

PROJECT NARRATIVE

AFFORDABLE HEALTH INSURANCE FOR UNINSURED LOW INCOME PART-TIME AND SEASONAL WORKERS – EXPANDING DIRIGO HEALTH

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INTRODUCTION

The purpose of this project is to expand access to affordable health insurance coverage to low income, part-time/seasonal workers in Maine's large businesses who cannot afford employer sponsored insurance or are not offered that coverage. This program is ready to implement immediately and is designed to significantly increase health coverage for the uninsured, low income, working population in Maine.

In 2003, with the assistance of a HRSA State Planning Grant, Maine developed and enacted the Dirigo Health Reform. That law is a comprehensive health reform that reflects the goals of Healthy People 2010: "The health of communities and individuals depends greatly on access to quality health care." Dirigo was designed to lower health care cost growth, improve quality, and increase access to coverage through three strategies: (1) strengthening and modestly increasing Medicaid eligibility; (2) establishing a subsidized health insurance product for citizens under 300% the Federal Poverty Level (FPL), DirigoChoice, for individuals, sole proprietors and small businesses where the majority of uninsured were found; and (3) launching a series of initiatives in public health and cost containment, including the establishment of the Maine Quality Forum, to ensure coverage was of high quality, maximized disease prevention, health promotion, and remained affordable for all those who currently had it.

Over the last five years, the Dirigo Health Agency (the Agency) created the Maine Quality Forum and DirigoChoice, now administered through Harvard Pilgrim Health Care (HPHC), and provided coverage through a Medicaid expansion to parents between 150% - 200% of FPL. Over 29,000 people have been served since these programs began and, according to the United Healthcare, "America's Health Rankings," Maine moved from 19th in 2003 to 5th best in 2008 in rates of uninsured.

However, more needs to be done to reach the working, low income uninsured. Maine has identified a significant population of uninsured, low income, part-time workers in Maine's large businesses – who are ineligible for DirigoChoice. Overall, nearly half (46%) of uninsured workers in Maine are employed part-time or seasonally¹. While the Agency has the statutory authority to expand DirigoChoice to large businesses, it has been unable to do so. The Agency has, through contractual arrangements with its health plan, been required to limit enrollment of non-group individuals to no greater than 50% of the DirigoChoice covered population to avoid adverse selection. The remaining 50% represent sole proprietors and small businesses. The limit on non-group individuals who can be enrolled in DirigoChoice has made it impossible for the majority of low income part-time/seasonal workers who do not have access to employer sponsored insurance through their employer to enroll in DirigoChoice. There is currently a waiting list of over 2,000 people for DirigoChoice.

For those low income workers in large businesses who have access to employer sponsored insurance, but cannot afford it, the Agency has not had the resources to assist with the affordability of the insurance.

¹ CPS pooled data for 2004-2006.

In this proposal we seek to create an Exchange in the Agency to administer a voucher program that enables uninsured, low-income, part-time/seasonal workers with incomes below 300% of FPL to purchase employer sponsored insurance that meets a test of credible coverage. Additionally, we will develop a new product designed for uninsured, low income, part-time/seasonal workers for businesses that do not provide employer sponsored insurance and/or who wish to provide an option that might better serve these workers. Sustainability plans including new federal waiver authority and a shared responsibility employer assessment will ensure that Maine can continue to support the citizens served through this grant beyond the grant period.

Goals & Objectives

1. Expand the reach of the Agency to connect uninsured, low income, part-time/seasonal workers in large businesses to affordable health coverage (the Dirigo Exchange) and to provide an option when employer sponsored insurance is unavailable (DirigoConnect²).
2. Institute a marketing campaign to target uninsured low-income part-time/seasonal workers and their employers.
3. Increase coverage of previously uninsured low income, part-time/seasonal workers and their dependents by 3,500 by 9/14/10.
4. Integrate public health objectives and link low income, part-time/seasonal worker participants to Maine's Universal Wellness initiative, ensuring each newly insured worker accesses a health risk assessment and is linked to the public health system and its community resources and that the project advances the goals of Healthy People 2010.
5. Ensure sustainability by obtaining federal waiver approval of existing and new access initiatives and by instituting a shared responsibility assessment on employers in proportion to their uninsured workforce.

NEEDS ASSESSMENT

Health Insurance Coverage in Maine and Characteristics of the Uninsured

Maine is a low-income state with high rates of part-time and seasonal work – factors that substantially raise the risk of uninsurance. Yet, over many years, Maine has aggressively and successfully implemented strategies to ensure health coverage. Maine's rate of uninsured is

² Product names are pending trademark filing.

well below the national average (11.2% for the population under age 65 in 2006).³ Universal coverage is within our reach.

Among Maine's more recent initiatives to cover the uninsured are:

- (1) Maine's decision in 2002 to cover childless adults up to 100% FPL under Medicaid. As of March 2009 there were 9900 enrollees, with an additional 12,000 on a waiting list due to an enrollment cap to stay within federal funding limits under the state's waiver. Current Population Survey (CPS) estimates are that there were 13,500 childless adults under 100% FPL in Maine in 2006/2007, representing 11.4% of Maine's 118,000 uninsured.
- (2) Maine's enactment in 2003 of Dirigo Health Reform, a multi-tiered approach to improving health care cost, quality, and access. Among other things, the law created the Agency, which developed the DirigoChoice product. The law requires the product to be public/private partnership. DirigoChoice is an insurance product, provided today by HPHC. In addition to the insurance coverage the plan provides sliding scale subsidies to individuals, the self-employed, and employees of small businesses with incomes up to 300% of FPL. DirigoChoice has served 24,000 people since its opening in January 2005. The Agency recently capped enrollment in DirigoChoice due to an unstable funding mechanism.
- (3) Maine's enactment in 2003 of Dirigo Health Reform also included an expansion of MaineCare, Maine's Medicaid program, to parents of State Children Health Insurance Program (SCHIP) children with eligibility rising from 150% to 200% FPL.

As of March 2009, Maine's Medicaid enrollment totaled 271,000 or 21% of the state's population. Of those 271,000:

- 5% are SCHIP children from 125 - 200% FPL
- 9% are Medicaid expansion parents from 150 – 200% FPL
- 4% are childless adults under 100% FPL under Maine's waiver
- the remainder are traditional Medicaid.

Of the approximately 727,000 Mainers with private health insurance:

- 40,000 are covered in the individual market, served predominantly by three carriers [Anthem (53% share), Mega (28%), and HPHC (19%, which includes DirigoChoice enrollment)];
- 106,000 are covered in the small group market, served predominantly by three carriers [Anthem (56%), Aetna (30%), and HPHC (8%, which includes DirigoChoice)];
- and 581,000 are covered in the large group market, with a roughly 65/35 split between employers who are self vs. fully insured [with the latter being served predominantly by four carriers: Anthem (65%), Aetna (16%), Cigna (11%), and HPHC (7%)].⁴

³ Estimate based on CPS survey data for years 2006 and 2007, combined.

⁴ Data on market share and enrollment in fully-insured products from carrier's Rule 945 filings with Maine's Bureau of Insurance. Total private enrollment estimate, large group estimate, and estimate of large employers who are self-vs. fully-insured derived by matching BOI data against coverage data from www.statehealthfacts.org.

Approximately 118,000 Mainers remain uninsured.

- 102,000 of them are adults (69% of whom have incomes below 300% FPL)
- 16,000 are children (71% of whom are in families with incomes below 300% FPL).
- Roughly three-quarters of uninsured adults are employed and nearly half (46%) work part time/seasonally.

The risk of uninsurance is greater among Maine's minority residents than among non-minority residents, with 14.4% lacking coverage compared to an overall rate of 11.2%.⁵ Nevertheless, while Maine has a growing refugee community in its southern cities, (46 different languages are spoken in the high school of Maine's largest city, Portland) the state as a whole is largely homogeneous; only 5.6% of the total population represent minorities, and only 7.8% of people in Maine speak a language other than English, compared to 18% nationally.⁶

Maine's Health Care Delivery System

Maine has a population of 1.2 million people spread over a large and rural geography. All the other New England states together could fit within the geographic borders of Maine. This geographic configuration presents challenges to the delivery of accessible, high quality and efficient health care, statewide. Maine's safety net of health care services for medically indigent patients is fully integrated within the framework of the health care system serving other Maine residents. The State is served by 36 community hospitals all of which are non-profit and provide significant public health and safety net services. The majority of physician practices are hospital owned or affiliated. Maine has 18 Federally Qualified Health Centers (FQHC) and 1 look-alike center.

