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**LEADING THE WAY?  
Maine's Initial  
Experience in  
Expanding Coverage  
through Dirigo  
Health Reforms**

*Final Report*

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## EXECUTIVE SUMMARY

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In 2003, Maine enacted the Dirigo Health Reform Act, which aimed to make affordable health care coverage available to every Maine citizen by 2009, slow the growth of health care costs, and improve quality of care. At the time of the legislation's enactment, Maine was the first state since the early 1990s to adopt comprehensive health care reform legislation and to set a goal of providing affordable health insurance coverage to all state residents.

Since then, several other states, notably Massachusetts and Vermont, have enacted similarly ambitious health reform and universal health coverage legislation, and Illinois adopted legislation to cover all children. In 2007, over a dozen states considered proposals that strive for universal health coverage. Hence, lessons from Maine's program implementation experience could be potentially useful to other states seeking to expand insurance coverage.

Based on several interim indicators and measures, this report evaluates Dirigo health's progress in expanding insurance coverage at the end of 2006, midway between the legislation's adoption and the 2009 goal. It focuses on enrollment trends and implementation experience with two coverage initiatives authorized under the Dirigo Health Act: (1) DirigoChoice, a health insurance program for eligible small businesses, self-employed workers, and individuals, which began in January 2005, and subsidizes premiums and deductibles for enrollees with family income below 300 percent of the federal poverty level (FPL); and (2) MaineCare (Maine's Medicaid program) eligibility expansions for parents of children under age 19, with income below 200 percent of FPL. The Dirigo Health Reform Act also authorized Medicaid eligibility expansion for childless adults with income below 125 percent of FPL; although a budget constraints under the terms of a federal Medicaid waiver prevented implementation of this expansion, the study examined enrollment trends among childless adults with income up to 100 percent of FPL who became eligible for Medicaid in 2002, because this option took place concurrently with the two Dirigo expansion efforts, thereby offering another avenue for low-income people to gain coverage.

In addition, this evaluation report examines the state's experience in trying to finance coverage expansion through an innovative approach--the savings offset payment (SOP)--which sought to capture savings to health care providers resulting from lower uncompensated care and other Dirigo health cost savings initiatives by assessing health insurance claims. The evaluation also identifies the relevance of Maine's experience elsewhere by analyzing similarities and differences in characteristics of states' uninsured populations, health care and health insurance markets, financing options, and other factors that can influence the feasibility of coverage expansion approaches.

## **EVALUATION DESIGN AND DATA SOURCES**

To analyze enrollment in Dirigo coverage initiatives and understand the factors that led to the level and mix of enrollment, the evaluation used a mixed methods approach that involved quantitative and qualitative data collection and analyses. We obtained DirigoChoice administrative data from the Dirigo Health Agency in order to conduct an independent analysis of enrollment trends and enrollee characteristics. We carried out a survey of small firms enrolled in DirigoChoice in fall 2006 and of a set of randomly selected small firms in Maine eligible to enroll in DirigoChoice that chose not to do so. In late 2006, we held in-depth interviews with key stakeholders representing various interest groups in Maine, including the insurance industry, business community, consumer advocates, providers, elected officials, state program administrators, and health policy analysts. We also conducted an extensive review of Maine's health care and insurance system and the evolution of Dirigo Health through a variety of studies, reports, legal rulings, and other documents.

## **MAJOR FINDINGS**

### **1. In September 2006, enrollment in MaineCare eligibility expansion groups exceeded that in DirigoChoice.**

- In September 2006, 20 months after the program began, DirigoChoice counted about 11,100 current members,<sup>1</sup> and since its inception in January 2005, about 15,000 people had ever enrolled in the program.
- By comparison, almost 23,100 individuals were enrolled in the two Medicaid eligibility expansion groups in September 2006. Just over 5,000 parents of children below age 19, with family income between 150 and 200 percent of FPL, were enrolled in the Dirigo-authorized Medicaid expansion group, and another 18,100 childless adults with income up to 100 percent of FPL were enrolled in this previously authorized MaineCare eligibility expansion group.

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<sup>1</sup> DirigoChoice member enrollment stood at 15,113 as of August 2007 (Dirigo Health Agency 2007).

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- Hence, during the period when Dirigo coverage expansions were in effect, approximately two-thirds (23,100) of the entire population (34,200) that gained coverage did so through MaineCare.

**2. Dirigo coverage expansions are effective in making insurance more affordable to low-income individuals and families.**

- Nearly 80 percent of DirigoChoice members receive premium and deductible subsidies. Almost half (46 percent) of all members and two thirds (66 percent) of all individual members have family income below 150 percent of FPL and therefore receive the greatest subsidy.
- In September 2006, mid-way between the program's adoption and its 2009 goals, DirigoChoice covered between 4,400 and 6,000 previously uninsured residents.<sup>2</sup> While the majority of previously uninsured are individual members, those *most likely* to have been uninsured for the entire 12 months before enrolling are small group members (37 percent) compared to 28 percent of individuals and 30 percent of sole proprietors.
- A majority of small firms enrolled in DirigoChoice that previously offered coverage to employees report that about the same number or more employees or dependents are covered as under their previous plan. This suggests that program subsidies are helping increase employee take-up of health benefits for a subset of small firm employees participating in the program.

**3. Despite these achievements, the number of uninsured individuals covered by Dirigo Health programs—DirigoChoice and the Medicaid eligibility expansion for parents—is modest relative to the estimated 136,000 uninsured individuals in the state in 2002.**

- Though it is too early in the program's implementation to judge its eventual impact on the state's rate of uninsured, the number of people gaining coverage under the two Dirigo coverage expansion initiatives to date who were previously uninsured is less than 10 percent of those lacking insurance at the start of the program.

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<sup>2</sup> The range covers estimates of DirigoChoice enrollees who had been uninsured for the entire 12 months before enrollment and those who were uninsured at the point of enrollment. The program allows small firms (with 2 to 50 employees) to enroll even if the firm previously offered insurance, and individuals with previous coverage may enroll if they do not have access to employer-sponsored coverage, unless their employer discontinued a previous offer of coverage, in which case the individual must wait 12 months to become eligible for DirigoChoice.

**4. Member mix affects the financing burden of coverage expansions. Differences between projected and actual enrollment in DirigoChoice by member type and income level have increased state program costs beyond original estimates, raising the amount needed to finance subsidies for low-income enrollees.**

- Small group participation--both overall and as a proportion of total enrollment (see table 1)—has not met initial expectations. Group-enrolled workers represented approximately 30 percent of total DirigoChoice enrollment in late 2006 compared to initial projections that such members would comprise the majority of total enrollment.

**Table 1. Enrollment In DirigoChoice Projected Year 1 (2005) versus Actual as of September 2006**

	<b>Projected Year 1 Enrollment (2005)</b>	<b>Current Enrollment (as of September 2006)</b>	<b>Ever Enrolled (as of September 2006)</b>
	Percent (number)	Percent (number)	Percent (number)
<b>Member Distribution</b>			
Small Group	90 (37,000)	30 (3,350)	35 (5,162)
Sole Proprietor		28 (3,051)	26 (3,896)
Individual	10 (4,000)**	42 (4,685)	38 (5,657)
<b>Total</b>	<b>100</b> (41,000 members)	<b>100</b> (11,086 members)	<b>100</b> (14,715 members)
<b>Discount Level</b>			
	Percent of Members	Percent of Members	Percent of Members
A (MaineCare-eligible)*	11	1	1
B	3	49	46
C	6	16	16
D	29	10	11
E	26	4	5
F (no subsidy)	24	20	22
<b>Total</b>	<b>100</b> (41,000 members)	<b>100</b> (11,086 members)	<b>100</b> (14,715 members)

Source: Maine Dirigo Health Agency, Request for Proposal, May 8, 2004; MPR tabulation of Maine Dirigo Health Agency administrative data as of September 2006.

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

\*\*The first-year enrollment cap of 4,000 sole proprietors and individuals, all expected to be subsidized, was later raised to 4,400.

## **5. DirigoChoice is well designed for some, though not all, segments of the small firm market.**

With the DirigoChoice program created to sustain and expand employer-based health insurance among small employers, employer response to the availability of DirigoChoice is an important indicator of the success of the state's coverage expansion strategy. It is also a critical determinant of program costs.

- As of September 2006, about 700 small firms with 2 to 50 workers were enrolled in the program, and their workers or dependents comprised about 30 percent of DirigoChoice enrollees. Very small firms—those with 2 to 9 workers—make up 82 percent of all firms enrolled, and those with 10 to 50 workers represent 18 percent.
- According to the small firm survey results, about half of enrolled firms (51 percent) did not previously offer coverage—a promising indication of the product's appeal to these firms.
- Among firms enrolled in DirigoChoice, the average monthly premium for single employees (\$336) was significantly lower than that among eligible firms that offered another health plan (\$365). The price difference, however, may not be enough to lead non-Dirigo-offering firms to switch to Dirigo, or the plans offered by non-Dirigo firms may offer more generous benefits or lower deductibles than Dirigo. The price difference may also reflect other factors not covered by the survey, such as group size and average age, that insurers may use to set premium rates.
- Among DirigoChoice-enrolled firms that did offer a previous insurance plan, a large majority (86 percent) paid per employee health insurance premiums that were the same or less than what they paid before, and four in five participating firms found the benefits to be as good as or better than previous benefits.
- Nearly four in five DirigoChoice firms report that they were satisfied with the plan, and a similar proportion indicated that they would very likely renew enrollment. Suggestions for improving the plan focused on reducing costs to companies.

Despite the positive reactions to DirigoChoice among small firms that chose to enroll, small firm enrollment remains very small relative to the number of firms eligible to enroll. The 700 enrolled firms represent about 2.5 percent of all such businesses in the state. Survey responses indicate that for many of the very smallest firms—those with just one or two employees besides the owner—DirigoChoice coverage is too expensive.

## 6. Sustainability of Program Financing Remains Uncertain

The long-term viability of the Dirigo Health coverage expansion initiatives depends on the sustainability of the expansions' financing sources. The large share of Dirigo Health revenues from sources other than employee and member contributions goes to subsidies for low-income enrollees in DirigoChoice and to the costs of covering parents in the Medicaid expansion group. The program expected that the SOP would finance most of these costs, though it relies on other sources as well. However, for each of the two years in which the aggregate measurable cost savings has been calculated (which determines the revenue that can be raised through the SOP), the savings have been lower than estimated by the Dirigo Health Board of Directors. This in turn has produced lower revenues for DirigoChoice subsidies than needed to allow higher enrollment in the program. Other revenue sources for the DirigoChoice financing strategy also fell short of expectations, including employer and higher-income enrollee premium contributions and federal Medicaid matching funds for MaineCare-eligible enrollees.

- The SOP proved to be the most controversial and difficult aspect of the Dirigo program. The rationale behind it, as in other state coverage expansion proposals, is that expanded coverage and other health care savings will reduce health care provider costs. The SOP was designed to link the expected cost savings to funding for premium subsidies and to capture the savings from insurers, who were expected to reduce payments to providers commensurate with lower costs.
- When DirigoChoice did not enroll as many uninsured as expected in the first and second years, bad debt and charity care costs did not drop significantly and therefore led to a corresponding drop in revenue raised by the SOP. Savings expected to result from other Dirigo cost containment efforts also have yet to materialize, or cannot be documented precisely.
- Maine's experience suggests that attempts to capture the "hidden tax" of cost shifting, and convert savings in the overall health system into an explicit source for financing coverage expansions, introduces a set of challenging technical, operational, and political decisions that can be as difficult to resolve as direct tax and assessment strategies. Though conceptually sound, the calculation of aggregate measurable cost savings was highly vulnerable to criticism about the validity of estimates and projections of program impacts, many of which cannot be directly observed.

A court case brought by insurers and the state Chamber of Commerce compounded the problems with the SOP. In May 2007, the Maine Supreme Court upheld the state's right to count the savings attributable to Dirigo Health initiatives *other than* reduced bad debt and charity care, in the aggregate measurable cost savings calculation. Nonetheless, ongoing controversies over how the savings are calculated likely will persist as long as the SOP continues as a Dirigo funding source. Virtually all observers view the SOP as politically

unsustainable in its current form and regard alternative funding sources as necessary in moving DirigoChoice forward.

## CONCLUSIONS AND LESSONS FOR OTHER STATES

Maine's overall health reform strategy uniquely reflects the state's political environment, health care market dynamics, regulatory history, and financing options. At the same time, the initiatives it chose for expanding access to insurance—a subsidized insurance product and modest Medicaid eligibility expansions—are much like those adopted or under consideration by other states. States interested in pursuing such coverage expansion initiatives may learn some lessons from Maine's implementation experience.

- ***Demand for fully or heavily subsidized insurance plans is greatest among low-income persons.*** MaineCare enrollment in the two Medicaid eligibility expansion groups—Dirigo parents and childless adults—is higher than DirigoChoice enrollment, and those eligible for the deepest subsidies in DirigoChoice have enrolled disproportionately. This suggests that low-income individuals find a fully subsidized public plan preferable to a partially subsidized private plan (or do not have access to private coverage). However, the result is an increased need for public subsidies. Most states have financial constraints that limit their capacity to expand public programs, yet raising funds through taxes is politically difficult.
- ***States with low employer offer rates may not be able to raise the offer rate substantially without strong employer incentives or mandates.*** DirigoChoice was reasonably successful in enrolling small firms, but its experience demonstrates the limits of a voluntary system. In states like Maine with high health care costs, mandatory employer contributions (depending on the level at which they are set) may place an unaffordable burden on small firms unless overall system costs can be brought under control.
- ***Partnerships and contracts between states and insurers must be carefully crafted around a realistic assessment of market conditions and the expected value of sharing responsibilities.*** Without sufficient numbers in the program to begin with and only one interested carrier, DirigoChoice did not have a great deal of leverage in price negotiations with private insurers. States with highly concentrated insurance markets may face similar challenges in developing an insurance plan that is more affordable than those currently on the market.
- ***Coverage expansions without forceful cost control mechanisms will confront affordability problems sooner or later.*** Even though DirigoChoice premiums were comparable to similar products in the market, problems with affordability for employers led the program to create a new plan option with very high deductibles. Further options for keeping premium rate increases low are limited as Maine has little managed care and provider competition and a

highly concentrated insurance market. A relatively comprehensive subsidized insurance product might be more successful in states with (1) lower health care costs owing to either greater competition among providers and/or more managed care; and (2) greater price competition among health plans or stronger regulation to constrain premiums.

### **Caveats and Limitations**

As a mid-term assessment of progress, this evaluation cannot measure the ultimate impact of Dirigo coverage expansions on Maine's uninsured rate. Because the state had just begun to implement its other reforms during the period of this evaluation (addressing cost, quality, and health promotion) and has designed those reforms to operate in concert with the Dirigo expansions, the impact of the full range of reforms on increased insurance coverage cannot yet be measured. In addition, data limitations constrain our ability to measure program impact on the state's uninsured rate at this time. A state household survey of insurance status has not been repeated since 2002, and annual Census Bureau data for the state are too imprecise and lagged to measure declines in the uninsured at an aggregate level for 2005 and 2006. This report therefore tells a story whose ending is not yet known.

## INTRODUCTION

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When enacted in 2003, Maine's health reform law, called Dirigo Health, captured the attention of policymakers and health policy analysts across the country. Maine was the first state since the early 1990s to adopt comprehensive health care reform legislation. The law's goals were to (1) make quality, affordable health coverage available to every Maine citizen by 2009, (2) slow the growth of health care costs, and (3) continually improve the quality of care provided to Maine citizens.

This report presents a mid-course assessment of the state's progress toward the goal of expanding access to affordable insurance coverage. The act neither defined a specific goal for what proportion of the state's population would have insurance coverage by 2009 nor specified what would be regarded as affordable. Yet, the policy discussion surrounding the law's adoption indicates that the intent was to insure most, if not all, of the state's 136,000 uninsured residents (Ziller and Kilbreth 2003). The law enacted two major initiatives to expand health insurance coverage:

1. A state-sponsored health plan, called DirigoChoice, open to enrollment by eligible small firms (with 50 or fewer workers), sole proprietors, and individuals. Administered jointly by the Dirigo Health Agency and a private health insurance carrier, the plan offers state subsidies to enrollees with family income below 300 percent of the federal poverty level (FPL).
2. Expansion of Medicaid (called MaineCare) eligibility to parents of children age 18 and younger if household income was between 150 and 200 percent of FPL. Parents with income below 150 percent of FPL were already eligible under the existing Medicaid or SCHIP programs. The law also authorized coverage of childless adults up to 125 percent of FPL.

