market.

- *Wrap-around and Additional, To-Be-Identified Initiatives*

The four initiatives described above are all targeted to expansions of insurance coverage. The Task Force will be charged with looking broadly at access barriers, including non-financial barriers such as provider shortages, time barriers imposed by the work schedules of single-parent or dually employed families, language barriers, and other problems that may be identified in the course of data collection and analysis. This proposal anticipates that additional proposals for reform initiatives may emanate from the Task Force to supplement, reinforce, or replace the four identified strategies. These as yet unidentified initiatives may include strategies for expanded direct service programs, such as school-based health clinics, expanded public health programs targeted to prevention and health education, or other approaches. The Task Force will create a work-group with functions that parallel the Reform Initiative Boards, to consider and develop these additional strategies.

Data Collection

The Department expects to use the Task Force and the reform initiative Boards to ensure that the data collected under the auspices of this project meets the specific analytic needs of the identified reform proposals. As a first step in the project, if funded, the Task Force will be convened to consider data and analytic needs and data collection strategies. In addition, members of the TAG will meet with each of the reform initiative Boards to get detailed information on the proposed structure of the reform initiatives. This information will shape the development of the data collection instruments. Prior to fielding the data collection efforts, the instruments will be shared with the Project Task Force for final comment and revision.

The analyses proposed for this project require four distinct primary data collection efforts. These include: a random household survey of Maine residents; a survey of Maine businesses; focus groups of Maine citizens; and information gathering on other state access initiatives -- structure, implementation and outcomes. Each of these data collection strategies is discussed below.

- *Household Survey*

As described in Section 5, State government in Maine has been proactive in pursuing demographic data needed to support the development and evaluation of specific policy initiatives. However, not since 1986, has Maine conducted a survey encompassing all citizens below age 65, and it has never gathered information on access barriers experienced by those above age 65. As a small state, state-specific data collection efforts are particularly necessary since the Maine sample for national surveys, such as the Current Population Survey (CPS), is quite small and the confidence intervals around estimates too large for careful program planning. For example, the CPS estimates of the total population of children in Maine dropped by over 100,000 from 1996 to 1998. Since the state did not experience a mass exodus of children in this time period, and the population, as a whole was growing, this statistic seems likely to be the

result of sampling error. In a state with a population of just 1.3 million people, estimation errors in the range of tens of thousands of persons can seriously undermine planning efforts. A statewide household survey will provide reliable estimates of the number of uninsured persons, and information on their socio-economic and demographic characteristics, health status, and experience of accessing health care services. Because Maine's health coverage expansion efforts, to date, have been targeted to specific sub-populations such as low-income children and their parents, we expect that the remaining uninsured population will fall into distinct groups perhaps requiring different strategies for improving access. Many young workers choose to go without coverage in the current market because costs are high and they do not anticipate substantial health service use. Early retirees may not yet be eligible for Medicare coverage but may be priced out of the private insurance market. In addition, Maine, which has a larger than average elder population, has an unusually large proportion (7 percent) of persons over age 65 who are not eligible for Medicare due to their employment history as workers who paid into State pension and health benefit plans. Self-employed workers and those in small businesses with chronic medical conditions may face exorbitant premium costs, precluding the purchase of coverage. The survey sample will be a stratified random sample, to assure the ability to estimate the extent of sub-groups, as well as the overall uninsured population. Over-sampling issues and the content of the survey instrument will be determined after consultation with the reform initiative boards and the Project Task Force. The survey will be conducted by telephone by a professional survey firm which will also have responsibility for developing sampling strategies, based on the Task Force specifications, and the appropriate weighting of the survey results to correct for design effects.

In addition to providing important information on the uninsured, the survey will be designed to capture information on under-insurance and the access barriers and financial consequences associated with inadequate insurance coverage. The Department recognizes that under-insurance is difficult to define and measure, since capacity to pay for care out-of-pocket varies with household income. Nevertheless, the dramatic change in the non-group (and potentially, the small group) insurance market to policies with a $5,000 deductible (see Section 5) warrants systematic examination.

The TAG, together with support staff at the Health Policy Institute of the Muskie School, will undertake responsibility for constructing an analytic file from the survey data, conducting analyses as specified by the Department, and preparing a report of survey findings for the Department to disseminate to the Task Force and the reform initiative Boards.

- *Employer Survey*

As indicated in Section 5, the employer-based insurance market in Maine is undergoing rapid change. Three of the four proposed initiatives are specifically targeted to segments of the employer benefit market. It is imperative, in assessing the feasibility of the policy options, to understand the direction and likely future structure of employment benefits in the state. The Department, therefore, proposes a survey to collect uniform and comprehensive information on the structure and costs of current employer benefit plans, and the division of cost between employer and employee. Information will also be requested on arrangements in the immediate

past, to determine whether employers are shifting strategies in response to rising health care costs.

As with the household survey, the content of the questionnaire and targeted sampling strategies will be developed in consultation with the reform initiative Boards and with ultimate approval of the Project Task Force. Prior to the development of a survey instrument, the TAG will consult with the Center for Tracking Health System Change, which has extensive experience with employer surveys, on questions of survey design. This information will be shared with the reform initiative Boards and the Task Force. The conduct of this survey will be subcontracted to a professional survey firm.

The TAG, together with support staff at the Health Policy Institute of the Muskie School, will undertake responsibility for constructing an analytic file from the survey data, conducting analyses as specified by the Department, and preparing a report of survey findings for the Department to disseminate to the Task Force and the reform initiative Boards.

