STATE OF MAINE
DIRIGO HEALTH AGENCY
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JOHN ELIAS BALDACCI
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KARYNLEE HARRINGTON
EXECUTIVE DIRECTOR

TO: Joint Standing Committee on Insurance and Financial Services

FROM: Karynlee Harrington, Executive Director, Dirigo Health Agency

CC: Trish Riley, Director of Governor's Office of Health Policy and Finance
Dr. Robert McAfee, Chair of the Dirigo Health Agency Board of Trustees
Jonathan Beal, Incoming Chair of the Dirigo Health Agency Board of Trustees
William Kilbreth, Deputy Director, Dirigo Health Agency

DATE: February 17, 2010

RE: P.L. of 2009, Chapter 359, Section 6.

On behalf of the Dirigo Health Agency, I am pleased to present this report to the Joint Standing Committee on Insurance and Financial Services.

Chapter 359, section 6 of the Public Laws of 2009 required the Dirigo Board of Trustees to do the following as it relates to Dirigo Health:

1. Develop products, procedures. Develop more affordable products and procedures that can reach uninsured and underinsured residents of the State to reduce uncompensated care;

2. Maximize federal initiatives. Use subsidies to maximize federal initiatives, including Medicaid and any national health reform;

3. Asset tests. Determine the impact of asset tests on determining eligibility;

4. Voucher program. Consider offering a voucher-based program to provide health insurance benefits; and

5. Redesign. Redesign the DirigoChoice product or products.

The intent of this report is to supplement the October 5, 2009 status report that the Agency submitted to the Committees on Insurance and Financial Services, Appropriations and Financial Affairs, and Health and Human Services. That report summarized the eligibility changes the Board adopted to further their goal of expanding access to the program's target population.

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Background:

In the spring of 2009 the Dirigo Board of Trustees began exploring various DirigoChoice redesign scenarios and recommendations specific to the requirements of what is now Public Law 2009, Chapter 359, section 6. All of the informational documents and detailed minutes of these Dirigo Board meetings can be found at http://www.dirigohealth.maine.gov/Pages/meetings.html.

Over the course of the summer of 2009, Agency staff prepared for the Board a series of informational presentations providing details specific to the current DirigoChoice program as well as information pertaining to health care coverage expansion initiatives in other States. The Agency contracted with Gorman Actuarial to provide expertise with actuarial modeling of various options specific to the DirigoChoice product and its redesign. Gorman Actuarial has spent the last five years working with various states, including Maine and Massachusetts, on health reform analyses. Their work includes financial modeling, premium rate development, product development and health policy design.

With the support of Gorman Actuarial, Agency staff developed a document titled "Options for Dirigo Board of Trustees Consideration". Staff presented this document to the Board in July 2009. Staff further developed subsequent amendments to this document as a result of the Board's feedback and requests. Attached to this report is a copy of the document, as well as other Board discussion documents from the summer, providing an overview of the following:

- Current distribution of DirigoChoice subsidy
- Results of a survey the Dirigo Board directed staff to conduct regarding the DirigoChoice program
- Eligibility options and proposals specific to asset test and income determinations
- Coverage options and estimated implications
- Future design considerations

The Board spent a significant amount of time debating the implications of the various redesign scenarios relative to the Agency's legislative mission to expand access. MRSA 24-A section 6902 and 6912 establish that the Agency is to arrange for the provision of comprehensive, affordable health care coverage; and to establish sliding-scale subsidies for the purchase of health care coverage for eligibles whose income is under 300% of the federal poverty level.

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As reported in my October 5, 2009 memo, after months of deliberations the Dirigo Board unanimously agreed to the following policy modifications and eligibility revisions:

Health Coverage Tax Credit (HCTC) Recipients:
Effective 10/1/09 HCTC recipients who are DirigoChoice members receive an 80% premium subsidy through HCTC and ARRA Federal Funds. The Agency will continue to subsidize the members' reduced deductibles and out of pocket maximums dependent on income level.

