Dirigo Health Agency

Annual Report
Program Overview 2005 & 2006

Presented to:

The Honorable John E. Baldacci, the Governor of Maine
and
Joint Standing Committees on:
Appropriations and Financial Affairs
Insurance and Financial Services
Health and Human Services

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Introduction – The Act and the Agency

"The Dirigo Health Act" refers to the set of health reforms that the Maine Legislature passed in 2003 (121 Session, Chapter 469, LD 1611) and subsequently revised in 2005 (122 Session, Chapter 400, LD 1577).

Dirigo Health Reform

Maine's Dirigo Health Reform is as a multi-faceted approach to address health care cost, quality, and access in Maine.

Overall, Dirigo has three strategies to assure all Mainers have access to affordable, quality health care.

- Address health care system costs and quality reforms to assure those who now have private coverage can continue to afford it.

- Use MaineCare – the state's Medicaid program – to provide coverage to the lowest income Mainers by capturing about $1.72 in federal funds for every $1 the state provides.

- Create DirigoChoice, an insurance program for small businesses, the self-employed and individuals who are not eligible for MaineCare. Sliding scaled subsidies are available to individuals and families with household incomes up to 300% of the federal poverty level ($58,050 for a family of four and $28,710 for a single adult).

The Dirigo Health Act created the Dirigo Health Agency (The Agency), an Independent Executive Agency, which is responsible for administering two components of the Dirigo Health Act:

1) Monitoring and improving the quality of health care in the state.

2) Arranging for the provision of comprehensive affordable health care coverage to small employers, self-employed persons, and other individuals on a voluntary basis.

Governance

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Attorney

Ned McCann

Dana Connors
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MaineHealth

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MHMC's Pathways to Excellence Project

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Medical Director, Anthem

Laureen Biczak, DO
Medical Director, MaineCare

Robert Keller, MD, Chair
Consultative Spine Care

Paul Tisher, MD
Vice President & Chief Medical Officer, Acadia Hospital

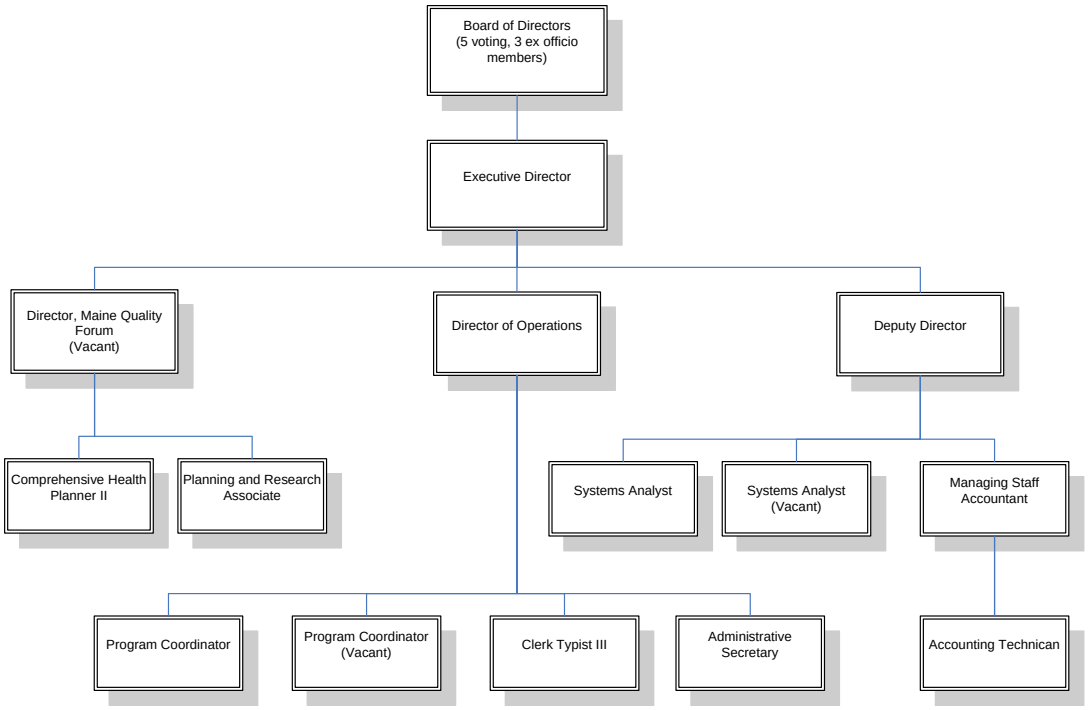
Kathy Boulet
Chiropractor

Agency Structure

Agency Staff

The Dirigo Health Act created the Executive Director position and the Maine Quality Forum.

The Legislature created 13 limited period positions in the 2005/2006 bi-annual budget.



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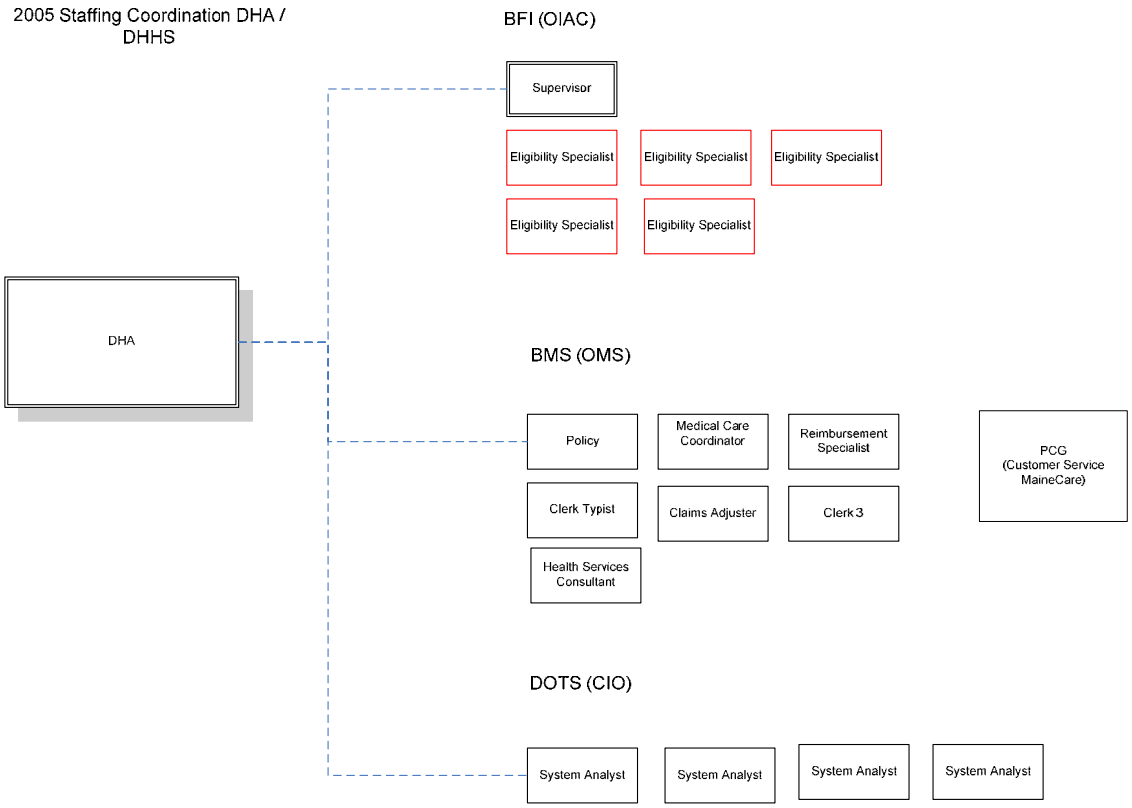
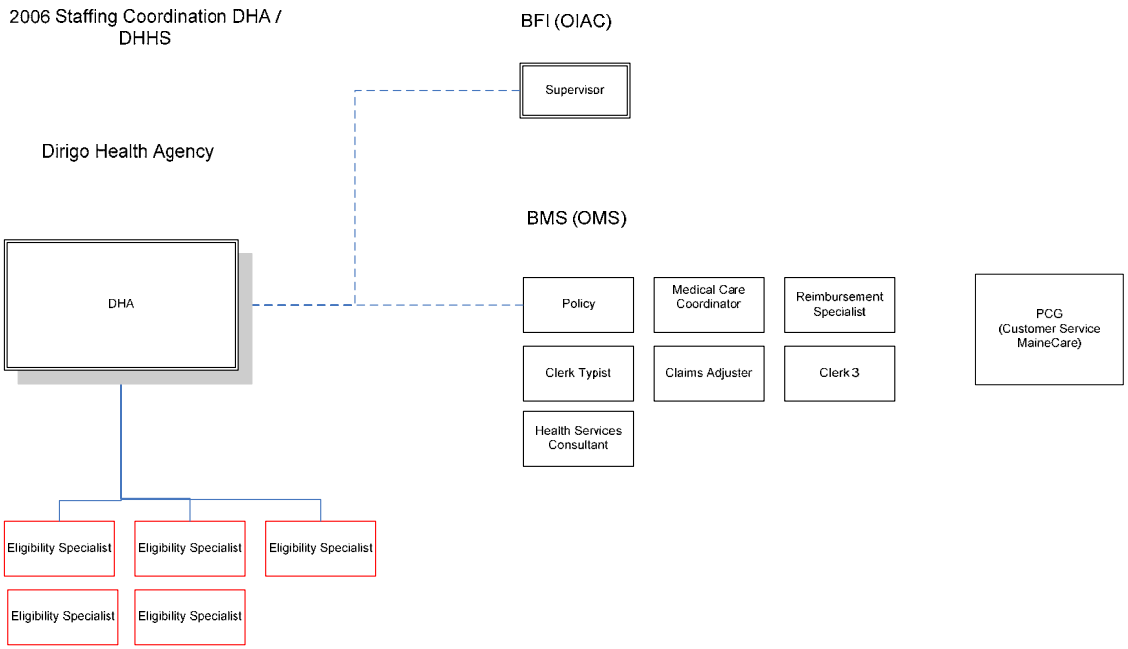
Enrollment Support