- *Focus Groups*

Access barriers can arise from multiple conditions ranging from shortages of providers, to stigma, to information deficits -- in addition to financial barriers. Further, these factors affecting health service use and, ultimately, population health, vary for different groups within the population. The information collected in a structured survey format is limited to major overarching distinctions. The Department proposes to conduct a series of focus groups to collect nuanced information that will supplement the survey data. Focus groups will be held with groups likely to face different barriers to appropriate care -- for example, the near elderly, rural self-employed residents, or persons with disabilities. Maine's largest cities have had a recent influx of immigrants from African and South Asian nations, and from former Soviet republics. These population groups experience language barriers and may also have cultural barriers that stand in the way of a productive provider/patient relationship. The target populations for the focus group information gathering will be developed in consultation with the reform initiative Boards and the Task Force. A total of eight focus groups are planned.

Staff from the Health Policy Institute of the Muskie School of Public Service, under the direction of the TAG, will conduct the focus groups and synthesize the findings into a report for the Department and for dissemination to the Task Force.

- *Information on State Reform Efforts*

States, since the mid-1980s, have been experimenting with a variety of approaches to expanding access to care while controlling health care costs. Some of these initiatives have been in place long enough to provide valuable assessment information on program effectiveness. Other strategies have been tried and abandoned. As one of the first steps in the project, the TAG will consult with the reform initiative Boards to determine what information regarding existing State programs would be useful to the Boards' efforts in designing the parameters of their proposed initiatives or in learning about implementation strategies and barriers. The TAG will conduct a selective search of information available from other states based on the identified needs. This

qualitative data collection effort will include gathering information on program structure, including the creation of a library of state laws, regulatory language, and program operations documents descriptive of various state programs. In addition, the TAG will collect reports documenting implementation strategies, successes, and failures, and program evaluations, where they exist. Document gathering will be supplemented with telephone interviews to key state officials, based on instruction from the Department and the Task Force, to gain additional and up-dated information on programs that look most promising to Maine's efforts.

The information gathered through this document collection and telephone interview process will be synthesized into a report by TAG staff for presentation to the Department of Human Services and for dissemination to the Task Force and the reform initiative Boards.

- *Use of Existing Data Sources*

In addition to the primary data collection described above, the Department expects to make extensive use of existing data sources within the state for analyses in support of this project. These data relate primarily to health care utilization and costs within Maine and will be used to support actuarial analyses and estimates of aggregate spending.

The Department of Human Services, as the state Medicaid Agency, has comprehensive claims, utilization, and enrollee administrative data on Medicaid program participants and dually-eligible populations. The Institute for Health Policy of the Muskie School has provided analytic support to the Department for over 15 years, using claims and administrative data for program evaluation, quality assessment, and the development of innovative reimbursement methodologies. The Institute for Health Policy also maintains Medicare claims and eligibility files for Maine residents for the years 1993 through 2000. These data have been linked to Medicaid claims, at the person level, for years 1993 through 1996. These analytic files have been used to provide information to the Medicaid program on the cost experience of the dually eligible population.

The Maine Health Information Center (MHIC) is an independent agency that collects and analyzes claims and utilization data for a consortium of the largest employers in the state, encompassing the utilization experience of about 200,000 people (approximately 25 percent of the privately insured population in the State). The MHIC will collaborate with the Health Policy Institute in analyzing the experience from the private sector, and in making data available to an actuarial sub-contractor for actuarial analyses. The MHIC and the Health Policy Institute have a history of collaborative work on data analysis, and worked together, for example, in conducting analyses in support of the Year 2000 Blue Ribbon Commission on Health Care Costs in Maine (see page 22).

Inpatient and outpatient hospital charge data are reported annually, for all hospitals in Maine, to the Maine Health Data Organization. The Maine Health Data Organization and the MHIC are currently collaborating to expand the scope of data sets to include non-hospital services. Plans are in place for collecting data from large, self-insured employers, insurance companies, and third party administrators. These data will be mined in support of analyses for the proposed project and made available to an actuarial consultant for analysis of proposed reform options.

Analysis and Model Development

The analytic work plan for this project focuses on developing assessments of the feasibility of the proposed reform initiatives, independently and collectively. Further, actuarial analyses will be used to assess the impact of the comprehensive reform plan that emerges, to develop cost estimates and to allow consideration of funding needs and possible revenue sources. The Department expects the analytic work conducted for the project to build on prior analyses, using the updated and more extensive information gathered through the data collection efforts.

- *Prior Analyses*

The Governor-appointed Year 2000 Commission on Health Care Costs recently completed a comprehensive analysis of Maine health expenditures that will serve as a solid foundation upon which further analyses can build. This Blue Ribbon Commission was charged with identifying the cost elements of Maine's health care system and determining cost allocations and patterns of cost shifting. The approach taken by the commission was to use a population-based approach, and identify both insurance payments and out-of-pocket expenditures for all population groups in the state, grouped by insurance status. Health expenditures were tabulated from actual claims experience, using the data sources identified above, and supplemented with information from Maine's Bureau of Insurance, census data, and national data sources for weighted estimates, where Maine-specific data were not available. The report generated by the Blue Ribbon Commission includes estimated health care expenditures in Maine by coverage category and by service type. It also estimates the total amount of uncompensated care and allocates these costs to payers.

The analytic support for the Year 2000 Commission Report was provided by senior researchers in the Health Policy Institute of the Muskie school, working in collaboration with the Maine Health Information Center and the Maine Data Consortium. This same expertise is represented on the TAG and will be made available as technical support to the project Task Force.

- *Work of the Reform Initiative Boards*

Simultaneous to the data collection activities proposed for this project, the reform initiative Boards will be working to develop preliminary "business plans" for their individual programs. The Boards will make decisions regarding the specifics of proposed program eligibility, benefit structure and cost-sharing arrangements, reimbursement arrangements, and program administration (whether contracted to private sector organizations or housed in a public agency). In addition, to the extent possible based on existing data such as the Blue Ribbon Commission Report, the Boards will cost out aspects of their proposed programs, such as projected administrative costs. These descriptive models and preliminary business plans will provide the Task Force with the specifics needed to begin to strategize about a coordinated and consolidated reform strategy.