Although Maine's statewide physician-to-population ratio is high relative to many other states', several of Maine's rural areas suffer from shortages of both specialty and primary care. In part as a result of less than optimal access to primary care, Maine's rate of visits to emergency departments is 30% higher than the national average and rural areas have consistently higher use-rates than urban areas. The need for accessible primary care in the community is reflected though the frequently seen diagnoses in emergency departments. Among the diagnoses that generated more than 2000 potentially avoidable visits each in 2006 were sore throats, upper respiratory infections, headache, lower back pain, anxiety disorders, asthma, conjunctivitis, and otitis media.⁷

Maine's health insurance market is dominated by three national insurance companies – Anthem Blue Cross and Blue Shield, Aetna and CIGNA, and one regional managed care company – HPHC. The state has no staff model HMOs and HMO products have a 38% share of the market, Provider networks generally do not differ by product and include almost all providers in the state.

⁵ Estimate based on pooled CPS data, 2006 – 2008.

⁶ 2008-2009 Maine State Health Plan

⁷ Analysis of 2006 Maine Emergency Department Use, Muskie School, University of Southern Maine.

Use of Medical Homes in the Proposed Expansion Program

Part of the determination of credible coverage for subsidized insurance offered through what will become the Dirigo Exchange will be a requirement that insurers participate in the Maine's Patient Centered Medical Home demonstration. There are 22 adult / family practitioners participating statewide in this demonstration, 4 of which are FQHCs, and 4 pediatric practices. This project is scheduled to launch in the fall of 2009.

Unmet Coverage Needs and Target Population for Proposed Coverage Initiative

While Maine has made great strides in combating medical indigence, more needs to be done. To expand coverage, this proposal targets a specific population that state and national data have consistently shown to fall through the cracks: low income part-time and seasonal workers in large firms. DirigoChoice targets those in small business where rates of uninsured have been highest and has primarily attracted Maine's "micro-businesses." The average firm size of small businesses enrolled in DirigoChoice is 4 employees.

In Maine, part-time work has been on the rise, with workers working fewer than 35 hours increasing from 28% of Maine workforce in 2000 to 32% in 2008,⁸ *Nearly half of all uninsured workers in Maine, 41,000 (46%), are part-time or seasonal.*⁹

Of these 41,000 part-time workers, *18,000 work at employers of 25 or more.*¹⁰ While larger employers are more likely to offer insurance, many low income part-time/seasonal workers face significant barriers to coverage as these employees are either ineligible to enroll or – if they are eligible – are unable to afford to do so. In fact, according to the most recent Medical Expenditure Panel Survey (MEPS) survey data, in 2006 in Maine 40% of part-time workers in establishments with 50 or more employees were eligible for insurance, but, of this eligible group, fewer than half took up the offer.¹¹ As described earlier, low income uninsured are more likely to experience health problems, avoid care and postpone treatment.

This proposal targets the estimated 14,000 part-time workers at firms with 25 or more employees with incomes below 300% FPL (22% of part-time uninsured workers in these firms are above 300% FPL).¹² The proposal would cover approximately 3,500 of these workers and their dependents in its first year.

One segment of the workforce that would be helped by this proposal is the direct care workforce, which in 2005 consisted of over 22,300 full- and part-time workers employed by agencies of various sizes.¹³ The wages and benefits received by these workers do not reflect the important

⁸ Maine Department of Labor analysis of CPS data.

⁹ CPS pooled data from 2006-2008.

¹⁰ CPS pooled data from 2006-2008.

¹¹ Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2006 Medical Expenditure Panel Survey-Insurance Component.

¹² CPS pooled data from 2006-2008.

¹³ Maine Department of Health and Human Services, *Study of Maine's Direct Care Workforce: Wages, Health Coverage, and a Worker Registry*, Report to the 123rd Maine Legislature (March 2007).

role they play in our society. A survey of more than 800 direct care workers employed by 26 Maine home-care agencies, found significant barriers to health coverage:

- One in two are primary wage earners for their household, 78% earn less than \$10/hour, 35% report annual household incomes of less than \$20,000;
- 68% of those who have access to employer-sponsored coverage report they do not participate mostly because they cannot afford their share of the premium; and
- 73% work part-time or in temporary positions, and 30% work more than one job (half of which are second direct-care jobs).¹⁴

With their work accounting for eight out of every ten hours of paid care received by consumers of long-term care,¹⁵ the assistance that the direct care workforce provides to older adults and people with disabilities or chronic health conditions has become increasingly important as Maine's population – which is already the oldest in the nation – continues to age. For over three years Maine has grappled without success with the challenge of extending coverage to this workforce, despite studies documenting the need for affordable coverage and several legislative efforts.

Other industries that compose a significant percentage of the State's growing low income part-time/seasonal workforce are:

- Jobs related to tourism, in which there are 33,000 part-time/seasonal jobs
- Jobs at food and beverage and department stores, at which there are 17,000 part-time/seasonal jobs.

Lessons Learned from Maine's Prior Reform Efforts

Maine has a long history of initiatives to expand access to both public and private coverage. Medicaid now covers nearly 21% of the population, including childless adults below poverty; insurance market reforms provide for guaranteed issue and modified community rating in the individual and small group markets, several Maine hospitals provide innovative programs to cover the low income uninsured (e.g., CarePartners¹⁶) and in 2003 Maine enacted Dirigo Health Reform.

The Dirigo Health Reform legislation was designed to make affordable quality coverage available to every Mainer. It is a comprehensive approach that includes strategies to reduce costs, increase access and improve the quality of health care in Maine. First, the program builds

¹⁴ Elise Scala and Lisa Morris, (2007) *Internal Report with Research Findings for the Grant Demonstration Project, Providing Health Coverage and Other Services to Recruit and Retain Direct Service Community Workers*, funded by the federal Centers for Medicare and Medicaid Services Grant # 11-P-92187/1-01.

¹⁵ Lisa Pohlmann, "A New State Study on the Direct Care Workforce", *Choices: Ideas for Shared Prosperity*, Maine Center for Economic Policy (April 25, 2007), Volume XIII, Number 3.

¹⁶ Since 1999 MaineHealth, the largest health system in the state, has administered CarePartners in an attempt to re-design uncompensated care to be delivered in a more coherent, accessible, and effective manner. The program serves people between 18 and 65 who are not eligible for other public programs and who have low incomes below 175% of poverty and are uninsured.

on the state's Medicaid program, MaineCare, and includes a modest expansion of eligibility. Second, it builds a bridge, DirigoChoice, between Medicaid and private insurance to eliminate the cliff of eligibility that now exists in the Medicaid program. DirigoChoice offers an sliding scale subsidy for a private health insurance plan with premium, deductible and out-of-pocket costs based on household income. The third and perhaps most significant of the Dirigo Health Reform strategies was a series of initiatives to restrain costs, and invest in public health strategies and to ensure coverage remained affordable to those now covered. The law reinvented state health planning, established a Capital Investment Fund to align capital spending with state planning priorities and launched a major initiative to establish a public health system for Maine.

An Advisory Council for Health System Development (ACHSD), established by the law, is charged with reviewing cost drivers in the health care system in Maine and making recommendations to the Legislature. It recently reviewed data on variation in health care in Maine based on a report from the Maine Quality Forum and the Forum's contractor, Health Dialog. ACHSD concluded that as much as \$400 million in savings could be achieved by reducing the significant variation that exists across the state in hospital admissions and outpatient services. The Legislature has now charged ACHSD with making recommendations next year on payment reform strategies.

Many of the proposals in the original reform bill met with fierce opposition. Insurers rejected the proposed funding mechanism – a 4% assessment that could not be passed on to premium payers. Hospitals resisted proposed global budgets. As a result, global budgets were replaced by voluntary hospital targets for cost containment and, later, a Hospital Cooperation Act that encouraged the collaboration of hospitals and protected them from anti-trust suits. (One significant merger of two hospitals has already occurred as a result of this law.) The proposed assessment on insurers and third-party administrators was replaced with a Savings Offset Payment. The Agency would be allowed to assess up to 4% of paid claims but only if savings in the health care system could be documented. The law set up a process for the Agency's Board to determine savings; those savings had to be validated by the independent Superintendent of Insurance in a separate proceeding.

The Savings Offset Payment proved to be the most contentious part of the Dirigo Health Reform. Insurers, the health plans and the Maine State Chamber of Commerce and others challenged the Savings Offset Payment in court. The case went all the way to the Maine Supreme Court where the Agency was upheld. Additional difficulties arose from an amendment in the Legislature which allowed the annual Savings Offset Payment to effectively be paid by insurers over a 27-month period, causing significant cash flow problems for the Agency that required cash advances and borrowing from the state. After several years of battle, the parties were able to achieve a new funding mechanism in 2007 in the Legislature that included a fixed assessment replacing the Savings Offset Payment and new funding through the imposition of small taxes on soda, beer and wine. Regrettably, that legislation was challenged by a Peoples' Veto, "Fed Up With Taxes", that was successful in overturning the Legislature and depriving the Agency of a new funding source.

