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LEADING THE WAY?
MAINE'S INITIAL EXPERIENCE IN EXPANDING COVERAGE THROUGH DIRIGO HEALTH REFORMS

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December 2007

ABSTRACT: Since enacting comprehensive health care reform in 2003, Maine's Dirigo Health program has helped expand coverage for low- and moderate-income individuals. By September 2006, about 16,100 individuals were enrolled in two coverage initiatives: DirigoChoice, a subsidized insurance product, and a Medicaid eligibility expansion for low-income parents of dependent children. While these programs are making health coverage more affordable to low-income individuals, small firms, and sole proprietors, with subsidies targeting those most in need, by late 2006, the initiatives had enrolled less than 10 percent of previously uninsured residents. To pay for this expanded coverage, Maine has utilized savings in the overall health care system due to lower uncompensated care and cost controls. However, the funds raised thus far are insufficient to pay for greater subsidized enrollment in Dirigo programs, leading to a search for other financing sources to sustain the program.

Support for this research was provided by The Commonwealth Fund and the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund, the Robert Wood Johnson Foundation, or their directors, officers, or staff. This report and other Fund publications are available online at www.commonwealthfund.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts. Commonwealth Fund pub. no. 1079. For more information on the Robert Wood Johnson Foundation's HCFO Initiative, visit its Web site at www.hcfo.net.

D. J. Lipson, J. Verdier, L. Quincy et al., *Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms* (Washington, D.C.: Mathematica Policy Research, Inc., Dec. 2007).

The complete report, including information about the study methods, can be found on Mathematica's Web site at http://www.mathematica-mpr.com/health/dirigochoice.asp.

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ACKNOWLEDGMENTS

The authors are grateful to many individuals who made this report possible. The full report (available at http://www.mathematica-mpr.com/health/dirigochoice.asp), which formed the basis for this overview, was coauthored by MPR staff Elizabeth Seif, research assistant; Shanna Shulman, Ph.D. researcher; and Matt Sloan, survey researcher; and by project consultant Robert E. Hurley, Ph.D., professor in the Department of Health Administration, Virginia Commonwealth University. They made invaluable contributions to the study approach, survey design and implementation, data analysis, and interpretation of results.

For their financial support of the project, we thank The Commonwealth Fund and The Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative. We especially appreciate the guidance and encouragement we received throughout the project from Commonwealth Fund staff Anne Gauthier, Rachel Nuzum, and former staff member Karen Adams, and HCFO staff Sharon Arnold and Bonnie Austin. We also acknowledge and thank Chris Hollander and Deborah Lorber at The Commonwealth Fund for their help in producing this report.

Several individuals in Maine deserve special thanks for sharing data, information, and views: Trish Riley, director of the Governor's Office of Health Policy and Finance, and Dirigo Health Agency staff Karynlee Harrington, Will Kilbreth, and Gloria Tomsa. We also wish to thank the dozens of stakeholders in Maine who generously shared their time and perspectives during interviews in late 2006 and early 2007, as well as nearly 800 small business owners or their staff who completed the small firm survey.

At Mathematica, many individuals provided indispensable staffing and support to the project. We thank John Hall and his team of statisticians and programmers who ensured the scientific integrity of survey sampling techniques; Margie Rosa, who managed the survey staff at MPR's Survey Operations Center; and Melissa Cidade, formerly of MPR, who helped design the survey and code results. We also appreciate the comments of Margo Rosenbach, Julie Ingels, Erin Taylor, and Peter Cunningham, who reviewed early drafts.

Editorial support was provided by Deborah Lorber.

LEADING THE WAY?
MAINE'S INITIAL EXPERIENCE IN EXPANDING COVERAGE THROUGH DIRIGO HEALTH REFORMS

OVERVIEW

In 2003, Maine adopted the Dirigo Health Reform Act, which aimed to make affordable health care coverage available to every Maine citizen by 2009, slow the growth of health care costs, and improve the quality of care. "Dirigo," the state's motto, meaning "I lead" in Latin, is a fitting name for the program. At the time the legislation passed, Maine was the first state since the early 1990s to enact comprehensive health care reform legislation and to set a goal of providing affordable health insurance coverage to everyone in the state.

Since then, several other states, notably Massachusetts and Vermont, enacted ambitious health reform and universal health coverage legislation, and Illinois adopted legislation to cover all children. In 2007, more than a dozen states considered proposals that strive for universal health coverage. Lessons from Maine's experience implementing the Dirigo Health program could be useful to these and other states in their efforts to expand insurance coverage.

Is Maine leading the way toward universal coverage? This study examined interim indicators of Maine's progress in providing affordable health insurance coverage after two years of program implementation, midway between the legislation's adoption and its 2009 goal. (The study's research methods and data sources are described at the end of this report.)

The evaluation focused on the state's progress in implementing Dirigo Health's two major coverage initiatives: 1) DirigoChoice, a subsidized health insurance program, initiated in January 2005, for eligible small businesses, self-employed workers, and individuals; and 2) an increase in the annual income eligibility level (from 150% to 200% of the federal poverty level, or FPL) in the state's Medicaid program (called MaineCare) for parents of dependent children under age 19.

These two initiatives built on a series of previous Medicaid eligibility expansions, including a program started in 2002 to cover childless adults earning up to 100 percent FPL. The Dirigo Health Reform Act authorized expanded eligibility for this group to 125 percent FPL, but it was not implemented due to budget constraints related to the terms of a federal Medicaid waiver. However, this study examined enrollment trends

among childless adults since that program operated concurrently with Dirigo expansions and offered another avenue for coverage gains among low-income individuals.

Key Findings

- **Enrollment in Dirigo Coverage Programs.** In September 2006, after 20 months of operation, almost 11,100 individuals were enrolled in DirigoChoice, about one-third of whom did not have coverage before enrolling. Another 5,000 parents with income between 150 percent and 200 percent FPL had enrolled in the Medicaid parent expansion. The number of previously uninsured individuals enrolled in the two Dirigo programs—an estimated 9,000 to 11,000—is modest relative to the estimated 136,000 residents uninsured in 2002.

- **Small Firm Response to DirigoChoice.** As of September 2006, about 700 small firms had enrolled in DirigoChoice. The average firm size is seven employees. Half of the firms had not previously offered health benefits to employees. Despite this progress, enrolled firms compose about 2.5 percent of all businesses in the state eligible to enroll. Survey results indicate that very small firms, those with two or three employees, find the product unaffordable.

- **Subsidies Targeted to the Working Poor.** Nearly 80 percent of DirigoChoice members have family income below 300 percent FPL, qualifying them for premium and deductible subsidies. Almost half (46%) of all DirigoChoice members earn less than 150 percent FPL and therefore qualify for the greatest discounts. In September 2006, twice as many individuals were covered by the two Medicaid eligibility expansions for parents and childless adults (about 23,100) than were enrolled in DirigoChoice (11,100), suggesting that low-income individuals found a fully subsidized public plan preferable to a partially subsidized private plan.

- **Financing Source for Coverage Expansion is Difficult to Sustain.** Maine planned to finance most of the cost of DirigoChoice subsidies through an innovative approach, called the "savings offset payment" (SOP). It sought to capture savings to health care providers from lower uncompensated care costs and other cost-saving initiatives through assessments on health insurance claims. However, the aggregate measurable cost savings attributable to Dirigo initiatives has produced lower revenues for subsidies than needed to finance much greater program enrollment. In addition, the process of measuring Dirigo's impact on costs has become so adversarial that nearly all stakeholders regard finding alternative funding sources for DirigoChoice subsidies necessary for sustaining the program.