In 2005, as part of the overall integration of DirigoChoice with MaineCare, DHHS provided the Agency with administrative support in the form of positions detailed below.

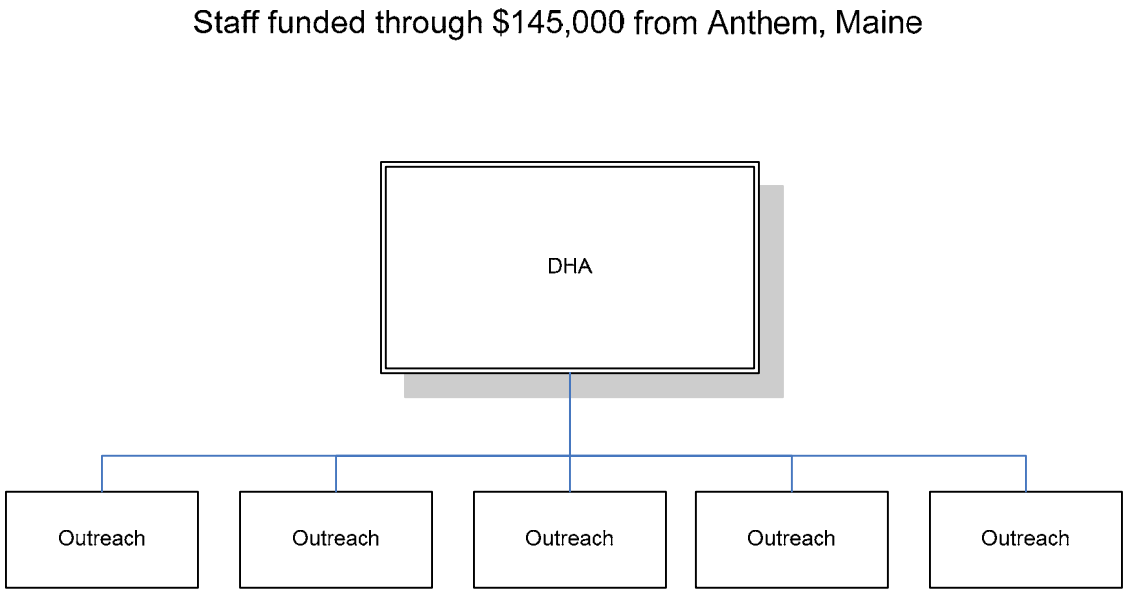


In 2006 the Agency consolidated administrative support in its Augusta office.



Call Center

In April of 2006 the Agency received a one time grant of $145,000 from Anthem to pilot an outreach and support call center.



The Maine Quality Forum

The Maine Quality Forum (MQF) was created within the Dirigo Health Agency to address the quality portion of the cost, quality and access triad. The Maine Quality Forum Advisory Council (MQF-AC) was established in the Dirigo Health Act.

The MQF-AC is a multi-stakeholder group consisting of consumers, providers, payers and insurers. The AC provides a wide range of perspectives and expertise specific to quality which helps guide the Quality Forum in its strategic planning and tactical implementation. The 17 member group is appointed by the Governor and approved by the Joint Standing Committee on Health and Human Services.

The Forum:

- Promotes and supports systems of health care that use best clinical practices.

- Promotes awareness of the need to use health care quality information as part of the decision making process for providers and patients.

- Provides information about health care quality to the people of the State that allows them to make informed decisions about the care they receive.

The Forum participates in a wide range of state and national quality programs and works with a number of other organizations in order to help coordinate and prioritize quality efforts in Maine. These programs and organizations include:

- Maine Health Access Foundation (MEHAF)
- Maine Heath Data Organization (MHDO)
- Maine Center for Disease Control (CDC)
- The Hanley Trust
- Maine Hospital Association (MHA)
- The Muskie School
- HealthInfoNet
- Maine Medical Association (MMA)
- Maine Osteopathic Association (MOA)
- Maine Health Information Center (MHIC)
- Maine Health Management Coalition (MHMC)
- Quality Counts
- National Quality Forum (NQF)
- Organization of Maine Nursing Executives (OMNE)
- Maine Emergency Medical Services (MEMS)
- Agency for Health Care Research and Quality (AHRQ)
- Medical Care Development (MCD)
- Association of Professionals in Infection Control and Epidemiology (APIC)
- Bath Iron Works (BIW)
- American Nurses Association (ANA)

Getting the Right Care at the Right Time

Patients in certain Maine communities are up to three times more likely to receive expensive procedures than an identical patient in another community, even when there is no evidence that the procedure is what's known as a "best practice" for a given medical condition. This variation – which can be high *or* low – is unrelated to underlying differences in the population (such as differences in age, for example, or the prevalence of disease), but instead are driven by the capacity of health resources in an area (or lack thereof) and the preferences and training of the medical personnel serving the population.

This variation can result in both wasted spending and in decreased quality and patient safety. MQF collects and analyzes data on medical practice around the state and serves as a clearinghouse of the latest information on best, and evidence-based practice, all of which helps providers improve their performance, reducing costs and improving quality.

In large part MQF is dependent on the rapidly expanding national effort around measurement of best practice compliance. The national consensus that transparency and accountability can be served by metrics of best practice is identical to the MQF approach. In recognition of the need to contribute on the national level, the Agency is active in National Quality Forum activities. MQF's Director has served on the Steering Committee for Additional Hospital Measures and chairs the Technical Advisory Panel for Implementation and Public Reporting of metrics of healthcare associated infections.

Transparency and Accountability through Data Analysis and Distribution

One of the Quality Forum's primary objectives is to be data driven. Through the Maine Health Data Organization (MHDO) Chapter 270 Health Care Quality Data Sets rule, MHDO obtains data directly from providers describing best practice care for heart attack, heart failure, pneumonia and prevention of infections contracted during surgery. In fact, the State of Maine is the first in the U.S. to collect on a state wide basis specific data about nursing care using nursing sensitive indicators. The indicators provide data about the success of nursing care as well as the quantity, training and experience of nursing care provided to patients in a hospital.