- *Analytic Work Conducted under the Auspices of the Project Task Force*

As the body charged with developing a consolidated plan for reform, the Task Force will undertake deliberations that place the specific reform initiatives in a broader context health needs in Maine. For example, all of the reform initiatives address insurance reform; none addresses the impact of the reforms on public health infrastructure or needs, or safety-net providers. The Task Force will need to consider broad-based population needs such as immunization, health education, smoking cessation campaigns and the relative efficiencies of health department or insurance-based delivery modalities. The Task Force will also need to address access barriers that arise from provider shortages and consider whether publicly funded direct services, such as school-based health clinics or public dental clinics are more or less likely to reduce shortages than insurance-based strategies. Based on the work of the reform initiative Boards and its own independent deliberations, the Task Force will develop one or more consolidated reform scenarios, encompassing some or all of the Boards' recommendations and, potentially, some independent recommendations as well.

The primary work of the TAG in support of the Task Force will be to work with actuarial consultants to project cost estimates for the proposed reform scenarios, and to present the Task Force with information that will allow an informed discussion of the financial feasibility of the proposed consolidated reform options, consideration of funding options, and phase-in strategies.

- *Actuarial Analyses and Model Development*

The per capita and total cost estimates developed for the Task Force's recommended reform options will rely on the secondary data sources described on page 21. In particular, expenditure data for the following will be collated:

- Maine's commercially and self-insured insured populations
- Maine Medicare beneficiaries
- Maine Medicaid recipients
- Workers Compensation medical claims
- Automobile insurance medical claims
- Federal expenditures for Maine residents on VA, Indian Health Service and military health services
- State and local health services expenditures
- Out-of-pocket expenditures; and
- Expenditures related to the uninsured.

A substantial portion of the data are readily available, particularly expenditures for government sponsored programs. Data on the commercially insured and self-insured populations will be more difficult to obtain. While some information is available through the Maine Health Information Center, which collects and analyzes claims and utilization data for over 200,000 commercially insured persons, this experience is limited to large employers.

The TAG, working in consultation with the actuarial consultants, will mine the employer survey information to gain perspective on insurance products currently selling in the Maine market, current benefits management strategies among self-insured employers, and issues facing payers

today. A work group, drawn from business and insurance representatives on the Task Force and the reform initiatives Boards will serve as a sounding board and a further source of information in developing projections of commercial and employer-sponsored coverage trends.

Costs associated with the uninsured will be the most difficult to obtain. There is no ready resource for this information. Information from institutional providers (hospitals, hospital-affiliated practices) on charity care provision and payments by uninsured individuals can be used to fill a portion of this gap. The information derived from surveys and focus groups of un/underinsured consumers can also serve to inform this data need. Finally, we anticipate that the actuarial contractor selected will be able to access information and data from other, similar states that have developed cost estimates/business plans for access initiatives. Such data may be used with adjustments to reflect the demographic and health characteristics of uninsured Mainers as reflected in the Maine survey.

While overall per capita costs are helpful, it is more useful to segment the population into distinct subgroups and consider each group's per capita costs separately. Certain proposals may impact subgroups differently, thus making it desirable to be able to model the impact of an initiative on subpopulations. For example, a proposal might specify the exclusion of the Medicare population. In such an instance, it would be necessary to tease out Medicare recipient spending from the equation in order to fairly assess the impact of the proposal on per capita expenditures. Similarly, the uninsured may be disaggregated into the medically uninsurable population, the "immortals" who possess the financial means to purchase coverage and/or services but who simply choose not to do so, and those persons who might be able to afford coverage and/or services if they were available at a lower price. By tracking expenditures for these subgroups separately, it will be easier to estimate take-up rates and program expenditures in a more accurate manner.

- *Baseline Systems Information*

Modeling the impact of various reform proposals requires a set of assumptions for system and market behavior for the next five to ten years. For example, understanding the current penetration of managed care in the state and where it is likely to be in the future is necessary to assess where baseline expenditures are likely to be over the next five to ten years. The TAG and the actuarial consultants will work with the Task Force business/insurance work group to develop these assumptions. These assumptions, in turn, will be used in assessing the impact of various proposed reforms on overall costs and on segments of the market.

Based on the agreed upon assumptions, baseline projections, assuming no substantive reforms will provide an estimate of what Maine's health care expenditures would be if current trends continued without intervention. These projections will break down total expenditures by pay source and possibly by type of service.

- *Impact Analyses*

The actuarial consultants, in conjunction with the TAG, will be responsible for building models that encompass the reform proposals recommended by the Task Force and developing impact analyses of these models. This analysis will encompass the steps described below.

The actuaries will use Task Force provided assumptions regarding the benefit structure, financing mechanisms, and targeted enrollment to model the impact of the proposed reforms. The probable impact of the proposal on employer costs, employee costs and State and federal costs will be developed. The projected impact of the proposal on the market for commercial coverage and on providers will also be considered. Depending on the outcome of these projections, some of the assumptions (for example, benefit structure) may be modified to weigh the trade-offs inherent in different program configurations. Ideally, the projections would be incorporated into an econometric model to allow an assessment of the proposal on Maine's economy, but such an exercise is currently beyond the scope of this project.

The actuaries will be asked to develop a range of estimates, projected out over a reasonable time period. This range will be predicated on a "best" or most favorable estimate, an estimate of the "most likely" outcome and a pessimistic or worst case scenario.

The arrival at a final reform package is expected to be an iterative process. As various options for coordinated strategies are considered by the Task Force, a second round of actuarial analyses may be undertaken that take into account the aggregate and symbiotic effect of the implementation of multiple strategies. These analyses will further inform the decision-making process of the Task Force.