MAINE'S HEALTH SYSTEM PRIOR TO DIRIGO HEALTH

When the Dirigo Health reform legislation was enacted in 2003, 13 percent of Maine's population under age 65 was uninsured (about 136,000 residents), compared with the national average of 17 percent.[1]

State policymakers focused their coverage expansion efforts on uninsured, low-income working families. A 2002 household survey showed that workers and families affiliated with small businesses or those that were self-employed made up more than half of the state's uninsured residents.[2] Since eligibility for the state Medicaid program had already been expanded, Maine tried to boost its relatively low rate of employer-sponsored coverage—50 percent of Maine's private employers offered health benefits to workers in 2004, compared with the U.S. average of 56 percent. This is attributable partly to the prevalence of small firms (i.e., 50 or fewer workers), which are less likely to offer health benefits than larger firms due to higher health insurance premium costs.

Indeed, in 2002, Maine had the second highest employer premium costs in the country, adjusted for the quality of benefits.[3] In 2004, Maine also had the second-highest personal health care spending per capita in the country, behind Massachusetts and tied with New York.[4] Before the adoption of Dirigo Health, employers were acutely concerned about premium growth. Average per member per year small group premiums increased 33 percent in 2001 and 29 percent in 2002.[5] While average rate increases have moderated since then, they have remained well above the rate of general inflation, even as the benefits covered by small group plans have declined.

The state's high cost of health care and health insurance premiums shaped the focus and design of the Dirigo Health coverage expansion initiatives. Reforms enacted by the state in the 1990s ensured that small groups and individuals seeking insurance could not be refused coverage, but many could not afford it. Thus, Dirigo Health reform was designed to link coverage expansion with cost containment efforts to make affordable products available to small businesses and to individuals. While this is a challenging goal anywhere in the country, the state's high premium costs from the outset made reaching it much more difficult.

ELIGIBILITY FOR DIRIGOCHOICE SUBSIDIES AND MEDICAID EXPANSION GROUPS

Dirigo Health's two major coverage expansion strategies, which both target low- and moderate-income people, were designed to work in tandem (Figure 1). DirigoChoice was created to make a small group and individual insurance product more affordable by partially subsidizing premiums and deductibles of eligible enrollees. At the same time,

eligibility for MaineCare was expanded to make fully subsidized health coverage available to the poorest residents: childless adults earning less than the poverty level and low-income parents of children under age 19 with family income of up to 200 percent FPL (increased from the previous limit of 150% FPL). Eligibility for both MaineCare programs is subject to a $2,000 asset limit.

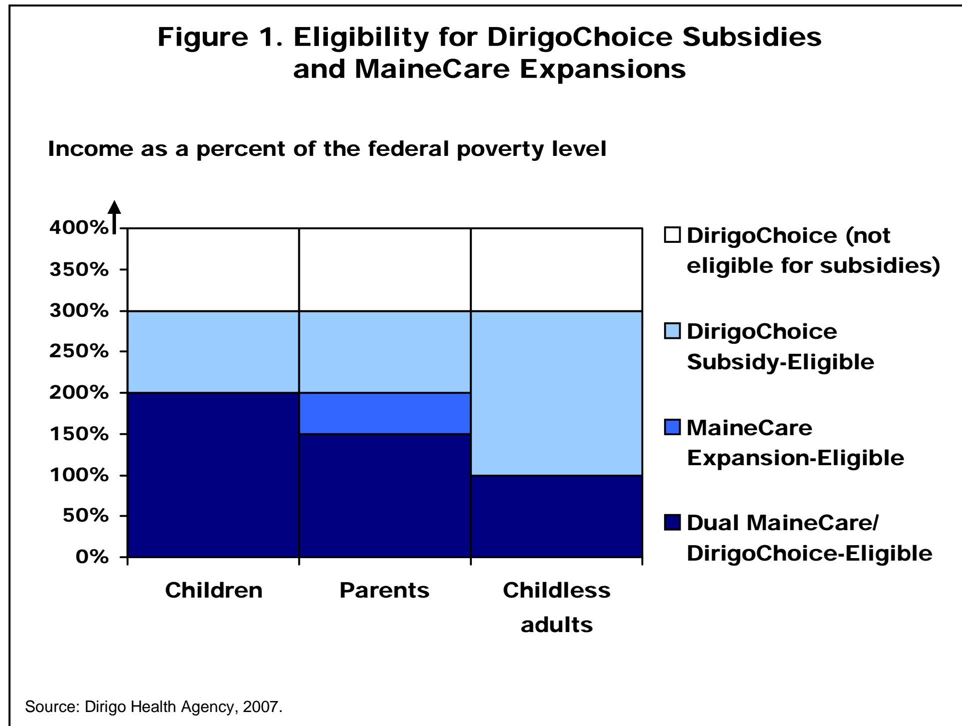


Figure 1. Eligibility for DirigoChoice Subsidies and MaineCare Expansions

Source: Dirigo Health Agency, 2007.

DirigoChoice members enrolled through an employer can be simultaneously enrolled in MaineCare if they qualify.[6] In such cases, MaineCare would cover the enrollee's DirigoChoice payments, including deductibles and other cost-sharing, and pay for any MaineCare benefits not covered by DirigoChoice. This arrangement also allows those enrolled in both programs to maintain their health coverage, if a wage increase makes them ineligible for Medicaid. In that case, they can switch to DirigoChoice coverage only, but still qualify for premium and other cost-sharing subsidies.

DIRIGOCHOICE SUBSIDY STRUCTURE

Maine residents at any income level may enroll in DirigoChoice, but only those with family income below 300 percent FPL qualify for discounted premiums and deductibles, and out-of-pocket maximums.[7] The discounts and out-of-pocket limits are based on a sliding scale relative to income (see Table 1). For workers and dependents enrolled

through a small employer, the discount on the monthly premium is applied only to the employee share of the premium. Enrollees with family income at or above 300 percent FPL must pay the entire monthly premium (or employee share if group-enrolled) and the entire deductible.

Table 1. Enrollee Share of DirigoChoice Premiums and Deductibles Covered by Subsidy for Each Discount Group

	Discount Group—Income Levels by Federal Poverty Level (FPL)*					
Member Type	A MaineCare Eligible**	B 100%–149% FPL**	C 150%–199% FPL**	D 200%–249% FPL	E 250%–299% FPL	F (no subsidy) ≥300% FPL
Individual	100%	80%	60%	40%	20%	0%
Small firm worker***	100	80	60	40	20	0
Sole proprietor	40	32	24	16	8	0

* The program uses FPL guidelines for the previous year. For example, 2005 federal guidelines apply to the program for those enrolling during 2006.

** Some people with incomes below 100% FPL may fall into Group B if their assets are above the state's Medicaid limits of $2,000 for individuals and $3,000 for couples (excluding one car and a house). Conversely, some parents with incomes between 100% and 199% FPL may fall into Group A because they are MaineCare eligible.

*** The subsidy percentage is the discount on the employee's share of coverage costs, not the full amount. When the employer pays the minimum 60% premium, the effective subsidy against the full premium (both employer and employee shares) would be 40% for Group A and 8% for Group E. The same applies to sole proprietors.

For example, a parent with one or more children whose annual earnings total $15,000 would qualify for the 80 percent discount (Group B); if the adult's employer did not offer coverage, he or she could enroll in DirigoChoice as an individual. The plan normally has a $3,500 annual deductible, but the Group B subsidy would reduce the member share to $700. Similarly, the monthly premium—about $600 for one adult and any number of children in late 2006—would be $120 per month after the subsidy.