The MHDO also holds a hospital discharge data base and a paid claims data base. Medicare data shows that administrative data can reliably predict clinical outcomes over a large group of patients. The ability to predict an outcome allows for the comparison of the predicted outcome to the actual outcome. The difference between the predicted outcome and the actual outcome reflects the contribution of the provider. If death is the outcome, then fewer deaths equal higher quality care.

The Forum analyzes the hospital discharge data using Agency for Health Care Research and Quality (AHRQ) software to generate Patient Safety Indicators (PSI) and Inpatient Quality Indicators (IQI). MQF follows the procedure endorsed by the Advisory Council and suggested by AHRQ to validate and publish the indicator results. The indicator results are provided to each hospital for validation. The indicators serve to focus provider and other interested parties' attention to areas of concern.

Promoting Compliance with Best Practices

Administrative data can also be used to generate measures of compliance with best practices of care. National groups such as NQF, Ambulatory Care Alliance, Joint Commission for Accreditation of Healthcare Organizations (JCAHO) and others have collaborated to develop and support metrics or measures of best practice. For example, most people after suffering a heart attack should be taking a medication know as a beta blocker that slows and protects the heart. MQF with its data contractor has measured how often patients after heart attack obtain the beta blocker medication. This is a measure of best practice. Other measures of best practice such as routine mammography screening for breast cancer can also be derived from administrative data. In fact, one study suggests that administrative data in this particular situation is better than patient memory (Health Care x006} Showing providers their success on best practices can help them focus on their challenges. Showing patients their providers' success on best practices helps connect and engage the patients in the effort to obtain the right care at the right time.

Measuring Unwanted Variation

Measuring variation, that is how much one community or geographical area differs from the expected on how often a service or surgery is performed is a well accepted method to look for quality lapses. Often times no one knows the exact rate or frequency that a surgery should be performed; however the occasional variation from the expected is so large that a problem variation can be recognized. MQF collects variation information from both the hospital discharge data base and the paid claims data base.

MQF completed in 2006, with the help of the Center for Outcomes Research, an analysis of the variation in the use of advanced imaging in Maine. Advanced Imaging, the use of CT scanning and MRI, varies depending on where you live. Northern Maine has been recognized as being an outlier in the use of advanced imaging associated with the diagnoses of back pain and abdominal/pelvic pain. MQF is researching the underlying causes of the variation. Typically, this type of variation is called supply sensitive. That means that when generally accepted guidelines are not available to support decision making, the use of a service strongly reflects the supply of the service available.

The science of analyzing administrative data is advancing to the point where we can describe the care that a patient receives and attribute control of that care to a physician or group of physicians. Patient identification does not exist in our data analysis. However we can discuss the care that a patient or a group of patients receives without knowing their identity. An example of the MQF vision for an analysis of care is the care of a patient suffering a heart attack. The data will support looking backward and forward in that patient's care. We can look backward from the time of the heart attack and determine what preventive care, diagnostic care and treatment the patient received before the heart attack occurred. We can then follow the treatment after the heart attack to understand the use of known effective care in attempting to prevent further complications of heart disease. This process requires ongoing effort to continually improve the data base and the analysis efforts so that the resulting information can help us make meaningful statements about the care received and the care systems that support that care.

Summary of Key Initiatives[1]

- The Quality Forum has provided a series of analyses focused on the quality of care provided to the people of Maine including:
    - Variation Analyses demonstrating that where you live impacts the care you receive
    - Hospital reported quality indicators that assess the quality of care for:
        - Heart Attack
        - Heart Failure
        - Pneumonia
        - Infection Prevention
        - Nursing
        - Discharge Practices
    - Analysis of Maine's unique All-Payers' Paid Claims Database including
        - Test of the database
        - Assessment of the use of advanced imaging throughout the state
        - A pilot analysis assessing patient care in primary care practices and selected specialties
- Creation of the MQF website dedicated to public reporting of healthcare quality information to help the people of Maine make better informed decisions about the care they receive and to help providers improve the care they deliver.
- Working with hospitals re: implementation of AHRQ's Patient Safety Indicators and Inpatient Quality Indicators to improve discharge coding and identify possible care concerns.
- Use of the PHC4 methodology for identifying possible healthcare associated infections using the discharge database.
- Funded and steered the feasibility study for the Maine Health Information Network Technology (a project focused upon the technology to connect healthcare providers and practitioners leading to shared access to critical patient health information regardless of where in Maine a patient is seen) and guided the transition to an established non-profit called HealthInfoNet.
- Review of Certificate of Need Applications to provide input and guidance to the State regarding the quality of hospital proposals for development.
- National Leader (national steering committee members and regional key informants) on implementation of NQF's Nursing Sensitive Indicators (a collection of measures that provide information about hospital nurse staffing patterns and patient outcomes associated with nursing care)

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[1] Guide to acronyms in this section:

AHRQ:	Agency for Healthcare Research and Quality
IPHIS:	Integrated Public Health Information System
MHMC:	Maine Health Management Coalition
MeHAF:	Maine Health Access Foundation
NQF:	National Quality Forum
PHC4:	Pennsylvania Health Care Cost Containment Council
RWJ:	Robert Wood Johnson Foundation
STEMI:	ST-Elevation Myocardial Infarction

- Convened study group on standardizing the identification and data collection of ventilator associated pneumonia rates

- Initiation and steering of the Voluntary Practice Assessment Initiative working with unaffiliated primary care practices/practitioners to conduct assessment of quality of care for specific patient groups

- Participation in multiple collaboratives focused on quality assessment, care practice improvement, patient/provider activation, database development (e.g. IPHIS white pages, MHMC Employee Activation Steering Committee, MeHAF's I3 initiative)

- Development of the Hospital Safety Star a recognition of hospitals with outstanding safety practices (full adoption of NQF's safe practices)

- Primary Collaborator and Fiscal Agent for RWJ Aligning Forces Grant

- Development of the Wellness Star (development of a framework to identify and recognize businesses that lead the way in adopting wellness models)

- At the request of the legislature, reviewed pending legislation (LD616), an act regarding the adoption of required nurse to patient ratios, and reported back to committee on the need to further develop our understanding of the relationship between nurse staffing and patient outcomes which lead to the adoption of nursing sensitive indicators within our Quality Indicators.

Detailed Look at one of the Forum's Key Initiatives: *In a Heartbeat (IHB)*

In a Heartbeat (IHB) is an initiative that exemplifies the type of collaborative effort the Maine Quality Forum has engaged. The following is a detailed overview of this initiative.

Medical treatment frequently fails because the system that supports the care is not always well integrated. For example, medical treatment for a sub type of heart attack caused by a blood clot blocking one of the arteries to the heart muscle can be very effective if given timely. Nationally one third of those that suffer a heart attack do not receive the care they need in the time they need it. As a result patients die and many lose enough heart function that they become "cardiac cripples".

Research shows two primary reasons for patients not receiving timely care. The first reason is that the victim fails to recognize the signs and symptoms of a heart attack and does not call 911. The reasons cited for not calling 911 are such things as not sure of what is wrong, don't want to put out the local EMS, and don't want the embarrassment of flashing lights in the driveway. The opportunity for improved outcomes is to educate the public on the signs and symptoms of a heart attack and that time matters. Treatment for a heart attack which is time sensitive and it begins by calling 911.

The goal of *In a Heartbeat* is to improve the quality of medical care, the rate of survival and the quality of life for people in Maine who experience a heart attack.

What is *In a Heartbeat (IHB)* doing to meet its goal?

- Creating a statewide heart attack treatment pathway and protocol

- Developing a system to collect EMS and hospital data about heart attack care to assess how well the system is working
- Reaching out to communities to increase awareness about heart attack symptoms and the need to call 9-1-1 immediately

Why does Maine need IHB?