The Agency was required to cap enrollment to ensure DirigoChoice operated within its budget. Governor Baldacci proposed this year an amendment that eliminates the Savings Offset Payment

and converts it to a fixed 2.14% assessment on paid claims (PL 2009 Chapter 359, “An Act To Stabilize Funding and Enable DirigoChoice To Reach More Uninsured”). In June, the Legislature enacted the Governor’s bill, putting an end to the controversy over the financing, allowing the program to re-pay the borrowing from the state, and to restructure its program offerings and re-open enrollment in July 2010.

In his bill the Governor further instructs the Agency to re-design the program, as it has long wanted to do, to provide more affordable options in the marketplace by: (1) developing new products and procedures that can reach additional uninsured and under-insured residents of the state to reduce uncompensated care; (2) using subsidies to maximize federal initiatives including Medicaid and any other national health reform; and (3) considering offering a voucher-based program to provide health insurance benefits. The Agency’s Board must report to the Legislature its changes to the DirigoChoice product by January 1, 2010. These mandates align with the opportunities provided by the SHAP program to reach new uninsured populations through new programmatic initiatives.

Despite a contentious start, the Agency has proven itself flexible and effective at program development and administration and has successfully targeted Maine’s “micro-businesses”, sole proprietors and individuals. The current contractor, HPHC, is Maine’s only non-profit health insurer and has been a solid partner through difficult times with a keen interest in expanding coverage. HPHC also has expertise from its experience in its home state of Massachusetts with uninsured initiatives. The partnership is a promising one for this coverage expansion proposal. HPHC’s contract with the Agency expires June 30, 2010. State purchasing rules require the Agency to submit a request for proposals to the marketplace for a new contract effective July 1, 2010.

The history of establishing the Dirigo Health Reform and, particularly, DirigoChoice has provided the state with significant experience that informs this proposal. Specifically, the Health Action Team that helped design the Dirigo program was dissolved after enactment of the original law. Clearly, one lesson from the initiative is that it is important to keep stakeholders at the table and to continue to work with them in developing and refining the program. While stakeholder input was ensured through a number of Advisory Groups and the independent Board for the Agency, maximizing stakeholder input is important to program design, implementation and sustainability. Importantly, the financing for any expansion initiative needs to be transparent and supported. Maine’s original proposal to pool employer dollars with other state resources to match Medicaid proved unsuccessful. Medicaid is an essential partner to ensure success of any expansion initiative. That lesson informs this proposal and we will seek a new Medicaid waiver to support these efforts.

As part of its administration of DirigoChoice, in January 2005, the Agency engaged in a marketing campaign that was designed to introduce DirigoChoice to the market, strengthen brand awareness, and emphasize the value proposition to our target market. As part of the campaign the following activities occurred:

- TV / Radio / Print blitz- Fall 2005
- Direct Mail to over 30,000 Small Business- Fall 2005

- TV blitz- Fall 2006
- Direct Mail to over 30,000 Small Businesses- Fall 2006

The result of the Agency's investment in its marketing efforts, based on an independent survey, was that 51% of Small Business and Sole Prop and 64% of Individual members learned about DirigoChoice through media (print, TV, and/or radio). Based on this experience we believe a comprehensive marketing campaign and an effective branding strategy are necessary and critical components of both the initial and proposed new programs. We will look to leverage our past experience and partner with a strategic marketing and research company that will assist us in building a marketing campaign for the Dirigo Exchange and DirigoConnect.

With enactment of the Governor's bill, these political discussions shift from the financing of the program to more constructive conversations about the breadth and design of the cost, quality, and access initiatives in the state. With a new and less controversial funding source the DirigoChoice program has a secure future.

National Context and Impact of Other State Approaches

The initiative outlined in this proposal has been informed by the examples set in the neighboring states of Massachusetts and Vermont. The proposed new approach to expand the Agency's capacity to serve as a health exchange will be done after a close study of the operations and impact of the Connector in Massachusetts. Similarly, the proposal to provide vouchers for individuals to purchase employer sponsored insurance will benefit from an examination of the experience with a similar approach in Vermont. These programs in neighboring states have also been under close observation by Maine stakeholders. Maine's proposed approach has garnered the support of important constituents in Maine, both those who have led the Court challenges and those frustrated by continued barriers to coverage. For example, The Maine State Chamber of Commerce, which has consistently challenged the program's funding, has agreed to support this program and serve on the Business Advisory Group. Also, the direct-care workforce, the subject of years of analysis and failed legislative attempts to provide affordable coverage, is participating in and supporting this initiative.

While the outcome of current health reform efforts at the national level is unknown, two factors seem certain. First, the high priority given to health reform by both the current administration and Congress increases the probability of a shared federal state partnership in expanding health coverage to uninsured populations. Second, there appears to be unanimity in support of approaches that build on, or leave in place, the current employer-based system of coverage. These dynamics are significant both to Maine's current reform structure and to the proposed new programs targeted to part-time and seasonal workers. Not just in Maine, but nationally, the population most vulnerable to falling through the cracks in an employer-based coverage system is the transitional and marginal workforce. As employed individuals, their incomes are frequently just above eligibility thresholds for safety net programs like Medicaid. As part-timers, they usually do not receive the level of employer contribution toward benefits as do full-time workers. And seasonal workers who may shift from employer to employer or from self-employed to employee status, do not "fit" with a system where the point of entry to health coverage is stable

employment. Maine's efforts to find a solution for this vulnerable population may help inform national models of coverage.

Maine exemplifies the dilemma of states addressing the access problem alone. Already a revenue poor state with unusually high health care costs, the stress on public sector initiatives is intensified when economic downturns increase need while simultaneously decreasing state revenues. Maine looks forward to an increased role for the federal government in ensuring access to all citizens. Most immediately, and relevant to the proposed coverage expansions, Maine will apply for federal waiver approval to insure federal participation in current and proposed access expansions to low income part-time/seasonal workers.

Maine's commitment to maintaining its side of this partnership is demonstrated through its recommitment, this legislative session, to state funding of its access programs, despite severe budget shortfalls, and its commitment (described elsewhere in this proposal) to provide state matching dollars for the proposed access expansions to part-time workers in large businesses.

METHODOLOGY

Approach

The proposed initiative has as its primary goal the extension of health insurance coverage to a particularly challenging population: low income, part-time and seasonal workers and their dependents. The project will implement two complementary strategies each providing an alternative route to health coverage. A voucher program will provide financial assistance toward the purchase of coverage through existing credible employer health benefit plans; a DirigoChoice insurance product (with subsidies for uninsured low income part-time/seasonal workers) will provide an alternative coverage option for these workers where employer benefits do not meet the definition of credible coverage or are not available. This latter option will be developed with extensive consultation with employers, providers and consumer advocates.

Maine's Governor's Office of Health Policy and Finance (The Governor's Office) and the Agency will dedicate in-kind staff support to develop and implement the voucher program for uninsured low income part-time/seasonal workers in large businesses and will develop protocols to link newly covered workers to Maine's Universal Wellness initiative by January 1, 2010. By July 1, 2010, a new DirigoChoice product will be developed for employees who do not have access to credible coverage. The voucher program will use the existing infrastructure of the Agency and expand its scope to serve as an "exchange", linking eligible employees to credible employer sponsored insurance. The new DirigoChoice product will rely on the existing Agency infrastructure which already has the capacity to provide enrollment and subsidization functions on behalf of both group and non-group enrollees in DirigoChoice.

Maine will meet HRSA's objectives by launching its first new coverage initiative within 4 months of project start-up.

The Agency's contract with HPHC limits enrollment of individuals to 50% of the total DirigoChoice population. In the fall of 2009 the Agency will request bids for a new contract

with a health insurance carrier with an effective date of July 1, 2010. The Agency plans to open enrollment to individuals, sole proprietors, and small businesses concurrent with the new contract. Included in the request for bids will be new specifications for the target population detailed in this proposal: uninsured low income, part-time/seasonal workers. Consistent with the new specifications, the Agency will require elimination of the 50% limit on individual enrollment.

Program One – The Exchange

The Agency will create a voucher program designed to assist uninsured, low income, part-time/seasonal workers to purchase credible coverage through their large employers. Learning from the lessons of Massachusetts and Utah, the Agency will establish rules for the exchange and create criteria for credible coverage to ensure that the vouchers pay for health insurance that meet standards for comprehensive health benefits including preventative services. One criterion for credible coverage will be a requirement for participation by the insurer in Maine's Patient Centered Medical Home demonstration described earlier.