DIRIGOCHOICE BENEFITS AND ADMINISTRATION

As in other states, DirigoChoice has struggled with trade-offs between coverage and cost in the design of its benefit package. The Dirigo Health Reform Act required the program to develop a comprehensive benefit package, but higher deductibles than initially desired were required to keep premiums competitive with other products on the market.[8] In addition, the program initially planned to require employers to contribute at least 60 percent of the premium for both single and dependent coverage. Small firm opposition forced the program to make it optional for employers to contribute to the cost of dependent coverage.

During 2005–06, the DirigoChoice program had two plan options, which differed by deductible level. Plan 1, available only to small groups, had an annual deductible of $1,250 for singles and $2,500 for families. Plan 2, the only option for individual enrollees, but also available to small groups, had an annual deductible of $1,750 for singles and $3,500 for families. By comparison, in 2006, nearly three-quarters of individual policies in Maine had deductibles of $5,000 or more.[9] Recent concern about employer premium costs led to the addition of a new option for small groups in 2007 that has a $2,500 deductible for singles. After the deductible has been met, most services require coinsurance payments of 20 percent for care provided by network providers and 50 percent from non-network providers.

Preventive benefits such as annual physicals, immunizations, and screening exams are covered in full, with no deductible, coinsurance, or copayment. The program promotes affiliation with a primary care physician by paying new DirigoChoice enrollees $25 when they select a primary care physician and $75 per family upon completion of a health risk assessment. Mental health services are covered to the same extent as physical health benefits, similar to plans offered by large employers in Maine but unlike typical plans of very small firms (10 or fewer employees) and individual policies, according to key informants. Copays for prescription drugs vary, depending on whether the drug is generic ($10), preferred brand name ($20), or non-preferred brand name ($40).

Unlike other individual insurance products in Maine, DirigoChoice does not impose preexisting condition exclusions. According to some key informants, this provision made the program a magnet for individuals with health conditions that made it hard for them to afford coverage outside of DirigoChoice. A few thousand people covered by Anthem Blue Cross Blue Shield's (Anthem) individual policy reportedly switched to DirigoChoice. However, initial claims experience for individuals in DirigoChoice does not indicate excessive adverse selection, as discussed below.

DirigoChoice was designed to be jointly operated by the public and private sectors. A publicly administered, privately insured plan would make the program more like other employer products, rather than a program run solely by a government agency. A privately insured plan was also favored by providers, who regarded further expansion of MaineCare as undesirable because of its low payment rates relative to private insurance rates.

The Dirigo Health Agency (DHA), an independent executive agency governed by a publicly appointed board of directors, manages the program. DHA has the authority to assess the SOP and administer subsidies to qualified enrollees. DHA issues DirigoChoice

contracts with employers on behalf of member employees and dependents, and with individual members.

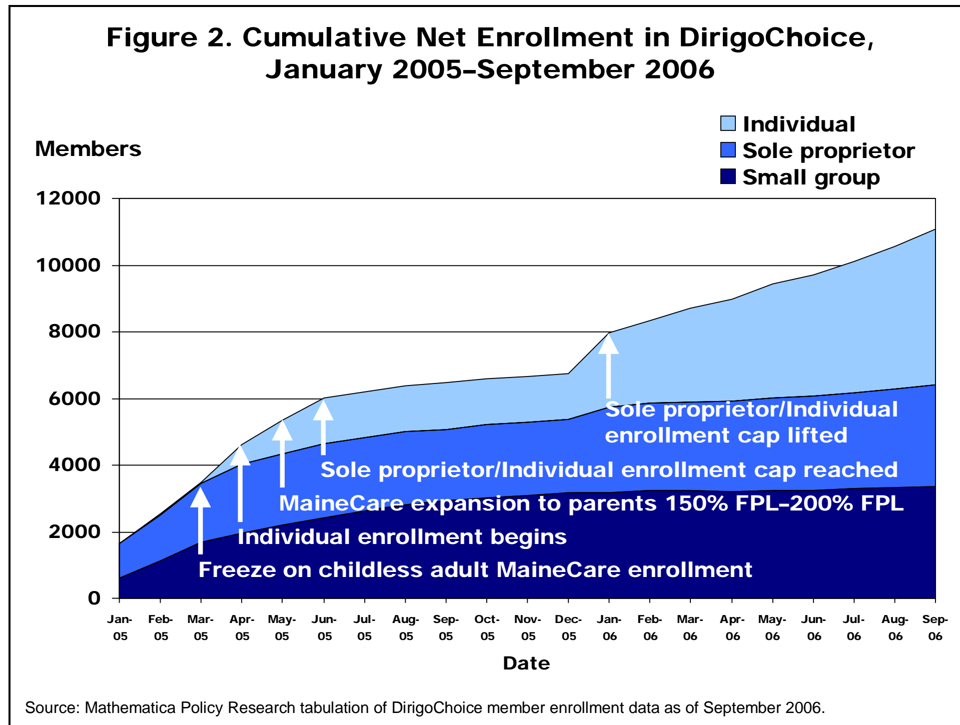
DHA and the Department of Health and Human Services, which administers the MaineCare program, contracted with a private plan to insure the product and administer claims. While the state sought bids from several carriers, only Anthem submitted one for the initial contract period. Thus, during the first three years, Anthem has been the insurer for DirigoChoice members. Since Maine law permits only state-licensed insurers and agents to sell insurance, small groups and individuals who purchase DirigoChoice must do so through Anthem's direct sales force and its agents, or via independent brokers. Applicants for DirigoChoice subsidies must submit a separate application to DHA.

Anthem's contract with DHA contained risk-sharing provisions to indemnify the company against the unknown risks associated with a group with medical expenses that could not be easily predicted. Called the "experience modification program" (EMP), the state agreed to pay $8 million in the first year if the medical loss ratio exceeded 80 percent.

ENROLLMENT IN DIRIGOCHOICE

As of September 2006, DirigoChoice had about 11,100 enrollees; enrollment was especially strong among individual enrollees and sole proprietors.

By September 2006, 20 months after the program began, the DirigoChoice program had about 11,086 current members, and 14,715 ever-enrolled members (i.e., including those who disenrolled).[10] About 42 percent were enrolled as individuals, 30 percent as small group members, and 28 percent as sole proprietors (Figure 2).



Anticipating that interest in the product would be high among sole proprietors and individuals, but concerned they might be a higher risk group, DHA set a limit of 4,400 enrollees from these groups for the first year. This also served to limit the cost of subsidies, which the state funded from general revenue during the first year. When enrollment exceeded this level after just three months, the program froze new enrollment to individuals and sole proprietors. In January 2006, the program lifted the freeze and by September 2006, individuals and sole proprietors represented double the maximum allowed in the first year.

Within Maine, much has been made of the fact that total DirigoChoice enrollment was less than the initial projection of 41,000 during the first year, 31,000 of whom were expected to qualify for subsidies. Enrollment by small groups in particular was well below initial projections. However, the enrollment estimates served as an upper limit on the state's potential financial obligation during the first year when subsidies would be funded by state general revenues. Therefore, comparing projected to actual enrollment is not a useful yardstick for measuring progress. Maine's experience, however, provides a sobering lesson to other states in setting public expectations regarding early enrollment.