Once the actuarial analyses are complete, the results will be presented to the Task Force for final deliberations. The Task Force will be charged with making final recommendations on the reform design, and a phase-in plan; with developing a preliminary business plan for the recommended reforms inclusive of budget estimates; and identifying revenues sources for the proposed initiative(s).

Reform Option Consensus Building and Decision Making

The Department will be the lead agency in the task of developing consensus among many different government agencies and private stakeholders. This is not a new role for the Department, which is often called upon by the Governor, the Legislature, or others to act in this capacity. As described elsewhere in this application, it was the Department that was responsible for many of the access expansion efforts implemented in the past, including the MaineCare Insurance Demonstration Project, the MaineHealth Program, Cub Care and the Maine SCHIP program. The Department has advocated for and implemented virtually all of the Medicaid expansions available to states and has worked diligently to maintain the integrity of Maine's comprehensive Medicaid program. Most recently, the Department has been the lead State agency responsible for the development and implementation of the Maine Rx Program and Healthy Maine Prescriptions, a low cost prescription program that has received national attention and recognition.

In order to successfully carry out these initiatives, the Department has had to develop, nurture and maintain relationships with all relevant stakeholders. Consumers and providers, in particular, have a voice and are consulted on Department policymaking with regard to the Medicaid Program and other initiatives affecting the delivery of health care services.

As the lead State agency on health care, the Department is often asked by the Governor to represent State government on private sector task forces and advisory groups undertaking initiatives on health. Leaders within the Medicaid program participate in the Maine Health Management Coalition, an effort by Maine's business community to work as a bloc to improve health care outcomes and promote efficiencies in service delivery. Medicaid representatives also participate in the newly established Maine Health Care Performance Council, described below (p. 27).

Under the direction of The Department, the Maine Development Foundation (MDF) will convene and staff the activities of the Task Force relating to the development of reform initiative integration and consensus for a comprehensive reform strategy. MDF frequently serves as convenor of public/private task groups and enterprises. MDF convenes the Maine Economic Growth Council, a permanent, 19 member Council appointed by the Governor, House Speaker and Senate President to establish and maintain a long range economic development plan for the state. MDF has coordinated five Conferences on Small Business on behalf of Governor King. MDF can provide valuable assistance to The Department in the effort to convene stakeholders around a table to discuss the issues germane to this project. The Task Force, under the leadership of the Department, will provide the coordinating function and serve as a decision-making body in reviewing the outcomes of the analyses of the various reform initiatives. The group will review aggregate cost estimates, and discuss the "fit" between the various reform initiatives both in operational terms and in terms of addressing the uninsured population. The group will also consider the timing and phase-in of various initiatives that are judged to serve as steps toward the ultimate goal of universal access.

Because the Task Force will include representatives of key private sector stakeholders, consumer advocacy groups, the legislature, and the broad range of government agencies engaged in managing publicly sponsored health services, it will serve as the locus of negotiation of a consolidated reform proposal that is responsive to the concerns and needs consumers and providers in Maine. This Department-sponsored process will be used to try to develop consensus among the reform proposal sponsors on a consolidation of the reform efforts into a bi-partisan package that meets all or most of the specific reform initiative objectives and is acceptable to their sponsors.

Collaboration and Stakeholder "Buy-in"

Maine already has in place a significant infrastructure to assure that the health reform planning process is inclusive and collaborative. A number of existing organizational structures in Maine will play an important role in developing consensus in the state and will be involved in reform implementation, should the planning process go through.

The Maine Health Access Foundation was created as the result of the sale of Blue Cross and Blue Shield of Maine (a non-profit health insurer) to Anthem Blue Cross and Blue Shield. Foundation's express purpose, as mandated by the legislature, is to use its resources to improve access to quality health care for medically uninsured and underserved residents of Maine. The Access Foundation is governed by an independent Board appointed by the Governor. The fifteen members of the Board include the Commissioner of the Department of Human Services and the Director of Maine's Bureau of Health. The rest of the Board is made up of knowledgeable individuals who have been engaged in health policy in Maine for many years, and who represent a variety of interests and sectors, ranging from persons with disabilities to rural providers, to Maine hospitals.

The Department views the Access Foundation as a key partner in the proposed project. In the first place, the Department will propose to the Access Foundation that it provide some matching dollars for this planning effort. For example, the proposed budget for this plan does not include micro-simulation econometric modeling of the estimated impact of proposed reforms on Maine's economy. Resources from the Access Foundation may serve to purchase expertise for such modeling. Second, the Foundation is a permanent institution in Maine with resources and a mission to expand access. As the reform planning proceeds and funding options are considered, the Access Foundation Board will need to be integrated into the planning for funding options and its resources considered as part of a potential funding stream for expanded access initiatives.

The Maine Health Care Performance Council is charged with developing outcome-based performance measures to monitor change in Maine related to health care access, cost, quality, efficiency, and service capacity. This body, which reports to the Governor and the Legislature, is made up of thirteen employers and consumers. The Council's initial support comes from a planning grant from the Robert Wood Johnson Foundation's State Initiatives Program. The work of the Performance Council will inform the development of reform options undertaken as part of this proposed project. In addition, the Council -- which is scheduled to continue its work for at least six years -- will provide a framework for monitoring and initial assessment of the initiatives undertaken as a result of the proposed planning effort. The Maine Health Care Performance Council is a project of the Maine Development Foundation, which will be serving in the role of convenor of the Task Force.

The Maine Health Management Coalition is a forum that brings together representatives of many of the largest employers in the state. This group has been meeting for a number of years to develop collective strategies for managing health benefits costs and improving quality of care. The Director of the State Employee Health Commission, which manages the State's employee health benefits program, is a member of this group, as is the State Medicaid Program Director. This group has developed sophisticated knowledge of the complexities of health care financing, of the history of cost containment efforts, and of the development of practice standards and measurement tools for monitoring and improving quality. They will serve as an effective point of communication with the large business community in Maine.