The Agency is currently administering a sliding scale subsidy program. The new voucher program will follow the same subsidy strategy now successfully deployed in the DirigoChoice product. Specifically, the Agency will screen applicants to determine eligibility for subsidies (in this case vouchers) based on their household income. However, to ensure equity in the voucher program the actuarial value of diverse benefits packages needs to be determined to ensure that subsidies equalize program participant contributions in relation to premium, deductibles, and out-of-pocket maximums. The Agency will contract for actuarial assistance to develop an algorithm to ensure equitable levels of subsidy payments. In order for the program to function smoothly with existing employer payroll deduction procedures, the vouchers will be administered through Electronic Benefit Transfers (an EBT card) to project participants. The Agency already has the appropriate contracts in place and uses the EBT for its subsidy program in DirigoChoice.

The Exchange initiative will begin coverage January 1, 2010.

Program Two – DirigoConnect

While the voucher program will be a significant new option for uninsured low income part-time/seasonal workers who currently cannot afford their employer's credible coverage, we recognize that significant numbers of these workers are not offered credible insurance or are not offered insurance at all. Therefore we are proposing a second program targeted at these workers that will go live July 1, 2010. The Agency will design this program with full transparency to be an innovative product offering for a low wage, part-time and intermittent workforce. Grant funds will fund actuarial assistance, research, marketing, and discussions with Massachusetts and Utah regarding their experiences to date.

One option that is under negotiation and may form the basis of the new product is an effort to partner with an already operational hospital-sponsored safety net program where providers donate services to eligible uninsured indigent patients and the parent (private, not-for-profit)

health company subsidizes prescription and hospitalization costs. Under this model, the provider organization will continue to sponsor and subsidize front-end health care needs and the Agency will provide a wrap-around, high-deductible health insurance product that covers the costs of enrolled individuals after an agreed upon threshold in spending.

Between these two programs we anticipate assisting 3,500 low income part-time/seasonal workers and their dependents access affordable health coverage.

Use of Grant Funds

Maine has invested in and created the infrastructure to allow coverage expansion through the Agency. The State also has the capacity to ensure sustainability and necessary policy changes through the Governor's Office, the lead for this project. Grant funds will be essential to design the exchange; establish its operational rules and protocols; to fund actuarial assistance to craft the voucher program and the subsidy algorithm; to conduct research through focus groups; to provide marketing and outreach strategies; and to support the stakeholder engagement critical to ensure sustainability of the program beyond its five years of grant funding.

In year one we request \$8,500,000 in grant funds for program start-up costs associated with actuarial assistance, plan development, research, marketing, and subsidies. The State plans to match these grant funds at 20%, providing \$1,700,000. We project that 79% of the overall project expenditures and 77% of the grant funds will be applied directly to the voucher and subsidization costs of the new outreach programs. An additional \$120,120 is being set aside for program evaluation activities. In years two through five, most grant funds (89%) will be applied directly to the voucher and subsidization costs of enrollees in the two new state initiatives. Please see Budget Justification narrative for a detailed proposed allocation of grant funds.

Our projection of 3,500 enrollees is based on:

- The current average costs per large group member as reported by insurers in the state¹⁷ trended forward by 6% for the time period September 2009 – September 2010: \$406.11.
- The average Agency premium subsidy for current DirigoChoice enrollees in businesses: 38%.
- The average contract size for current DirigoChoice contracts and other comparable markets as reported by insurers in the state: 1.6 members per contract.
- An assumption that employers will contribute toward the cost of their employees' health insurance: at least 35%.

Based on these assumptions, the Agency calculates that its average subsidy cost per member per month will be \$188.50. Assuming an even distribution of grant and State funds for subsidy

¹⁷ Health insurers in Maine are required to report their annual costs per enrollee per market segment to the Bureau of Insurance (the 945 reports).

during year one, the total amount for subsidy in any given month will be approximately \$670,477 (\$8,045,718 / 12 months). Therefore the Agency will be able to provide subsidies to approximately 3,557 members in any given month ($\$670,477 / \188.50)¹⁸.

Readiness to Implement

The law that created the Agency includes language authorizing the Agency to expand its coverage to large employers. That law (24-A MRSA, Ch. 87, §6902) allows the Agency, after one year of operation, to define “eligible business” by rule to include large public and private employers. The Agency will conduct necessary rulemaking to implement the uninsured low income part-time/seasonal worker initiative.

The Agency is an independent state agency, governed by a Board of Trustees made up of nine voting members and four ex-officio members appointed by the Governor and confirmed by the Maine State Senate. The thirteen-member Board is chaired by Dr. Robert McAfee of Portland, former president of the American Medical Association. Two members are appointed by the Minority Leaders in the Maine House and Senate to ensure bi-partisanship. The four ex-officio members include the Director of the Governor’s Office, the State Treasurer, and the Commissioners of the Department of Finance and Administrative Services and the Department of Professional and Financial Regulation. The Agency’s Executive Director serves at the pleasure of the Board. The Agency has been operational since 2003 and administers the DirigoChoice subsidized health plan, Medicaid parent expansion and the Maine Quality Forum.

Universal Wellness

The Legislature recently enacted LD 1363, “An Act To Establish and Promote Statewide Collaboration and Coordination in Public Health Activities and To Enact a Universal Wellness Initiative”, which makes permanent the public health infrastructure established through the Dirigo Health Reform and its Public Health Workgroup, convened by the Governor’s Office and Maine CDC. This infrastructure consolidates 128 disparate grants to fund 28 Healthy Maine Partnerships statewide; strengthens the local health officer system, establishes 8 public health districts with out-stationed CDC staffs, creates in each district a Coordinating Council and a statewide Coordinating Council. The law charges the infrastructure to create Maine’s Universal Wellness initiative, incorporating many of the goals of Healthy People 2010 and of Maine’s State Health Plan, which aims to make Maine the healthiest state in the nation.

Work is underway at Maine CDC and with this public health infrastructure to identify an appropriate Health Risk Assessment, revise it as needed to meet the population’s cultural and linguistic needs, and have it available on-line and in public places for those without access to computers. The Health Risk Assessment will identify behavioral risk factors and provide feedback to all who complete it. In addition, information will be provided to link people to appropriate community based resources and support. A report card based on Healthy Maine 2010 data, will report trends over time on health status by district.

¹⁸ Our projections are based on most recently available data, and are subject to reforecast as market conditions and enrollment patterns change

The coverage expansion initiatives will coordinate with Maine CDC and the Universal Wellness initiative to ensure compatible messaging, outreach and marketing. We will encourage employers who offer worksite wellness to include low income part-time/seasonal workers. The Universal Wellness initiative will launch a pilot test in July 2009, with a statewide launch January 2010. This will ensure maximum coordination with the Dirigo Exchange.

Tasks and Timetable

A detailed description of tasks and timetable are presented in Attachment 3. The first proposed initiative, the voucher program, will be implemented January 1, 2010. This initiative requires the Agency to establish the administrative functions to serve as an Exchange, to create protocols that define credible coverage and subsidies based on worker household income and insurance features, and to create a mechanism to provide vouchers to eligible workers. The second initiative, DirigoConnect, will be implemented July 1, 2010. This initiative will require input from seasonal employers and workers as well as an understanding of the regulations governing this type of plan both on a state and federal level. The Agency will conduct focus groups and research these issues in order to obtain this understanding. The Agency will further establish the administrative functions to provide this product, create protocols for subsidies based on worker household income, and create the appropriate mechanisms for distribution of the subsidies and collection of multiple employer contributions.

Pre-Implementation Activities

Pre-implementation activities are those tasks specifically related to the start up of the proposed expansion programs.

The Governor's Office and the Agency will form a project leadership team who will be responsible for developing and maintaining a detailed project plan. This plan will allow the project team to plan, measure progress against key milestones, allocate resources, and take appropriate action for contingencies. The project leadership team will conduct weekly meetings with the appropriate staff and consulting resources, produce regular management reports for ACHSD and HRSA, and will be responsible for the overall leadership of the project.

The Agency and the Governor's Office will establish a Business Advisory Group composed of business representatives and consumers to provide guidance and input on the development and administration of the programs.

The Governor's Office and the Agency will work with ACHSD and the Agency Board to gain guidance and direction on issues of policy and sustainability.

The Agency will conduct a series of focus groups in order to better understand the needs and challenges of employers employing part-time/seasonal employees and to gain insight on how to market the program offerings to the employers and their part-time/seasonal employees. The Agency will work with its consultant to interpret the results of the focus groups and incorporate these results into the design of its two programs and marketing strategy.

The Agency will engage in an actuarial analysis of its target population and the current large employer plan offerings (i.e., level of deductibles, co-insurance, co-payments, core coverage, exclusions, lifetime limitations, and HSA options) available to low income, uninsured, part-time/seasonal workforce. This analysis will inform the program's design, eligibility guidelines, and policy.

The Agency will also consider the feasibility, regulatory, and actuarial issues relating to connecting multiple employers of part-time/seasonal workers under a single coverage plan for shared employees.

Once the plan is designed, the Agency will work further with its actuary to develop its initial monthly enrollment and cost projections.