Enrollment in MaineCare expansion groups exceeded DirigoChoice enrollment. In September 2006, just over 5,000 parents were enrolled in the Dirigo-authorized Medicaid expansion parent group. Another 18,100 individuals were covered through the

Medicaid eligibility expansion for childless adults with family income below 100 percent FPL, which was open to enrollment periodically during the same time that the Dirigo-authorized coverage expansions went into effect. Hence, in September 2006, of the 34,200 individuals covered under MaineCare eligibility expansion or through DirigoChoice, MaineCare covered two-thirds (23,100). This suggests that low-income individuals found a fully subsidized public plan preferable to a partially subsidized private plan, and that a large number of low-income uninsured people do not have access to DirigoChoice through their employers. Despite the popularity of Medicaid, further expansion of coverage via Medicaid remains politically difficult in Maine, as program expenses consume almost one of every four dollars of the state general fund.

About one-third of DirigoChoice enrollees were previously uninsured. Between 31 percent and 36 percent of DirigoChoice enrollees did not have health coverage prior to enrollment.[11] Thus, in September 2006, midway between the program's adoption and its 2009 goals, DirigoChoice covered an estimated 4,400 to 6,000 previously uninsured residents. Data about previous insurance status of parents and childless adults covered through Medicaid eligibility expansions are not available, but it is generally assumed that most did not have insurance at the time they enrolled.

Individual members composed the majority of 2006 DirigoChoice enrollees who were previously uninsured for the entire 12 months prior to enrollment. However, within DirigoChoice member categories, small group members were most likely to have been uninsured for the entire 12 months before enrollment (37% of such members), compared with 30 percent of sole proprietors and 28 percent of individuals (Table 2).

Table 2. Previous Health Coverage Among DirigoChoice Members Who Enrolled in 2006

	Had any coverage in past 12 months	No coverage for all 12 months	No usable response
Small group	54%	37%	9%
Sole proprietor	67	30	3
Individual	68	28	4
All members	65	31	4

Source: MPR tabulation of DirigoChoice member enrollment as of September 2006.

The Dirigo Health Reform Act aimed to make coverage more affordable, not simply increase coverage rates. This explains why so many DirigoChoice members had insurance before enrolling. DHA reported 29 percent of previously insured members were

underinsured, which they defined as those with annual income less than twice the FPL and deductibles greater than 5 percent of income. It also explains why the state does not require individuals to go without coverage for a minimum period of time before joining, and allows small firms that previously offered coverage to enroll. The program does try to dissuade employers from dropping worker health benefits by requiring individuals whose employer discontinued a previous offer of coverage to wait 12 months before becoming eligible.

DirigoChoice subsidies have helped make health insurance more affordable to low-income individuals and families.

Overall, nearly 80 percent of DirigoChoice members receive premium and deductible subsidies. Almost half (46%) of all members, and two-thirds (66%) of individual members, receive the greatest subsidies (Group B) because their family income is below 150 percent FPL (Table 3).

Table 3. Enrollment in DirigoChoice, Projected Year 1 (2005) vs. Actual as of September 2006

Member Distribution	**Projected Year 1 Enrollment (2005)*** Percent (number)	**Current Enrollment (as of 9/06)**** Percent (number)	**Number Ever Enrolled (as of 9/06)**** Percent (number)
Small group	90% (37,000)	30% (3,350)	35% (5,162)
Sole proprietor	10% (4,000)***	28% (3,051)	26% (3,896)
Individual		42% (4,685)	38% (5,657)
Total	100% (41,000 members)	100% (11,086 members)	100% (14,715 members)
Subsidy Discount Level	Percent of members	Percent of members	Percent of members
A (MaineCare Eligible)****	11%	1%	1%
B (below 150% FPL)	3	49	46
C (150%–199% FPL)	6	16	16
D (200%–249% FPL)	29	10	11
E (250%–299% FPL)	26	4	5
F (no subsidy, ≥300% FPL)	24	20	22
Total	100 (41,000 members)	100% (11,086 members)	100% (14,715 members)

* Source: Maine Dirigo Health Agency, Request for Proposal, May 8, 2004.

** Source: MPR tabulation of Maine Dirigo Health Agency administrative data as of Sept. 2006.

*** In Year 1, the program set an enrollment cap of 4,000 self-employed and individuals, all expected to be subsidized, but this was later raised to 4,400.

**** DirigoChoice rules specify that individual applicants (i.e., not small firm employees) who are MaineCare eligible cannot be dually enrolled in both programs, but administrative data shows some individuals as dual enrollees. This could be due to data inaccuracies or special circumstances (e.g., a parent is an individual in DirigoChoice and child is in MaineCare).

The study's survey of small businesses in the state indicates that among firms enrolled in DirigoChoice that previously offered health coverage, most reported they are covering about the same (69%) or more (20%) employees than under their prior plan.[12] The most common reason given for an increase in employee take-up of health benefits was the affordability of DirigoChoice to workers; in these cases, subsidies made employee premium contributions to DirigoChoice more affordable.

MEMBER MIX AFFECTS COST AND FINANCING

Differences between projected and actual enrollment in DirigoChoice—in terms of member type and income level—have increased state program costs for low-income enrollee subsidies beyond original estimates.
While lower-than-expected enrollment in DirigoChoice is not a problem per se, less-than-expected enrollment among certain segments of the eligible population has had negative repercussions.

For example, in September 2006, small group-enrolled workers represented approximately 30 percent of total DirigoChoice enrollment, compared with initial projections that such members would compose a majority of total enrollment (Table 3). The low proportion of small group members in DirigoChoice relative to total enrollment increased the state's financial burden for subsidizing individuals' premiums and deductibles, because the state pays the entire cost rather than just the employee share.

In addition, lower-than-anticipated enrollment in DirigoChoice among the previously uninsured has meant less reduction in providers' bad debt and charity care than was expected, which limits the revenues that can be raised from the SOP. These funding constraints have forced the state to institute recurring freezes on enrollment, which has resulted in periodic waiting lists.

DIRIGO'S IMPACT ON MAINE'S UNINSURED

The total number of previously uninsured individuals covered by Dirigo Health programs—DirigoChoice and the Medicaid eligibility expansion for parents—is modest relative to the estimated 136,000 uninsured individuals in the state in 2002.
The number of previously uninsured people who gained coverage under Dirigo's initiatives (DirigoChoice and the parent expansion group) to date is less than 10 percent of those lacking insurance before the start of the programs. While this is a good start, Dirigo Health coverage expansion initiatives have not yet made a large dent in the state's uninsured rate.

When the number of people covered through the Medicaid expansion program for childless adults is also taken into account, the share of uninsured residents gaining coverage through state coverage expansion initiatives since 2002 rises—possibly as high as 25 percent. But the number of people enrolled in the MaineCare childless adult program has been highly volatile during 2005 and 2006, with enrollment freezes frequently being instituted and then lifted.

Dirigo Health's eventual impact on the state's rate of uninsured cannot yet be determined. DirigoChoice is still undergoing changes; its early experiences are not indicative of future success. In addition, Dirigo Health coverage initiatives were intended to work in concert with broader health reforms addressing cost, quality, and health promotion. The state had just begun to implement these other reforms when this evaluation was conducted. Finally, data limitations constrain our ability to measure the impact on the state's uninsured rate. There has not been a state household survey of insurance status since 2002, and annual Current Population Survey data from the U.S. Census Bureau on the insurance status of state residents are too imprecise and delayed to measure declines in the uninsured that may be attributable to Dirigo coverage initiatives.

SMALL FIRM RESPONSE TO DIRIGOCHOICE

Participation in and opinions of DirigoChoice differ, indicating it is well-designed for some but not all segments of the small firm market.