- Nationally, about one-third of heart attack victims do not receive the care that they need, when they need it, resulting in lost heart muscle and lives
- Most heart attack patients wait two or more hours after symptoms begin to call 9-1-1. Others never call 9-1-1.
- 88% of Maine residents cannot correctly identify the warning signs of a heart attack and the need to call 911.

How is IHB organized?

- Executive Committee to provide oversight and guidance
- 3 Workgroups to address specific areas of need :
  - Community Engagement
  - Medical Response and Treatment
  - Metrics and Data
- MQF serves as neutral convener and provides project staffing

What are the Workgroups doing right now?

- **Medical Response and Treatment**
  - Training EMS personnel to conduct 12-lead electrocardiograms (ECGs) in the ambulance to expedite early diagnosis of heart attacks.
  - Rolling out a Quality Improvement Tool to evaluate and revise system performance
- **Metrics and Data**
  - Finalizing data elements to be collected within EMS, emergency departments and hospitals
  - Negotiating a contract with a vendor to begin creating the database for data collection and analysis
- **Community Engagement**
  - Finalizing a timeline for a project that will train people (EMS, community educators, etc) to educate large groups of community members about heart attack symptoms and calling 9-1-1
  - Creating a press release for February (heart month) about symptoms and calling 9-1-1 that MQF, hospitals, and Healthy Maine Partnerships (among others) can tailor to their communities and distribute to local media

Why collect data?

- The *In a Heartbeat* data analyses will seek to answer the following critical questions:
  - How well is the medical system doing in reducing the time from onset of symptoms to treatment?
  - How well is the medical system doing in reducing the time from call to 9-1-1 to treatment?
  - How well are EMS services and hospitals doing at maximizing the efficiency of the process of care for STEMI*****?
  - How well are the outcomes of STEMI care improving within hospitals and across the state?
  - What do the data tell us regarding the use of thrombolytics and percutaneous coronary intervention (PCI) relative to care outcomes?
  - What barriers to improved care can be addressed within hospitals and across the state?

*STEMI = a specific kind of heart attack known as “ST-elevation myocardial infarction” that occurs when there is a blockage of a major artery that feeds the heart.

The Maine Quality Forum website (www.mainequalityforum.gov) provides more in depth information specific to the analysis and activities of the Forum.

Access

Dirigo Health expands access to coverage by:

- Building on the current private employer based system through DirigoChoice by:
    - Offering sliding scale subsidies to members who are below 300% of the Federal Poverty Limit (FPL) but who do not qualify for MaineCare.
    - Integrating the MaineCare program, thereby expanding employer based coverage for even the lowest wage workers. The plan allows the State to pool multiple funding sources and combine with MaineCare in order to maximize the Federal Medicaid match.
- Established modest expansions in MaineCare Eligibility. Federal law restricts state capacity to expand Medicaid just for DirigoChoice. As such, the expansion covers both those who come through an employer and those who go direct to MaineCare.

DirigoChoice

Contractual Arrangement

Effective January 1, 2005, the Agency entered into a two year contract with Anthem Blue Cross Blue Shield of Maine (Anthem) to offer DirigoChoice. The Department of Health and Human Services entered into a two year contract with Anthem separately to offer coverage to the DirigoChoice/MaineCare members. The initial two year contract expired on December 31, 2006.

The Superintendent of Insurance designated the Agency as an "other group" under 24-A M.R.S.A. § 2808 in 2004. As an "other group," the Agency is the Group Policy Holder. As the Group Policy Holder, the Agency enters into separate agreements with each policy holder (i.e., each Small Group, Sole Proprietor, or Individual) to offer coverage. Anthem provides the standard insurance administrative functions and holds the risk of the insurance product.

Key Agency responsibilities include:

Finance

- Manage payments to Anthem
- Manage payments to EBT/EFT accounts (discount process)
- Manage payments to DHHS
- Reconcile billed and paid accounts
- Manage Savings Offset Payments and collection process
- Produce monthly income statements and balance sheets
- Produce year end financial statements
- Work with State Controller and Office of Audit
- Coordinate DHHS and DHA accounting

Eligibility

- Determine discount eligibility and level
- Provide customer service for over 5,000 accounts

Systems

- Manage and produce reports and ad hoc data requests
- Manage data files sent to and received from Anthem
- Develop and maintain website and online tool development
- Provide end user support
- Develop and maintain call tracking, financial, and enrollment systems

Management

- Coordinate product offerings with Anthem & DHHS
- Manage the Memorandum of Understanding Agreement with DHHS
- Provide community relations and outreach
- Liaison with Anthem's appointed producers
- Administer Agency policy

Plan Eligibility

DirigoChoice is available to:

- Small Business (2-50 employees) Employees
- Sole Proprietors (self employed of one)
- Individuals who:
    - Are unemployed
    - Work for a Small Business that does not offer insurance

- Own a Small Business but cannot get enough employees to join a Small Group plan
- Work less than 20 hours a week for any single employer
- Are early retirees whose employer does not contribute to health benefits

Subsidy Eligibility

The following information is a summary of subsidy eligibility. These definitions should not be read as final eligibility criteria.

Subsidy eligibility is based on household income and household size as summarized below:

Household income is based on:

- Applicant gross wages, tips and salaries (before any deductions)
- Spouse or domestic partner gross wages, or tips and salaries (before any deductions)
- Net self-employment income (gross receipts minus allowable business expenses)
- Investment income (dividends from stocks, bonds, annuities, trusts, mutual fund shares)
- IRA and 401K distributions
- Pensions and annuities
- Net rental income (gross rents minus allowable expenses), royalties, trusts, etc
- Unemployment compensation
- Social Security
- Gross child support and/or alimony received

The following deductions are allowed:

- Childcare expenses - $200 per child per month if under 2, $175 per child per month if 2 or older. Caregiver must be a person outside the household.
- Child support paid out (only allowed for children that will not be covered by the applicant's policy).

Household size includes the plan applicant and all of his or her dependents (i.e., spouse, domestic partner, unmarried child under 19, student under 23, or child of any age who is disabled and dependent upon the applicant).

Subsidy Structure

The Subsidy program for DirigoChoice enrollees has two parts:

1. subsidy on the monthly coverage cost and
2. reduced deductibles and out of pocket expenses.

- Households with income under 300% of FPL[2] receive subsidies on the cost of coverage.
- The subsidies are structured on a sliding scale, with 5 separate subsidy levels:

[2] 2005 Federal guidelines – the program is using 2006 Federal guidelines for current enrollment.

Subsidy Group	A MaineCare Guidelines	B 100-149%	C 150-199%	D 200-249%	E 250-299%
Subsidy on eligible coverage cost	100%	80%	60%	40%	20%
Household Size	**Annual Income Less Than:**				
1	Income/assets	$14,355.00	$19,140.00	$23,925.00	$28,710.00
2	Income/assets	$19,245.00	$25,660.00	$32,075.00	$38,490.00
3	Income/assets	$24,135.00	$32,180.00	$40,225.00	$48,270.00
4	Income/assets	$29,025.00	$38,700.00	$48,375.00	$58,050.00
5	Income/assets	$33,915.00	$45,220.00	$56,525.00	$67,830.00
6	Income/assets	$38,805.00	$51,740.00	$64,675.00	$77,610.00

Note: Group A members are MaineCare eligible. MaineCare eligibility is based on income level as well as other factors.