The Agency will engage in a marketing plan to build public support for expanded access initiatives, encourage large businesses with low-income, part-time/seasonal, uninsured employees to support the program, promote awareness of the program among low-income, part-time/seasonal, uninsured employees. The marketing plan will incorporate feedback from the focus groups analysis as well as input from the Business Advisory Group.

The plan will define the Agency's objectives, creative strategy and approach, customer insight, value proposition, and overall tactics. The plan will include analysis of best media (i.e., print / radio / television / internet). This analysis will also include an examination of how to maximize the media buys for greatest reach. The Agency will launch and run the media campaign over the period(s) of time that best promote awareness of the program consistent with program go-live. The Agency will coordinate the marketing effort with the Maine Center for Disease Control (CDC) and the State's Universal Wellness initiative. Finally, the marketing plan will include development of a web site presence in order to provide information to the target populations as well as identified stakeholders.

Implementation Activities

Implementation activities are those tasks relating to the administration and ongoing support of the program.

The Agency will provide ongoing technical and end-user support for the technical systems developed for the programs, including help-desk and troubleshooting services.

The Agency will provide ongoing financial operations support for the program, including monthly reporting and accounting services as required.

The Agency will respond to all incoming requests for information on the new programs.

Agency staff will maintain enrollment processing / eligibility determination operations. Agency staff will continue to provide supervisory and management functions for the operations and support of the programs.

The Agency will provide ongoing, periodic financial and enrollment reports (as defined in the pre-implementation activities)

The Agency will provide ongoing enrollment and financial forecasting, as well as annual/quarterly budgets.

The Governor's Office and the Agency will continue to sponsor The Business Advisory Group. The Group will monitor actual enrollment to projections, actual program costs to projections, and recommend corrective actions as appropriate.

The Governor's Office and the Agency will manage a formal communication plan focusing on:

- Goals and benchmarks
- Actual enrollment to projections
- Actual program costs to projections

Post Implementation Activities

Post implementation tasks will include program evaluation and monitoring activities. Please see the Evaluation section below for further details on these tasks.

The Governor's Office and the Agency will continue to sponsor The Business Advisory Group. The Group will monitor actual enrollment to projections, actual program costs to projections, and recommend corrective actions as appropriate.

The Governor's Office and the Agency will manage a formal communication plan focusing on:

- Goals and benchmarks
- Actual enrollment to projections
- Actual program costs to projections

Maximizing Enrollment

In order to maximize enrollment we seek grant funds to support a comprehensive marketing strategy for both the voucher program and DirigoConnect. The Agency will contract for a marketing and research companies to conduct focus groups and implement a statewide marketing campaign. In addition, we will work closely with Consumers for Affordable Health Care, a private non-profit organization with a significant track record in reaching the uninsured. Consumers for Affordable Health Care whose director has agreed to serve on the Business Advisory Group, has a statewide outreach capacity and a hotline for people seeking affordable health coverage. Both Consumers for Affordable Health Care and the Business Advisory Group will be critical components of our outreach and marketing strategy. In addition, the Maine State Chamber of Commerce, as a member of the Business Advisory Group will be instrumental in helping us reach employers to complement the consumer outreach to workers. Membership will

include Home Care for Maine, a major employer of part-time direct care workers; the Director of Maine's Office of Tourism, part-time workers; and the Superintendent of Maine's Bureau of Insurance. Letters of commitment are included.

Project Leadership, Collaboration, Contractors and Supporters

The Governor's Office is the governor-designated lead agency for these initiatives. The Governor's Office will work in close collaboration with the Agency which will house and operate the new program initiatives and maintain oversight of the contractual relationships with the insurance partner.

Details of the individuals in leadership roles are provided in Attachment 5. Job descriptions for key personnel are provided in Attachment 4.

The Governor's Office and the Agency will work in close consultation with ACHSD and the Business Advisory Group. In addition, the Agency will report to its Board on these new initiatives, as it currently does for its existing programs.

We envision at least three subcontractors to assist in the development of these initiatives: actuarial, marketing/research and sustainability. Due to state purchasing rules, contractors will be chosen through a competitive bidding process. Program evaluation will be carried out by researchers from the Muskie School of the University of Southern Maine which provides research support to Maine State Government through legislatively authorized cooperative agreements. Funds and a detailed budget for the evaluation are included in the grant budget justification narrative.

Identification and documentation of existing critical program components and key relationships needed to accomplish program goals.

The Agency does not act as an insurer but contracts for insurance coverage on behalf of its clients. As indicated earlier, the current insurance partner for existing DirigoChoice products is HPHC. Obtaining the cooperation and active support of this organization is key to the success of the proposed initiatives. As indicated earlier, current contractual arrangements with HPHC limit on a percentage basis the number of enrollees insured as individuals rather than as small groups or sole proprietors. While the voucher program will not affect the partnership with HPHC, the launching of a new Dirigo product targeted to uninsured low income part-time/seasonal workers who do not have access to employer-based coverage will expand Dirigo products to a new, individually enrolled population. The working relationship between the Agency and HPHC has been positive and negotiations around this new initiative are promising. However, as indicated earlier, the insurance contract for DirigoChoice is scheduled to be rebid allowing an opportunity to seek alternative relationships should the need arise.

Discussion of strategies to enhance the utility of HRSA funded program and to produce information to share with other states.

Maine's proposed initiatives tackle a "problem" population where there is little experience of success in extending employer-based coverage. As such, Maine's experience in developing alternative coverage models for uninsured low income part-time and seasonal workers may provide information of value to other states and federal policymakers. Maine will actively participate in HRSA sponsored grantee meetings and, if appropriate, will initiate a list serv and regular conference calls among related state projects to exchange best practices, ideas and products. In addition, we will post at our website all products developed by the project. We anticipate the following products:

- (1) Algorithm to determine benefit value and subsidy/voucher amount (software);
- (2) Strategies to effectively reach and cover the uninsured low income part-time large business workforce;
- (3) Marketing materials including broker incentives; and
- (4) Web-based health risk assessment with feedback from and strategies to link individuals to community resources to improve wellness.

How the plan will contribute to national information and relevance to Healthy People: 2010

Maine anticipates developing regular reports on project progress and products and participating in HRSA sponsored and other national meetings to disseminate that information. Specifically, by focusing on part-time workers in industries that have historically had difficulty affording coverage and/or ensuring low wage workers could access it, the project will provide new information to the national discussion. The rural nature of Maine and our emphasis on the direct care and tourism industries may provide information for the national debate. In addition, an integral part of the project is to link our access initiative with our comprehensive public health initiative. We recognize that uninsured low income part-time/seasonal workers do not readily have access to workplace wellness initiatives, even if they are offered by the employer. Therefore, this project will link participants in the project directly with community resources and our universal wellness initiative to ensure health risk assessments are conducted and reported on and individuals know, understand and take action to reduce their behavioral risks for disease and disability.

By linking a public health initiative and an access initiative we will address Healthy People: 2010's goal to increase the quality and years of healthy life and specifically address Objective 1: "To improve access to comprehensive high quality health care services." Objective 7: To increase quality, availability and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life."

Cultural & Linguistic Competency

Public information produced during this project will comply with Cultural & Linguistic Competency defined in HRSA strategic Goal 3, Objective 3.3: "Promote access to, and appropriate use of, health care information and Goal 4, Objective 4.3: "Promote the integration of cultural competency into HRSA programs, policies, and practices". Maine CDC's Office of Minority Health will advise on cultural diversity.

Reporting

The project management team will comply with all HRSA reporting and review requirements, including:

- Audit Requirements
- Payment Management Requirements
- Financial Status Report
- Progress Report
- Performance Review

State Matching Requirements

Over the past year, the fiscal challenges facing state government have grown increasingly more difficult. Maine's economic forecast has tracked the deterioration seen nationally; each subsequent forecast has grown more and more pessimistic. The same stressors impacting the national economy have taken their toll in this state and, despite the 2008 efforts at federal interventions such as the stimulus bill, economic conditions continue to weaken, leading to job losses, a freeze on credit and a high level of anxiety among consumers and businesses. The underlying weakness of the national economy, in conjunction with the wind-down and impending closure of the Brunswick Naval Air Station have been primary drivers in the deterioration of Maine's economic forecast.

The state's revenue stream has spiraled downward at a stunning rate. The December 2008 revenue forecast adjusted General Fund revenues downward by more than \$140 million on a base of slightly less than \$3 billion. The forecast was revised again in May, again reduced by another \$129 million. In the very same month, actual revenue fell short of the revised projections by more than \$20 million, primarily driven by shortfalls in the sales, income tax and withholding lines, reflecting the underlying weakness in Maine's job market and consumer/business confidence.

This economic climate has resulted in the development and enactment of a General Fund budget that reflects markedly lower spending levels than seen in the past several years. The budget for the biennium beginning July 1, 2009 is comparable to that in place in 1996 and reflects difficult reductions in spending across State government.