### PURPOSE AND ORGANIZATION OF THIS REPORT

This report assesses the progress made by Maine's coverage expansions as of year-end 2006 in achieving the goal of increasing access to affordable health coverage for all citizens

by 2009. It focuses on several interim indicators that can usefully measure the state's progress to date in expanding insurance coverage while helping to answer the evaluation's research questions:

1. How many and what were the characteristics of the people who enrolled in the DirigoChoice product, what was their previous insurance status, and many low-income parents and childless adults gained coverage under Dirigo Health Medicaid expansions?
2. Why did small firms choose to enroll or not to enroll in DirigoChoice, what are their views on program affordability, and to what degree did the program help increase employer offer or employee take-up rates?
3. How sustainable are the program's financing sources, and is the Savings Offset Payment (SOP)—the primary financing mechanism proposed to pay for DirigoChoice subsidies—a feasible way to finance a larger share of the state's low-income uninsured population in future years?
4. What are the lessons for other states based on Maine's approach and experience in implementing its health coverage expansion initiatives?

Chapter I describes the methods and data sources used to address the above questions. Chapter II explains the Maine health system, market conditions, and regulatory context that gave rise to the Dirigo Health reforms. Chapter III provides detail on the two Dirigo coverage expansion initiatives—the DirigoChoice product design and Medicaid eligibility expansions.

The next three chapters present the major research findings. Chapter IV summarizes enrollment trends in DirigoChoice and the Medicaid expansion groups. Chapter V presents small firms' views of DirigoChoice and their reasons for enrolling or not enrolling in the program. Chapter VI explains program funding sources and costs, discusses the rationale for the SOP and the issues that led to a lawsuit challenging it, and assesses the sustainability of the SOP as a long-term financing source.

The last two chapters review the implementation challenges faced by DirigoChoice and discuss how the program's experience can inform the efforts of other states involved in pursuing similar coverage expansion strategies. Chapter VII reviews the major problems Maine encountered in implementing a subsidized insurance product and the options now under consideration for addressing those problems. Chapter VIII discusses the relevance of Maine's experience to other states based on an assessment of similarities and differences in the characteristics of the uninsured population, health insurance market and delivery system features, and financing sources or available capacity.

As a mid-term assessment of progress, this evaluation cannot measure the ultimate impact of Dirigo coverage expansions on Maine's uninsured rate. Because the state had just begun to implement its other reforms during the period of this evaluation (addressing cost, quality, and health promotion) and has designed those reforms to operate in concert with the

Dirigo expansions, the impact of the full range of reforms on increased insurance coverage cannot yet be measured. Moreover, the DirigoChoice program continues to change in response to implementation experience. In addition, data limitations constrain our ability to measure program impact on the state's uninsured rate at this time. A state household survey of insurance status has not been repeated since 2002, and annual Census Bureau data for the state are too imprecise and lagged to measure declines in the uninsured at an aggregate level for 2005 and 2006. This report therefore tells a story whose ending is not yet known.



# CHAPTER I

## DATA SOURCES AND METHODS

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The evaluation employed a mixed methods approach based on quantitative and qualitative data collection and analyses. Sections A, B, and C briefly describe the data sources for the three major data collection components of the evaluation. We provide further details later in the report or in the appendices on these three components and other sources of data.

### A. DIRIGOCHOICE AND MEDICAID ENROLLMENT DATA

MPR obtained DirigoChoice enrollment data from the Dirigo Health Agency's (DHA) administrative files, which maintained information on members ever enrolled since the program began in January 2005 through September 2006. For each member, the dataset contained information about member type (individual, self-employed, small group); member role (subscriber, spouse or partner, dependent); age; discount level for those who applied for premium and cost-sharing subsidies; previous insurance coverage<sup>3</sup> and deductible level (if any); and date of enrollment and disenrollment.

DHA also provided summary Medicaid enrollment data based on data reported by the Maine Department of Health and Human Services, Office of Medical Services, and the Maine Legislature's Office of Fiscal and Program Review. Summary data included monthly enrollment levels from October 2002, when expansion began for a group covered by the

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<sup>3</sup> DirigoChoice enrollment data on insurance coverage status before the advent of DirigoChoice had serious limitations and gaps. As the program did not require applicants to report information on earlier coverage status until January 2006, data from those who enrolled during 2005 are incomplete. In addition, the wording of the question on the application about previous coverage changed. In 2005, the question asked applicants, "Have you had health insurance in the last 12 months?"; in 2006, the question was rephrased to ask, "Were you covered by another health insurance plan *for all 12 months* prior to applying for DirigoChoice?" If applicants wanted to cover dependents through DirigoChoice, they were also asked in 2006 if those dependents had health insurance for all 12 months before applying for DirigoChoice. Thus, the information provided by applicants about previous coverage was different in each year.

Medicaid Section 1115 waiver, to November 2006. The data tracked enrollment for groups covered by a MaineCare eligibility expansion implemented before Dirigo Health—childless adults with family income below 100 percent of FPL—as well as for Maine Care’s eligibility expansion authorized by the Dirigo Health Act for parents of children under age 19 with family income between 150 and 200 percent of FPL.

## **B. SMALL EMPLOYER SURVEY**

MPR conducted a survey of small employers and selected the survey sample to allow valid comparisons between Maine firms eligible for DirigoChoice participating in the program and similar firms that were eligible and not participating. We screened all surveyed firms to ensure that they met program requirements and therefore were eligible for DirigoChoice. Appendix A details the survey design, sampling methods, survey administration, response rates, and weighting techniques.

Using a list of all businesses participating in DirigoChoice that we obtained from DHA, we received a file of all 713 firms offering DirigoChoice. We selected an additional 800 comparable firms in Maine not currently participating in DirigoChoice from a list provided by Dunn and Bradstreet (D&B), a firm that maintains information on businesses throughout the country. While we randomly drew the survey sample of non participating DirigoChoice firms, the DirigoChoice survey sample file contained all participating firms except the 25 firms that took part in a pretest of the survey. The total firm sample size was 1,513, which included 713 firms offering DirigoChoice and 800 firms not offering DirigoChoice.

The MPR DirigoChoice survey of small Maine firms asked questions about whether the firm offered insurance and whether it offered various coverage options. It also inquired about plan enrollment, cost to the employer and employee, barriers to offering health coverage if the firm did not offer it, and opinions about DirigoChoice. If a firm offered DirigoChoice, the survey asked the respondent to rate his or her satisfaction with the plan and to compare DirigoChoice to any previous coverage. The survey asked all firms about average wages; gender and age distribution of employees; and size, industry, and age of firm.

MPR fielded the survey from October 2006 through January 2007. Of the 1,513 firms sampled, 776 eligible firms completed the survey; an additional 376 firms were determined to be ineligible. The remaining 360 firms did not complete the survey because they refused to participate, could not be located, or could not be interviewed during the field period. The overall weighted response rate was 69 percent.

## **C. KEY INFORMANT INTERVIEWS**

MPR conducted semi-structured interviews with 35 key stakeholders involved in the development or implementation of DirigoChoice from November 2006 to January 2007. Interviewees included state executive agency officials and staff (7); state legislators (3); insurance plans, agents, and brokers (9); consumer advocates (4); provider organizations (3); small businesses (6); and health policy analysts (3). We conducted most interviews in person in Portland and Augusta and some by telephone. We developed interview guides with a

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common set of questions for all interviewees and with additional questions for those familiar with specific areas. The interviews addressed the following topics:

1. Trends and factors affecting Maine's small group and individual insurance markets
2. Maine's regulatory environment for small group and individual health insurance
3. Current insurance product offerings and how they compare to DirigoChoice
4. Views on DirigoChoice enrollment trends to date and the factors that affected participation and/or interest by small firms, sole proprietors, and individuals
5. The Savings Offset Payment, its sustainability, and possible alternative financing options
6. The MaineCare (Medicaid)-DirigoChoice interface

Before presenting results for these analyses, the next chapter provides some background on the healthcare system in Maine before the passage of the Dirigo Health Reform law.



## CHAPTER II

# MAINE'S HEALTH INSURANCE SYSTEM BEFORE DIRIGO HEALTH REFORM

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To understand Maine's approach to coverage expansion and the design of the DirigoChoice product, it is important to appreciate the problems facing the state's health care system and health insurance market when the Dirigo Health Act was enacted in 2003. This chapter provides background on the state's uninsured problem in the early part of the current decade, the cost of health insurance in the small group and individual markets, the state's previous efforts to address health insurance access and premium costs, and the dynamics that characterized the health insurance market and health care delivery at the time of the Dirigo Health Act's passage.

### A. HEALTH INSURANCE COVERAGE BEFORE DIRIGO HEALTH

When the Dirigo Health reform legislation was enacted in 2003, data from the Bureau of the Census indicated that Maine's uninsured rate for people under age 65 was 13 percent, less than the national average of 17 percent (CPS 2003). A household survey conducted by MPR for the state in 2002 also found that Maine's 136,000 uninsured residents under age 65 accounted for an uninsured rate of 13 percent (Ziller and Kilbreth 2003).

Among the reasons for the state's relatively low uninsurance rate is Maine's relatively generous Medicaid program, known as MaineCare. Before Dirigo Health reform, MaineCare covered children in families with incomes up to 200 percent of FPL with no assets test; in addition, parents with dependent children were eligible at incomes up to 150 percent of FPL. Maine is one of 15 states that provides coverage to parents at or above the poverty level. Moreover, before Dirigo, Maine had expanded Medicaid eligibility to childless adults between the ages of 21 and 65 with incomes below 100 percent of FPL; Maine is one of about a dozen states that covers poor childless adults. MaineCare also covers disabled adults below 125 percent of FPL, which is a higher threshold than that of most other states (one exception is Massachusetts). These eligibility levels have led the state to the top of the charts, along with Vermont and the District of Columbia, in the percentage of the non-elderly population covered by Medicaid, 21 percent in 2004–2005 in Maine (KFF State Health Facts).

In contrast to its relatively expansive public coverage, Maine is characterized by a relatively low rate of employer-sponsored health insurance offer. In 2004 before the launch of DirigoChoice, 50 percent of all private employers in Maine offered health benefits to workers as opposed to the national average of 56 percent (AHRQ 2004). Maine's lower rate may be a function of the higher percentage of small firms in the state (80 percent with fewer than 50 workers) relative to the national average (75 percent). Further, Maine's small employers are less likely than employers in other states to offer coverage; in 2004, 39 percent of Maine's small firms with fewer than 50 workers offered health benefits to their workers, a rate lower than the U.S. average of 42 percent and substantially lower than that of neighboring New England states (AHRQ 2004).<sup>4</sup> MPR's 2002 state household survey showed that workers and their families affiliated with small businesses (including self-employed individuals) made up more than half of the state's uninsured residents (Ziller and Kilbreth 2003). Thus, Dirigo Health's expanded coverage reflected a desire to increase the health benefit offer rate among small firms.

## **B. MAINE'S DEMOGRAPHIC AND ECONOMIC ENVIRONMENT**

Maine's geography and economic environment pose challenges to health care access and affordability. At 55 percent, Maine claims the nation's fifth-highest proportion of rural residents in the country. Its emergency room visit rate of 554 per 1,000 residents was almost a third higher than the U.S. average (AHA 2005), possibly reflecting problems of access to primary care in rural areas.

While the proportion of the state's population with low incomes (less than 200 percent of FPL) is about the same as the national average (35 versus 36 percent for the United States as a whole), the median annual household income for the 2003-2005 period (\$42,000) was lower than the U.S. median (\$46,000) and much lower than the median in neighboring New Hampshire (\$58,200) (KFF State Health Facts), thereby making it difficult for more individuals to afford health insurance premiums.

## **C. SMALL GROUP AND INDIVIDUAL HEALTH INSURANCE MARKET CHARACTERISTICS**

In 2002, Maine had the nation's second-highest insurance premium costs, adjusted for the quality of benefits (Gabel et al. 2006). To some degree, the state's high premium costs reflect underlying per capita personal health spending; at \$6,540 per person in 2004, Maine reported the second-highest rate of health spending in the country after Massachusetts and the second highest per capita spending on physician services (Martin et al. 2007).

Other factors have fueled recent growth in premium costs. There has been growing concentration and limited competition in the small and individual group markets. From 2000 to 2005, the number of carriers writing small and non-group coverage in Maine

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<sup>4</sup> In other New England states, small firm employer offer rates are 50 percent or greater, except for Vermont's small firm offer rate of 44 percent in 2004, which was still 5 percentage points higher than Maine's rate (AHRQ 2004).

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declined largely because of acquisitions by other plans; as a result, market concentration increased (GAO 2002 and 2005). In 2002 and 2003, Maine had the nation's second-highest dominance (70 percent) of the entire health insurance market by a single plan (Robinson 2004). By 2005, Anthem Blue Cross and Blue Shield of Maine (Anthem), which acquired Maine BCBS in 2000 and Maine Partners (a Health Maintenance Organization) in 2004, accounted for 65 percent of the small group market, up from 39 percent in 2002. In 2005, only Aetna among other small group carriers had any significant market share--20 percent of the small group HMO market and 8 percent of the small group indemnity/Preferred Provider Organization (PPO) market.<sup>5</sup>

In the individual health insurance market, five indemnity carriers offered coverage in Maine in 1994, but only Anthem now actively markets and offers new individual policies.<sup>6</sup> State rules require Aetna, CIGNA, Harvard Pilgrim, and other small group carriers to renew previously issued individual policies, but these plans do little or no marketing in the non-group market.

At the time Dirigo Health reforms were adopted, employers were acutely concerned about escalating premium costs. Average (per member per year) small group premiums increased by 33 percent in 2001 and by 29 percent in 2002 (Maine Bureau of Insurance 2006). While average rate increases have moderated since then (16 percent in 2003, 13 percent in 2005, 14 percent in 2007), they remain well above the rate of general inflation, even as small group benefits decline. Responding to a survey of 400 small businesses sponsored by the Maine Center for Economic Policy in 2004, half of small businesses said that they raised deductibles, and a quarter of respondents reported that they increased copayments, reduced benefits, or delayed pay raises to cover increased costs (O'Hara and Pohlmann 2005). In addition, 8 percent of small businesses responding to the survey dropped health coverage entirely.

High premium costs and high rates of annual premium increases also contributed to shrinking proportions of non-elderly enrollment in individual insurance. About 5.8 percent of Maine's non-elderly residents were covered by individual policies in 2005, down from 10 percent in 1994 (CPS 1995). The reduction may have expanded the rolls of those without any coverage, although some of those who lost individual coverage may have gained Medicaid coverage, which has recently expanded its eligibility criteria and therefore enrollment. The proportion covered by Medicaid rose from 10.5 percent in 1994 to 20.5 percent in 2005 (CPS 2006). Some key informants believed that declines in both the small group and individual markets increased the risk profile of those who remain insured, but data to support this contention are unavailable.

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<sup>5</sup> CIGNA exited the small group market at the end of 2004, leaving just Harvard Pilgrim and MEGA Life and Health to cover the remaining 5 percent of the small group market (Maine Bureau of Insurance 2006).

<sup>6</sup> All HMOs are required to offer individual insurance if so requested. MEGA Life and Health offers coverage to self-employed individuals who are members of the National Association for the Self-Employed.

#### D. INSURANCE REGULATION AND PREMIUM RATING PRACTICES

According to some stakeholders, the current regulatory system also contributes to high premium costs in Maine's small group and individual markets. In 1993, in an effort to increase access to health insurance, the Maine legislature required modified community rating for small group and individual products. Consequently, Maine's insurance premiums do not vary by gender, health status, claims experience, or length of time with coverage. Instead, community rates are established for each type of family unit, e.g., individual, individual and children, individual and spouse, and individual plus spouse and children. Insurers may adjust individual policy premiums by up to 20 percent above or below the community rate for age, occupation, geographic area, and smoker status. Insurers may adjust small group premiums by up to 20 percent above or below the community rate by average age, size of firm, geographic location, and type of business.

The 1993 reforms also required guaranteed issue and guaranteed renewal for both small group and individual policies. Maine's small group guaranteed issue statute predates (and fully complies with) the federal Health Insurance Portability and Accountability Act (HIPAA), which in 1997 required all insurers in the small employer health insurance market to provide coverage to any small firm group (of 1 to 50 employees) that applies for insurance and to renew such coverage annually. Maine's statute includes sole proprietors, although insurers may offer them an individual policy instead. In addition, Maine law specifies that the insurer or HMO cannot require more than 75 percent of eligible employees and dependents (who do not otherwise have coverage) to participate.<sup>7</sup> It also specifies that the maximum lapse in coverage is 90 days before pre-existing condition exclusions may be restarted.