The DirigoChoice program was designed to shore up employer-based health insurance among small employers. Thus, their response is an important indicator of the success of the state's coverage expansion strategy. It is also a critical determinant of program costs.

A survey of small firms in Maine conducted for this evaluation found that very small firms (two to 10 workers) are disproportionately enrolled in the program; the average size is seven employees.[13] By contrast, firms offering health plans other than DirigoChoice have an average of 18 employees, and firms not offering any health plan have, on average, five employees (Table 4). DirigoChoice has also attracted many "micro" firms (i.e., those with three or fewer workers), but its appeal diminishes as the average percent of employees earning less than $12 per hour increases. This suggests very small firms with more workers earning such low wages are less able to afford employee health benefits.

Table 4. Employer Characteristics by Dirigo Participation Decision

	All firms responding (100%)	**Firms that offer DirigoChoice** (66%)	**Firms offering another health plan** (16%)	**Firms that do not offer coverage** (18%)
Average number of employees	8	7	18*	5*
Average percentage of employees earning <$12/hour	44%	45%	26%	55%
Average monthly employer cost of single coverage	N/A	$336**	$365**	N/A
Main reason did not enroll in DirigoChoice	N/A	N/A	Too costly for firm (48% of respondents)	Too costly for firm (68% of respondents)

* p<.01 statistically significant difference relative to the mean for firms offering DirigoChoice.

** p<.05 statistically significant difference between the two groups based on linear regression model predicting per member per month contribution for single employees adjusted for firm size.

Source: MPR Survey of Small Firms in Maine, 2006.

About half of DirigoChoice enrolled firms did not offer health benefits previously; affordability drove most decisions to join.

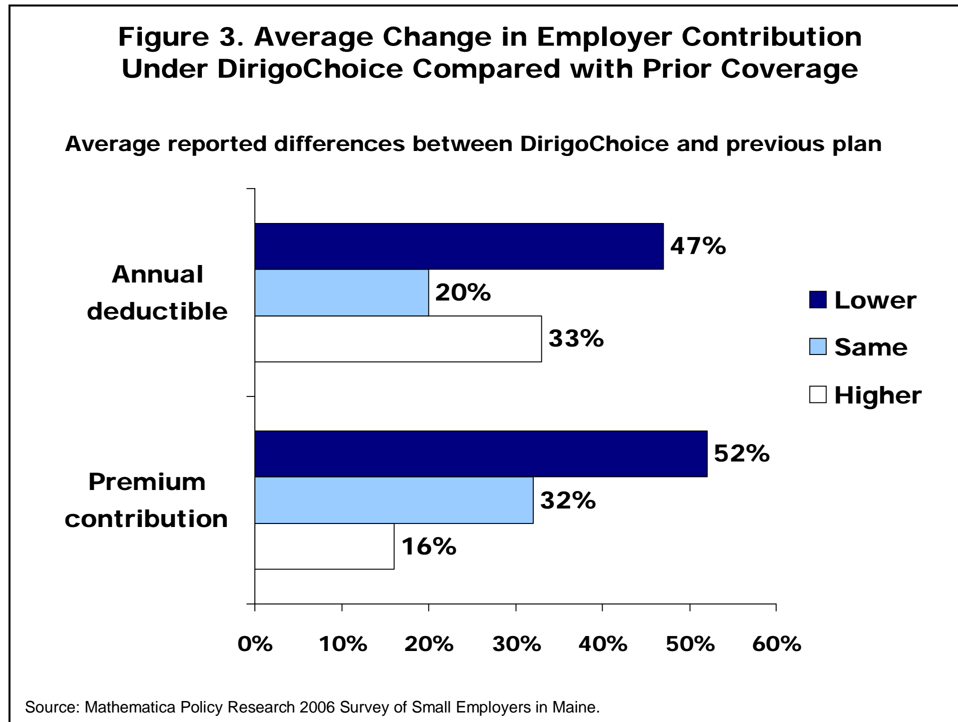
Just over half of DirigoChoice enrolled firms (51%) did not previously offer coverage—a promising indication of the product's appeal to these firms. Such firms were more likely to have three or fewer employees, compared with firms that did offer health benefits prior to enrolling in DirigoChoice. Their primary reason for enrolling in the program was affordability (55%), followed by a belief that it offered the best coverage for their business (19%), or they had no other plan options (9%).

DirigoChoice firms pay lower monthly premiums for single employees than firms offering other plans.

Among firms enrolled in DirigoChoice, the average monthly premium for single employees ($336) was lower than the premiums paid by firms offering other health plans ($365). While the difference is statistically significant, the $30/per month in savings appears to be too small to persuade small firms already offering coverage to switch to DirigoChoice. The higher price paid by firms offering non-Dirigo plans could reflect many factors, including more generous benefits, lower deductibles, and differences in group size, average age, and type of business, all of which can be used by insurers to adjust small group premium rates.

Most firms that previously offered insurance found DirigoChoice cost and benefits to be equal to, or better than, prior plans.

Among DirigoChoice firms that switched from another insurance plan, most reported per-employee health insurance premiums that were the same or lower than what they paid before (Figure 3). Four of five DirigoChoice firms that previously offered coverage found benefits to be as good as, or better than, those under their prior plan.



Small firm enrollment remains modest relative to the number of eligible firms, mostly due to unaffordable premium costs.

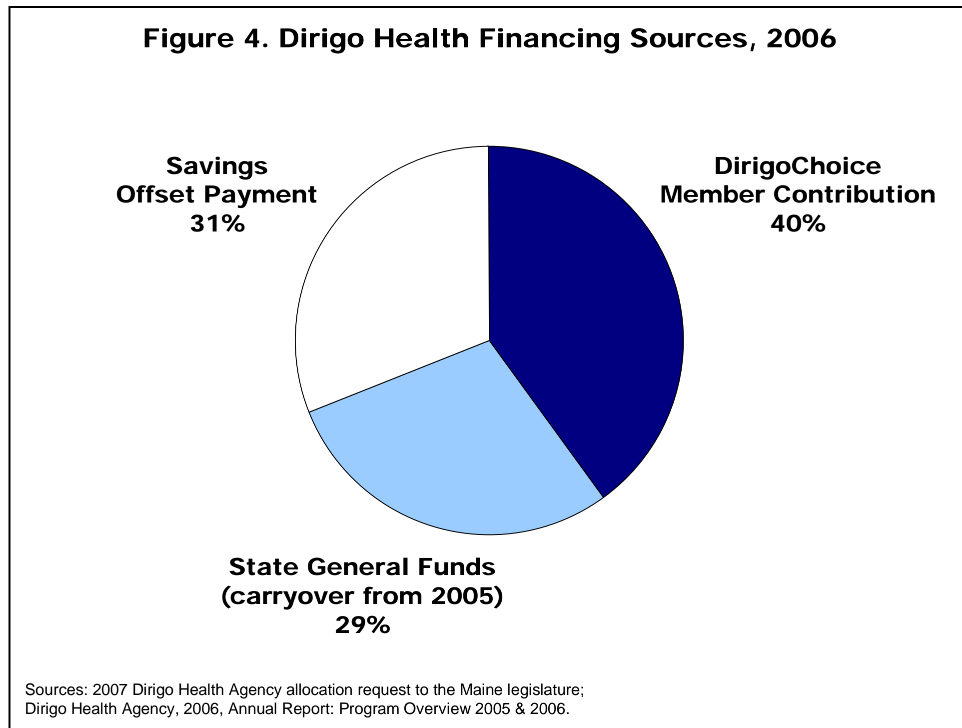
The 700 firms enrolled in DirigoChoice in September 2006 compose an estimated 2.5 percent of all eligible small businesses in the state. The limited participation is not due to a lack of awareness about the program. Among firms not currently offering any health benefits to their workers, 64 percent were somewhat or very familiar with DirigoChoice; only 9 percent had never heard of it. Over half (53%) of non-offering firms thought the program would be good for the firm and two-thirds thought it would be good for their employees. By a large margin (83%), non-offering firms say they do not offer any coverage—either DirigoChoice or another plan—because premiums are too high. While the program is changing to respond to the needs of small firms, the survey results indicate that for many firms, especially the smallest, DirigoChoice coverage remains too expensive. Dirigo's

broader cost-savings efforts continue, but it remains to be seen whether they can drive down costs to make premiums more affordable to such firms.