- Deductibles and Out of Pocket Expenses based on Subsidy Group:

	A	B	C	D	E	F
$1250						
Deductible (Single)	$0	$250	$500	$750	$1000	$1250
Out of Pocket (Single)	$0	$800	$1600	$2400	$3200	$4000
Deductible (Family)	$0	$500	$1000	$1500	$2000	$2500
Out of Pocket (Family)	$0	$1,600	$3200	$4800	$6400	$8000
$1750						
Deductible (Single)	$0	$500	$800	$1125	$1450	$1750
Out of Pocket (Single)	$0	$1600	$2600	$3600	$4600	$5600
Deductible (Family)	$0	$1,000	$1600	$2250	$2900	$3500
Out of Pocket (Family)	$0	$3200	$5200	$7200	$9200	$11200

Note: Out of pocket includes the deductible

Examples of the Application of the Subsidy

Small Business Employee

- An employer selects the DirigoChoice $1750 Plan for her employees. The monthly cost is based on $1750 individual / $3500 family deductible.
- One employee has a wife and 2 children.
- The employee's family's household earned and unearned income, based on filed tax returns, is $36,000, putting them in Group C.
- In this example, monthly cost for family coverage is $1,032.
- The employer pays 60% or $206.24 of the employee only monthly cost (monthly cost in this example is $343.74)
- The employer withholds the remainder of the monthly cost ($825.76) from the employee's paycheck.
- The employee receives a monthly cash subsidy through a debit card in the amount of $495.46
- This leaves the employee with a $330.30 monthly obligation vs. $825.76
- Additionally, this family's deductible is $1,600 vs. $3,500.

Individual

- An individual selects the DirigoChoice $1750 Plan. The monthly cost is based on $1750 individual / $3500 family deductible.
- The individual has a wife and 2 children.
- The employee's family's household earned and unearned income, based on filed tax returns, is $27,000, putting them in Group B.
- In this example, monthly cost for family coverage is $1,213.00
- The employee receives a monthly cash subsidy through a debit card in the amount of $970.56.
- This leaves the employee with a $242.44 monthly obligation vs. $1213.00.
- Additionally, this family's deductible is $1,000 vs. $3,500.

DirigoChoice Product: 2005 through 2006

- PPO[3] plan with two options (1) $1250 deductible or (2) $1750 deductible (Individuals and Sole Props are only eligible for option 2). Final deductible amounts are based on subsidy group determination.

- Preventive services as defined by Anthem covered at 100% (in network); Rx subject to three tier copayment structure $10 generic/$20 formulary/$40 non-formulary; $20 office visit co-payment; mental health parity for all; no pre-existing exclusions; no lifetime maximum.

- Healthy Maine incentive program: The Agency provides cash incentives for members and employers who select a primary care physician and who complete a health risk assessment.

- Anthem's Care Management, Disease Management and SpecialOffers@Anthem™ are included in the product.

Pricing: 2005 through 2006

- The basis for the monthly rates charged for the DirigoChoice product is Anthem's small group adjusted community rating methodology[4]. Anthem modifies the community rate for specific DirigoChoice benefits and then increases the rate by an additional 2.5% for what Anthem actuaries consider additional risk associated with an unknown population.

- The Agency established an Experience Modification Program (EMP) for the first two years of the contract. An EMP is a form of experience underwriting not uncommon in start-up association-like plans where the risk of the population is unknown. The EMP protects the DirigoChoice pool from adverse selection. If the experience outcome is more favorable in the DirigoChoice plan and the loss ratio is at or close to 80%, then Anthem returns all or some of the EMP payments to the Agency. In CY05 approximately $8.0 million was paid in EMP of which $7.3M was returned to the Agency in the final CY05 EMP settlement. In CY06 approximately $14.9 million was paid in EMP. The final settlement for CY06 is in May 2007.

- The unadjusted community rates for DirigoChoice for the fourth quarter (Q4) of calendar year 2006 are:[5]

1250	One Adult	Two Adults	Two Adults and Child(ren)	One Adult and Child(ren)
	$364.61	$765.68	$1,093.83	$656.30
1750				
	$337.09	$707.89	$1,011.27	$606.76

[3] Preferred Provider Organization.

[4] A method of establishing the level of premiums in which the premium is based on the average for the entire block or pool of business. The premium is then adjusted by factors that are specific to a particular group, e.g., age, geographic location, standard industry code (SIC), and firm size.

[5] Anthem may adjust rates for group size, geography, and age.

Contribution Requirements

Small Group Employers (2-50 employees) and Self-Employed of One are required to contribute a minimum of 60% of the employee only (One Adult) coverage cost for employees who work more than 30 hours per week. Employers may pro-rate their contribution for employees who work 30 hours or less per week.

Sales Distribution and Marketing

Anthem's network of appointed producers (insurance brokers) is the primary distribution channel for the DirigoChoice product

	Small Groups	Sole Props	Individuals
Producers	66%	20%	17%
Anthem Direct	34%	80%	83%

Prior to the introduction of DirigoChoice, approximately 5% to 8% of Anthem's small group business was received on a direct basis. [6]

The Agency has engaged in marketing activities to introduce the product to the market, strengthen brand awareness, and emphasize the value proposition to the small business employer.

The Agency launched the following key marketing initiatives in 2005/2006:

- 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

51% of Small Business and Sole Prop and 64% of Individual members learned about DirigoChoice through media (print, TV, and/or radio).[7]

Franklin Community Health Network Incentive Program

The Franklin Community Health Network established an endowment in 2005 to increase access to health care services in greater Franklin County.

The Franklin Community Health Network has leveraged this endowment to help uninsured/underinsured businesses in greater Franklin County, including sole proprietors, purchase DirigoChoice for their employees.

Through this incentive program previously uninsured/underinsured employers, including sole proprietors, are eligible for discounts on their share of the monthly coverage cost. The discounts are 30% in the first year and 15% in year two.

Franklin Community Health Network defines uninsured as not offering coverage within one year prior to enrolling in DirigoChoice.

Franklin Community Health Network defines underinsured as a policy with a deductible of $5,000 or greater.

[6] Anthem sales figures as of 07/26/2005.
[7] Percentages from Muskie DirigoChoice Member Survey August 2006.

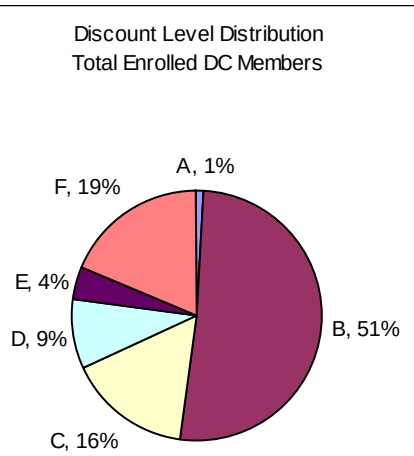
Enrollment/Membership as of December 2006

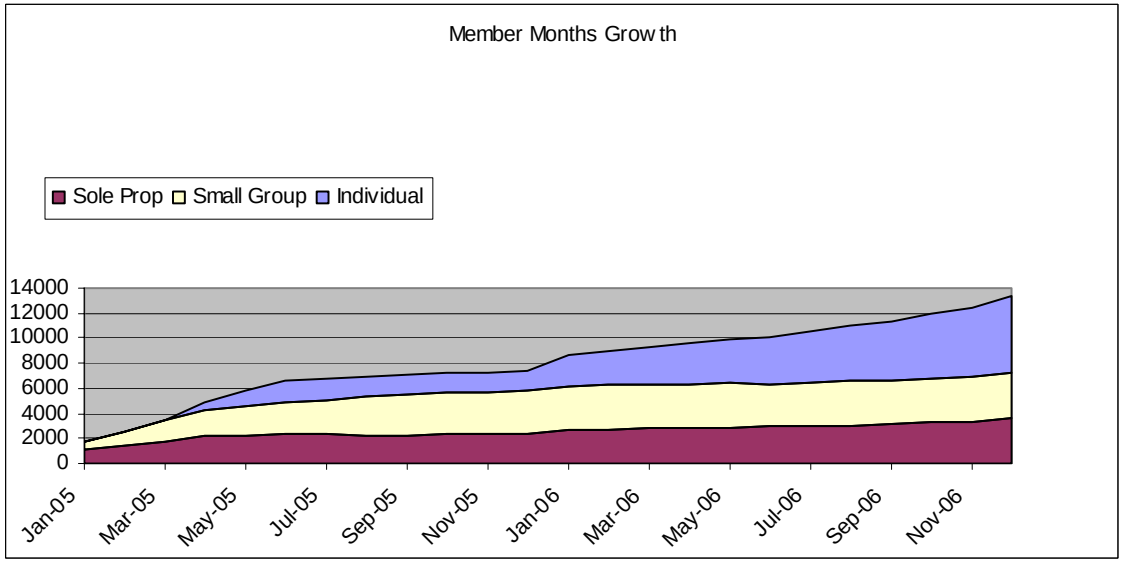
Note: All figures presented without citation are from the Agency's Enrollment System.