Maine is one of just six states that requires guaranteed issue of individual policies; in other words, insurers cannot turn down applicants based on health or risk status. According to one study (Towers Perrin, undated), guaranteed issue is the primary cause of limited availability of individual indemnity coverage; by generating adverse selection, the report argues, guaranteed issue has led to escalating premiums (which one key informant called "prohibitive"), driving all but Anthem from the market. Many stakeholders in Maine concur with the study's assessment, characterizing the individual insurance market as in a "death spiral." However, consumer advocates claim that ballooning rates have benefited insurers at the expense of individual policyholders. Given that Maine requires guaranteed issue and renewal, it does not have a high-risk pool,<sup>8</sup> although Dirigo legislation authorizes

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<sup>7</sup> Eligible employees are those who work 30 or more hours per week. At the employer's option, others may be eligible: (1) part-time employees working as few as 10 hours per week and (2) retired employees. <http://www.maine.gov/pfr/insurance/employer/smallemp.htm>.

<sup>8</sup> From 1990 to 1995, Maine operated a high-risk pool funded by assessments on hospital gross patient service revenues, but it capped enrollment in response to insufficient funds. Guaranteed issue for non-group policies went into effect in 1993, and the pool was disbanded two years later.

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consideration of such a pool in 2008 if a study finds that premium escalation exceeds that in other states with high-risk pools.<sup>9</sup>

Insurers must submit initial and renewal rates for premiums to the Bureau of Insurance for review. Individual policy rates must be formally approved. Until 2003, small group rate changes were just filed and published, but the 2003 Dirigo Health Reform Act required insurers choosing to “file and use” rates for small group policies to maintain a minimum loss ratio of 78 percent on average (for each comprehensive health product) over a three-year period. This provision took effect in 2004; therefore, 2007 is the first year in which the rule will be implemented through a “look-back” review. Policies that exceed or have not met the minimum average loss ratio will be reconciled through refunds issued to policyholders. According to a Bureau of Insurance spokesperson, most policies are expected to meet the requirement.

#### **E. MAINE’S HEALTH CARE DELIVERY SYSTEM AND COSTS**

In addition to demographic and economic factors, several features of the state’s health care delivery system contribute to Maine’s high health care costs. Owing to the state’s largely rural nature, Maine accounts for many small and widely dispersed hospitals and health care facilities. Key informants pointed to significant excess capacity in the system, especially in the state’s northern and more rural areas. Yet, with most hospitals the sole provider in their respective communities, residents fiercely protect the institutions in order to maintain access to care. In addition, hospitals often carry considerable political and economic weight as a major—if not the largest—employer in rural communities. Reflecting their small scale of operation and perhaps because they face little competition, many Maine hospitals operate with high unit costs relative to national and regional averages. Average private-pay rates to hospitals in Maine were 30 percent higher than in neighboring states (Dirigo Health Agency 2005), leading to the Dirigo Health Reform Act’s inclusion of voluntary targets for hospital operating margins.

Despite a long-standing certificate of need (CON) program that reviews hospitals’ proposed capital expenditures, Maine’s CON program was regarded by many stakeholders as ineffective at controlling new construction. Dirigo Health strengthened the program by establishing a state health plan to guide capital investments and setting a global limit on capital expenditures. Currently, capital projects subject to CON review include new buildings that cost \$2.4 million or more; major medical equipment that costs \$1.2 million or more; and new services that cost more than \$110,000 or have third-year operating costs of \$400,000 or more.

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<sup>9</sup> Title 24-A: Maine Insurance Code, Ch. 87: Dirigo Health (P.L. 2003, c. 469, Pt. A, §8 (new), Subchapter 3: Dirigo Health High-Risk Pool.

## F. CONCLUSION

Maine's high cost of health care and health insurance premiums and high degree of concentration in the insurance market influenced the design of the Dirigo Health coverage expansion initiatives. While the state believed that it had already addressed access to coverage—almost anyone in the state could purchase coverage—a considerable number of residents still could not afford it. Thus, Dirigo Health's access and coverage goals focused on making more affordable products available to small businesses and individuals. Such goals would have posed a challenge anywhere, but Maine's high health care costs and insurance premiums made achieving of Dirigo's goals especially difficult. The next chapter describes the design of the DirigoChoice product, the structure of the Medicaid eligibility expansions, and the state's plan for financing premium subsidies.

## CHAPTER III

### DIRIGO HEALTH COVERAGE EXPANSIONS: DIRIGOCHOICE AND MEDICAID ELIGIBILITY EXPANSIONS

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**D**irigo Health enacted two major coverage expansion strategies. First, through premium subsidies, DirigoChoice was designed to make a small group and individual insurance product more affordable to employees in small firms, sole proprietors, and individuals. Second, the Dirigo Health Act increased access to health coverage by expanding eligibility for Medicaid (called MaineCare), making fully subsidized health coverage available to the poorest citizens—those below the poverty line—and low-income parents of children under age 19. The two initiatives were designed to operate in tandem by allowing working adults with Medicaid coverage to transfer to the DirigoChoice subsidized program, allowing them to accept a job offer or wage increase without fear of losing their health insurance coverage.

This chapter explains the two programs' design features. First, it describes DirigoChoice eligibility and how low-income residents may qualify for DirigoChoice or Medicaid; the structure of DirigoChoice's income-based premium subsidies; the covered benefits; and administration and financing. The chapter then explains Medicaid eligibility expansions, both those authorized by the Dirigo Health Act and a previous expansion that targeted a group that could be eligible for DirigoChoice.

#### **A. DIRIGOCHOICE ELIGIBILITY**

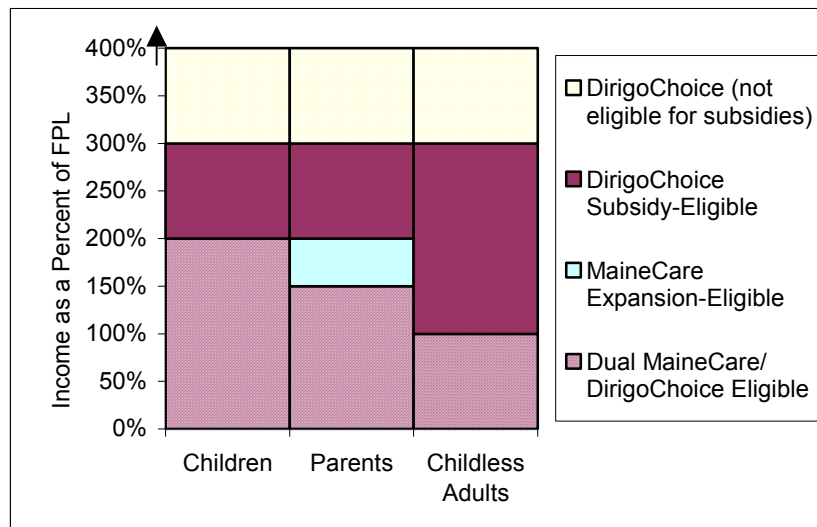
Those eligible to enroll in DirigoChoice include:

1. Small employers with 2 to 50 employees, whether or not the firm currently offers coverage, if at least 75 percent of eligible workers enroll in the program.
2. Self-employed workers who are sole proprietors, defined as a business in which the owner is the only employee and from which he or she derives 50 percent of more of his or her income.

3. Individuals without access to employer-sponsored coverage because they (a) are unemployed, (b) work for a small business that does not offer insurance and has not offered coverage in the previous 12 months,<sup>10</sup> (c) own a small business but cannot get enough employees to join a small group plan, (d) work fewer than 20 hours a week for any one employer, or (e) are early retirees whose former employer does not contribute to health benefits.

DirigoChoice allows residents who apply for subsidies through an employer or as a sole proprietor and who are eligible for MaineCare to enroll in both programs. These “dual eligibles” include childless adults with income below 100 percent of FPL and parents and children under age 19 with family income below 200 percent of FPL (childless adults and parents must also meet applicable asset tests). MaineCare pays the full cost of dual enrollees’ DirigoChoice monthly coverage costs, deductibles, and other cost sharing as well as wraparound coverage for MaineCare-covered services not covered by DirigoChoice. In contrast, people who apply to DirigoChoice as individuals (not as a worker in a small firm or as a sole proprietor) and are Medicaid-eligible may enroll only in MaineCare. Figure III.1 illustrates the DirigoChoice and Medicaid coverage options for those who may be eligible for either program.

**Figure III.1. Eligibility for DirigoChoice and MaineCare By Family Income as a Percent of Federal Poverty Level**



Should dual enrollees’ income rise such that they are no longer eligible for MaineCare, DirigoChoice members may remain in the plan as long as they and their employers continue to make premium payments. As noted, this arrangement was intended to remove any

<sup>10</sup> An individual whose employer discontinued an offer of coverage must wait 12 months to become eligible to enroll in DirigoChoice (also applies to residents who apply as a self-employed worker).

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disincentive that would prevent MaineCare beneficiaries from taking better-paying jobs or accepting wage increases that would result in loss of health coverage.

## **B. EMPLOYER PREMIUM CONTRIBUTIONS AND SUBSIDIES FOR ENROLLEE COSTS**

Maine residents at any income level may enroll in DirigoChoice. Those with family income below 300 percent of FPL are eligible for discounted premiums<sup>11</sup> and deductibles on a sliding scale relative to income. Enrollees with income higher than 300 percent of FPL must pay the entire premium (or employee share if group-enrolled) as well as the full deductible.

Table III.1 displays the schedule of subsidies for the five “discount groups,” corresponding to the income ranges that qualify for different subsidy levels. While initial plans called for employers to pay at least 60 percent of the premium for both individual and family coverage, small firm representatives opposed a plan that required any minimum share of family coverage. Thus, DirigoChoice requires the employer to pay at least 60 percent of single premiums but does not require contributions for dependents. For workers and dependents enrolling through a small employer, the discount applies only to the employee’s share of the premium.

## **C. BENEFITS**

The DirigoChoice product offers a comprehensive set of inpatient, outpatient, and prescription drug benefits. After enrollees meet the initial deductible, they are responsible for a coinsurance payment of 20 percent for most services provided by network providers (50 percent from a non-network provider). However, DirigoChoice covers preventive benefits (annual physicals, immunizations, and screening examinations) in full, with no deductible, co-insurance, or copayment. The program promotes affiliation with a primary care physician and pays new DirigoChoice enrollees \$25 when they select a primary care physician and \$75 (per family) upon completion of a health risk assessment, which is intended in part to help promote healthy behaviors. DirigoChoice covers mental health services to the same extent as physical health benefits, as is typical of large employer coverage in Maine but not common in small group policies, according to key informants. Copayments for prescription drugs vary by whether the drug is generic (\$10), preferred brand-name (\$20), or non-preferred brand-name (\$40). Providers receive payment according to the carrier’s (Anthem Blue Cross Blue Shield for the 2005–2007 period) regular rate schedule. Unlike other individual insurance products in Maine, DirigoChoice does not impose a pre-existing condition exclusion period on individual enrollees.

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<sup>11</sup> Dirigo Health Agency refers to monthly premiums as “monthly cost of coverage,” since the payments by employers and individual members are made to the Agency, not to the insurer. This report uses the term premium, which makes the concept easier to understand for readers.

**Table III.1. Enrollee Share of DirigoChoice Premiums and Deductibles Covered By Subsidy For Each Discount Group (percent)**

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

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

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

\*\*\* The subsidy percentage is the discount on the employee's share of the premium, not on the full premium.

The program offers two plan options that vary by level of the annual deductible. Plan 1 (available only to small groups) has an annual deductible of \$1,250 for singles and \$2,500 for families. Plan 2 (the only option for individual enrollees, but also available to small groups) has an annual deductible of \$1,750 for singles and \$3,500 for families. By comparison, in 2006 nearly three quarters of individual policies in Maine had deductibles of \$5,000 or more (Gorman Actuarial, 2007).

For instance, a parent with one or more children whose annual earnings total \$15,000 would qualify for the Group B discount level of 80 percent, which would reduce the \$3,500 annual deductible to \$700. Both plan options limit total annual out-of-pocket costs, also adjusted for family income. For example, Plan 2 has a maximum out-of-pocket limit of \$5,600 for a nonsubsidized single member (\$11,200 for a family), which is reduced to \$1,600 for a single member (\$3,200 for a family) for those in Discount Group B.

While the Dirigo Health Act directed DHA to develop a comprehensive benefit package, the trend toward higher deductibles and greater employee cost sharing in competing commercial products forced Dirigo to develop a plan with deductibles higher than initially planned (Rosenthal and Pernice 2004). Continuation of this trend led DHA to offer small groups a \$2,500 deductible plan in 2007.

#### **D. ADMINISTRATION, MARKETING, AND RISK SHARING**

DirigoChoice was designed to be administered jointly by state government and private insurers. DHA, an independent executive agency governed by the publicly appointed Dirigo

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Health Board of Directors, manages the program and has the authority to assess the SOP and administer subsidies to qualified enrollees. It contracts with individual enrollees and with employers on behalf of participating employees and their dependents to provide DirigoChoice health coverage.

DHA and the Maine Department of Health and Human Services (DHHS), which administers the MaineCare program, issued a Request for Proposal in May 2004, seeking interested carriers to provide health insurance and administrative services for DirigoChoice members. Only Anthem submitted a bid. DHA negotiated with Anthem on the terms of a two-year contract for DirigoChoice coverage, which became effective with the start of enrollment in 2005. DHA subsequently extended the contract for another year, to the end of 2007, while the state considered other options for the program's insurance and administrative functions (discussed in Chapter VII). Anthem continued to offer its other small group and individual products, giving it an opportunity to steer customers toward DirigoChoice or to its own products.

Small groups and individuals may enroll in DirigoChoice only through state-licensed insurance sellers, including Anthem's direct sales force and network of agents, and independent brokers. If individuals interested in applying for the program call DHA directly, the agency refers them to independent brokers. However, applicants for DirigoChoice subsidies must submit applications directly to DHA. Thus, application for subsidized coverage is a two-step process. Employers choosing to enroll in the program must submit a separate application and do not know in advance which, if any, of their employees will qualify for subsidies until the employees have submitted their own subsidy applications.

DHA and Anthem jointly conducted marketing and public education campaigns to publicize DirigoChoice—including direct mail, television, radio, and newspaper advertisements; DHA sent direct mail to small businesses in fall 2005. Anthem also conducted a marketing campaign for all of its small business products, including DirigoChoice. Unlike other insurers that pay broker commissions calculated as a percentage of the total premium, Anthem now pays brokers a flat fee per enrollee in any of its products. Anthem's fee for DirigoChoice enrollees (\$14.50 per enrollee) is a little less than the fee it pays for its other products. Anthem made up to \$500,000 available in bonuses (based on the number of members enrolled) for insurance agents who enrolled small businesses during the program's first year, but according to stakeholders, not much of the funds were awarded.

DHHS's MaineCare has its own contract with Anthem to insure and administer claims for dually enrolled DirigoChoice/MaineCare beneficiaries. Dual enrollees receive DirigoChoice and MaineCare cards that allow them to access services through either Anthem's providers for DirigoChoice-covered services or other MaineCare providers for wraparound services.

Anthem's contract with DHA contained risk-sharing provisions to indemnify the company during the first two years against undue risk associated with serving a population whose expected expenses were uncertain. In what is called an "experience modification program" (EMP), the state agreed to return to Anthem a portion of the \$8 million EMP in

the first year if the medical loss ratio exceeded 80 percent. The second year EMP totaled about \$15 million. The idea behind the EMP was if the DirigoChoice population was very costly to Anthem and their premiums did not cover their care, the EMP would make up the difference in cost to Anthem. If the DirigoChoice population was no more at risk than the rest of the population as demonstrated by Anthem's medical loss ratio, then Anthem would return a portion of this payment to DHA. Anthem had to return nearly all of the EMP to DHA after the first year, and about three-quarters after the second year.

## E. FINANCING

During the DirigoChoice program's first year of operation, employer and enrollee contributions and state and federal funds financed the program. In subsequent years, the state planned to finance DirigoChoice subsidies through two innovative, largely untested mechanisms. The first mechanism authorized the SOP, which was designed to capture (1) savings from reduced bad debt and charity care as a consequence of expanded health coverage as well as (2) savings from the Dirigo Health Act's other cost control initiatives. The amount of the SOP was based on the "aggregate measurable cost savings," determined annually through an adjudicated process in which the Superintendent of Insurance issues a ruling based on evidence of actual savings. The SOP is then turned into assessments on health insurers and third-party administrators of self-insured companies, but cannot exceed 4 percent of annual paid claims. (Chapter VI provides a detailed description of the SOP.)

As for the second mechanism, Dirigo Health would claim federal Medicaid matching funds on employer premium contributions for DirigoChoice enrollees eligible for the state Medicaid program.<sup>12</sup>

## F. MEDICAID ELIGIBILITY EXPANSION GROUPS

In 2004, before the launch of DirigoChoice, MaineCare covered approximately 255,000 individuals each month, or about 20 percent of the state's population, which is well above the U.S. average of 14 percent of state residents insured by Medicaid (Ellis et al. 2006). Although program eligibility was already relatively expansive, the Dirigo Health Act authorized an expansion in MaineCare income eligibility for two groups:

- 1. Parents with dependent children with family income from 150 to 200 percent of FPL.** The Dirigo Health Reform Act expanded eligibility for MaineCare for parents of children under the age of 19 in families with income up to 200 percent of FPL, extending the previous limit of 150 percent of FPL. Eligible parents are subject to a \$2,000 asset limit. The state submitted a state plan amendment to Center for Medicare and Medicaid Services (CMS), which was approved and took effect on May 2, 2005.