THE CHALLENGE OF FINANCING DIRIGOCHOICE SUBSIDIES

Revenues from the savings offset payment have been insufficient to cover substantially more individuals needing subsidies, thereby limiting higher enrollment in DirigoChoice.

The program anticipated that the SOP would finance most of the cost of subsidizing DirigoChoice premiums and deductibles for low-income enrollees, and for the MaineCare parent eligibility expansion (Figure 4). So far, the aggregate measurable cost savings, which determines the SOP assessment, has been less than the amount needed to allow much higher enrollment among those qualifying for subsidies in DirigoChoice, requiring the state to rely more on general revenues. (Figure 4).



The premise of the SOP, as in some other state expansion proposals, is that expanded coverage will reduce health care provider costs associated with delivering care to those without insurance. Maine sought to capture the savings associated with increases in coverage, as well as savings due to other cost-control efforts, through an assessment on

insurers. Health plans were expected to recoup the cost by reducing payments to providers commensurate with the reduction in the provision of uncompensated care and other costs.

The strategy depended on enrolling a substantial number of uninsured people into DirigoChoice or the Medicaid eligibility expansions authorized by the Dirigo law and on producing evidence of savings from these and other initiatives. When DirigoChoice did not enroll as many uninsured as expected, and greater savings from other Dirigo initiatives could not be documented, there was a corresponding drop in revenue that could be raised through the SOP.

Other anticipated revenue sources also fell short. As mentioned, less-than-expected enrollment both by small firms and higher-income enrollees reduced employer and member contributions. Federal Medicaid matching funds for MaineCare-eligible enrollees were also lower than expected because very few DirigoChoice group members were eligible for MaineCare.

Savings offset payment proved controversial, difficult to sustain.

Though conceptually sound, the process for estimating aggregate measurable cost savings, which determine the SOP amount, was vulnerable to criticism about the validity of program impact estimates, many of which cannot be directly observed. The criticism escalated into a legal challenge by insurers and the state chamber of commerce. In particular, the case focused on whether to count all savings attributable to Dirigo Health, or only reductions in bad debt and charity care arising from expanded coverage.

In May 2007, the Maine Supreme Court upheld the state's right to count savings attributable to all Dirigo Health initiatives, rather than just its coverage expansions. Nonetheless, controversies over how the savings are calculated are likely to persist as long as SOP continues to be a Dirigo funding source. Virtually all informants interviewed for this study view it as politically unsustainable in its current form and regard alternative funding sources as necessary for moving DirigoChoice forward.

DIRIGOCHOICE: MID-COURSE ADJUSTMENTS AND NEXT STEPS

In addition to the SOP controversy, DirigoChoice has faced a number of implementation challenges. To its credit, the program has made several adjustments to respond to implementation experiences and changes in the health insurance market.

However, most key informants interviewed believe more significant changes are needed for the program to make a greater contribution toward offering more affordable health coverage to all Maine residents by 2009.

Benefit Design

Maine tried to create an affordable, comprehensive benefit package for low-income individuals that costs less than available commercial products. Though attractive to some small firms, the comprehensive benefit package was criticized as running counter to market trends for products targeted to small employers. Firms that wish to offer coverage can find less comprehensive—and therefore, less expensive—products in the commercial market, though they are likely to come with very high deductibles.

The inclusion of coverage for preexisting conditions made the program susceptible to attracting high-risk individuals who could not afford coverage otherwise. Indeed, some critics contended that the mental health benefits induced adverse selection. Reports that as many as 3,000 people enrolled in Anthem's individual product switched to DirigoChoice heightened this concern, although it is unclear whether they did so to gain access to cost-sharing subsidies or to secure coverage for particular services.

Some evidence suggests DirigoChoice did not enroll a high-risk group. Anthem's overall medical loss ratio was 76 percent in 2005 and 2006, well within industry norms. Moreover, because DirigoChoice claims fell below 80 percent of total premiums, Anthem was obligated to return to DHA most of the EMP funds held in reserve to compensate for losses in excess of this amount during the program's first two years.

To attract more small businesses and low-risk uninsured individuals, some stakeholders believe DirigoChoice benefits should be less comprehensive. They contend that small firms and younger people with modest incomes and limited medical needs would be more interested in narrower benefit packages that provide primarily catastrophic protection or products with very high cost-sharing and coinsurance provisions, if the premiums were markedly lower.

In 2007, DirigoChoice responded to such criticism and tried to hold the line on premium increases by offering a new $2,500 deductible option to small employers. Consumer advocates and some providers criticized this decision, expecting that it would lead to low-income workers forgoing care, increased bad debt for providers, or both.

The ongoing debate around the benefit package clearly illustrates the trade-off between coverage and cost. The decision to allow individuals with previous insurance to enroll was important to address underinsurance—coverage that does not adequately protect against high health care costs—especially for residents at lower incomes. While the program's comprehensive benefit design may have remedied this problem for enrollees who had previous coverage with higher deductibles and excluded services, it drove up program costs overall.

Pooling of Small Groups and Individuals and High-Risk Pools

DirigoChoice attempted to combine small firms and individuals into one pool to lower premiums to individuals, and to address the failing individual insurance market by creating a larger pool. Other states such as New York and Massachusetts have tried or are pursuing a similar strategy to lower the cost of insurance to individuals.

Pooling small groups and individuals usually raises the cost to small groups, though the increase can be relatively small if individuals do not compose the majority of enrollees. For example, an actuarial analysis estimated that the Massachusetts reforms would reduce individual premiums by 15 percent while increasing small group premiums just 1.5 percent—assuming the individual market would represent just 11 percent of the merged market.[14]

DirigoChoice did not experience such a favorable enrollment composition; individuals and sole proprietors represented approximately 70 percent of total enrollment, making small group coverage more expensive. Despite an overall 76 percent medical loss ratio in 2005–2006, Anthem reported a medical loss ratio of 102 percent for individuals compared with 66 percent for small groups and 73 percent for sole proprietors. In 2007, the Insurance Superintendent required DirigoChoice to divide the pool for premium rating purposes, although the difference in medical loss ratios for the groups may have forced the program to do this eventually to keep small group premiums competitive.

The medical loss ratio experience for individuals in DirigoChoice also spurred a renewed push for a subsidized high-risk pool that would remove the highest-cost persons from the DirigoChoice risk pool. Skeptics have argued against a high-risk pool, believing that it would increase market segmentation. Alternatively, a combined small group and individual strategy is being explored as well as a reinsurance strategy that might mitigate the impact of high-cost users by limiting carrier exposure to risk, thereby reducing premiums. Advocates of the reinsurance strategy cite the successful experience of Healthy New York in curbing premium growth; a reinsurance feature protects carriers from very high claims.[15]

Dirigo Health's Cost Containment Provisions

To make health insurance expansion affordable, Maine recognized the importance of systemwide cost containment, as well as cost control within the DirigoChoice product. These goals remain elusive.