Despite the hardship these circumstances have created, Maine policymakers have demonstrated an ongoing, steadfast commitment to ensuring access to appropriate health care services for Maine citizens. In the legislative session ending this June, the legislature enacted a new funding arrangement for the Agency and the health programs the agency sponsors by authorizing an annual assessment of 2.14% of paid claims on insurers and self-funded employer benefit plans as a revenue source for the Agency's programs. In addition, the Agency will continue to receive approximately \$ 5,000,000 annually from the Fund for Healthy Maine, Maine's revenues from the tobacco settlement.

Despite the unusually harsh economic climate, Maine will demonstrate its commitment to the new proposed initiatives and reinforce its claims to long-term sustainability by waiving a hardship claim in this application and providing the required 20% match through a combination of in-kind contributions and an allocation of a portion of the Agency's revenues toward these new expansion programs.

Sustainability Plan

Maine has sustained its Dirigo Health Reform initiative for six years, despite significant political, economic and legal challenges. The team that has successfully sustained the current comprehensive reform initiative is committed to sustain and grow the part-time worker coverage expansion funded through this grant beyond the five years of the grant period. Specifically, the team with input from ACHSD and the Business Advisory Group, will build a significant stakeholder investment in the project and its sustainability. A key lesson learned from the controversy over Dirigo financing, discussed earlier, is that transparency and sustained, consistent stakeholder input is key to program success and sustainability. This strategy will be crucially important, particularly given that in 2011 a new Governor will take office. Therefore, the sustainability strategy will launch on Day One of the project to ensure its success.

The project design includes extensive transparency and engagement by a bi-partisan group of stakeholders. The Agency's Board includes two appointees appointed by Minority leaders in the Legislature, in addition to those appointed by the Governor and confirmed by the Senate. The Board will now have broad oversight over program design and, the establishment of the Exchange and all program and marketing activities. Members of ACHSD are appointed by the Governor with review by the Legislature and include five bi-partisan Legislators appointed directly by the Legislature. Both bodies will be instrumental in program implementation and oversight and all members serve terms that are not co-terminus with the Governor and all meetings are public. In addition a Business Advisory Group will be formed for the duration of the project. All meetings will be held in public and extensive stakeholder outreach will ensure engagement of all key stakeholders in the program implementation and the plans for sustainability.

The Business Advisory Group will be appointed by the Governor, following a nomination process and guidance from ACHSD.

The project proposes three approaches to secure sustainable funding beyond the grant period.

(1) A Medicaid waiver for coverage for people below 300% of the federal poverty level. Both the current DirigoChoice program and the proposed expansion program to cover uninsured, low income, part-time/seasonal workers in large firms target individuals with incomes at this level. Dirigo initially sought Medicaid funding by pooling employer contributions to increase state match and draw down Federal funds. Last year CMS rejected this approach. With grant support we will examine how Massachusetts and Vermont were able to achieve waivers for programs similar to the Dirigo Health Reform. They, too, provide sliding scale subsidies to purchase coverage for people below 300% of the federal poverty level. Both states were able to secure Medicaid financing through Medicaid waivers to assist in financing coverage to those

populations. With the assistance of grant funding, we will secure consultants with expertise in Medicaid waivers and in the Massachusetts and Vermont designs to develop a similar waiver request in the first year of the project. Should we be successful in securing Medicaid funds, those dollars would be available to sustain and grow the uninsured, low-income, part-time/seasonal worker program beyond the grant period. Maine's DHHS will be a partner in this activity and will be responsible for seeking the waiver as the single state Medicaid agency. As a result of PL 2009 Chapter 359, the Agency has the authority to seek a Federal waiver both to continue the current coverage categories and to expand coverage, as initiated through this grant.

The Governor's Office and ACHSD will lead the sustainability work. We will seek, in a competitive bidding process, consultants with proven track records in Medicaid waivers for expansion populations and we will build on Maine's success in achieving and administering waivers, such as that which supports childless adults.

Our goal is to seek a waiver within the first year of grant award in hopes of obtaining approval in 2010 before a new Governor takes office. In the event that is not possible, the Governor's Office of Health Policy and Finance will develop a detailed transition document with DHHS and the Agency. The direct and regular involvement of ACHSD and its bi-partisan legislative members will further ensure a successful transition.

We expect, based on similar populations served by waivers in Massachusetts and Utah, that we will be successful but recognize the process to develop, submit, negotiate and secure a waiver of this magnitude is unpredictable. And, adequate time will be required for needed rulemaking prior to the launch of a new waiver. Thus, we anticipate the earliest a waiver could "go live" would be 2011.

(2) Shared Responsibility. In 2007, Governor Baldacci proposed a shared responsibility initiative to the Legislature based on the deliberations of a Blue Ribbon Commission on Dirigo Health Reform. That proposal included an individual mandate and a modified employer "pay or play" provision. The proposal was made to the Legislature just as the Massachusetts' Legislature was enacting its reforms and Maine's Legislature elected to hold off on implementing such a change in Maine pending the experience in Massachusetts. We will work with our Business Advisory Group, ACHSD, and the Agency's Board as well as the Legislature to develop a proposal for an individual mandate and a provision for an employer assessment on uninsured employees for review by the Maine State Legislature. The shared responsibility model will be developed to generate adequate revenue to continue the low income, part-time/seasonal worker program beyond the grant period. Grant funds are requested for a contract or contracts with expert consultants in shared responsibility and ERISA and for research into programs in Massachusetts, Vermont and San Francisco.

Maine's unsuccessful effort to enact a Shared Responsibility program in 2007 identified specific questions that will need to be addressed to gain legislative support. They include analyses of Massachusetts' and now other similar programs in San Francisco and Vermont; provisions to ensure affordability for low wage individuals and the survival of low margin businesses that are key to Maine's economic future. Small business, and service and tourism related industries, are the backbone of Maine's economy.

To develop a Shared Responsibility plan we will use our Business Advisory group and ACHSD to more fully understand stakeholder concerns. We will hold a series of educational forums with experts and state officials from “shared responsibility” states to better understand their experience. Consultants will provide necessary data analysis, model and test approaches and work with the Governor’s Office, the Business Advisory Group and ACHSD to develop a proposal by October 2010. The Governor’s Office staff will draft legislation for submission in the 125th Legislature which commences January 1, 2011. If successful, the law would be effective October 2011 and we would anticipate at best one year to develop and phase in the program. The grant created Exchange program will be critical to implement shared responsibility but provisions to assess individuals and employers will also require significant work by the Department of Administrative and Financial Services, significant public engagement and marketing .

The ACHSD, with its five legislative members and the Business Advisory Group will play a pivotal role in building public understanding. We would contemplate a Shared Responsibility law to be implemented no sooner than 2012, to ensure needed public buy-in, an equitable financing strategy and the capacity to provide coverage for not just the expansion population supported by this grant but a broader population of Maine’s remaining uninsured, now representing about 118,000 people.

(3) Success of national health reform. While the project’s sustainability does not rely on the success of national health reform, we are hopeful for such a result. Should the current proposal being deliberated by the Senate Finance Committee reflect a final national health reform strategy, for example, we would anticipate that the availability of tax credits for those below 400% of the federal poverty level who purchase in the individual and small group markets would relieve the Agency of its current responsibilities to fund subsidies for people below 300% of poverty in those markets. Those funds would then be available to sustain this HRSA initiative covering low income part-time/seasonal workers in large firms who would not be eligible for the tax credits as they are proposed today. We are well aware that the debate and deliberations are in early stages and that there are no guarantees that federal reform will be achieved, but we are supportive of that reform and want to make clear that we do not anticipate any new funds supplanting our current effort but rather allowing us to re-direct funds to sustain the initiatives funded through the HRSA grant.

As a result of recent legislation, the Agency will have secure and reliable funding of approximately \$42 million per year from the assessment on paid claims and about \$4.7 million from tobacco settlement dollars already funding the program to keep the program open and repay the state for previous borrowing.

In State Fiscal Year 2010 (July 2009 – June 2010) The Agency will spend approximately \$10,000,000 to repay the state and \$24,600,000 to continue current enrollment in DirigoChoice. During this period, enrollment will remain capped and DirigoChoice, now at about 9,600 members, will decline to about 5,500 as a result of expected attrition. However, by July 1, 2010, the state will be repaid. Ending this deficit allows the Agency to commit more of its annual funding to program expansion. Maine is committing \$1,700,000 million of those funds over the

next five years to match HRSA grant funds to allow the program to expand coverage to a new population group and to do so January 1, 2010. The Agency's remaining funds will be used to open enrollment to those currently eligible for DirigoChoice (small business, sole proprietors and individuals). However, Maine commits to continue its \$1,700,000 million cash contribution beyond the grant period to help sustain the program and will secure the remaining \$8,500,000 through Medicaid waivers and/or contributions provided through individual payments resulting from an individual mandate and contributions from employers who do not now pay for health insurance but would be required to do so as part of the shared responsibility legislation.