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<sup>12</sup> Employer premium contributions are not normally eligible for federal matching funds when paid to private insurance plans, but because the state would collect the funds and transfer them to the Medicaid program, the state could claim the funds as Medicaid expenditures.

**2. Childless adults up to 125 percent FPL.** This Dirigo expansion group intended to build on a Medicaid eligibility expansion, operating under a federal waiver, which began in October 2002. The waiver group includes adults between the ages of 21 and 65 who do not have minor children living at home, are not disabled, have incomes up to 100 percent of FPL and countable assets below \$2,000 (\$3,000 for couples). Dirigo planned to extend the income limit for this group to 125 percent of FPL, the maximum allowed under the waiver, in part to achieve equity with a scheduled rise in income eligibility for disabled adults from 100 to 125 percent of FPL. However, when program costs exceeded the spending cap set under the terms of the federal Medicaid waiver program, the state implemented a freeze on new enrollment for those with incomes below 100 percent of FPL in March 2005, and cancelled implementation of the expansion for those earning up to 125 percent of FPL. Those who applied after March 2005 were put on a waiting list. In July 2006, new enrollment for those earning up to 100 percent of FPL resumed.

This background on MaineCare eligibility expansions is important for understanding enrollment trends in DirigoChoice because (1) the two programs operated concurrently, and (2) low-income adults may be eligible for either program, depending on their income, resources, and employment situation. The next chapter examines how many enrolled in each of the coverage expansion programs and the characteristics of DirigoChoice enrollees.



## CHAPTER IV

### DIRIGOCHOICE AND MEDICAID EXPANSION GROUP ENROLLMENT

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In 2005, Dirigo Health coverage expansions took effect. The DirigoChoice subsidized insurance product began serving its first members on January 1, 2005. The MaineCare eligibility expansion for parents took effect in May 2005. How many people responded to these new coverage opportunities, and to what degree are the products helping to expand access to affordable insurance coverage?

This chapter uses administrative data provided by DHA to examine enrollment trends in the two programs at the end of 2006. It also reports on the composition of DirigoChoice enrollees (small group, sole proprietors, individuals); characteristics of enrollees by family income, age, and dependent coverage; and enrollees' previous insurance coverage. Recognizing that low-income individuals may have gained coverage under either program, the chapter then briefly examines enrollment trends in the MaineCare eligibility expansion groups. It concludes with an overall assessment of the two programs' progress to date in expanding access to affordable coverage.

#### A. DIRIGOCHOICE ENROLLMENT

As of September 2006, approximately 11,100 people were enrolled in DirigoChoice, of whom 42 percent were individuals, 30 percent small group members, and 28 percent sole proprietors. These numbers are far lower than the 41,000 enrollees projected to enroll in the first year alone, of whom 31,000 were expected to qualify for premium and deductible subsidies (DHA 2004). According to some key informants, these projections represented an upper bound needed to estimate the program's likely maximum financing needs in its first year. Thus, a comparison of projected to actual enrollment is not a valid yardstick for measuring progress.

However, the sizeable gap between expected and actual enrollment in the distribution among member types and discount groups does matter because it has significant implications for program financing (Table IV.1). For example, by September 2006, 3,400 small group members had enrolled (DHA 2004) and accounted for 30 percent rather than

the projected 90 percent of all enrolled members. The number of program enrollees, including those in small groups, was generally in line with early experiences in other states with voluntary health insurance subsidy programs (Kilbreth 2006). Nevertheless, lower enrollment among small groups in relation to the total eligible membership means fewer people to offset the costs of sole proprietors and individuals, whose subsidy costs are higher. In other words, per capita subsidy costs are higher when small group enrollees represent a smaller share of all program enrollees.

**Table IV.1. Enrollment in DirigoChoice Projected Year 1 (2005) versus Actual as of September 2006**

	<b>Projected Year 1 Enrollment (2005)</b>	<b>Current Enrollment (as of September 2006)</b>	<b>Ever Enrolled (as of September 2006)</b>
	Percent (number)	Percent (number)	Percent (number)
<b>Member Distribution</b>			
Small Group	90 (37,000)	30 (3,350)	35 (5,162)
Sole Proprietor	10 (4,000)**	28 (3,051)	26 (3,896)
Individual		42 (4,685)	38 (5,657)
<b>Total</b>	<b>100 (41,000 members)</b>	<b>100 (11,086 members)</b>	<b>100 (14,715 members)</b>
<b>Discount Level</b>			
	Percent of Members	Percent of Members	Percent of Members
A (MaineCare-Eligible)*	11	1	1
B	3	49	46
C	6	16	16
D	29	10	11
E	26	4	5
F (No Subsidy)	24	20	22
<b>Total</b>	<b>100 (41,000 members)</b>	<b>100 (11,086 members)</b>	<b>100 (14,715 members)</b>

Source: Dirigo Health Agency, Request for Proposal, May 8, 2004; MPR tabulation of Maine Dirigo Health Agency administrative data as of September 2006.

\*DirigoChoice rules specify that individual applicants (i.e., not employees of small firms) who are MaineCare-eligible cannot be dually enrolled in both programs, but administrative data show some individuals as dual enrollees. Their dual status could be attributable to data inaccuracies or special circumstances, e.g., parent is an individual in DirigoChoice with a child in MaineCare.

\*\*The first-year enrollment cap of 4,000 sole proprietors and individuals, all expected to be subsidized, was later raised to 4,400.

During the first year of DirigoChoice, as many more sole proprietors and individuals enrolled than expected, DHA drew on a safeguard built into its authorizing legislation and imposed a temporary freeze on enrollment after just three months in June 2005. In January 2006, the program lifted the freeze on enrollment among these groups so that, by September

2006, after about 12 months of eligibility to enroll, individual and sole proprietor members represented double the maximum target for the first year.

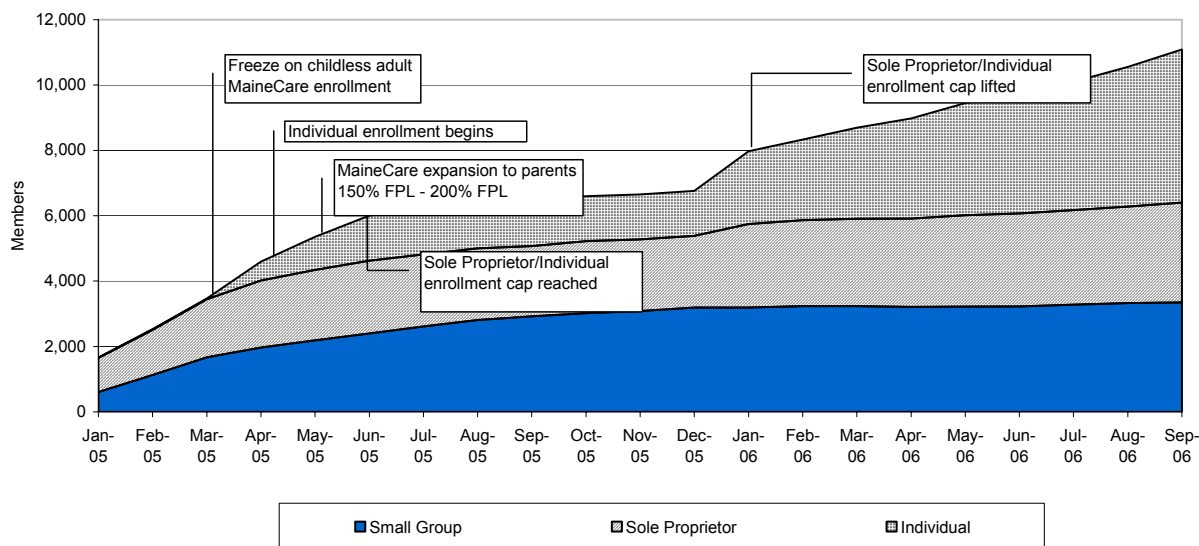
The distribution of enrollees by subsidy group also differed from what was expected. Of the 11,100 enrolled as of September 2006, about 80 percent received subsidies to cover premiums and deductibles, close to the projected 76 percent (DHA 2004). However, the percentage of those qualifying for the greatest discounts differed markedly from what was expected. Enrollment in Discount Group B greatly exceeded projections. First-year projections called for 3 percent (1,300 participants) of the entire DirigoChoice group to fall into Group B, which subsidizes 80 percent of members' premiums and deductibles. By September 2006, 49 percent of enrollees (5,400 participants) were in Discount Group B, which raised the state's cost of subsidizing premiums and deductibles to a level much higher than planned.

At the same time, enrollment of MaineCare-eligible individuals (Discount Group A) has been low (about 200) compared to the 4,500 individuals estimated by the state for enrollment in the first year (DHA 2004). As a result, the state received less revenue than expected because it did not receive federal Medicaid matching funds on employer contributions for as many enrollees as planned.

## B. DIRIGOCHOICE ENROLLMENT TRENDS AMONG SMALL FIRMS, SOLE PROPRIETORS, AND INDIVIDUALS

**Small Group Enrollment.** Small groups could begin enrolling in DirigoChoice in fall 2004 for coverage effective January 2005. By September 2006, 738 small businesses were enrolled in DirigoChoice, with their 3,350 enrolled workers representing approximately 30 percent of all DirigoChoice members (Figure IV.1).

**Figure IV.1. Cumulative Net Enrollment in DirigoChoice (January 2005–September 2006)**



Despite relatively fast growth in small group enrollment in the program's first year of operation, the rate of net new enrollment declined steadily during 2005. This pattern may reflect annual health plan enrollment by firms, which typically occurs at the beginning of the calendar year. Throughout 2006, average small group enrollment hovered around 3,300 workers.

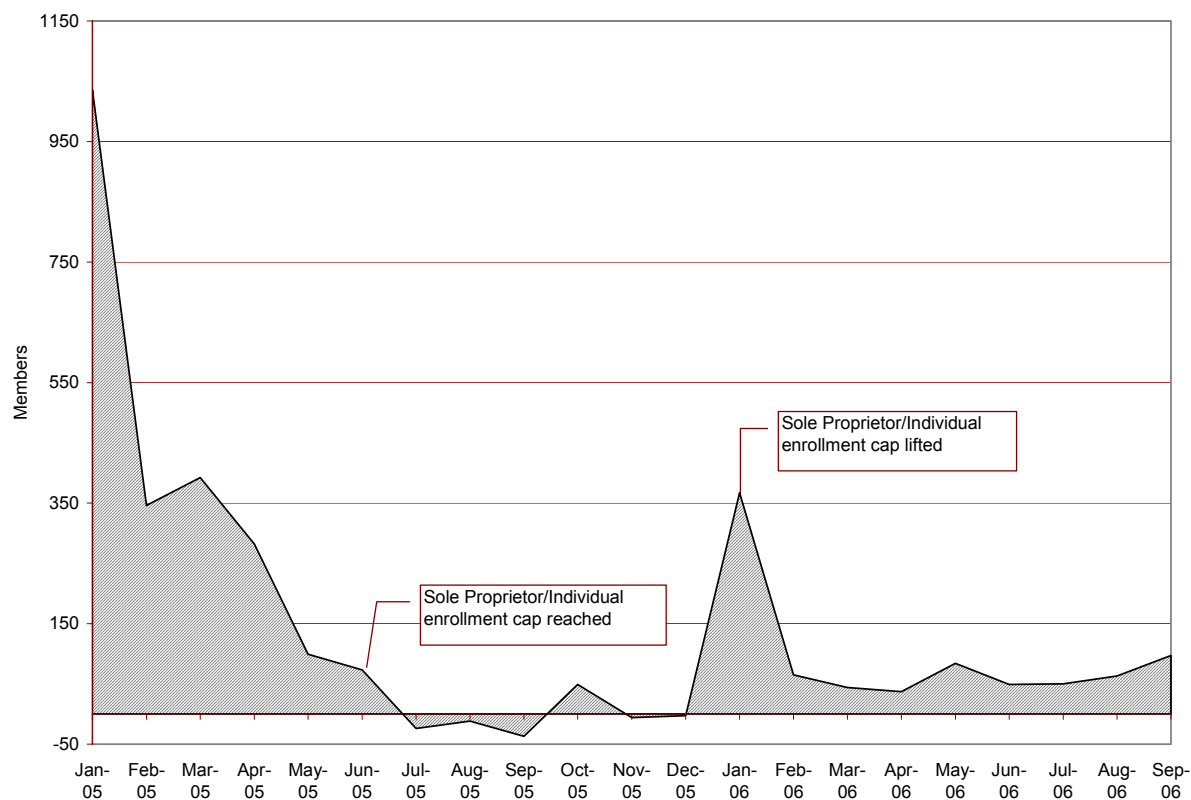
In September 2006, the average number of employees ever enrolled in small groups was 3.5, with an average of 2 dependents per enrolled worker. Most employer groups that enrolled in DirigoChoice are small. Respondents to the employer survey indicated that the average firm size was 7 employees (including workers eligible and not eligible for health benefits) among firms offering DirigoChoice. Because DirigoChoice firms are required to enroll at least 75 percent of eligible workers (excluding employees with coverage from any other source), the total number of workers in participating firms is likely to be higher than the number enrolled in DirigoChoice. Small group enrollees have selected the two plan options (low versus high deductible) in approximately even numbers since the program began.

***Sole Proprietor Enrollment.*** DirigoChoice coverage for sole proprietors began January 1, 2005. Enrollment for sole proprietors (in combination with other individual enrollees) was capped at 4,400, owing to the state's limited general revenue funds to subsidize individual enrollees during the program's first year. Enrollment hit the cap in June 2005, freezing new enrollment for sole proprietors and individuals for the remainder of the year. In July through September, the program experienced a net loss of enrollment due to attrition (Figure IV.2). By December 31, 2005, about 3,000 people were on a waiting list for sole proprietor and individual coverage.

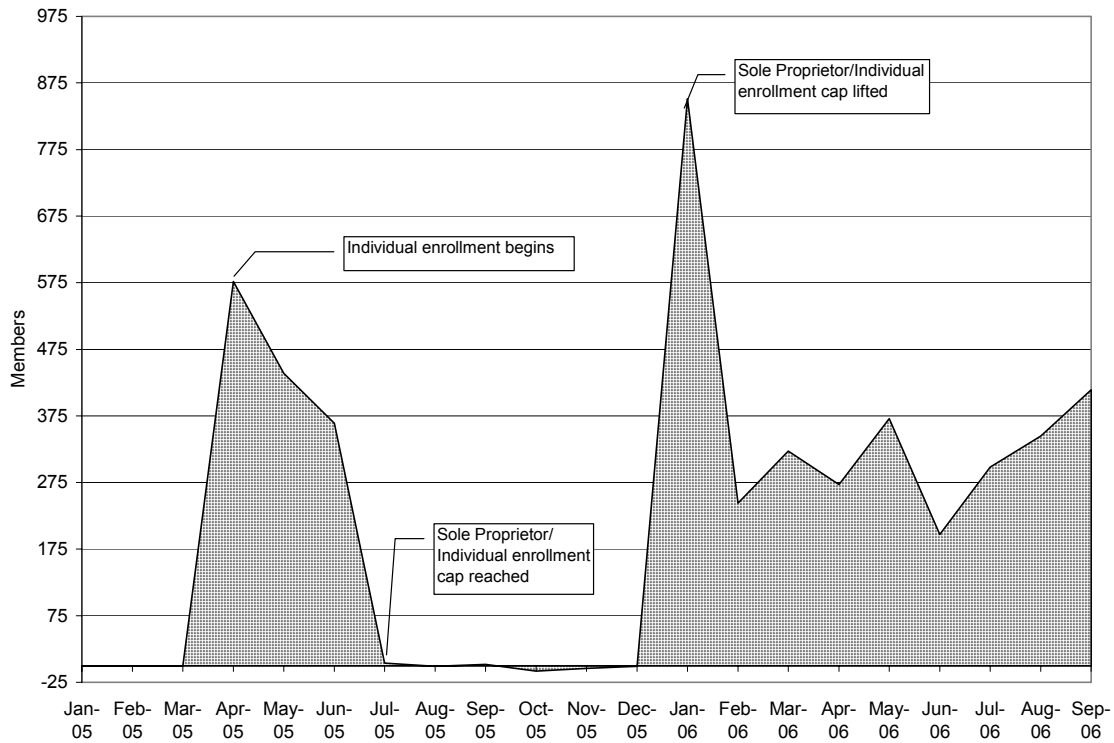
After the state lifted the freeze on new enrollment in January 1, 2006, and worked down the waiting list, net monthly enrollment stabilized at about 60 new sole proprietor enrollees (Figure IV.2). In September 2006, sole proprietors and their dependents accounted for just over 3,000 enrollees, or about 28 percent of all DirigoChoice members.