Because premiums reflect systemwide health care costs, the Dirigo Health Reform Act took steps to constrain overall health spending. It strengthened the state's certificate of need statute in an attempt to reduce excess capacity in the delivery system and produce future savings. It also established the Maine Quality Forum to administer public reporting and quality measurement activities that may yield cost savings in the long run. And, it set a minimum 80 percent medical loss ratio for small group products, set voluntary targets for hospital operating margins, and bolstered state health planning mechanisms.

However, the defeat of more far-reaching cost-control proposals leads some observers to believe that the initiative will not adequately address the problem of high cost and rapid medical inflation in Maine. For example, voluntary targets on hospital cost growth (3% annually) and operating margins (3.5%) replaced a more stringent proposal to impose a global hospital budget limit.

Meanwhile, DirigoChoice premiums have grown by about 17 percent from the start of the program in 2005 to the last quarter of 2006. With individuals now facing higher premium rates than those enrolled through small groups, many observers believe that rate increases will make the product increasingly unaffordable to individuals, especially those ineligible for subsidies. The program has explored ways to add more care and cost management features, including formal disease management programs for enrollees with chronic conditions, which are major drivers of cost. However, it is uncertain whether these strategies can reduce premiums sufficiently to make the product affordable to unenrolled small firms and individuals.

Plan Administration, Marketing, and Risk-Sharing Arrangements

While support for a public–private venture remains high, Anthem's role in DirigoChoice's administration drew mixed reviews. Some stakeholders expressed concerns that neither Anthem nor its brokers did enough to promote the program, and some leveled charges that Anthem agents actively dissuaded interested buyers. As the dominant carrier in the small group and individual markets, Anthem had leeway to steer customers to or away from DirigoChoice. It is unclear to what extent it did so. Insurance representatives counter that their marketing strategies were not to blame for lower-than-expected enrollment. Most small firms know about the plan, as shown by the study's survey findings

that nearly two-thirds of small firms in the state that do not offer health benefits to their employees were very or somewhat aware of the program. Instead, insurers say the problem lies in the product design.

Additional points of friction between DHA and Anthem have been the profit Anthem makes on the contract and Anthem's role in the lawsuit challenging the SOP. The need to re-bid the contract during 2007 put these issues on the legislative agenda in 2006 and again in 2007, when several alternatives to the current arrangement were proposed. One option was for the state to self-insure. Another was to select a different carrier to insure and market the product. A third was for DHA to offer competing products from multiple carriers, similar to Massachusetts' Connector program. A variation on the last approach would convert DirigoChoice into a voucher program. Individuals would use vouchers as a subsidy to defray the cost of a plan selected from a menu of products that would vary in benefits and price. This option, however, presumes a level of competition among plans that does not currently exist in Maine.

Under the self-insurance option, DHA would enter into an administrative services-only contract with a single vendor, either an insurer or third party administrator.[16] DHA believed this approach would save EMP funds spent on the risk-sharing arrangement with Anthem and on the insurer's profit margin on the product. Those who supported this option cited the success of the state employee health plan, which recently switched from a fully insured to a self-insured arrangement. They argued that Dirigo should pursue a similar course—possibly even by affiliating with the state employee program and pooling DirigoChoice participants with state employees.

Critics argued that changing to a self-insured arrangement could provide only one-time financial relief and would make no substantial difference in cost trends over time. They also charged that it would be perilous for the state to accept both the insurance and business risks of operating its own program. Their concern stemmed from problems in the MaineCare program, including the implementation of a new claims payment system that was plagued with problems and a long-delayed settlement of a backlog in hospital payments, both which have undermined confidence in the capabilities of a publicly sponsored program.

Because DHA did not know if it would obtain authorization and funding from the state legislature to self-administer the product, DHA continued to negotiate with Anthem on the terms of a new contract. [17] When DHA and Anthem could not reach agreement, DHA pursued other options. In September 2007, DHA announced that it was

switching the DirigoChoice contract from Anthem to Harvard Pilgrim Health Plan, a nonprofit plan that has served a very small share of the Maine market. This gives DirigoChoice the possibility of gaining one-time savings from the EMP payments that Anthem required as its price for accepting higher-than-average risk and to achieve a specified profit margin. The savings are relatively small (about $4 million) and it remains to be seen whether the new carrier will be more successful than Anthem in marketing DirigoChoice to small businesses.

Increasing Small Firm Participation: Small Firm Incentives, Employer Mandate
Some key informants charged that DirigoChoice can do little to increase small firm offer rates unless it offers greater incentives to motivate non-offering employers to initiate coverage. Key stakeholders have considered—and continue to debate—various incentives to persuade more small firms to offer health benefits to workers. For example, Governor John Baldacci included a proposal in his 2007 Dirigo reform package to mandate employer contributions to workers' health coverage, but Maine lawmakers rejected it. Other possibilities include subsidies to certain types of firms and a reduction in the minimum employer share of DirigoChoice premiums, which is currently 60 percent. The legislature's lack of action in 2007 leaves unresolved the debate over the merits of voluntary incentives versus an employer mandate.

LESSONS FOR OTHER STATES

To some extent, Maine's health reform strategy uniquely reflects the state's political environment, market dynamics, regulatory history, and financing options. But the initiatives ultimately selected—a subsidized insurance product for low- and moderate-income individuals and modest Medicaid eligibility expansions—are much like those adopted by or considered by other states. As such, Maine's experience in designing and implementing the initiatives could be useful to other states seeking to expand insurance coverage.

The greater the subsidy, the greater the demand. However, raising funds to finance such subsidies is politically difficult, regardless of the source.
As demonstrated by high levels of enrollment in the Medicaid eligibility expansion groups, more people with very low income will enroll in a fully subsidized health plan than in one requiring enrollee contributions, even when premiums and deductibles are heavily subsidized.

Greater reliance on Medicaid eligibility expansions to increase coverage, however, raises the cost to state government. Nearly every state has constraints on the financial resources available to expand public programs. Taxing providers, insurers, employers, or

consumers of health care carries political risks. At the same time, Maine's experience suggests that attempts to capture savings in the overall health system and use them to finance coverage expansions can be as difficult to implement as enacting direct taxes.

States with low employer offer rates may not be able to raise them substantially without strong employer incentives or mandates.

Despite the desire by many state policymakers to expand health insurance by building on and shoring up the employer health insurance system, Maine's experience demonstrates the limits of a voluntary system. DirigoChoice was modestly successful in enrolling small firms, but total small group enrollment remains low relative to the number of small firms eligible.[18] States that want to increase—rather than simply maintain—employer offer rates must consider stronger incentives to persuade employers to offer and contribute to employee health insurance costs. However, in states like Maine with high health care costs, employer mandates may pose an unaffordable burden on small firms unless overall system costs can be brought under control.

Partnerships and contracts between states and insurers must be crafted based on a realistic assessment of the market and the expected value of sharing responsibilities.

Without a guaranteed number of enrollees in the program and only one interested carrier, DirigoChoice did not have a great deal of leverage in price negotiations with Anthem. Any state creating a new program will face a similar problem—unknown risk that may dissuade insurers from participating or lead them to demand additional payment to take on the risk. These issues are aggravated in states with highly concentrated insurance markets; most states fall into this category.[19]

Coverage expansions without forceful cost control mechanisms will confront affordability problems, sooner or later.