Program Monitoring and Report Preparation

The structure of the proposed project is complex and requires cooperation and communication among many parties and adherence to a very tight schedule of data collection, analysis, and decision-making.

The structure of the proposed work effort calls for a number of interim reports that can serve as benchmarks of progress toward the project goals. Reports will be prepared on the results of the household survey, the business survey, the focus groups, and the findings from other states. The timely completion of these interim reports will be used as one important mechanism of self-evaluation and monitoring. In addition, the Task Force is scheduled to be convened four times, over the course of the project, to develop interim decisions and recommendations, based on the analytic information presented to it. The successful convening of this group and the preparation of materials for its review will also serve as markers of project progress toward goals.

The Department expects to bring closure to the planning process with the development of a report to the Secretary of Health and Human Services that synthesizes the results of the analyses and includes the final reform recommendations and preliminary business plans for reform implementation. The TAG will have major drafting responsibilities for the final report. They will work under the instruction of the Principal Investigator in the Department of Human Services, and the drafting of the recommendations section will be based on the findings and determination of the Task Force and the Department. The structure and content of the report will follow the guidelines provided by the Health and Human Services Administration. The report will detail the findings from the various data collection and analysis efforts. It will describe, in detail the proposed reform strategy that results from the planning effort, including definitions of targeted populations, descriptions of proposed health care delivery mechanisms, descriptions of the proposed administrative mechanisms, including marketing and enrollment, specification of the proposed covered benefits, cost-sharing requirements, and proposed funding sources. In addition, the final report will include the findings from the actuarial impact analyses, providing assessments of the likely impact of the reforms on employers, the health insurance market, and providers.

The Department is prepared to share with the Health and Human Services Administration, all interim reports prepared in the course of project activities, as well as data sets generated through survey activities and through the collation of cost and utilization data from secondary data sources.

The Department also hopes that the planning process will culminate in the development of a legislative proposal that the Department can submit to the legislature with a prior commitment of support from the legislative leaders who have been engaged in the planning process.

B. Project Management Plan

	Timetable	Responsible Agency/Person	Anticipated Results	Evaluation/ Measurement
Task 1: Project Management				
a. Organize project team; finalize DHS- Muskie Agmt.	Month 1	DHS/Gessow Muskie /Kilbreth	Project management plan developed	Project management systems in place.
b. Seek IRB approval.	Month 1	Muskie /Kilbreth	IRB approval	IRB approval
c. Finalize composition and roles of Task Force.	Month 1	DHS/Gessow Muskie /Kilbreth	Composition of Task Force finalized	Agenda for Task Force Meeting
d. Convene Task Force.	Month 2	DHS/MDF	Task Force defines goals and roles	Task Force convened
Task 2: Identify Information Needs of Reform Initiatives				
TAG meets with each Reform Initiative to identify data and other information needs/issues.	Month 2-3	Muskie/Nalli and Schneiter	Research questions and data needs identified.	Surveys and other research focused on needs of Reform Initiatives.
Task 3: Collect and Analyze Primary Data				
3.1 Conduct Household Survey				
a. Develop framework for sampling plan and survey questions.	Month 2-3	Muskie/ Kilbreth, Nalli and Schneiter Task Force	Key research/ policy questions identified to inform sampling plan.	Specifications for scope of work
b. Select survey firm.	Month 3	DHS/ Muskie	Survey firm selected	Execute contract with survey firm
c. Conduct Household Survey.	Month 3-6	Subcontractor	Surveys completed	Data file submitted to Muskie School
d. Construct Analytic File, and analyze data.	Month 6 -7	Muskie/Salley	Analytic File prepared for analysis	Analysis completed
e. Prepare Report.	Month 8	Muskie /Ziller, Loux	Results inform the Reform Initiatives	Distribution of Final Report
3.2 Conduct Business Survey				
a. Develop framework for sampling plan and survey questions	Month 2- 3	Muskie/ Nalli, Schneiter Task Force	Key research/ Policy questions identified to inform sampling plan.	Specifications for scope of work
b. Select survey firm.	Month 3	DHS/ Muskie/	Survey firm selected	Execute contract with survey firm
c. Conduct business survey.	Month 3-6	Subcontractor	Surveys completed	Data file
d. Construct analytic file and analyze data.	Month 6	Muskie School/Ziller	Analytic File prepared for analysis	Analysis completed
e. Prepare Report.	Month 8	Muskie School, Ziller, Schneiter	Results inform the Reform Initiatives	Distribution of Final Report
3.3 Conduct Focus Groups				
a. Develop criteria for composition of focus groups.	Month 3	DHS/ Muskie/Kilbreth Task Force	Memebership of focus groups finalized	Plan for focus group recruitment
b. Conduct focus groups.	Month 4-6	Muskie School/Richards	Issues from focus groups identified	Final Report Distributed
Task 4: Analysis of Secondary Data				
4.1 Research from other States				