The high demand for DirigoChoice among sole proprietors is especially notable because the subsidy structure for sole proprietors is less favorable than that for small firm workers. Sole proprietors pay the full "employer's" share of the premium (60 percent) and are subsidized on the balance only. Hence, the effective subsidy compared to the full premium (both employer and employee shares) is 40 percent for Discount Group A and 8 percent for Discount Group E, lowering the state's subsidy obligation relative to that for individual enrollees. Sole proprietors may be responding to problems with existing products in the market, such as unaffordable premiums, high deductibles, or rating practices that offer them individual rather than small group rates.

**Figure IV.2. Net Monthly Enrollment of Sole Proprietors (January 2005–September 2006)**



**Individual Enrollment.** DirigoChoice began enrolling eligible individuals on April 1, 2005. Enrollment was so strong that the program reached its first-year enrollment cap of 4,400 (in combination with sole proprietor enrollees) in just three months. At the start of 2006, the state lifted the freeze on new individual enrollment and saw enrollment surge, surpassing even that among sole proprietors. Net new monthly enrollment for individuals continued to average 300 individuals a month between February and September 2006 (Figure IV.C). In September 2006, individual enrollees and their dependents represented nearly 4,700 enrollees, or about 42 percent of all DirigoChoice members.

**Figure IV.3. Net Monthly Enrollment of individuals (January 2005–September 2006)**

### C. CHARACTERISTICS OF DIRIGOCHOICE ENROLLEE GROUPS

While most DirigoChoice enrollees are subsidized, those who enroll as individuals are most likely to qualify for subsidy while those who enroll as small group members are least likely to be MaineCare-eligible. The distribution of subsidy eligibility has been a challenge to financing the program.

**Income/Discount Level.** Overall, nearly 80 percent of DirigoChoice members receive premium and deductible discounts, and almost half (46 percent) receive the greatest discounts. Two-thirds (66 percent) of those enrolled as individuals have family income below 150 percent of FPL and are therefore eligible for the deepest discounts (Discount Groups A and B), which subsidize at least 80 percent of the premium and deductible (Table IV.2).

In contrast, just 22 percent of small group enrollees qualify for Discount Group A or B. Conversely, nearly 40 percent of small group enrollees have family income greater than 300 percent of FPL and therefore receive no discount. The wider income distribution of small group enrollees may reflect the range of income levels among workers in small firms.

Sole proprietors are somewhat less likely than individual enrollees to qualify for the highest level of discounts—a situation that may reflect either problems of affordability related to the subsidy structure for sole proprietors or sole proprietors' generally higher

income. It is important to recall that DirigoChoice requires sole proprietors to pay the employer's share (60 percent of the premium) and subsidizes only the remaining 40 percent of premium. Even though sole proprietors can deduct the full premium expense from their federal taxable income, the deduction may be of little value to those with low income; in any case, the tax benefit may come too late to be helpful in paying current-year premiums.

**Table IV.2. Number of DirigoChoice Enrollees by Discount (Subsidy) Levels and Member Type (Ever-Enrolled as of September 2006)**

Discount Group (by family income)	Small Group		Sole Proprietors		Individual		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Group A: MaineCare-eligible*	115	2	59	2	27	1	201	1
Group B: <150% of FPL	1,030	20	2,014	52	3,695	65	6,739	46
Group C: 150 to 199% of FPL	846	16	655	17	844	15	2,345	16
Group D: 200 to 249% of FPL	714	14	387	10	457	8	1,558	11
Group E: 250 to 299% of FPL	454	9	168	4	104	2	726	5
Group F: >300% of FPL (no subsidy)	2,003	39	613	16	530	9	3,146	21
Total	5,162	100	3,896	100	5,657	100	14,715	100

\* DirigoChoice rules specify that individuals who are MaineCare-eligible cannot be enrolled as dual enrollees in both programs, but the administrative data show some individuals and sole proprietors as dual enrollees. This could be to data inaccuracies or special circumstances (for example, parent is an individual in DirigoChoice and child is in MaineCare). For our purposes, we include them as part of the small cross-section of small group participants who are DirigoChoice-MaineCare-dual eligible.

DirigoChoice enrolls few small firm workers who also qualify for MaineCare, classified as Discount Group A members. As of September 2006, just 201 people had ever enrolled in both DirigoChoice and MaineCare. Nearly all of these individuals were enrolled through a small group or as sole proprietors. About 70 percent of dual enrollees were dependent children of subscribers, with family income less than 200 percent of FPL. Only 33 enrollees were subscribers; by MaineCare eligibility rules, they were childless adults with income below 100 percent of FPL who enrolled before March 2005 or parents with children under age 19 and family income below 200 percent of FPL.<sup>13</sup>

Several factors explain the low enrollment of dual enrollees. First, the state did not raise MaineCare eligibility for childless adults to 125 percent of FPL as was planned; thus, only childless adults below 100 percent of FPL may qualify for both programs. Second, lower participation by small employers reduced the number of working poor adults who might have enrolled in DirigoChoice as small group members. Other possible explanations include the following:

<sup>13</sup> While parents in families with income below 200 percent of FPL might not qualify for MaineCare on the basis of asset tests, children in the same family might qualify because they are not subject to asset tests.

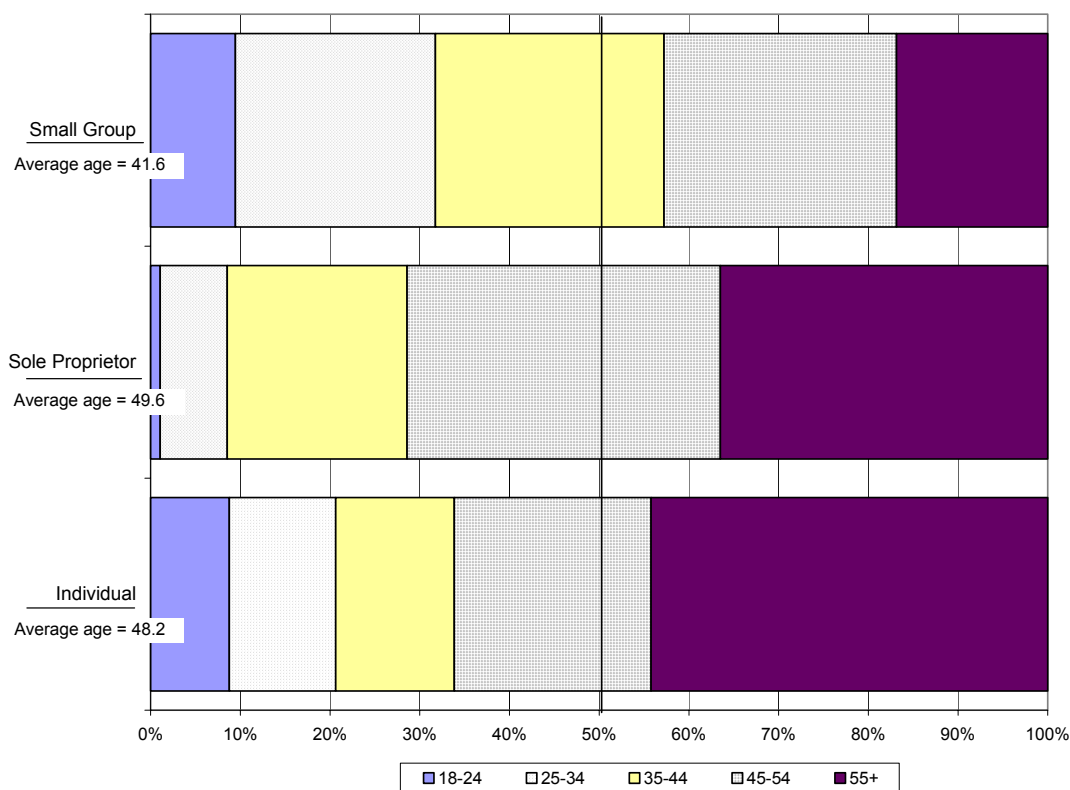
1. Relatively few workers may qualify when both income and assets are taken into account.
2. More workers might qualify but choose not to reveal information to the state about their assets.
3. Parents with income below 200 percent of FPL must meet an asset test, but some applicants might not realize that children in families below this income level do not need to meet the test.
4. Low-income workers in DirigoChoice firms may be ineligible to enroll if they work part-time (and their hours are fewer than what their firm requires for qualification for health benefits).
5. MaineCare-eligible employees may directly enroll in MaineCare (not through DirigoChoice). Given that MaineCare counts as qualified coverage for purposes of determining the firm's employee participation rate for DirigoChoice, employers would benefit from the following arrangement: a worker who enrolls directly in MaineCare would not be considered an "eligible employee" for the purpose of calculating minimum participation, and the employer would not need to contribute at least 60 percent of the worker's premium to enroll in DirigoChoice. At the time of the Dirigo Health Act's adoption, plan opponents vociferously pointed to this "loophole" in the program's proposed financing structure; as a result, many small employers may have become aware of it.

The gap between expected and actual enrollment of MaineCare-eligible individuals in the DirigoChoice product poses a significant challenge to the state's ability to cover more of its uninsured. Part of the state's financing strategy was predicated on use of employer premium contributions for dual enrollees as the basis for obtaining federal matching funds.<sup>14</sup> Without more dual enrollees, the DirigoChoice program's financing may be less sustainable. When individuals enroll in MaineCare alone, the state and federal governments bear the full cost.

**Age.** Overall, DirigoChoice members enrolled through small groups are younger on average (41.6 years) than those enrolled as individuals (48.2 years) or as sole proprietors (49.6 years). In addition, a much larger share of small group enrollees are adults age 18 to 44 (Figure IV.4). Among small group members, 57 percent are under age 45 compared with 34 percent among individual enrollees and 27 percent among sole proprietors. Conversely, just 17 percent of small group policyholders are age 55 or older compared with 44 percent among individual enrollees and 37 percent among sole proprietors.

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<sup>14</sup> In January 2007, the federal government provisionally allowed the state to draw down federal matching funds but had yet to decide whether the employer premium contributions would continue to qualify for such funds.

**Figure IV.4. Percent of DirigoChoice Enrollees Ever Enrolled By Age and Member Type**

**Dependent Coverage.** Most DirigoChoice enrollees (69 percent) select single coverage; they do not cover other family members. Those who enroll as individuals are the most likely to enroll as singles—74 versus 65 percent for small firm enrollees. Sole proprietors are the least likely to purchase single coverage (52 percent) and the most likely to cover family members other than children, such as spouses or partners. Sole proprietors and small group enrollees are equally likely to cover children in DirigoChoice.

#### D. PREVIOUS COVERAGE AMONG DIRIGOCHOICE ENROLLEES

On average, 31 percent of DirigoChoice enrollees were uninsured for all 12 months before enrollment in 2006 (Table IV.3).<sup>15</sup> Small firm workers were more likely to have been uninsured for all 12 months before enrollment (37 percent) than either sole proprietors (30 percent) or individuals (28 percent). Among the 65 percent of 2006 enrollees with previous coverage, the most frequent insurer was Anthem Blue Cross Blue Shield, which is Maine's

<sup>15</sup> Because the administrative data provided by DHA on the previous coverage status of DirigoChoice members were incomplete for 2005, we used previous coverage data from 2006 enrollees for this analysis. Even though DHA asked enrollees about their previous insurance status on its enrollment forms, a response was not mandatory until 2006.

largest carrier in the small group and individual markets and the current administrator of DirigoChoice coverage.

Among DirigoChoice members who enrolled during 2005, an even larger proportion had been uninsured at some point in the 12 months before they enrolled. According to a survey of members, 36.5 percent of all respondents were uninsured at the time of enrollment, and another 7.5 percent had been uninsured at some point in the 12 months before enrolling in DirigoChoice (Bowe and Thayer 2006). The 2005 cap on individual and sole proprietor enrollment and the necessity of instituting a waiting list that year may have led some to buy commercial coverage on a temporary basis before enrolling in DirigoChoice. Indeed, several stakeholders reported that some individual DirigoChoice members switched from Anthem's individual policies once they could enroll in DirigoChoice.

**Table IV.3. Previous Coverage of DirigoChoice Members Enrolling in 2006 By Member Type (Percent)**

	Small Group	Sole Proprietors	Individuals	Total
Previous Coverage in Past 12 Months	54	67	68	65
Uninsured for All 12 Months	37	30	28	31
Not a Usable Response	9	3	4	4

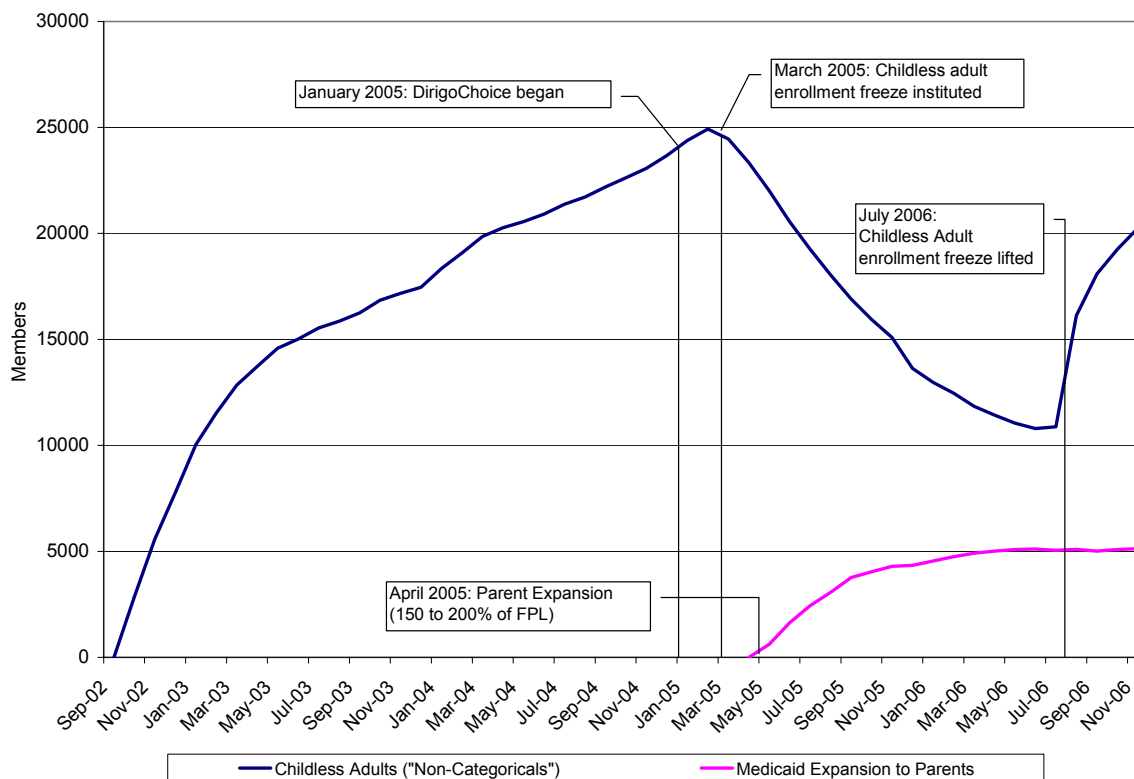
#### E. ENROLLMENT TRENDS IN THE TWO MAINECARE ELIGIBILITY EXPANSION GROUPS

***Dirigo Health Parents.*** Enrollment in the Dirigo-authorized MaineCare expansion for parents with incomes between 150 and 200 percent of FPL was strong as soon as it became effective in May 2005. Within six months, over 4,000 parents had enrolled (Figure IV.5). By the end of the first year in April 2006, enrollment stood at just over 5,000, with parent enrollment subsequently leveling off for reasons that remain unclear. Some observers speculate that otherwise eligible parents may have resources in excess of the state's asset limits or are reluctant to declare assets to gain eligibility.

***Childless Adults.*** Although the MaineCare eligibility expansion for childless adults up to 125 percent of FPL, authorized by the Dirigo Health Act, did not take effect as planned, enrollment trends in the state's waiver program, which was available to those below 100 percent of FPL, indicate strong demand. For example, enrollment by childless adults below 100 percent of FPL grew rapidly as soon as the waiver took effect in October 2002 (Figure IV.5). In the first four months, over 10,000 childless adults enrolled in the waiver program, and after one year, enrollment totaled more than 16,000, which was 40 percent greater than the projected first-year enrollment. By March 2005, when the freeze on new enrollment in the waiver program took effect, the monthly caseload totaled more than 24,000. During the next 18 months, when the waiver enrollment freeze was in effect, the number of people

covered by the waiver steadily declined to 10,872 as of July 2006; people cycled off the rolls as a consequence of increased income or other reasons.