Medicare Recipients:
DirigoChoice members who turn 65 and or are over age 65 and eligible for Medicare will no longer receive a subsidy off the monthly cost of DirigoChoice coverage as of 11/1/09 forward. Should they elect to continue the DirigoChoice coverage they will pay the full monthly rate for their coverage.

MaineCare (Medicaid):
DirigoChoice applicants and renewing members who wish to apply for the highest subsidy level (80%) will be required to submit proof of denial of MaineCare coverage to the Dirigo Health Agency in order to receive the 80% subsidy. This is effective for 1/1/2010 renewals and new business going forward.

Social Security Recipients:
Social Security Administration and Railroad Retirement received by DirigoChoice applicants and renewing members will count as income effective 1/1/2010.

Assets Counted In Subsidy Determination:
DirigoChoice applicants and renewing members will be required to provide asset information in addition to income to qualify for a subsidy. The subsidy determination will be based on a sliding scale methodology using asset and income information. The Agency will implement the asset test 7/1/2010.

The primary intent of these changes is to ensure that DirigoChoice subsidy serves those who do not have access to other sources of coverage. The eligibility decisions made by the Board were made in an effort to spread limited subsidy dollars in the most appropriate manner.

In addition to the Legislative direction in Chapter 359, purchasing rules required the Agency go out to competitive bid for the DirigoChoice services for a July 1, 2010 contract effective date. The Board decided to take advantage of the competitive bidding process and leverage the creativity of the private market relative to proposals that would further reduce costs.

To that end, the Board agreed that the DirigoChoice request for proposal for health insurance services would include two bids:

Bid One - Status Quo

The Board requested rates for the current DirigoChoice benefit and subsidy design (although incorporating the eligibility changes described above).

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Bid Two – Alternate:

The Board's goals for an alternate bid were to:

1. Expand access to uninsured and underinsured. Specifically, the Board targeted a 30% - 40% growth from the Agency's Status Quo membership projections of 10,000 members (i.e., a target enrollment of 13,000 – 14,000 members).

2. Simplify the number of options offered to small group, self-employed and individuals from the current 25 options down to 6.

3. Change the subsidy distribution as a way to expand access but keep subsidized members' monthly premium costs similar to what they pay today.

4. Establish members' total financial exposure at no more than 22% of the average household income for non-group members.

To achieve these goals, the Board requested bidders to provide plans based on an aggregate target revenue per member per month (PMPM). This target PMPM was developed by the Agency's consulting actuary. This targeted approach is similar to the strategy other states have taken (e.g., Massachusetts).

To further develop the Alternate Bid, the Board established the following Principles:

1. Include robust prevention, wellness, and disease management benefits.

2. Include mental health parity.

3. Do not exclude pre-existing conditions.

4. Reduce over-use and under-use of health care by aligning quality and efficiency incentives among providers across the continuum of care so that physicians, hospitals, and other health care providers are encouraged and enabled to work together towards the highest standards of quality and efficiency. For example, provide tiered networks based on quality metrics and/or pay for performance (P4P) incentive models.

5. Adhere to evidence-based best practices and therapies that reduce hospitalization, manage chronic disease more efficiently and effectively, and implement proven clinical prevention strategies.

6. No payment for "never" events.

7. Target a medical care ratio of 90% (i.e., at least 90% of every dollar must go toward medical services as opposed to the carrier's administrative costs or profit).

8. Include strong incentives to promote the use of generic medications when available.

9. Promote the use of medical homes and primary care.

10. Provide an actuarial value of at least 65%.

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The Board requested the following plans:

Small group market for all income levels:

- High Deductible
- Low Deductible
- Health Savings Accounts (HSA)

Non-group (Individuals and Sole Props) market:

- Plan 1 – Target income group B
- Plan 2 – Target income group C
- Plan 3 – Target income group D and above

The Agency released the request for proposals on October 5, 2009.