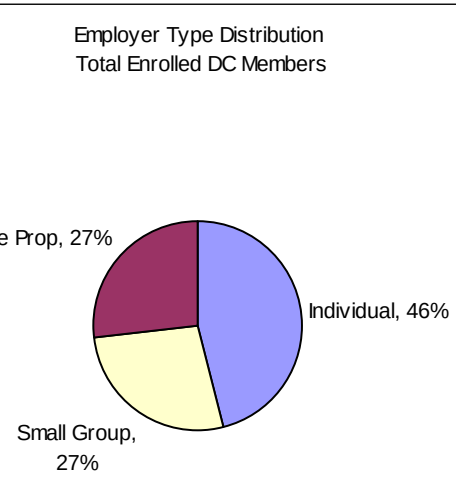
Total Group Demographics

Dirigo Health Monthly Numbers December 2006
Reported by Dirigo Health Agency 12/28/2006

Total Members Served, DC + Parents	22653
New DC Members	1014
New Parents	39
Total Enrolled DC Members	13290
Total Enrolled Parents	5129



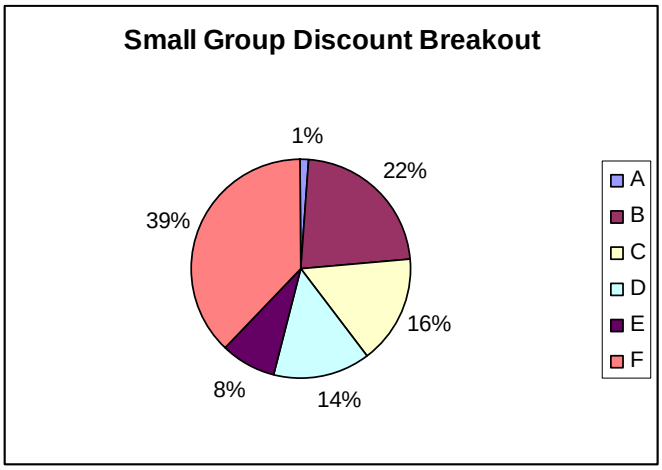


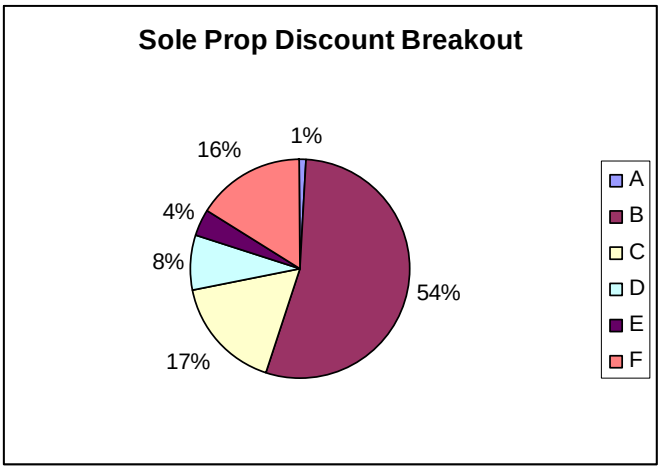


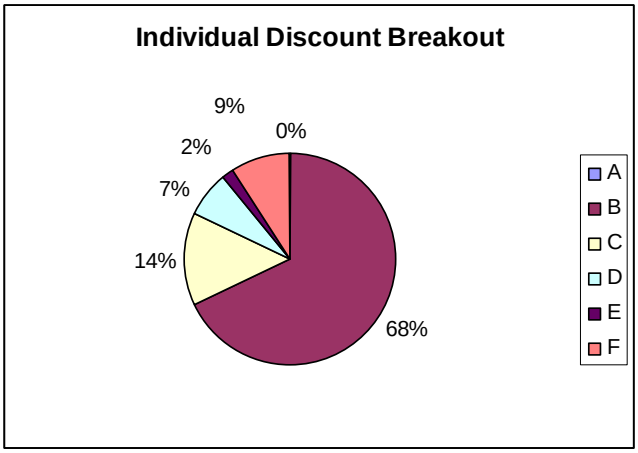
Notes:

1. Total Members Served refers to the total number of members ever enrolled (beginning 01/01/2005) for any period of time in the DirigoChoice or MaineCare Parent Expansion programs
2, Total New Members refers to the number of new members enrolled in the reporting month.
3. Total Enrolled Members refers to the number of members currently enrolled in the reporting month.
4. The current report does not include December Parent Expansion numbers.

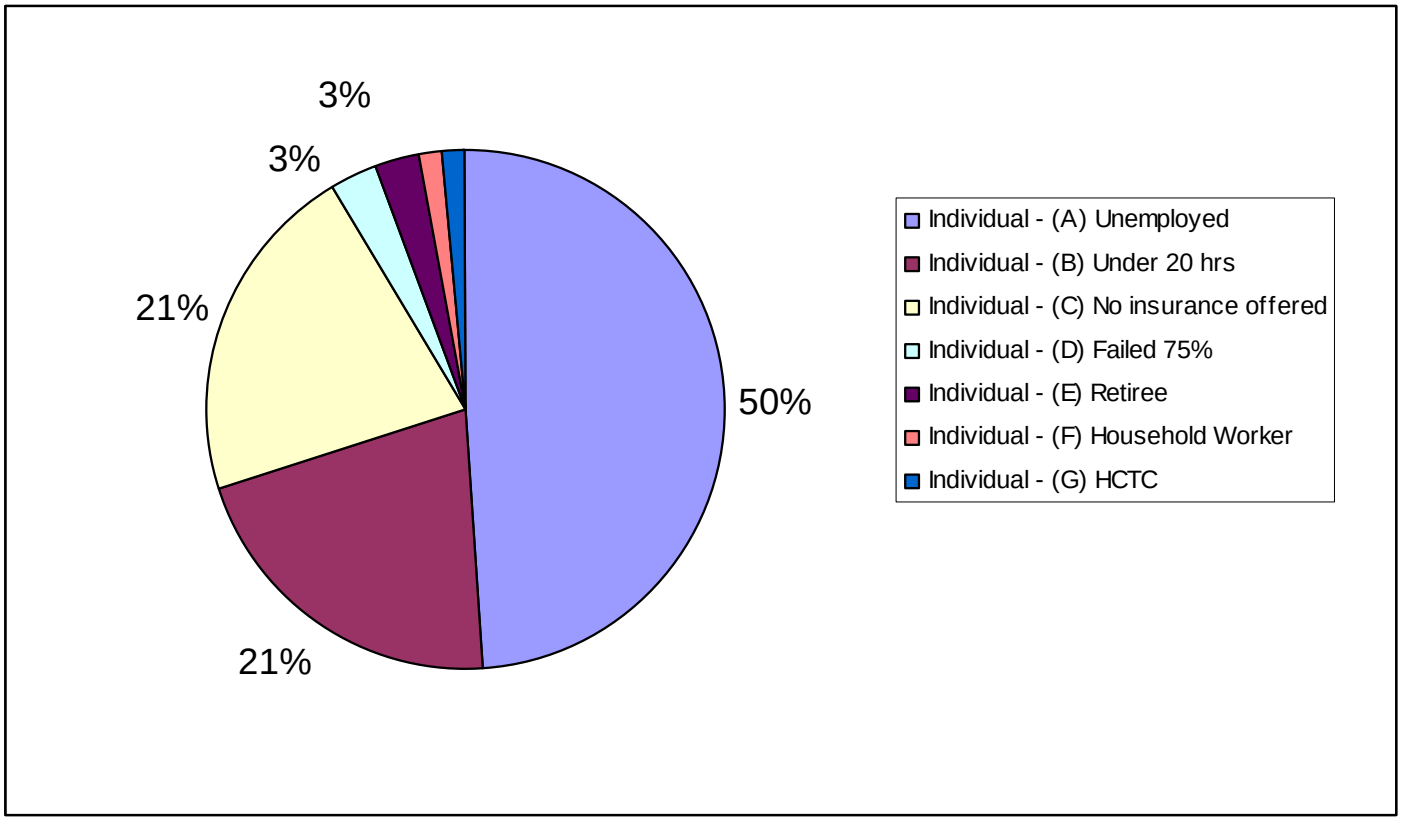
Employer Type Breakout by Discount Level







Individual Enrollment Breakout



DirigoChoice Program Experience 2005 through 2006

DirigoChoice enrolls members monthly for a 12 month contract period. In CY 2006 the program experienced a 93% monthly persistency rate (93% of members eligible to renew chose to do so).