**Figure IV.5. MaineCare Enrollment in Medicaid Expansion Groups 2002 to 2006**



Source: Maine Department of Health and Human Services, Office of Medical Services, and Maine Legislature Office of Fiscal and Program Review, 2006.

After the state gained federal permission to modify the waiver benefit package to reduce costs and the legislature approved state funding to restart the program, the waiver program began accepting new enrollees in July 2006. The number of waiver enrollees skyrocketed; by November 2006, enrollment once again exceeded 20,000. Higher enrollment in MaineCare among childless adults below the poverty line (in the waiver program) relative to parents with incomes between 150 and 200 percent of FPL may reflect the former group's fewer assets relative to the latter group, thereby making it easier for childless adults to qualify for Medicaid.<sup>16</sup>

<sup>16</sup> Other studies that have examined enrollment rates among children in Medicaid and the State Children's Health Insurance Program (SCHIP) have found that the process of identifying and proving the value of assets can be an important barrier to enrollment (Mann 2006).

## F. CONCLUSION

Measurement of the changes in Maine's health insurance coverage rate as a result of the Dirigo Health Act needs to account for both DirigoChoice and MaineCare expansion group enrollment. Overall, it appears that, of the entire population that gained coverage since 2005—through DirigoChoice, the MaineCare parent expansion group, or the MaineCare waiver program for childless adults—two-thirds directly enrolled in MaineCare.

In September 2006, at the midpoint between its adoption and its 2009 goals, DirigoChoice covered about 11,100 people, of whom between 4,400 and 6,000 were previously uninsured.<sup>17</sup> Another 5,000 parents were covered under the Dirigo-authorized Medicaid eligibility expansion, and about 18,100 childless adults with income below the poverty line had enrolled in the Medicaid waiver program. While their previous insurance status is not known, a substantial majority of both sets of MaineCare enrollees most likely lacked coverage for all or most of the year before their enrollment in MaineCare.

While the combined impact of the two Dirigo coverage initiatives on the uninsured rate remains unclear,<sup>18</sup> the number of uninsured individuals who enrolled in DirigoChoice and the Medicaid eligibility expansion for parents is modest relative to 2002's estimated 136,000 uninsured Maine residents. Moreover, the recurring freezes on enrollment of childless adults in the Medicaid waiver program and on individual enrollment in DirigoChoice mean that not all who wish to enroll may do so. In August 2007, for example, DirigoChoice again froze new enrollment by individuals when their number reached 50 percent of total members.

The success of the state's coverage expansions is not measured solely on the basis of enrollment numbers. Given that the Dirigo Health Reform Act intended to strengthen the small group market and stabilize insurance premium rates for small firms in order to maintain or increase small firm offer rates, the response of the small business community to DirigoChoice is also an important indicator of health reform progress, which is the topic of the next chapter.

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<sup>17</sup> The figures assume that the proportion of members ever enrolled as of September 2006 without previous insurance is between 30 percent, according to MPR's analysis of 2006 administrative data, and 40 percent, according to the University of Southern Maine, Muskie Institute's DirigoChoice member survey (Bowe and Thayer 2006).

<sup>18</sup> Data sources and tools for measuring the impact of the program on the uninsured are subject to several limitations. In 2002, Maine conducted a comprehensive household survey but has not repeated the survey. Annual March Current Population Survey Household Survey data for the state are too imprecise and too lagged to measure any declines in uninsured at an aggregate level.

## CHAPTER V

### SMALL FIRM RESPONSE TO DIRIGOCHOICE

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Given that one aim of the Dirigo Health reform law was to sustain and expand employer-based health insurance among small employers, employer response to the availability of DirigoChoice is an important indicator of the success of the state's coverage expansion strategy. This chapter presents results from the small employer survey.<sup>19</sup> It compares the characteristics of firms that enrolled in the program to those of firms that were eligible for the program but did not enroll. It then presents small firms' views of DirigoChoice, including their reasons for selecting or rejecting the program, reported differences in benefits and costs under DirigoChoice compared to any previously offered plan, and enrolled firms' satisfaction with the program.

Overall, the survey indicates that several factors distinguish firms that have enrolled in DirigoChoice from those that have not enrolled. Firms that enrolled in DirigoChoice were smaller than firms offering an alternative plan and slightly larger than non-offering firms (Table V.1). Among firms enrolled in DirigoChoice, the average monthly premium for single employees (\$336) was significantly lower than among eligible firms that offered another health plan (\$365). However, those offering other plans may offer more generous benefits (such as lower deductibles) that the survey did not ask respondents to explain.<sup>20</sup> Most firms that offered a different health plan or did not offer any coverage reported that they had not enrolled in DirigoChoice because it was too costly. These findings indicate that DirigoChoice is meeting the needs of some small, but not all, firms in Maine.

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<sup>19</sup> Appendix A provides a full description of survey methods, sampling techniques, response rates, and weighting. Appendix B displays detailed survey results in a series of tables.

<sup>20</sup> They also may differ in terms of the various factors that insurers use to set premiums, such as enrolled workers' ages and the firm's group size, industry, and occupational mix.

**Table V.1. Employer Characteristics By DirigoChoice Participation Decision**

	All Firms Responding (100%)	Employers Offering DirigoChoice (66%)	Employers Offering Another Health Plan (16%)	Employers Not Offering Coverage (18%)
Average Number of Employees	8	7	18	5
Average Percent of Employees Earning Less than \$12 per Hour	44%	45%	26%	55%
Average Monthly Employer Cost of Single Coverage	N/A	\$336	\$365	N/A
Main Reason Did Not Enroll in DirigoChoice	N/A	N/A	Too costly for firm (48% of respondents)	Too costly for firm (68% of respondents)

Source: MPR Survey of Small Employers in Maine about Employee Health Benefits and DirigoChoice, 2007.

#### A. CHARACTERISTICS OF SMALL FIRMS ENROLLED IN DIRIGOCHOICE RELATIVE TO SIMILAR FIRMS

***Firm Size and Average Wages.*** Firms that enroll in DirigoChoice group coverage tend to be small, averaging 7 employees.<sup>21</sup> However, almost half of DirigoChoice firms have 2 to 3 employees (Figure V.1). A large percentage of enrolled workers (45 percent on average) earn less than \$12 per hour (Table V.1). In contrast, firms that offer alternative coverage are larger (averaging 18 employees,  $p < .01$ )<sup>22</sup> and have a greater percentage of high-wage employees (greater than \$18 per hour,  $p < .01$ ). Firms that offered no health benefits were still smaller on average than DirigoChoice firms and had a still greater percentage of low-wage employees (55 percent).

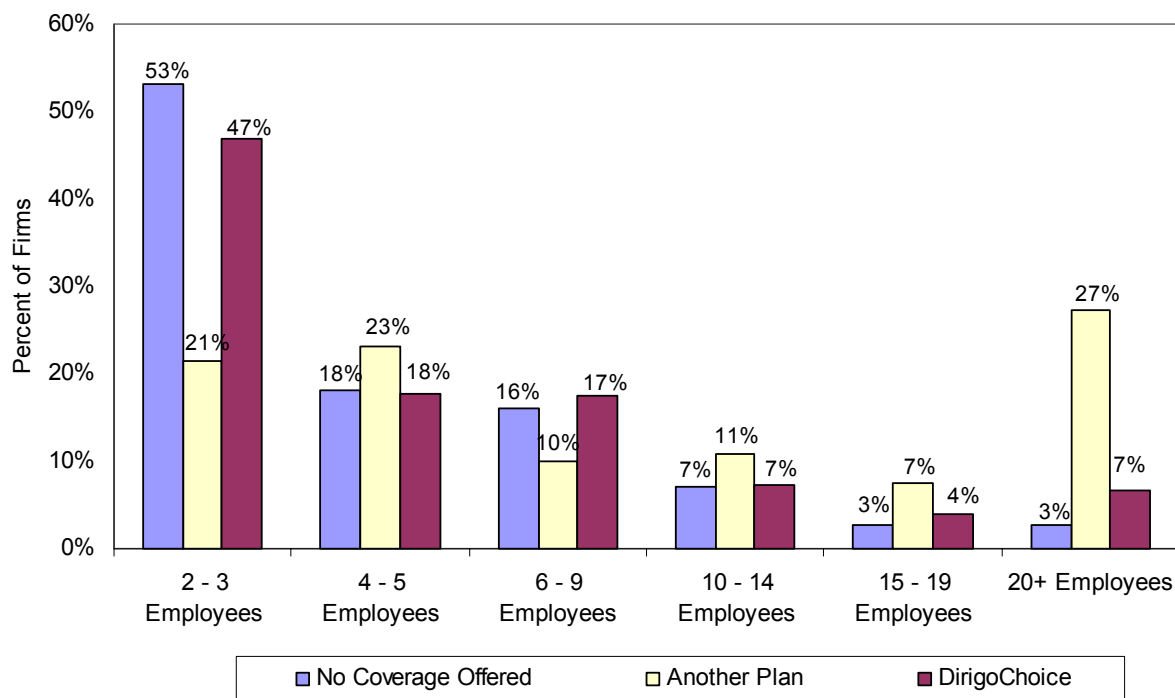
***Industry and Age of Firm.*** Compared with all firms, those offering DirigoChoice were more likely to be in the mining, construction, or utility industries ( $p < .05$ ). About a third (30 percent) of the firms offering coverage other than DirigoChoice were in professional

<sup>21</sup> This result differs from Dirigo Health Agency administrative data, which show an average of 4.3 employees among firms enrolled in DirigoChoice. DHA's average is based on the number of employees *eligible* for health benefits, while the survey result is based on *total* number of employees, including part-time workers (less than 20 hours per week) and those employed less than 26 weeks per year, who are generally not eligible for health benefits.

<sup>22</sup> All "*p* values" correspond to the statistical level of significance:  $p < .05$  means a statistically significant difference between observed and expected outcomes at the 95 percent confidence level;  $p < .01$  means a statistically significant difference at the 99 percent confidence level.

services and management industries which is significantly higher than firms that offered DirigoChoice or no coverage at all ( $p < .01$ ). Compared with all other firms, those enrolled in DirigoChoice were less likely to be in the education, health care, or social assistance industries ( $p < .05$ ) and have been in business for fewer years ( $p < .01$ ) (Appendix B, Table B.1).

**Figure V.1. Distribution of Number of Employees in Firm, by Type of Coverage**



Source: MPR Survey of Small Employers in Maine about Employee Health Benefits and DirigoChoice, 2007.

## B. SMALL FIRM KNOWLEDGE AND OPINIONS OF DIRIGOCHOICE

Nearly all firms not currently offering DirigoChoice reported that they had heard of the program (93 percent; Appendix B, Table B.2), and many were at least somewhat familiar with the program (63 percent). Most firms learned of DirigoChoice through media advertisements (34 percent) or media programs (28 percent). Insurance brokers were important sources of introduction to DirigoChoice; 22 percent of firms that enrolled in DirigoChoice learned about the program through a broker while 19 percent of firms that did not enroll also had learned about the program through a broker. Firms that offered no coverage were more likely not to have heard about the program at all; if they had, they were more likely to have heard of DirigoChoice through a business association (12 percent) than through an insurance broker (8 percent) ( $p < .01$ ).

Firms reported favorable opinions of DirigoChoice, although support for the program differed widely between firms that offered DirigoChoice and those that did not (Appendix

B, Table B.2). A strong majority of firms enrolled in DirigoChoice believed that the program was good for their firm (94 percent) and their employees (94 percent) and that it should continue in its current form (82 percent). Of the 67 DirigoChoice firms that recommended changes to the plan, half (54 percent, data not shown) wanted a reduction in the employer's cost of premiums. Other suggested changes called for improved program administration (16 percent) and greater competition among insurance carriers within DirigoChoice (10 percent).

Those firms that did not offer DirigoChoice were much less likely than DirigoChoice-enrolled firms to believe that DirigoChoice would benefit their firm or their employees (Appendix B, Table B.2). Among firms offering other coverage, 25 percent believed that DirigoChoice would be good for their firm. But more than half of those that do not offer health benefits (53 percent) believed that it would be good for their firm. Similarly, 31 percent of firms offering other plans thought that DirigoChoice would be good for their employees, and 66 percent of non-offering firms thought it would be good for their employees. Most nonparticipating firms felt that DirigoChoice should continue (56 percent among firms offering other coverage plans and 70 percent among firms not offering health benefits), although less than half thought the program should be continued in its current form. Similar to the DirigoChoice firms, firms not offering DirigoChoice suggested that the program could be improved by reducing employer costs (data not shown).

### C. WHY SMALL FIRMS DID OR DID NOT ENROLL IN DIRIGOCHOICE

**Firms Previously Not Offering Coverage Attracted by DirigoChoice's Affordability.** About half (49 percent) of firms that enrolled in DirigoChoice did not previously offer their employees a health plan. These firms were more likely to be very small (with three or fewer employees) compared with firms with four or more employees that had offered health coverage before DirigoChoice ( $p > .01$ ). The main reason firms chose to offer health benefits was their perception that DirigoChoice was affordable (55 percent); firms also believed that the program offered the best coverage for a small firm (19 percent) or that they had no other coverage options (9 percent). The last reason may stem from the fact that few health plans in Maine operate in the small group market.

**Affordability Drives the Decision to Enroll in DirigoChoice.** A majority (60 percent) of all firms that enrolled in DirigoChoice say that the plan's affordability was the primary reason for enrollment (Appendix B, Table B.3). However, larger firms were slightly more likely than smaller firms (13 and 5 percent, respectively) to state that their primary reason for enrolling in DirigoChoice was affordability for *employees* ( $p < .05$ ). The quality of the plan was the second most frequently reported reason for choosing DirigoChoice (17 percent). When asked about the significance of preventive benefits in their enrollment decision, most firms (84 percent) reported that DirigoChoice's wellness and preventive benefits were very or somewhat important to their enrollment decision. The "Healthy Me Incentive" program was also an important factor among nearly half (46 percent) of firms enrolling in DirigoChoice.

**Nonparticipating Firms Often Perceived DirigoChoice's Premium Costs as Too High.** Half of the firms not offering DirigoChoice had considered DirigoChoice but rejected the program as too costly (Appendix B, Table B.4).<sup>23</sup> Other reasons for firms not enrolling in DirigoChoice (cited by just a few firms) included inadequate benefits and the belief that the firm was ineligible for coverage. Very few firms were dissuaded by insufficient employee interest, preference for a different insurer, perceived complexity of the application, or concern about rising premiums or the uncertain future of DirigoChoice.

Most firms (90 percent) that did not offer any health benefits to employees perceived premiums for any plan as too costly (Appendix B, Table B.5). Half of these firms had, however, considered DirigoChoice; in fact, one-quarter of them had begun or completed the DirigoChoice application but either failed to complete it or later dropped coverage, almost always because of cost.<sup>24</sup> Other reasons given by these firms for not offering coverage included the firm's small size, the firm's ability to attract good employees without offering insurance, and the administrative burden of providing benefits. In addition to high premiums, the availability of coverage through a spouse in firms with relatively high percentage of female employees ( $p < .05$ ) was a particularly important factor working against the provision of employee health benefits.

**DirigoChoice Firms Reported the Same or Lower Employer Contributions than Firms Offering Other Plans.** Controlling for firm size, the average firm cost of DirigoChoice for single coverage is less than the cost of alternative coverage (\$336 versus \$365 per member per month (pmpm) ( $p < .05$ )) (Appendix B, Table B.6).<sup>25</sup> The average cost to firms for DirigoChoice family or dependent coverage also appears to be lower than that of alternative coverage (\$454 versus \$557 pmpm), but not statistically different.<sup>26, 27</sup> On average, DirigoChoice firms enrolled about the same percentage of employees in the plan as

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<sup>23</sup> A separate analysis of the 17 firms offering private coverage through a plan other than DirigoChoice and reporting that cost was their main reason for not enrolling in DirigoChoice revealed that 5 firms were paying more in pmpm premiums for single coverage for their employees than the average DirigoChoice firm (\$357 versus \$336 pmpm), but less in family coverage (\$392 versus \$454 pmpm). Neither difference is statistically significant.

<sup>24</sup> The survey responses did not further define "too expensive"; therefore, it is not possible to know if responding firms were concerned about costs for the firm or for employees.

<sup>25</sup> Within insurance markets, small firm size is generally associated with higher premiums; larger firms are often able to negotiate lower premiums. For example, within DirigoChoice, smaller firms contribute a higher pmpm for both "single coverage only" and "employee and others" plans than do larger firms (data not shown). The program permits premium adjustments for firm size.