Program viability is directly tied to efforts to control cost growth. Options for restraining premium rate increases were limited in Maine, a state with little provider competition or managed care and a highly concentrated insurance market. A relatively comprehensive subsidized insurance product might be more successful in states with: lower health care costs, either due to greater competition among providers or more managed care; and greater price competition among health plans or stronger regulation to constrain premiums.

METHODOLOGY AND DATA SOURCES

DirigoChoice and Medicaid Enrollment Data. Mathematica Policy Research, Inc. (MPR) obtained DirigoChoice enrollment data from the Dirigo Health Agency (DHA) to conduct an independent analysis of trends and enrollee characteristics. DHA's administrative files included data on DirigoChoice members ever enrolled since the program began in January 2005 through September 2006. DHA also provided summary Medicaid enrollment data based on data reported by the Maine Department of Health and Human Services, Office of Medical Services, and the Maine Legislature's Office of Fiscal and Program Review.

Small Employer Survey. MPR conducted a survey of small firms enrolled in DirigoChoice in the fall of 2006, among randomly selected small firms in Maine eligible to enroll in DirigoChoice that chose not to do so. MPR selected the survey sample to ensure valid comparisons between Maine firms eligible for DirigoChoice participating in the program, and similar firms that were not. All surveyed firms were screened to ensure they were eligible for DirigoChoice by meeting program requirements. The sample file of DirigoChoice firms was created from a random sample of 713 firms offering DirigoChoice coverage from a list of all businesses participating in DirigoChoice obtained from DHA. The DirigoChoice sample file contained all 713 participating firms except the 25 firms that took part in a pretest of the survey. An additional 800 comparable firms in Maine not currently participating in DirigoChoice were randomly selected from a list provided by Dunn and Bradstreet, a firm that provides information about businesses throughout the United States. MPR fielded the survey from October 2006 through January 2007. Of the 1,513 firms sampled, 776 eligible firms completed the survey; an additional 376 firms were determined to be ineligible. The remaining 361 firms did not complete surveys because they refused to participate, could not be located, or could not be interviewed during the field period. The overall weighted response rate was 69 percent. A complete review of the survey design, sampling methods, survey administration, response rates, and weighting techniques can be viewed in Appendix A of the full report, found at http://www.mathematica-mpr.com/health/dirigochoice.asp.

Key Informant Interviews. In late 2006, MPR held in-depth, semi-structured interviews with 35 key informants representing various interest groups in Maine, all of whom were involved in the development or implementation of DirigoChoice from November 2006 to January 2007. Interviewees included: state executive agency officials and staff (7), state legislators (3), insurance plans, agents, and brokers (9), consumer advocates (4), provider organizations (3), small businesses (6), and health policy analysts (3). Most interviews were conducted in person in Portland and Augusta, and some were held by phone. MPR also conducted an extensive review of Maine's health care and insurance system, and the evolution of Dirigo Health, through a variety of studies, reports, legal rulings, and other documents.

NOTES

[1] Current Population Survey (CPS) (Washington, D.C. U.S. Bureau of the Census, 2003); and E. Ziller and E. Kilbreth, *Health Insurance Coverage Among Maine Residents: The Results of a Household Survey 2002* (Portland, Maine: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, May 2003), available at http://www.muskie.usm.maine.edu/m_view_publication.jsp?id=1649.

[2] Ziller and Kilbreth, *Health Insurance Coverage,* 2003.

[3] J. Gabel, R. McDevitt, L. Gandolfo et al., "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up and Wyoming Is Down," *Health Affairs,* May/June 2006 25(3):832–43.

[4] A. B. Martin, L. Whittle, S. Heffler et al., "Health Spending by State of Residence, 1991–2004," *Health Affairs* Web Exclusive (Sept. 18, 2007):w651–w663.

[5] "Market Snapshot—Small Group Health Insurers" (Augusta, Maine: Maine Bureau of Insurance, 2006), available at http://www.maine.gov/pfr/insurance/employer/snapshot_small_group.htm.

[6] Such "dual eligibles" include childless adults with income below 100% FPL, as well as parents of children under age 19 and children who live in families earning less than 200% FPL. People who apply to enroll in DirigoChoice as individuals or sole proprietors (i.e., not as a worker in a small firm) who are Medicaid eligible are enrolled only in MaineCare.

[7] State program officials refer to premiums as "monthly cost of coverage" since payments on behalf of members are made to Dirigo Health Agency (DHA), not the insurer and because these payments may come from multiple sources (employer, employee, individual, and DHA revenues) depending on the type of enrollee and their subsidy level.

[8] J. Rosenthal and C. Pernice, *Designing Maine's DirigoChoice Benefit Plan* (Portland, Maine: National Academy for State Health Policy, Dec. 2004).

[9] B. Gorman, D. Gorman, E. Kilbreth et al., *Actuarial Report of Reform Options for Maine's Individual Health Insurance Market* (Marlborough, Mass.: Gorman Actuarial, LLC, May 2007). Prepared for the Maine Bureau of Insurance.

[10] In August 2007, DirigoChoice member enrollment stood at 15,113 (Dirigo Health Agency, 2007, Monthly Numbers, Aug. 2007).

[11] The range covers estimates of DirigoChoice enrollees who had been uninsured for the entire 12 months prior to enrollment, and those who were uninsured at the point of enrollment.

[12] Results of Mathematica's 2006 survey of small firms in Maine conducted as part of this evaluation are summarized in Chapter V of the full report, available at http://www.mathematica-mpr.com/health/dirigochoice.asp.

[13] Dirigo Health Agency (DHA) administrative data show an average of 4.3 employees among firms enrolled in DirigoChoice. DHA's average is based on number of employees eligible for health benefits, while the survey average is based on total number of employees, including part-time workers (less than 20 hours per week) and those employed less than 26 weeks per year, who are generally not eligible for health benefits.

[14] Gorman Actuarial, LLC, DeWeese Consulting, Inc., Hinckley, Allen & Tringale LP, *Impact of Merging the Massachusetts Non-Group and Small Group Health Insurance Markets* (Marlborough, Mass.: Gorman Actuarial, LLC, 2006). Prepared for the Massachusetts Division of Insurance and Market Merger Special Commission.

[15] E. Kilbreth, *Comparing the DirigoChoice Program Experience with Other State Initiatives Targeted to Small Businesses and Individuals* (Portland, Maine: University of Southern Maine, Edmund S. Muskie School of Public Service, Institute for Health Policy, Aug. 2006), available at http://www.muskie.usm.maine.edu/m_view_publication.jsp?id=3809.

[16] The Dirigo Health Reform Act allowed for a self-insurance option, but only if no bidder came forth or it could not reach mutually agreeable terms.

[17] Legislation passed in the 2007 session, LD 431, appeared to authorize DirigoChoice to be self-insured, but required the state to authorize reserve funds, in case revenues were insufficient to pay claims. However, the legislature did not appropriate funds for the reserves.

[18] The 700 small firms enrolled in DirigoChoice represent about 2.5% of small firms in the state (about 28,000). This suggests that even if data on employer offer rates for the 2005–2006 period show that Maine beat the national rate of decline in employer health insurance offer rates, the contribution of DirigoChoice would be minor, especially since Anthem and other insurers also introduced other small group products during this period.

[19] J. C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* Nov./Dec. 2004 23(6):11–24.

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Designing Maine's DirigoChoice Benefit Plan (December 2004). Jill Rosenthal and Cynthia Pernice, National Academy for State Health Policy.