The project team will regularly report to both ACHSD and HRSA on progress in developing the sustainability models.

EVALUATION PLAN

Beginning in Year One and continuing through the duration of the five year HRSA grant, the major focus of the evaluation will be an assessment of progress toward stated goals through measurement of explicit benchmarks. The stated goals of the project are:

1. Expand the reach of the Agency to connect uninsured low income part-time/seasonal workers in large firms to affordable health coverage and to provide an option when employer sponsored insurance is unavailable.
2. Institute a marketing campaign to target uninsured low income part-time/seasonal workers and their employers.
3. Increase coverage of previously uninsured low income part-time/seasonal workers by 3,500 by 9/14/10.
4. Integrate public health objectives and link Dirigo low income part-time/seasonal participants to Maine's Universal Wellness initiative, ensuring each newly insured worker accesses a health risk assessment and is linked to the public health system and its community resources and that the project advances the goals of Healthy People 2010.
5. Ensure sustainability by obtaining federal waiver approval of existing and new access initiatives and by instituting a shared responsibility assessment on employers in proportion to their uninsured workforce.

The first year of the project includes program development and implementation activities. During this year, a major portion of the evaluation will focus on the achievement of specific dated milestones, identified in the project work plan, to monitor timely progress to the operational phase of the project. These Year One activities, focused on implementation are detailed below in the section on Program Implementation. The strategies for evaluating program goals over the five year life of the project are set out in the section, *Evaluation of Program Performance*.

The key staff of the evaluation team are currently engaged in a comparative analysis of current access expansions in Maine, Massachusetts and Vermont. The focus of this study (part of the

Robert Wood Johnson SHARE initiative) is on measurement of program costs, health care utilization by enrollees, and program sustainability. This analysis will provide helpful baseline and comparative data for the evaluation of the proposed new access initiatives in Maine.

Evaluation of Program Implementation

The Project Team has established January, 2010 as the start date for the voucher program and July 1, 2010 as the start date for the new DirigoConnect product targeted to uninsured low income part-time and seasonal workers. To bring these initiatives to the point where individuals start to receive coverage, between September, 2009 and July, 2010 project staff will:

- Develop agreements with insurance and provider partners
- Refine the insurance products
- Develop the necessary infrastructure modifications to accommodate the new programs
- Obtain Bureau of Insurance regulatory approval of product modifications and insurance contracts
- Conduct focus groups and develop a marketing campaign
- Hire and train new staff and
- Develop a working definition of credible insurance coverage.

In relationship to the goal of program sustainability, the Governor's Office, with consultants, will conduct analyses in preparation for a waiver application process to the Centers for Medicare and Medicaid to attain federal approval of the targeted population as an eligible waiver coverage population and of the program design as an allowable coverage strategy for the waiver group. Attaining this approval will provide the state with federal matching dollars toward the long-term coverage costs of this population beyond the period of the HRSA grant. In addition, the Governor's Office will be responsible for analyses of the shared responsibility programs in Vermont and Massachusetts inclusive of individual coverage mandates and assessments on employers proportional to the size of their uninsured workforce. As first steps in building political support for legislation to institute a similar shared responsibility framework in Maine, the Governor's Office will collect and share information on the structure, economic impact, and health care cost impact of these initiatives with the Business Advisory Group and the ACHSD.

During this period, the successful completion of clearly defined staged implementation steps with established deadlines will be used as milestones of program progress. The Executive Director of the Agency and the Director of the Governor's Office, as the project management team, will meet weekly to discuss progress, identify unanticipated problems and delays and identify corrections and solutions to implementation barriers. In addition, the management team will produce progress reports at monthly intervals for review by the Agency's Board and the Evaluation team. Based on these management reports, the Governor's Office will make quarterly progress reports to the Business Advisory Group and the ACHSD. These reports will provide a documentation record of implementation progress and keep oversight bodies apprised of the status of the new initiatives. **Specific action steps, timetable for completion, and metric of measurement are provided in Attachment 3.**

Evaluation of Program Performance and Progress to Project Goals

This proposed coverage expansion initiative has four overarching goals: to test two model strategies for extending health insurance coverage to low income part-time and seasonal workers; to reduce uninsurance to the maximum extent possible; to promote a primary care and prevention intensive model of health care delivery for newly insured and previously medically indigent populations; and to create a politically and financially sustainable coverage program drawing on both public and private funds. The evaluation will be organized around measuring the success of these four goals.

Year One Evaluation activities with regard to these stated goals will, of necessity, be primarily focused on the voucher program, since only three months of enrollment for the other initiative will fall within the first project year. Experience with the voucher program will be measured using the metrics listed below. For five of the eleven metrics, explicit benchmarks are being set to measure program experience against expectations and goals.

1. total program enrollment
2. year end net enrollment – Benchmark for first year: 3,500 covered lives
3. retention rate – Benchmark for first year: 80%
4. enrollee characteristics in terms of demographics, income, family composition and geographic location
5. enrollee satisfaction – Benchmark for first year: 40% satisfied or very satisfied with overall program experience
6. self-reported use of health care services and identification of a medical home – Benchmark for first year: 50% self-report an established relationship with a primary care provider
7. numbers and characteristics of employers participating in voucher program.
8. producer rating of program experience, identification of barriers, and strategies for improved enrollment performance
9. total grant costs and public costs – Benchmark for first year: total grant spending at or below \$8,500,000. Expenditures on coverage subsidies at or below \$8,045,718.
10. ratio of public costs to private (employer and enrollee) contribution
11. ratio of benefit plans deemed credible coverage to those deemed non-credible coverage among program applications

These measurements will be reviewed and analyzed by the evaluation team using de-identified administrative data made available through the Agency and a household telephone survey of a sample of program participants.

The findings will be presented descriptively and graphically in a report that will be presented to the Agency's Board, the Governor's Office, ACHSD, and the Business Advisory Group. Findings and reports will also be shared with the HRSA program office and at HRSA grantee meetings and will be disseminated, on request to state policymakers engaged in access initiatives

Evaluation Years Two through Five

The evaluation in years two through five of the project will be organized around the four stated goals: testing models of coverage for low-income part-time and seasonal workers; maximizing insurance coverage in the workforce; ensuring a medical home model of care that emphasizes primary care and prevention; and ensuring program sustainability.

Each year, the two plan models will be compared with each other and with the pre-existing DirigoChoice program targeted to small business and self-employed individuals on the metrics 1 – 5, listed above. This analysis will provide a comparative assessment of program growth rates, enrollment demographic profiles and enrollee satisfaction. Metrics 7 through 11 will be monitored in aggregate across the programs using Agency administrative data. Enrollee surveys are scheduled for years one, three and five of the project so that trends in enrollee satisfaction can be monitored and so that more detailed information on enrollees than is available through Agency administrative can be captured.

In addition, in years two through five, the evaluation team will undertake annual insurance claims analysis and reporting on the DirigoConnect initiative. The claims analysis can be used to compare health care utilization and costs, to test for adverse risk selection across program models, to monitor the extent of use of primary care services and medication use for chronic conditions. These analyses will be used to assess success in meeting the goal of ensuring appropriate primary and preventive care in a medical home setting and in assessing long-term financial sustainability.

Also in years two through five, the evaluation team will track the state's overall rate of uninsured through use of the Current Population Survey. While this database has limitations in monitoring changes from year to year given the broad confidence intervals around the relatively small sample from Maine, it will assist in the detection of trends over the full project period. In addition, if Maine successfully legislates and implements the shared responsibility initiative, inclusive of an individual mandate together with new employer assessments, this survey data base will allow the determination of the immediate impact of these new requirements on the Maine population.

Evaluation Qualitative Component

The data analysis will be supplemented in all five years of the project with a gathering of qualitative information through document compilation, observation and key informant interviews. Members of the evaluation team will attend the Agency' Board meetings, meetings of the ACHSD, Business Advisory Group meetings, and project planning meetings with consultants and stakeholders and other relevant public functions to observe the dialogue and will monitor legislative debates on bills relevant to the future status of the initiatives. Key informant interviews will be used, particularly toward the end of the five-year funded project to assess program support among important constituents.

The qualitative portion of the analysis will be used both to assess program sustainability and to maintain an on-going monitoring of program implementation and mid-course corrections to respond to operational problems. Among the activities that will be monitored using qualitative

techniques will be the state's progress in its waiver application and development of shared responsibility legislation.