<sup>26</sup> The range of employer contributions reported for family or dependent coverage was large (\$0 to \$8,130) and included both family coverage and "employee-plus-one" coverage. These factors make it difficult to detect a statistically significant difference for family or dependent coverage at traditional levels of significance.

<sup>27</sup> Within firms offering alternative plans, the average employee contribution was \$80 pmpm for single coverage and \$374 pmpm for family or dependent coverage. Given that DirigoChoice employee premium contributions vary for each enrolled worker's income, this information was not collected from DirigoChoice firms.

firms offering alternative coverage (63 versus 60 percent, respectively; Appendix B, Table B.6).<sup>28</sup>

#### **D. DIRIGOCHOICE FIRM BENEFITS AND COSTS COMPARED TO PREVIOUS COVERAGE**

**Half of DirigoChoice Firms Previously Offered Coverage.** Nearly half of firms (49 percent) enrolled in DirigoChoice had previously offered health coverage to their employees. Of these firms, most (69 percent) reported covering about the same number of employees under DirigoChoice as under their previous plan, but 20 percent reported covering more employees under DirigoChoice (Appendix B, Table B.7). The most common reason for an increase in employee enrollment was the affordability of DirigoChoice for employees (60 percent). Most of the same firms (81 percent) also reported that health plan benefits were equal to or better under DirigoChoice owing to lower deductibles, more covered services, and more preferred providers accepting DirigoChoice.<sup>29</sup>

**DirigoChoice Firms Have Lower Average PMPM Costs than under Previous Coverage.** Premium contributions and annual deductibles were more likely to be the same or lower under DirigoChoice than under previous plans (Figure V.2). Half of firms (52 percent) with previous coverage reported that their employer contributions toward premiums for single coverage were lower—on average, \$155 lower pmpm—under DirigoChoice than under their previous plan (Appendix B, Table B.7). One-third (32 percent) reported that employer premium contributions were about the same. For the 16 percent of firms reporting higher premium contributions under DirigoChoice, the average increase was \$191 pmpm.<sup>30</sup>

**DirigoChoice Firms Have Lower Deductibles than under Previous Coverage.** Nearly half of firms (47 percent) reported that annual deductibles under DirigoChoice were lower than under their previous plan. The survey did not ask respondents to indicate which DirigoChoice plan option they chose, but small firm enrollment in the two options—one with a \$1,250 and the other with a \$1,750 individual deductible—has been almost evenly divided since program inception. Twenty percent of firms reported that deductibles were about the same under DirigoChoice; one-third (33 percent) said that they were higher (Figure V.2).

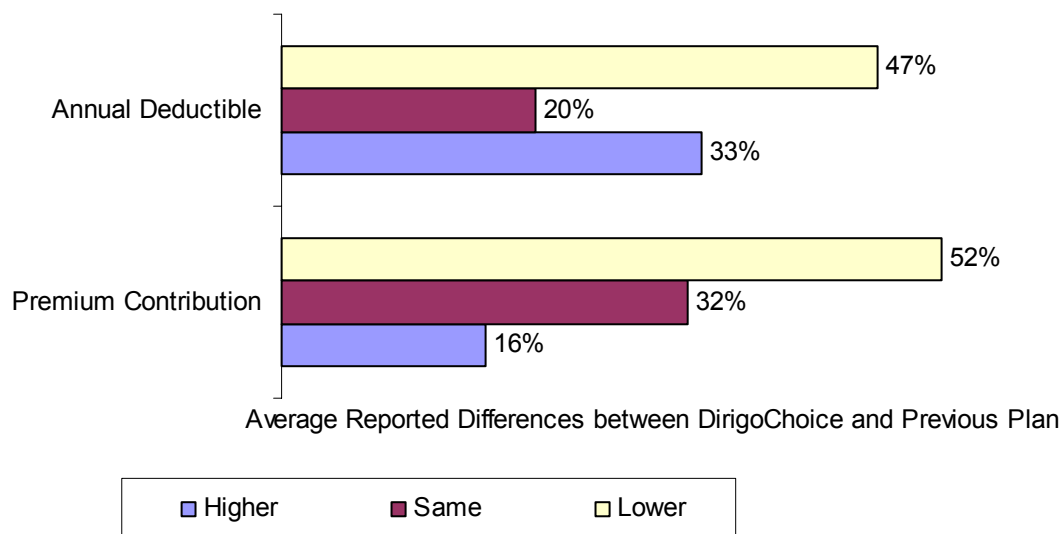
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<sup>28</sup> DirigoChoice firms must enroll at least 75 percent of *eligible* employees; when not all employees are eligible, the proportion enrolled is less than 75 percent of *all* employees. The definition of eligible employees does not include employees with coverage from another source (such as through a spouse).

<sup>29</sup> Several data problems impeded our ability to track changes reliably in take-up rates among enrollees in DirigoChoice-enrolled firms. Of the 509 DirigoChoice firms in the study sample, only 209 (41 percent) could be linked to individual enrollee data in the DirigoChoice enrollment files. Of those, only 103 (49 percent) had at least one employee who reported on previous insurance status. Moreover, it was not possible to determine how many other employees of each firm may have been missing from the enrollment files.

<sup>30</sup> The average difference in premium contribution under DirigoChoice and a previous plan, both negative and positive, is sensitive to outliers within the data set. The median pmpm difference in premium contributions, both negative and positive, hovered around \$100.

**Figure V.2. Average Change in Employer Contribution under DirigoChoice Compared to Previous Coverage**



Source: MPR Survey of Small Employers in Maine about Employee Health Benefits and DirigoChoice, 2007. Based on responses from 250 firms that switched from previous coverage to DirigoChoice.

#### E. DIRIGOCHOICE FIRM SATISFACTION AND INTENT TO RENEW COVERAGE

Almost all DirigoChoice firms (78 percent) reported that they were satisfied with the plan, and the smallest firms were particularly likely to report that they were “very satisfied” ( $p < .01$ ; Appendix B, Table B.8). Most firms reported that they were very likely to renew their enrollment in DirigoChoice (77 percent). Conversely, a small percentage (6 percent) reported that they were somewhat or very unlikely to renew coverage. As noted, firms that suggested changes in the plan were most concerned about costs to the firm; a small percentage also called for improvements in program administration and greater competition in the DirigoChoice market.

#### F. CONCLUSION

About 25 percent of Maine’s uninsured are members of families whose workers are employed by small firms. Therefore, persuading these firms to continue or begin offering employee health benefits was and is important to the state’s effort to expand access to affordable coverage.

Several findings indicate that DirigoChoice is well designed for at least some segments of the small firm market. About half of enrolled firms (51 percent of firm respondents) did not previously offer coverage—a promising indication of the product’s appeal to small firms. Among DirigoChoice-enrolled firms that *did* previously offer coverage, a large majority (86 percent) paid employee health insurance premiums that were the same as or lower than they

paid before, and four in five employees found the benefits to be as good as or better than their previous benefits. And about one in five DirigoChoice firms that previously offered coverage reported that more employees signed up for DirigoChoice than had enrolled in coverage under the previous plan, largely because the subsidies made the employees' share of premiums more affordable.

But the employer survey results also suggest that for many of the smallest firms—those with just one or two employees—DirigoChoice remains too expensive. The relatively low number of small group members increases the state's financial burden for subsidizing the full cost of low-income individuals' premiums and deductibles. The sustainability of program financing, along with the ability to tap additional resources for continued growth in enrollment, is therefore a critical element of Dirigo Health's success. The next chapter closely examines Dirigo Health's financing sources and their long-term viability.

## CHAPTER VI

### SOURCES AND SUSTAINABILITY OF FINANCING FOR DIRIGOCHOICE

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The long-term viability of the Dirigo Health coverage expansion initiatives depends on the sustainability of financing sources. The majority of Dirigo Health spending, other than payments to cover the monthly premiums for DirigoChoice members, covers subsidies to low-income enrollees in DirigoChoice. The expectation was that the Savings Offset Payment (SOP) would supply most of the revenues to cover such subsidies, but DHA has had to rely on other sources of funds as well. This chapter describes Dirigo Health funding and assesses the sustainability of the program's various sources of financing, of which the SOP is the largest and most controversial. It then examines proposed alternatives to replace or supplement the SOP.

#### A. OVERVIEW OF DIRIGO HEALTH SOURCES AND USES OF FUNDS

Financing for Dirigo Health reform programs comes from a variety of sources:

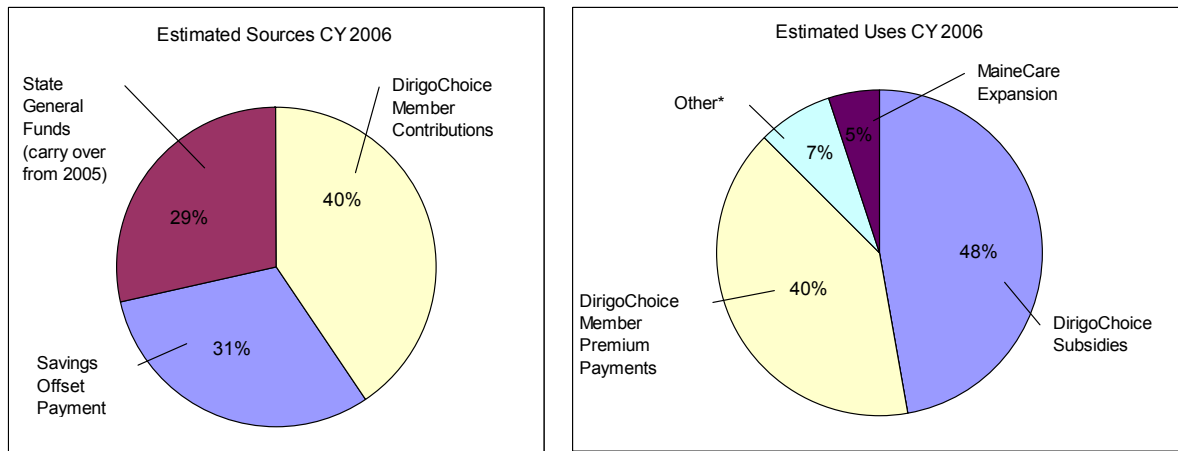
- ***State General Revenues.*** The legislature appropriated \$53 million to cover start-up costs and enrollee premiums for 2005, the first year of Dirigo operation, some of which carried over to CY 2006.
- ***Insurance Premiums.*** Employers, employees, and individuals enrolling in DirigoChoice pay monthly premiums and program fees.
- ***Medicaid.*** State and federal Medicaid funds provide expanded Medicaid coverage for low-income parents, and federal Medicaid funds match employer premiums paid on behalf of Medicaid-eligible employees enrolled through DirigoChoice-enrolled employers. (The Maine Department of Health and Human Services receives the federal Medicaid match.)

- **SOP.** In the second and subsequent years of DirigoChoice, insurers and third-party administrators pay a percentage of their annual paid claims equal to the health care cost savings estimated to result from the Dirigo Health initiatives.

In 2006, 29 percent of Dirigo Health funding came from the SOP (Figure VI.1) and 40 percent from contributions paid by employers, employees, and other enrolled individuals. The balance—31 percent—came from state funds.

On the expenditure side, about 40 percent of program funds were paid to Anthem to cover DirigoChoice members' medical and administrative costs, 48 percent paid for subsidies for qualifying enrollees, and 5 percent covered the state's cost of the Medicaid parent expansion group coverage. DHA used about 7 percent of total funding to finance DirigoChoice administration, the Maine Quality Forum, and other initiatives.

**Figure VI.1. Dirigo Health—Sources and Uses Estimates, Calendar Year 2006**



\*Other includes DirigoChoice administration, Healthy Maine, Maine Quality Forum, Wrap Around Services, and other costs.

Sources: 2007 Dirigo Health Agency allocation request to the Maine legislature <http://www.dirigohealth.maine.gov/March2007/bar%20graph%20fy0809.pdf>; Dirigo Health Agency, 2006, Annual Report: Program Overview 2005 & 2006 and email communication with DHA staff, 10/29/2007.

## B. OVERVIEW OF THE SAVINGS OFFSET PAYMENT

The SOP was designed to capture health care cost savings from the DirigoChoice and Medicaid expansion of health insurance coverage and other Dirigo Health-related cost containment initiatives. It is assessed on health insurance carriers, third-party administrators, and employee benefit excess insurance (or “stop loss”) carriers. The SOP amount that each insurer must pay represents a percentage of these parties' annual paid claims for health care for Maine residents (including DirigoChoice-paid claims); it cannot exceed 4 percent of those claims in any year.

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The rationale underlying the SOP is that insurers can reduce payments to providers if more patients have insurance coverage and providers incur commensurately lower costs of uncompensated care. Provider payments can also be reduced if other cost containment efforts result in lower costs. Failure to capture the savings associated with reduced costs can thus be viewed as a windfall gain to insurers and providers, who have embedded the cost of uncompensated care in their premiums, charges, and contractual allowances. Defining the true beneficiaries of such windfalls—insurers, providers, or some combination—depends on market conditions and the bargaining leverage of the various parties. The design of the SOP placed on insurers the responsibility for capturing provider savings. Insurers in turn were expected not to pass the cost of the SOP on to their customers in the form of higher insurance premiums; however, the law did not explicitly prohibit them from doing so.

One of the premises of the SOP is similar to that underlying most state health insurance expansion initiatives—that is, one effect of expanded coverage is a reduction in the costs to the health care system of providing care to those without insurance. While Maine is unusual in making explicit the linkage between cost savings and coverage program funding, it is not unusual for a state to fund health insurance expansions from assessments of some type levied on health insurers and providers.

### **C. COMPONENTS OF THE SOP**

The Dirigo statute requires the Dirigo Health Board of Directors to determine annually the “aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this State as a result of the operation of Dirigo Health and any increased MaineCare [Medicaid] enrollment due to an expansion of MaineCare eligibility occurring after June 30, 2004” [24-A M.R.S.A. § 6913(1)(A)]. These estimated savings provide the basis for the SOP. The state Superintendent of Insurance is charged with reviewing and approving the Dirigo Health Board’s estimated savings.

In October 2005, the Superintendent of Insurance ruled that the first-year (2006) aggregate measurable cost savings totaled \$43.7 million—equal to about 2.4 percent of paid claims in 2006. In July 2006, the cost savings (and the amount to be collected through the SOP) came to \$34.3 million for the 2007 calendar year. If implemented, the 2007 SOP assessment is projected to equal 1.85 percent of 2007 paid claims.

Table VI.1 shows the components of the savings estimates that underlie the 2006 and 2007 SOP assessments, including both the Dirigo Health Board of Director’s estimates and the reduced amounts approved by the Superintendent of Insurance. The SOP’s major components and reasons given by the Insurance Superintendent for reducing the board’s estimates are explained below.

**Table VI.1. Measurable Cost Savings and Total SOP Amounts, 2006 and 2007** (in millions of dollars unless otherwise noted)

Savings Initiatives	Dirigo Health Board Estimate (2006)	Approved by Superintendent of Insurance (2006)	Dirigo Health Board Estimate (2007)	Approved by Superintendent of Insurance (2007)
Hospital Savings Initiatives	\$57.6	\$33.7	\$14.5	\$14.5
Total Uninsured Savings Initiatives	\$5.7	\$2.7	\$6.7	\$5.5
Bad debt and charity care	\$2.7	\$2.7	\$2.7	\$2.7
MaineCare adult expansion	None	None	\$3.9	\$2.8
“Woodwork effect”	\$3	None	\$57K	None
Certificate of Need and Capital Investment Fund Savings Initiatives	\$9.8	None	\$5.4	None
Health Care Provider Fee Savings Initiatives	\$26.3	\$7.3	\$15.2	\$14.3
Total	\$110.6	\$43.7	\$41.8	\$34.3

Sources: Maine Superintendent of Insurance, 2005; Maine Superintendent of Insurance, 2006.

- **Hospital savings initiatives** are the largest component of the SOP calculation. The savings reflect the voluntary caps on hospital cost growth and operating margins that Dirigo Health and the legislature have asked hospitals to observe for 2004 and subsequent years. The savings estimate is based on actuarial calculations of the rate of growth in hospital costs that would have occurred in the absence of the voluntary savings initiatives as compared with actual cost growth.<sup>31</sup> While the rate of growth that would have occurred is projected from past trends, stakeholders have disagreed about the appropriate data and methodology for use for the projections. The substantial reduction from 2006 to 2007 in savings estimated for the initiatives largely reflects more conservative assumptions about the hospital cost trends that would have occurred in the absence of the Dirigo reforms.
- **Uninsured initiatives savings** are estimated as the reduction in charity care and bad debt costs attributable to DirigoChoice’s and MaineCare’s coverage of previously uninsured or underinsured patients. Even though the number of

<sup>31</sup> The Dirigo Health Act defined the savings in terms of expenses per case mix-adjusted discharge and consolidated operating margins, which had different percentage caps for 2004 and different methodologies for 2005 and subsequent years.

such people who enrolled in the programs each year is reasonably well documented, the amount of the reduction in charity care and bad debt costs (and thus the need for providers to charge uncovered costs to private payers) must be estimated. The Superintendent of Insurance generally accepted the Dirigo Health Board of Director's estimates of these savings, with some modifications. However, the superintendent rejected the board's estimate of savings from additional enrollment in MaineCare induced indirectly by DirigoChoice (the "woodwork effect") as conjectural.