	Timetable	Responsible Agency/Person	Anticipated Results	Evaluation/ Measurement
a. Summarize findings from other State initiatives.	Month 3-6	Muskie/ Schneiter	Findings inform Reform Initiatives and Task Force	Report on other State initiatives.
4.2 Construct common claims and administrative data set				
a. Identify variables for data set (population groups, geographic units, services, provider classes).	Month 1-3	Muskie/ Nalli, Schneiter, Mcguire Task Force	Variables for Data collection	Common set of variables and definitions
b. Compile data from multiple sources (Medicaid, Medicare, private claims).	Month 3-5	Muskie/ Mcguire,Thayer MHIC	Analytic file prepared for analysis by actuary	Analytic administrative and claims file
c. Construct per capita/per member costs by payor, market segment)	Month 6	Muskie/ Mcguire MHIC	Preliminary data set for actuarial analysis	Data set prepared
Task 5. Evaluate implications of data analysis				
a. Present findings from primary and secondary analysis.	Month 7-8	DHS/Muskie	Options for Reform Initiatives refined	Findings presented
Task 6. Develop preliminary consensus for Consolidated Strategy				
a. Identify preliminary reform strategies.	Month 7-8	DHS/Muskie/ TaskForce/ MDF	Identify common and conflicting goals for each strategy	Preliminary actuarial assumptions
Task 7. Conduct Actuarial Analysis				
a. Develop Invitation to bid/RFP.	Month 4	DHS/Gessow Muskie/Nalli,	Specifications of work developed	Invitation to bid
b. Review and select actuarial firm.	Month 4-5	DHS/Gessow Muskie/Nalli	Actuary selected	Contract signed
c. Clarify Maine specific issues for actuary (employment, economy, market trends).	Month 6-7	DHS/Muskie/ Actuarial consultant	Final assumptions for analysis	Analysis plan completed
d Develop baseline expenditure model by payor/market segment etc.	Month 7-8	Muskie/Actuary	Baseline expenditures by payor	Baseline model agreed upon by all parties
e. Apply expenditure model to access proposals.	Month 8-12	Actuary	Cost impact of proposals developed	Cost impact analysis prepared
f. Present findings to interested groups.	Month 10-12	Muskie/Actuary	Findings presented	Meetings with interested groups
Task 8. Formulate Final State Strategy				
a. Present actuarial results/cost estimates to Task Force.	Month 11	Actuary	Findings inform Task Force deliberations	Consolidated reform package developed
b. Develop aggregate cost analysis for consolidated plan.	Month 11	Muskie School/ Schneiter Actuary	Cost impact of aggregated or phase-in plan developed	Impact Statement developed
c. Recommendations for a consolidated/phase-in of Reform Initiatives developed.	Month 12	DHS/Task Force/MDF	Analysis of fit of various reform strategies	Recommendations/ Plan developed
e. Develop aggregate cost analysis for consolidated plan.	Month 12	Muskie/Kilbreth,Schneiter Actuary	Cost impact of aggregated or phase-in plan developed	Impact Statement developed
Task 9: Final Report	**Month 13**	**DHS/ Muskie**	**Final Report**	**Final Report**

C. Governance

Structure – See Figure 1.

The Maine Department of Human Services will be the lead agency for this project. Eugene Gessow, the Director of the Bureau of Medical Services will serve as the Principal Investigator. He will contribute 10 percent of his time to this project. Mr. Gessow is responsible for the overall management of the Medicaid program including the financial management, quality management, policy development and service planning. Mr. Gessow also directs Maine's Certificate of Need Program and oversees the licensure of medical institutions including acute care facilities and nursing homes. As Director of the Bureau of Medical Services, reporting to the Commissioner of Human Services, he will be in a position to assure collaboration and coordination with all the major stakeholder groups and organizations in the State that are working on improving access to health care coverage in the Maine. Mr. Gessow was formerly Deputy Secretary for Finance in the New Mexico Human Services Department and Budget Director for the Massachusetts Division of Medical Assistance. He has his JD from the University of Denver, his LLM from New York University an MPA from the Kennedy School of Government and a BA in economics from the University of Wisconsin.

Christine Zukas-Lessard, the Deputy Director of the Bureau of Medical Services, will serve as the overall Project Director and is contributing 10 percent to her role on this project. She will be responsible for the project's overall success. She will coordinate all aspects of the project including project management, oversight, preparation of reports and coordination with project subcontractors. Ms. Zukas-Lessard also serves as the Commissioner's designee on the Health Security Board. Ms. Zukas –Lessard, who has been Deputy Director of the Bureau of Medical Services since 1998, and was formerly director of the Division of Medicaid Policy and Programs, has a BS, Health Administration and Planning, from University of New Hampshire.

State oversight of the project budget will be located in the Office of Management and Budget within the Department of Human Services, under the direction of Rudolph Naples, Deputy Commissioner for Finance. The Muskie School will act as the master subcontractor, managing all project activities and grant funds on the State's behalf (see below).

Subcontractors: In this project, The Maine Department of Human Services continues its 25 year history of successful collaboration with the Muskie School of Public Service at the University of Southern Maine. Maine statutes encourage a close working relationship between State executive agencies and the University system through the execution of Cooperative Agreements. Using the existing Cooperative Agreement mechanisms, the Muskie School will act as the master subcontractor for all technical work on this project. As master subcontractor, the Muskie School will provide research and analytic support to the Maine Department of Human Services and will manage other subcontractors on the State's behalf, ensuring maximum efficiency and coordination of the project's activities. The State's very restrictive policies regarding the creation of new State agency positions has made the relationship with the Muskie School critical to proper staffing of grant projects such as this one. Working very closely with the State, the Muskie School will use existing staff and create new positions as needed to adequately support grant activities.