Dissemination

The evaluation team will produce annual reports with findings from that year's analysis and with trend analyses based on comparing new findings with prior years' reports. These reports will be disseminated to the Dirigo Board, the Governor's Office, the Business Advisory Group and ACHSD and shared with HRSA grantee states through meeting presentations and production of white papers and/or papers for publication.

As indicated earlier, the evaluation team is currently analyzing both quantitative and qualitative data related to the access reforms in Maine, Massachusetts, and Vermont. To the extent that these earlier analyses provide contrasting or reinforcing information in relation to the evaluation data from Maine's proposed HRSA access initiative, these comparisons will be presented in a report intended for Maine's policymaker community and for a broader audience of policymakers and analysts engaged in federal reform design and in other state initiatives.

WORKPLAN

Management Accounting and Governance Structure

The grant will be managed by the Governor's Office, with grant budget and accounting services provided through the Department of Administration and Financial Services.

This initiative will be led by an experienced and seasoned project team with a long history of successful collaboration and shared responsibility. The project will be administered by the Governor's Office and its director, Trish Riley, will serve as Project Director with overall responsibility for grants management and ensuring project tasks are completed in full, on time and on budget. She will be the key liaison to HRSA and will be directly responsible for the Business Advisory Group, communication with all stakeholders including the ACHSD and Legislature and for developing and implementing the sustainability plan.

Karynlee Harrington, Director of the Agency, will be responsible for establishing and implementing the creation of the Exchange and the effort to develop a part-time/seasonal worker alternative product (DirigoConnect). She will lead the marketing and research efforts to support these initiatives. She will negotiate with a carrier or carriers to provide the product and enter into and administer contracts with those carriers. She will participate actively in developing and implementing the sustainability plan. She will also oversee the day to day operations of the new initiatives, once implemented, and will take primary responsibility for determining the need and structure of mid-course corrections based on reports and feedback from program monitoring.

Elizabeth Kilbreth, Associate Research Professor, Health Policy Institute, Muskie School of Public Service, will lead the evaluation of the project and participate as appropriate in HRSA meetings and other national meetings to share information about the project.

The project leaders, Trish Riley and Karynlee Harrington, and their teams will meet at least weekly to review progress and compliance with work plan goals. Their work plan (see Attachment 3) will be the organizing tool of the project. In addition, to provide maximum transparency and to ensure compliance with work plan goals and timetables, management team will report monthly to the Agency Board and quarterly to the Business Advisory Group and ACHSD.

DHHS will work collaboratively with the Governor's Office and the Agency regarding sustainability strategy to secure Medicaid waiver financing and its Centers for Disease Control will lead the Universal Wellness initiative and ensure appropriate linkages to the project. The Governor's Office currently convenes a bi-weekly Health Policy meeting that includes DHHS and the Agency. Those meetings will ensure coordination and collaboration between entities; provide early identification of potential delays; and be a forum to resolve issues.

RESOLUTION OF CHALLENGES

The members of the project team have worked closely and collaboratively over six years implementing the Dirigo Health Reform, programs that have been challenged politically, in the Courts, and financially. The team has withstood those challenges and consistently provided alternatives to address them. In this legislative session a bill was successfully enacted that ends the controversy over Dirigo financing and allows the program to stabilize, reorganize and rebuild, as discussed earlier in this proposal.

The track record of the project team speaks to its ability to respond flexibly and intelligently to both anticipated and unanticipated challenges. The DirigoChoice Program, in the short period of its operations has made many modifications to accommodate demands from employers and enrollees and to survive in an environment where funding has been always uncertain and frequently changing. In addition, the project team is proposing a structure to the proposed grant which will provide the base team with support from a wide range of expert consultants and allow delegation of analytic tasks, leaving the core team free to build an infrastructure of political and technical support, respectively, for the new programs.

We see two potential challenges to the work ahead. First, we are uncertain what the take-up rate will be of uninsured low income part-time/seasonal workers. Nor do we know how the changing economy in this recession has affected employer decisions about health coverage. Our Business Advisory Group will be able to provide helpful, timely information to keep abreast of a rapidly changing economic environment so that we can be flexible in how the project addresses its goals. Second, in 2011 a new Governor will take office in Maine. By engaging the Business Advisory Group, the Agency Board and the ACHSD, key stakeholder groups with legislative members who serve terms that are not coterminous with the Governor, significant public engagement will ensure a seamless transition. However, this will require the team to develop a comprehensive transition plan for the new Administration to ensure a seamless transition. It should be noted that when Governor Baldacci took office we inherited a HRSA Planning Grant from the previous Administration, notably an Administration not of the Governor's political party. The HRSA Planning Grant proved instrumental in launching Governor's Baldacci's Dirigo Health Reform

and providing important information to assist us. We expect the same transition in 2011 and note that we have built a sustainability plan that starts on Day One.

Maine's project targets an important and growing sector of the workforce – uninsured low income part-time and seasonal workers. Our experience in encouraging employer sponsored insurance and using an exchange mechanism to connect part-time workers to it will inform national experience as will the development of a low cost affordable product for low income part-time/seasonal workers without access to employer sponsored insurance.

Because Maine has already significantly reformed its insurance marketplaces (e.g., guaranteed issue, modified community rating) the means to establish an affordable product may require new linkages with provider based programs like CarePartners through which hospital systems provide primary care and support to the uninsured. We will work to explore relationships with those programs. Such a model would be particularly important in advancing the goals of Healthy People 2010 since those partner programs serve minority populations disproportionately and reach a very low income group and provide primary care to them.

EVALUATION AND TECHNICAL SUPPORT CAPACITY

Attachments 4 and 5 provide detailed job descriptions and professional experience for key personnel.

The members of the project team identified in this proposal have all been directly responsible for the development and/or implementation of the Dirigo Health Reform. The reform effort has, as described above, included a series of initiatives targeted at providing access to affordable health coverage in the State. Most relevantly, the team has been responsible for the development and implementation of DirigoChoice, the State's subsidized insurance product targeted at low-income uninsured and underinsured citizens who are unemployed, self-employed, or who work in small businesses.

This development and implementation work has involved all aspects of policy establishment, program design, system building, and operational support. The team brings a wide array of relevant experience in health policy, insurance operations, and technical development to the project, and has a proven track record of success in overall program development and rollout.

The team has also established a history of success in collaborating with a variety of other government departments and agencies (e.g., ACHSD, DHHS, CDC, Department of Financial Services, Maine Health Data Organization, Department of Labor), as well as private sector insurance companies (i.e., Anthem, Harvard Pilgrim Health Care), and community organizations (e.g., Consumers for Affordable Health Care, Maine Equal Justice, Office for the Aging).

The skills and experiences of the team include, but are not limited to:

- State Medicaid policy
- State insurance regulations
- Federal health policy

- Insurance industry operations (e.g., enrollment, claims processing, customer service, etc.)
- Insurance industry sales and marketing best practices
- Technical system development and support
- Government and Fortune 500 financial accounting practices

The research team for the proposed SHAP evaluation includes research faculty and senior policy analysts from the Muskie School Health Policy Institute who bring a range of quantitative and qualitative research skills to the project. For more than twenty years, the Muskie School has provided research support and policy analysis for agencies of Maine State Government, including the Department of Health, Maine CDC, the Agency, the Bureau of Insurance and the Maine legislature. Included on the team are researchers with substantial experience using national survey data and large insurance claims databases for analytic purposes. The Muskie team leader is currently the principal investigator of a Robert Wood Johnson Foundation funded study comparing the impact of health access initiatives in Maine, Massachusetts and Vermont.

ORGANIZATIONAL INFORMATION

The Governor's Office of Health Policy and Finance was established by Governor Baldacci with the mission of leading the state's health reform efforts. The Director of this Office, Trish Riley, has direct access to the Governor and is ideally positioned to coordinate the necessary participation of other government agencies such as the DHHS, the Bureau of Insurance, the Agency, and the Department of Labor. Staff for the Office provide the Governor's liaison to the Legislature and provide the Governor's representation to advisory bodies such as ACHSD. This Office and its Director can provide the necessary central coordination to undertake the development of the proposed initiatives.

The Dirigo Health Agency was established as part of the Dirigo Health Reform Act of 2003 with the mission of arranging for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. The Agency is also responsible for monitoring and improving the quality of health care in this State. The Agency administers the DirigoChoice Program, The MaineCare Parent Expansion, and the Maine Quality Forum. The Agency manages the contracts with the insurers participating in DirigoChoice, handles eligibility determination and enrollment functions for DirigoChoice, oversees the marketing of the product, and is responsible for the forecasting and overall budget for all its programs.

The Research Institute of the Muskie School of the University of Southern Maine conducts nationally recognized research and policy analysis to identify and promote solutions to complex health care challenges. The Institute links leading scholarship with policy and practice to improve health care and human services. The Research Institute has worked on project about and for the State of Maine for many years and produces reports valued by the legislature, administrative bodies, and external audiences both within state and nationally.