Effects of Plan Changes

Eligibility Changes

As noted above, with the exception of the change to HCTC subsidy, the majority of the Board approved eligibility changes went into effect on January 1, 2010 and are effective as accounts renew. The eligibility changes were made as soon as possible as a way to manage expenses. Because more people are staying on the program than have done so historically the Agency has experienced higher than expected subsidy costs in the fiscal year.

The Agency's analysis of January 2010 renewals shows that in the absence of the eligibility changes its SFY 2010 subsidy costs would have been approximately $1.9 million higher. These estimates are detailed in the table below.

Change	Financial Impact	Date	Notes
HCTC	$410,000 (22%)	10/2009 All Contracts	
Medicare	$450,000 (24%)	11/2009 Rolling on birthday month	225 termed (of which 207 Bs, 11 Cs, 3 Ds and 4 Fs)
MaineCare Shift	$150,000 (8%)	1/2010 Rolling on anniversary date	January Renewals: 139 B → C 14 B → D 5 B → E 6 B → F
MaineCare Transition	$450,000 (24%)	1/2010 Rolling anniversary	85 (net) B terminations in January
SSI	$420,000 (22%)	1/2010 Rolling anniversary	128 accounts shifted downward due to SSI income in January
Total	$1,880,000		

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DirigoChoice Plan Changes

The Agency received two bids for DirigoChoice health coverage services. The Agency evaluated the proposals and awarded the contract to Harvard Pilgrim Health Care[1]

Based on the pricing of the Alternate plan, the Agency estimates that SFY 2011 subsidy PMPM will be approximately $270.00. This amount represents a 21% reduction from the Agency's spring 2009 Status Quo projections of $341.54. Between 7% and 9% of this reduction is due to program changes, and the remaining 12% to 14% of the reduction is due to the approved eligibility changes.

Comparison of Benefits: Alternate Plan to Status Quo

Alternate Plan		Deductible	OOP
Small Group Low	All income levels		
	Single	$ 750	$ 3,000
	Family	$ 1,500	$ 6,000
Small Group High	All income levels		
	Single	$ 2,000	$ 5,000
	Family	$ 4,000	$ 10,000
Small Group HSA	All income levels		
	Single	$2,500	$ 5,000
	Family	$ 5,000	$ 10,000
Non-Group B	Under 150% FPL		
	Single	$ 500	$ 1,600
	Family	$ 1,000	$ 3,200
Non-Group C	Under 200% FPL		
	Single	$ 1,000	$ 3,000
	Family	$ 2,000	$ 6,000
Non-Group D,E,F	Under 300% FPL		
	Single	$ 1,750	$ 4,000
	Family	$ 3,500	$ 8,000
Co-Payments			
Primary Care Physician Office Visits			$25
Specialist Office Visits			$35
Rx			$10/$30/$50
Routine/Preventive			$0

Status Quo		Deductible	OOP
Group B	Under 150% FPL		
Plan 1	Single	$ 250	$ 800
	Family	$ 500	$1,600
Plan 2	Single	$ 500	$1,600
	Family	$1,000	$3,200
Plan 3	Single	$ 500	$ 700
	Family	$1,000	$1,400
Group C	Under 200% FPL		
Plan 1	Single	$ 500	$1,600
	Family	$1,000	$3,200
Plan 2	Single	$ 800	$2,600
	Family	$1,600	$5,200
Plan 3	Single	$1,000	$1,400
	Family	$2,000	$2,800
Group D	Under 250% FPL		
Plan 1	Single	$ 750	$2,400
	Family	$1,500	$4,800
Plan 2	Single	$1,125	$3,600
	Family	$2,250	$7,200
Plan 3	Single	$1,500	$2,100
	Family	$3,000	$4,200
Group E	Under 300% FPL		
Plan 1	Single	$1,000	$3,200
	Family	$2,000	$6,400
Plan 2	Single	$1,450	$4,600
	Family	$2,900	$9,200
Plan 3	Single	$2,000	$2,800
	Family	$4,000	$5,600
Co-Payments			
Primary Care Physician Office Visits			$25
Specialist Office Visits			$35
Rx			$10/$30/$50
Routine/Preventive			$0

[1] This decision is currently under appeal.