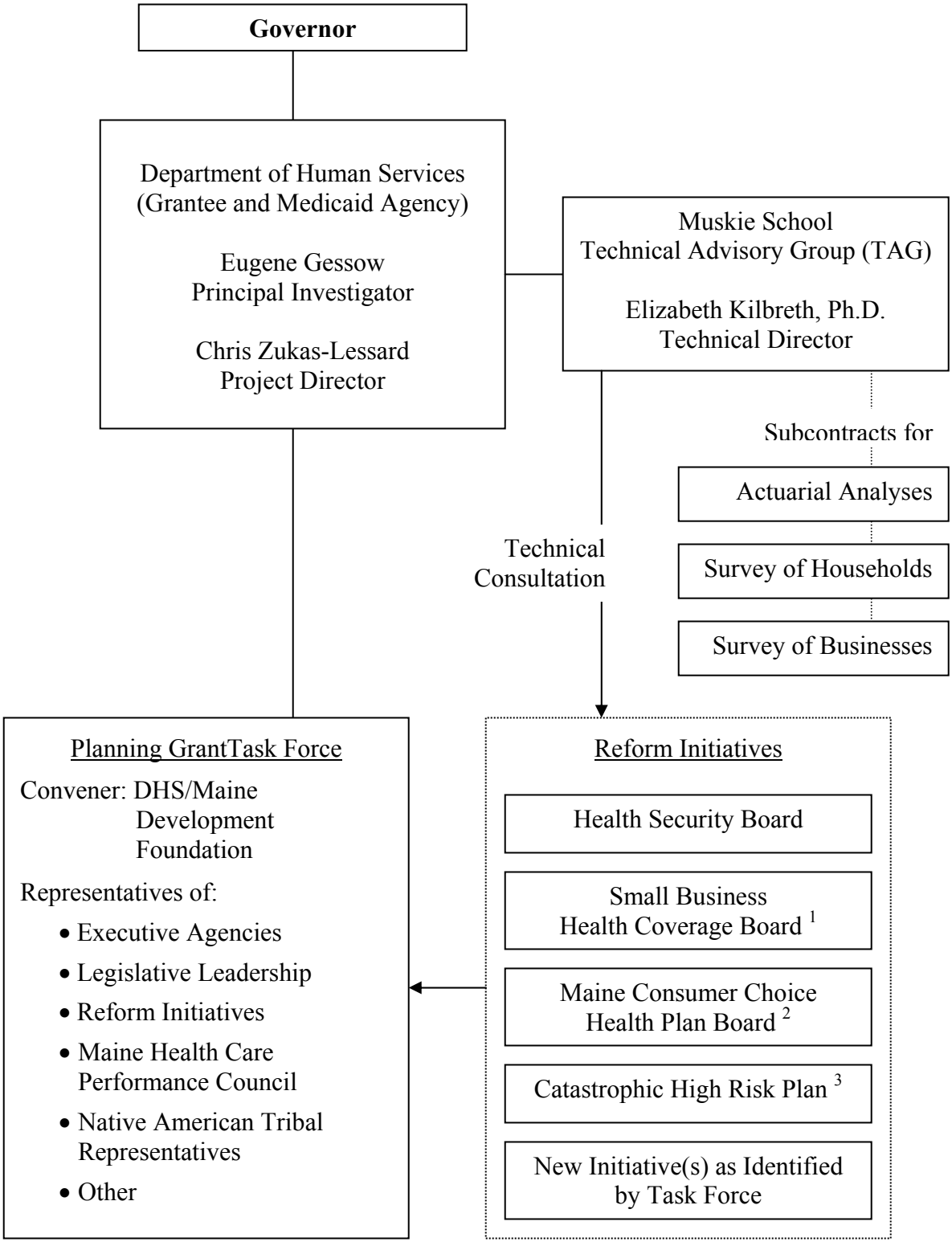
The Institute for Health Policy at the Muskie School conducts nationally recognized research and policy analysis to identify and promote innovative solutions to complex health care issues. Through its research and public service activities, the Institute seeks to increase access to health care, improve the quality of care and eliminate disparities in the availability and delivery of services. Health Care Access and Finance is a particular area of focus within the Institute. Within this area, the Institute contributes to sound policy formulation and business strategies by providing unbiased and objective information to policymakers, businesses, providers and the general public. Work in this area has included surveys and studies of the uninsured in Maine, studies of health insurance coverage in urban and rural areas, and development of collaborative models for pubic and private sector solutions to finance and health access issues. The Muskie School also has a strong data analysis capacity and has extensive experience using and conducting analysis of Medicaid claims data, Medicare claims data and linked Medicare and Medicaid data.

In support of this project, the Institute for Health Policy will form a Technical Advisory Group, (TAG) comprised of four senior researchers within or contractually linked to the Institute. The TAG will take overall responsibility for the sub-contracted data collection and analysis tasks, and will be supported in their efforts by research and data analysts within the Health Policy Institute. The TAG will work closely with the Department Project Leadership to assure that analytic tasks and the reports of findings are targeted to the specific needs of the State Planning Project. Elizabeth Kilbreth, Ph.D., who will serve as Technical Director for the project, will meet regularly with the project Principal Investigator and Director, to monitor overall progress and plan the activities for the next steps of the overall planning process.

Elizabeth Kilbreth, Ph.D., will serve as the project director for the work conducted by the Muskie School and will devote 50% of her time to the project. She will maintain responsibility for oversight of the TAG activities and products and will contribute to the design and analysis of the household survey and consumer focus groups. Ms. Kilbreth directs research within the Muskie School's Institute for Health Policy related to health care access and children's health issues. Her particular area of research interest is comparative state analysis with a focus on issues related to health care access and financing. She teaches graduate level courses on managed care and health politics within the Muskie School. She is currently a member of Maine's Health Security Board and previously directed the MaineCare Demonstration Project, an initiative to expand health insurance among small businesses in Maine. She has her Ph.D. in Health Policy from the Heller School at Brandeis University. Ms. Kilbreth will be responsible for managing the tasks conducted by the Muskie School, will oversee the subcontracts for the project and will coordinate the activities of the Muskie School with the project director at the Department of Human Services.

Gino Nalli, MPH, will direct Task 7 – the development of actuarial analysis and business plans, provide technical assistance to the research initiative boards, and participate in designing the business survey. Mr. Nalli directs the Access and Finance Program Area within the Institute for Health Policy. His area of interest and expertise are the interface between public and private financing and insurance arrangements and monitoring changes in health care costs. He developed

Figure 1. Maine State Planning Grant



[1] Proposed in L.D. 1784, An Act to Address the Health Coverage Crisis for Maine's Small Business and Self-Employed Persons

[2] Proposed in L.D. 2146, An Act to Establish The Maine Consumer Choice Health Plan

[3] A proposal to develop Universal Catastrophic Health Coverage

the cost profile that was incorporated into Governor King's Year 2000 Blue Ribbon Commission on Health Care and has been actively working with the Portland Chamber of Commerce in the development of an innovative Health Care Purchasing Alliance. He will be responsible for identifying the criteria for actuarial analysis and managing the subcontract with an actuarial firm. Mr. Nalli also provides staff support (and provides supervision to Muskie School graduate students who are also staffing the Council) to the Maine Health Performance Council.