- Average 2% monthly off-cycle termination rate (members leaving due to non-payment and new employment are the top two reasons for off-cycle termination).
- Approximately 65% of DirigoChoice members were either uninsured[8] or underinsured[9] prior to enrolling.[10]
- Approximately 36% of DirigoChoice members were previously uninsured.[11]
- Approximately 43% of Small Employers enrolled were previously uninsured.
- The average household income[12] for DirigoChoice (subsidy eligible) members is $15,144.36.
- The average household size for DirigoChoice (subsidy eligible) members is 2.01, with an average enrollment of 1.64.

Average Household Income by Subsidy Level

Level	Avg. Income	Avg. Declared Household	Avg. Enrollment	Income per Declared	Income per Enrolled
A	$18,243.56	3.34	2.36	$5,462.14	$7,730.32
B	$8,056.19	1.95	1.57	$4,131.38	$5,131.33
C	$23,616.35	2.19	1.8	$10,783.72	$13,120.19
D	$29,412.08	2.09	1.74	$14,072.77	$16,903.49
E	$34,673.55	1.95	1.61	$17,781.31	$21,536.37
Avg.	$15,144.38	2.01	1.64	$7,534.52	$9,234.38

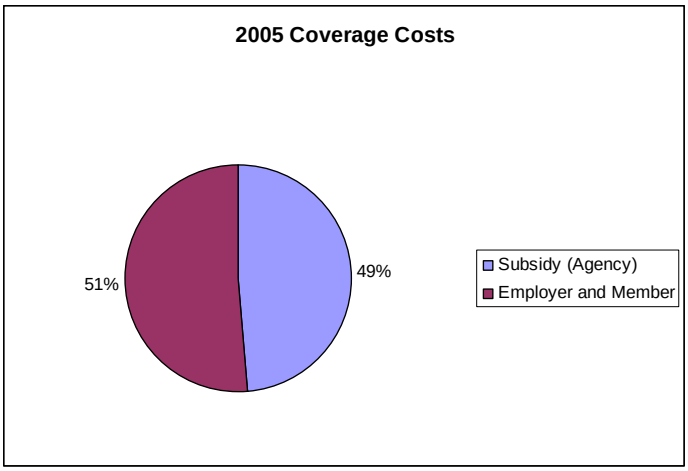
[8] Did not have coverage in the year prior to enrolling in DirigoChoice.
[9] Defined as deductibles exceeding 5% of income and income was less than 200% FPL. The DHA Board adopted this definition of underinsured in 2005.
[10] Based on Muskie DirigoChoice member survey and DirigoChoice application material.
[11] Based on Muskie DirigoChoice member survey and DirigoChoice application material.
[12] Household income as defined in subsidy eligibility above.

Costs

The following section describes the subsidy cost paid by the Agency in CY2005 and CY2006 and the Agency's operating costs. During CY2006 the growth in member months was 90% higher than what the Agency experienced in CY2005 with no increase in staffing.

Coverage/Subsidy

CY 2005		
Total DirigoChoice Cost of Coverage (Amount Paid to Carrier)	$23,598,639	348.43 PMPM[13]
Total Employer and Member Contributions	$12,104,746	178.73 PMPM
Total Subsidy paid by Agency[14]	$11,493,893	169.71 PMPM
Total Member Months[15]	67728	

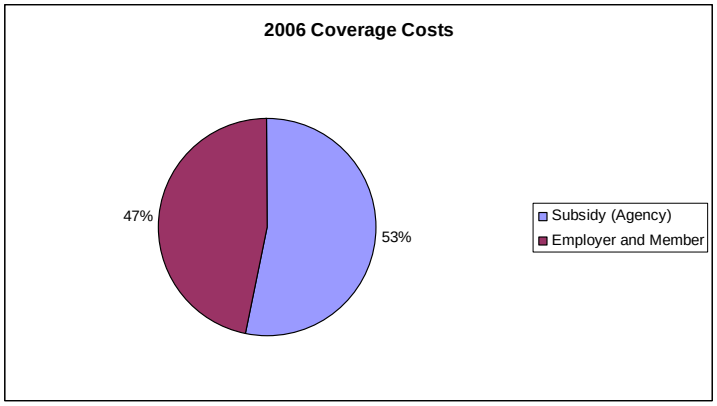


[13] Refers to the cost or revenue from each plan member for a month. Indicates revenue, expenses or utilization of services.

[14] Includes final EMP settlement.

[15] The total of all months that each member is covered by a plan. A plan with 1,000 members in January and 1,200 members in February has year-to-date 2,200 member months as of March 1. Member months, and ratios calculated by member months provide the most relevant statistics for evaluating a plan's financial performance.

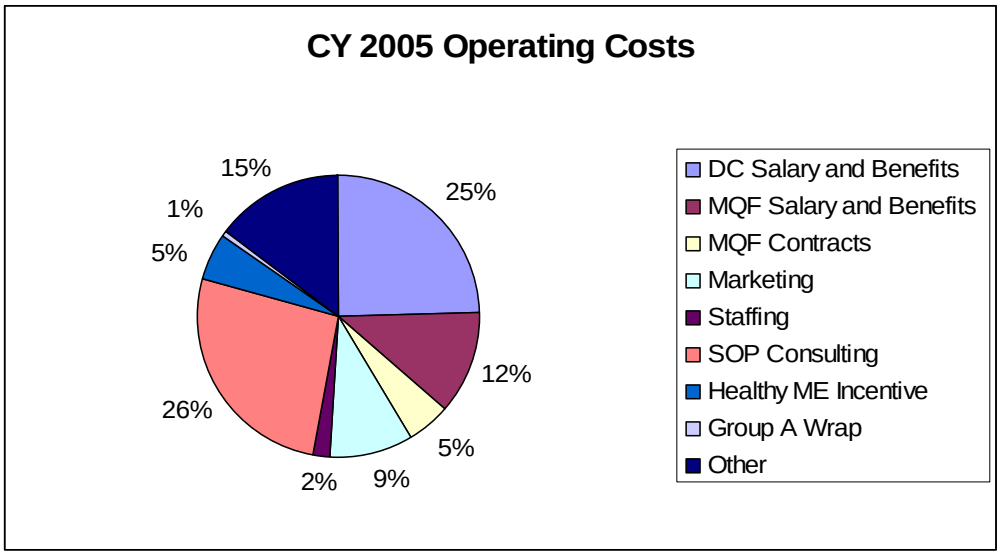
CY 2006		
Total DirigoChoice Cost of Coverage (Amount Paid to Carrier)	$51,458,377.67	$399.68 PMPM
Total Employer and Member Contributions	$23, 330,519.50	$187.94 PMPM
Total Subsidy paid by Agency[16]	$27,260,836.25	$211.73 PMPM
Total Member Months	128754	



[16] Includes EMP costs with initial January 2007 reconciliation.