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Notes:

Under Status Quo, Plan 1, Plan 2, and Plan 3 refer to the non-subsidized $1,250, $1,750, and $2,500 plans, respectively. Non-group members are not eligible for Plan 1 under the Status Quo.

Routine/Preventive services include any associated diagnostic tests and x-rays

Comparison of Single only (no dependents) Costs: Alternate Plan to Status Quo

Alternate Plan			Status Quo	
Plan (Deductible)			Plan (Deductible)	
Small Group Low (750)			Small Group Plan 1 (1250)	
B (750)	37.29		B (250)	34.24
C (750)	74.58		C (500)	68.47
D (750)	111.87		D (750)	102.71
E (750)	149.16		E (1000)	136.95
Small Group High (2000)			Small Group Plan 2 (1750)	
B (2000)	32.54		B (500)	31.56
C (2000)	65.09		C (800)	63.11
D (2000)	97.63		D (1125)	94.67
E (2000)	130.17		E (1450)	126.22
Small Group HSA (5000)			Individual Plan 3 (2500)	
B (5000)	24.20		B (500)	31.57
C (5000)	48.40		C (1000)	63.15
D (5000)	72.59		D (1500)	94.72
E (5000)	96.79		E (2000)	126.29
Individual B (500)	136.33		Individual Plan 2 (1750)	
			B (500)	109.57
			C (800)	219.15
Individual C (1000)	252.06		D (1125)	328.72
			E (1450)	438.30
Individual D,E,F (1750)			Individual - Plan 3 (2500)	
D (1750)	335.02		B (500)	109.64
E (1750)	446.69		C (1000)	219.27
			D (1500)	328.91
			E (2000)	538.54

Notes:

Deductibles presented are for Single coverage. Family deductibles are 2x the Single.

Member coverage costs are for monthly single coverage. Small Group costs assume a 60% Employer contribution (DirigoChoice required minimum). Sole Proprietors (not presented) are also responsible for 60% of the single cost before application of subsidy.

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HRSA Grant

In June of 2009 HRSA awarded the Governor's Office of Health Policy and Finance an $8.5 million grant to expand coverage to the uninsured. GOHPF directed most of the funds to the Agency to expand access to the uninsured by leveraging existing Agency infrastructure and competencies. The Board approved use of these funds to test a voucher program. The Agency will provide vouchers to uninsured, low-income, seasonal, part-time and direct care workers to buy into their employer's health coverage offerings.

Conclusion

The Agency has complied with criteria for review included in Chapter 359, section 6 of the Public Laws of 2009. Those were:

1. Develop products, procedures.

Action: The Board has taken steps to better target uninsured and uninsured populations in Maine who do not have access to other assistance.

2. Maximize federal initiatives. Use subsidies to maximize federal initiatives, including Medicaid and any national health reform;

Action: The HRSA grant includes consulting assistance to evaluate the feasibility of a Medicaid waiver and staff continues to monitor the potential impact of any national reform.

3. Asset tests. Determine the impact of asset tests on determining eligibility;

Action: An asset test is completed and will be effective July 1, 2010.

4. Voucher program. Consider offering a voucher-based program to provide health insurance benefits;

Action: A voucher program has been developed through the HRSA grant and will launch this spring

5. Redesign. Redesign the DirigoChoice product or products.

Action: A lower cost alternate product has been developed. The Board will finalize the product redesign and rates for the DirigoChoice product subsequent to the resolution of the current appeal of the insurance award. At that time the Agency will update the Committee on final program changes and cost reductions.

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