Ellen Schneiter will work in a consultant capacity as one of the principal members of the TAG. She will take primary responsibility for research of other state reform initiatives and for collation of secondary data sources necessary for the cost and actuarial analyses. She will also work with the actuarial consultant in the development of assumptions for modeling reform initiatives, and provide technical support to both the reform initiative Boards and to the Project Task Force. Ms. Schneiter is the Associate Director of the Maine Medical Assessment Foundation, a private, non-profit health services research and quality improvement organization in Manchester, Maine. As Associate Director, she is responsible for oversight of all programmatic, fiscal and administrative matters. She manages the Foundation's research activities, which are supported by a mix of federal, state and private funders. Prior to joining the Foundation, Ms. Schneiter served as Executive Director of the Maine Health Care Reform Commission, statutorily charged with the development of alternative models of health system reform in Maine. This work involved the formulation of policy options for consideration by Commissioners, the Governor and the State Legislature. Ms. Schneiter has considerable experience in the area of State health policy, having served as the Director of Policy for the State's hospital rate setting commission and as member of the policy staff for Maine's Medicaid program. From 1992-1994, she was a Research Associate at the Muskie Institute, University of Southern Maine, where she worked on a range of projects focusing on access to and financing of public health care programs. Ms. Schneiter is currently the President of Maine's Consumers for Affordable Health Care Foundation and a member of the Maine Public Health Association Executive Committee. She has a Masters in Health Services Administration from the University of Michigan School of Public Health.

Catherine McGuire will maintain quality control of the analytic file construction activities, both for survey data and the administrative and claims data sets. Ms. McGuire has worked for over 17 years in the design, development and analysis of health policy options with a particular emphasis on issues related long term care. She has extensive experience in the synthesis, design and analysis of the administrative data including Medicare and Medicaid claims and enrollment information for policy and financing issues associated with the Medicaid and Medicare programs. Ms. McGuire has been the Director of Computer and Data Systems for the Muskie School for over ten years.

The four senior researchers on this project will be supported by a team of research and data analysts within the Institute for Health Policy at the Muskie School.

The Muskie School project staff will contract with and oversee the work of subcontractors. Contractors to conduct survey work and actuarial analyses will be identified after the award of the project. The Maine Development Foundation is already identified as a subcontractor to

convene and staff the activities of the Task Force relating to the development of reform initiative integration and consensus for a comprehensive reform strategy (see discussion, page 26).
MDF was created by the Maine Legislature over twenty years ago as a private, non-profit corporation with a mandate to promote Maine's economy. It operates with an elected Board of Directors representing business, educators, government officials, and community leaders. MDF currently has, as one of its projects, the Maine Health Care Performance Council whose purpose is to prepare and maintain a long-range vision, goals, objectives, and performance measures for the health care delivery system in Maine (see discussion, page 27).

End Notes

[1] Census Bureau Current Population Survey data, 2000.

[2] Kilbreth, E. and Agger, M. *Health Insurance Coverage Among Maine's Children: The Results of a Household Survey 1997.* Edmund S. Muskie School of Public Service, University of Southern Maine: Portland (1998).

[3] Ormond, C., Salley, S. and Kilbreth, E. *Health Insurance Coverage Among Maine's Children: The Results of Two Surveys 2000.* Edmund S. Muskie School of Public Service, University of Southern Maine: Portland (2000).

[4] Kaiser Family Foundation, *State Health Facts Online,* "Health Coverage and Uninsured: Private Sector Coverage, 1990." http://www.statehealthfacts.kff.org.

[5] Census Bureau, "Health Insurance Coverage Status and Type of Coverage by State -- People Under 65: 1987-1999. http://www.census.gov. (As reported in *A Primer on Health Care Coverage in Maine,* Maine Health Access Foundation, Inc., Portland Me, 2002.)

[6] This demonstration project *Community Partners,* is sponsored and administered by MaineHealth and is funded through the Robert Wood Johnson Foundation Communities in Charge Initiative.

[7] Ormond, C., Salley, S. and Kilbreth, E. *MaineHealth Access Project: Profiling Uninsured Persons in Three Maine Counties.* Edmund Muskie School of Public Service, University of Southern Maine: Portland (2000).

[8] Year 2000 Blue Ribbon Commission On Health Care. *The Cost of Health Care in Maine: An Analysis of Health Care Costs, Factors that Contribute to Rising Costs, and Some Potential Approaches to Stabilize Costs.* Augusta, ME: Maine Development Foundation, 2000.

[9] Information on non-group enrollment provided by Anthem Blue Cross and Blue Shield of Maine, 2001.

[10] Information from Maine's Bureau of Insurance.

[11] National Association of Community Health Centers, Inc. 1999. http://www.nachc.com.

[12] Kilbreth and Agger: 12-15.

[13] Ormond, Salley and Kilbreth. *MaineHealth Access Project:* 29-32.

[14] Edmunds, M., Teitelbaum, M., and Gleason, C., *All Over the Map: A Progress Report on the State Chilren's Health Insurance Program.* Children's Defense Fund: Washington, D.C. 2000: 4.

[15] Ormond, Salley and Kilbreth. *Health Insurance Coverage Among Maine's Children:12.*

[16] Maine Health Reform Commission. *Recommendations for Health System Reform: Final Report*. Augusta ME, 1995.

[17] Year 2000 Blue Ribbon Commission on Health Care. *The Cost of Health Care in Maine.* Maine Development Foundation, Augusta ME, 2000.