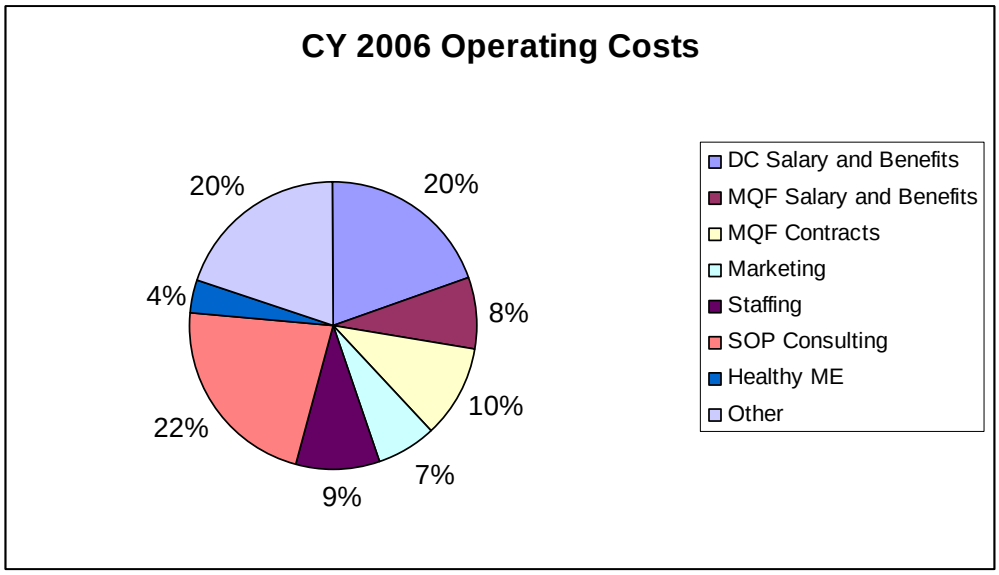
Operating

CY 2005	
Total Operating Cost	$ 3,287,095
Total Operating Cost DirigoChoice	$ 2,736,490
DirigoChoice Operational Cost PMPM	$ 40
Percent of Agency DirigoChoice Cost	19.23%



DirigoChoice Operating Costs are defined as the day-to-day expenses incurred in administering DirigoChoice, such as personnel, marketing, etc., as opposed to subsidy expenses. Personnel expenses associated with the Quality Forum are not included.

CY 2006	
Total Operating Cost	$ 4,208.972
Total Operating Cost DirigoChoice	$ 3,215,919
DirigoChoice Operational Cost PMPM	$ 24.98
Percent of Agency DirigoChoice Cost	5.88%



DirigoChoice Claims Experience

- Most recent report from Anthem reflects the DirigoChoice Loss Ratio[17] for claims incurred January 2005 paid through November 2006 is 79.1% (Small Group is 64%, Sole Prop is 72.7% and Individual is 101.3%).

- As of September 2006 there were 981 members identified with "high risk pool" criteria as defined in the Dirigo Health Act. The majority of these members were identified based on diagnosis; less than 20 members were identified based on claims in excess of $100,000.

- For the most recent incurred period (as reported by Anthem) January 2006 through December 2006 the top 1% of claimants drove 29.1% of the plan costs. This percentage compares to the Anthem norm of 30%.

- For the most recent incurred period (as reported by Anthem) January 2006 through December 2006 the average cost for those members who submitted a claim during the reporting period was $2,875. This compares to $2,786 for the Anthem norm.

- In this reporting period generic drug utilization was 59.3%

- Top five major practice category groups: orthopedic & rheumatology, cardiology, malignant neoplasm, gastroenterology, behavioral health. These categories account for approximately 51% of costs.

Operations

In 2005 the DHHS office in Skowhegan performed enrollment and eligibility determination work as well as customer service.

In 2006 the Agency consolidated enrollment and eligibility determination and customer service into the DHA Augusta office. Additionally, the Agency secured funding from Anthem to pilot a dedicated 800 number for prospects and customer service.

The Agency developed an internal enrollment system for DirigoChoice, and has implemented MAS-90 for its financial efforts.

[17] The ratio of the annual claims paid by an insurance company to the premiums received.

MaineCare Parent Eligibility Expansion

Enrollment for the time period May 2005-June 2006 for expansion parents that enroll directly through MaineCare was 5,108 for a total of 53,603 member months.

DHHS estimates the medical costs for this population for this time period at approximately $7 million. The State is responsible for approximately $2.7 million and the remaining $4.2 million is paid with federal funds.[18]

The estimated medical PMPM for this group based on above medical costs is $130.59 of which the Dirigo Health Agency is responsible for $50.37.

Savings Offset Payment

The Agency currently uses the Savings Offset Payment (SOP) to fund the subsidy cost of DirigoChoice and the activities of the Maine Quality Forum.

Pursuant to 24-A MRSA 6913, sub-1, the Dirigo Board shall determine annually the aggregate measurable cost savings. Within 30 days of the Boards determination pursuant to paragraph A, the Board shall file with the Superintendent of Insurance its determination as well as supporting information for that determination. The Superintendent shall issue an order approving, in whole or in part, or disproving the filing under paragraph B.

If there is a determination that there are aggregate measurable cost savings reasonably supported by the evidence in the record then pursuant to 24-A MRSA 6913, sub-2, The Dirigo Health Board shall determine annually a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and third party administrators. The Board shall calculate the savings offset payments as a percentage of paid claims, as defined by the Board.

The savings offset payment can not exceed 4.0% of annual paid claims on polices issued pursuant to the laws of this State that insure residents of the State; for third party administrators, the savings offset payment can not exceed 4.0% of annual paid claims for health care for residents of this State and for employee benefit excess insurance carriers, the savings offset payment can not exceed 4.0% of annual paid claims on employee benefit excess insurance policies issued pursuant to the laws of this State that insure residents of the State.

In the first year the Superintendent of Insurance determined that there was $43.7M in aggregate measurable savings. The Dirigo Board then determined that the savings offset payment would be 2.408% of paid claims. Year one savings offset payments apply to claims paid for plan years beginning on or after January 1, 2006. The Dirigo Health Agency allows entities to self declare their SOP payments using a standard reporting template. The template must be completed and remitted with each monthly/quarterly payment. The Dirigo Health Agency reserves the right to have independent auditors verify the basis of an entity's SOP payment. The Agency will provide 60 days notice of any audit to the entity.

[18] Pending final DHHS reconciliation.

In the second year the Superintendent of Insurance determined that there was $34.3M in aggregate measurable savings. The Dirigo Board then determined that the savings offset payment will be 1.85% of paid claims in the event that the assessment is collected.

Key Agency Activities/ Accomplishments of 2005 & 2006

- DirigoChoice began enrollment activities in November 2004 and has been providing coverage since January 1, 2005.
- Dirigo was named a top government innovation for 2006 by Harvard University's Ash Institute and the Council for Excellence in Governance.
- Consolidation/streamlining of operations
- DirigoChoice was designated as the State's HCTC (Health Care Tax Credit) Plan
- Commonwealth funds an independent evaluation of the DirigoChoice program
- DirigoChoice Business Advisory Group established
- *In a Heartbeat* – A hospital collaborative to improve heart attack care all across the state to reduce the deaths from this disease.
- Make hospitals safer – Using the Agency for Healthcare Research and Quality's patient safety indicators and inpatient quality indicators to help hospitals identify possible targets for quality improvement. The MQF Hospital *Safety Star* recognizes and promotes hospitals' full adoption of the National Quality Forum's Safe Practices.
- Make sure best practices are in every physician's office – Working with physicians to measure the quality of patient care in independent practices.
- Provide tools to the public to improve quality – Created the MQF website dedicated to public reporting of healthcare quality information to help the people of Maine make better informed decisions about the care they receive and to help providers improve the care they deliver.
- Reduce inappropriate and costly variation in how care is delivered – Published a variation analyses for a range of services showing that care is delivered very differently in different parts of the state- and that raises cost and quality concerns.
- Make sure quality of care is a criterion for spending on new services and technology – Collaborates with the Department of Health and Human Services in reviewing Certificate of Need applications.