- ***Certificate of Need and capital investment initiatives savings*** are estimated as the effect of capital spending projects forgone by hospitals and other providers. Over time, forgone projects are expected to reduce the need for payer rate increases. The Dirigo Health statute changed the Certificate of Need review criteria and limited the annual amount that could be invested by all providers. The Dirigo Health Board of Directors included the "present value" of future cost savings in its estimate, but the Superintendent ruled that the savings should not be recognized until they actually occur.
- ***Health care provider fee savings*** are the second-largest component of the SOP calculation. Provider fee savings amount to additional Medicaid payments to hospitals and physicians authorized by the Dirigo Health Act and other state policy decisions. The additional payments—\$58 million to hospitals and \$8 million to physicians in state fiscal year 2007—were intended to reduce the need for providers to shift Medicaid costs to private payers. While the amount of the increased Medicaid payments to providers can be readily determined, the impact of those payments on provider cost shifting must be estimated.

#### D. MAJOR ISSUES IN THE SOP CONTROVERSY

In 2006, the Maine Association of Health Plans and the state Chamber of Commerce challenged the methodology for calculating the SOP in court. The various interested parties made a number of legal arguments and raised other issues before the Dirigo Health Board, the Superintendent of Insurance, the court and the legislature, and in public debate more generally. The arguments and issues related to the following:

- ***Types of savings to count.*** As a matter of legal interpretation, the Dirigo Health Board of Directors concluded that the Dirigo statute authorized the calculation of the SOP to include all savings to health care providers that are "a result of Dirigo Health," including the hospital savings initiatives and the effects of additional Medicaid payments to hospitals and physicians. Opponents argued for a narrower interpretation that would include only bad debt and charity care savings and savings from post-2004 expansions of MaineCare eligibility.
- ***Assumptions, data, and methodology.*** The parties argued over the assumptions, data, and methodologies used to calculate savings in each of the

four major categories of the SOP calculation. As noted, many of the elements of the SOP depend on assumptions that lend themselves to reasonable disagreement, data that may be incomplete or unreliable, and methodologies for which there are plausible alternatives. The Dirigo Health Board of Directors and other parties engaged actuaries and other experts to assist with their respective estimates. The decisions of the Superintendent of Insurance for assessment years 2006 and 2007 and the submissions of interested parties summarize the arguments on the issues associated with the estimated savings.

- ***Ability of insurers to capture the savings.*** Insurers, health care providers, employers, and others who opposed the SOP argued that the broader savings would not accrue to the insurers that must pay the assessment.
- ***Passing the assessment on to purchasers of insurance.*** The Dirigo Health Act states that insurers shall use their “best efforts” to recover savings offset payments from providers and pass them on in the form of lower premium [24-A M.R.S.A. § 6913 (7)]. Anthem, however, has instead overtly passed the cost on to customers instead of seeking to negotiate lower reimbursement rates with providers. Even if they tried to recoup the costs from providers, however, the amount of any reduction would depend on the parties’ relative bargaining leverage. Providers joined health plans and the Chamber of Commerce in proposing alternatives to the SOP. As large employers, hospitals had additional reason to oppose the SOP, which was passed on to them in the form of higher health insurance premiums.

***Maine Supreme Court Decision Upholding the SOP.*** In a 5-1 decision, the Maine Supreme Court upheld the \$43.7 million SOP assessment for 2006, which was the first assessment year (Maine Supreme Judicial Court 2007). Subsequently, the Dirigo Health Board approved collection of the SOP assessment of \$34.3 million for the second assessment year (2007) and, as of this report, has scheduled hearings on the 2008 assessment.

In considering whether the Dirigo Health Act allowed the Dirigo Health Board of Directors to include in the SOP any savings beyond the savings in bad debt and charity care that result from expanded DirigoChoice and MaineCare coverage, the court said:

Although reasonable people may, and do, disagree with the Board, the Legislature conferred broad authority on the Board to implement the Act, and the Board’s interpretation is based on the rational position that the term “aggregate measurable cost savings” may include savings realized through the implementation of the full Act to Provide Affordable Health Insurance. Because section 6913 and its legislative history do not clearly indicate a contrary intention, they do not compel a narrower interpretation. (Maine Supreme Judicial Court, 2007, pp. 34-35)

The Maine Supreme Court affirmed the superintendent’s decision for the 2006 assessment year, in part upholding the Dirigo Health Board of Directors’ determination

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about the SOP. The court found that the board “1) interpreted an ambiguous statute, 2) acted within its field of expertise, and 3) reasonably interpreted the ambiguous statute” (Maine Supreme Judicial Court, 2007, p. 19).

## E. CONCLUSION

While the Maine Supreme Court’s decision settled the issue of the SOP’s legality, controversies over how to calculate the SOP will likely persist as long as the SOP continues to serve as a source of Dirigo funding. At the time of this report, DHA was proceeding with collection of the SOP for the 2007 assessment year as well as with calculation of the assessment for 2008. However, most stakeholders do not view the SOP as politically sustainable in its current form. Virtually all observers see the dispute and litigation over the SOP as a major distraction that has deflected attention and dissipated energy from Dirigo Health’s overall reform goals.

Recognizing that the controversy over the SOP was sapping support for the broader goals of health reform, the governor appointed a Blue Ribbon Commission on Dirigo Health in May 2006 and charged it with making recommendations for alternative funding sources. And, while the failure of the SOP to produce more revenue and political support is the most obvious part of the financing strategy that did not work as planned, other aspects of the DirigoChoice financing strategy also did not proceed as expected due to differences between the expected and actual enrollment mix:

- Lower-than-expected small group enrollment significantly reduced employer premium contributions as a source of financing.
- Paltry small group enrollment of MaineCare eligibles failed to capture the expected federal match that employer premiums would have leveraged for dually eligible workers.
- A greater-than-expected number of enrollees eligible for the highest subsidy levels increased the state’s financing obligation.

The next chapter discusses options and strategies under consideration for addressing the implications of DirigoChoice’s current enrollment mix, for achieving a more financially favorable roster of members, and for replacing or modifying the SOP.



## CHAPTER VII

### DIRIGOCHOICE IMPLEMENTATION CHALLENGES AND PROSPECTS FOR CHANGE

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The controversy and challenges facing DirigoChoice have convinced most of the key informants interviewed for this evaluation that significant mid-course corrections are needed for the program to make greater progress toward the Dirigo Health Reform Act's goal of extending affordable health coverage to all Maine residents by 2009.

Some changes have been, or can be, made by program managers without changes in state law. Other changes require legislative approval and the 2007 legislative session was expected to address some of them. For example, consensus that the SOP is failing to yield necessary funds led to a number of proposals for alternative financing sources. In addition, since DHA had to re-bid the contract for DirigoChoice's insurance carrier, stakeholders used the opportunity to propose alternatives to the state's contract with Anthem. Other changes to benefit design, marketing, and cost control mechanisms that could affect the program's long-term success were also under consideration.

This chapter discusses the challenges faced by the state in implementing DirigoChoice, program managers' response so far, and legislative proposals to address issues that some stakeholders believe make the product more expensive or less affordable to more state residents and small businesses than necessary. The chapter begins to compare Maine's experience to that of similar state programs, but leaves a more thorough assessment of the relevance to other states of Maine's coverage expansion strategy and experience to the next chapter.

#### A. DIRIGOCHOICE BENEFIT PACKAGE

With DirigoChoice, Maine tried to create an affordable, comprehensive benefit package that would be affordable for low-income individuals. Yet, for many small employers, the premium costs are such that, at least in some cases, those wishing to offer coverage can find less comprehensive—and therefore less expensive—products in the commercial market.

Though attractive to some small firms and individuals, the DirigoChoice benefit package has come under criticism as contrary to market trends for commercial products marketed to small employers. The inclusion of coverage for preexisting conditions, for example, made the program particularly susceptible to becoming a magnet for individuals who could not afford coverage outside DirigoChoice. Some critics contend that mental health benefits, in particular, induce adverse selection. Reports that as many as 3,000 people formerly enrolled in Anthem's HealthChoice, the carrier's non-group product, switched to DirigoChoice have only heightened concerns about adverse selection. Nonetheless, DirigoChoice's core supporters resist the retreat from a comprehensive benefit package in order to ensure that it provides protection from high costs for those who become seriously ill.

Some stakeholders have proposed that the program institute pre-existing condition exclusions—for example, a waiting period for coverage of conditions treated in the past six months—to make DirigoChoice offerings more consistent with competing products, especially in the individual market. But those who favor DirigoChoice's policy of providing immediate coverage of treatment for pre-existing conditions argue that such exclusions hurt persons most in need of coverage. Others believe that the problem argues for a high-risk pool that could divert high-cost individuals from DirigoChoice. In turn, opponents of a high-risk pool say that DirigoChoice does not attract a high-risk group: Anthem's overall medical loss ratio was 76 percent in 2005 and 2006, well within industry norms. Indeed, since DirigoChoice claims fell below 80 percent in both years, Anthem had to return to DHA most of the funds held in reserve to compensate for losses in excess of this amount.

In an effort to respond to the changing small group market, and to hold the line on premium increases, DirigoChoice created a new \$2,500 deductible option for small employers in 2007. Consumer advocates (and some providers) criticized this development, expecting that it would result in bad debt for providers, force low-income workers to forgo care, or both. On the other hand, some critics allege that the high deductible plan still will not entice so-called "young invincibles," who typically have modest incomes and limited medical needs. They believe this group would be more interested in an even narrower benefit package that offers markedly lower premiums in exchange for primarily catastrophic protection or products with considerably higher cost-sharing and coinsurance provisions.

The ongoing debate around the benefit package clearly illustrates the trade-offs between coverage and cost. The decision to allow individuals with previous insurance to enroll in the program was important for addressing "underinsurance"—coverage that does not provide adequate protection against high health care costs—especially for lower-income residents. While the program's comprehensive benefit design may have remedied the underinsurance problem for enrollees whose previous coverage had higher deductibles and excluded certain services, it came at a higher cost to the program overall.

## **B. POOLING SMALL GROUPS AND INDIVIDUALS**

In an effort to lower costs to individuals and address the failing individual insurance market, DirigoChoice attempted to combine small firms and individuals into one larger pool.

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Other states have tried or are currently pursuing a similar strategy to lower the cost of insurance to individuals. For example, Healthy New York pools small firms and individuals in one product, and the Massachusetts “Connector” program, called Commonwealth Choice, pools small groups and individuals in all commercial products sold through it as of July 2007.

Pooling small groups and individuals tends to raise the cost to small groups, though the increase could be relatively small if individuals do not represent the majority of enrollees. For example, an actuarial analysis estimated that the Massachusetts reforms would reduce individual premiums by 15 percent while increasing small group premiums by just 1.5 percent—assuming the non-group market accounted for just 11 percent of the merged market (Gorman Actuarial et al. 2006). DirigoChoice, however, has not experienced such a favorable proportion of individuals versus small group enrollees. As enrollment trends show, individual and sole proprietor enrollment in DirigoChoice has represented approximately 70 percent of total enrollment, making small group coverage potentially more expensive. Moreover, despite an overall 76 percent medical loss ratio in 2005–2006, Anthem reported a medical loss ratio of 102 percent for individuals compared to 66 percent for small groups and 73 percent for sole proprietors. In 2007, the Superintendent of Insurance required DirigoChoice to divide the groups for premium rating purposes, although the difference in medical loss ratios between small groups and other members may have forced the program to do so eventually to keep small group premiums competitive.

The medical loss ratio experience for individuals in DirigoChoice also spurred a renewed push for a subsidized high-risk pool that would remove the highest-cost persons from the DirigoChoice risk pool. Skeptics have opposed a high-risk pool on the grounds that it would increase market segmentation. Alternatively, a merger of all small group and individual policies in the market is being examined as well as a proposal to reinsure all small group and individual policies to mitigate the impact of high-cost users, limit carrier exposure, and reduce premiums. Advocates of this strategy cite the successful experience of Healthy New York in curbing premium growth, because its reinsurance feature protects carriers from particularly high claims (Kilbreth 2006).

### **C. DIRIGO HEALTH’S COST CONTAINMENT PROVISIONS**

To make health insurance expansion affordable, Maine recognized the importance of system-wide cost containment as well as cost containment within the DirigoChoice product itself. The small firm survey results suggest that for those businesses that enrolled, the DirigoChoice product is less expensive than commercial products sold by Anthem or other carriers, at least for “smaller” small groups, with fewer than 10 employees.

At the same time, DirigoChoice does not appear to cost substantially less than commercial products for “larger” small groups (those with 10-50 employees), due in part to underlying health care costs. Experience to date underscores the difficulty of implementing strategies that significantly control costs in the state’s health care system overall.

To address system-wide costs, the Dirigo Health Act strengthened the state's CON statute, which may help reduce excess capacity and produce future savings. And the Maine Quality Forum, whose public reporting and quality measurement activities have earned the acclaim of most stakeholders, may pave the way for greater progress in containing long-term cost growth. However, many observers believe that the Dirigo Health reform initiative did not adequately address Maine's problems of high costs and rapid medical inflation, especially after several far-reaching measures were sidetracked. For example, voluntary targets on hospital cost growth (3 percent annually) and operating margins of 3.5 percent replaced a proposal to impose a global hospital budget limit.

In addition, the national trend of steadily rising health care costs, coupled with the absence of provider and insurer competition in Maine, leaves DirigoChoice with few tools for effectively addressing cost containment. Now that individuals face premium rates that differ from those for small groups, many believe that rate increases will make coverage unaffordable for individuals. The program has explored ways to add more care and cost management features, including formal disease management programs targeted to the chronically ill, whose conditions are major drivers of costs. However, it is uncertain whether such strategies can reverse premium trends and make the product affordable to those small firms and individuals who still decline to purchase coverage.

#### **D. PUBLIC/PRIVATE PLAN ADMINISTRATION, MARKETING, AND RISK-SHARING ARRANGEMENTS**

The DirigoChoice administrative design reflected support for a publicly administered, privately insured plan. Policymakers believed such a system would make the program more acceptable by appearing to be like other employer products, compared to a program run solely by a government agency. In addition, providers were more accepting of a private plan than further expansion of MaineCare, which they viewed as undesirable owing to the program's low payment rates relative to private insurance rates.

Despite the theoretical advantages of a public-private partnership, Anthem's role in DirigoChoice administration has drawn mixed reviews. Some stakeholders expressed concern that neither Anthem nor its brokers adequately promoted the program and, in some cases, may even have dissuaded interested buyers from program participation. As the dominant carrier in the small group and individual markets, Anthem's critics point out that it had leeway—which it used—to steer customers to or away from DirigoChoice. Insurance representatives counter that DirigoChoice's lack of appeal was due more to its failure to offer incentives to motivate nonoffering employers to initiate coverage, which might be remedied if subsidies were available to employers, or firms could pay a minimum share of the premium less than the current 60 percent.<sup>32</sup>

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<sup>32</sup> In addition, some critics note that one source of low group enrollment is the process by which employees apply for the premium subsidy. Until all employees submit their own subsidy applications, an employer already offering insurance does not know whether employees will be better off under DirigoChoice versus existing policies.

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To try to reach more potential customers, DHA recently instituted a toll-free hotline and expanded its internal capacity (1) to field direct calls and refer prospects to brokers with a track record of promoting enrollment and (2) to provide other assistance with the enrollment process. Whether such outreach will increase enrollment is unclear: two-thirds of small firms not any offering health benefits to employees were very or somewhat aware of DirigoChoice.

In any case, the greatest points of friction between DHA and Anthem have been the profit earned by Anthem on the contract and Anthem's role in the lawsuit challenging the SOP. The need to re-bid the contract with Anthem during 2007 helped put these issues on the legislative agenda in 2006 and again in 2007, when several alternatives to the current arrangement were proposed.

One option was for the state to self-insure the product. Another was to select another carrier to insurance and market the product. A third option, similar to the Massachusetts Connector program, called for DHA to offer competing products from several carriers. A more radical proposal would convert DirigoChoice into a voucher program; individuals would use the voucher as a subsidy to defray the cost of a plan selected from a menu of products that would vary in comprehensiveness and price. But all of these options presume a level of competition among plans that may not be attainable in Maine.

Under the self-insurance option, DHA would enter into an "administrative services only" (ASO) contract with a single vendor, either an insurer or a third-party administrator (TPA).<sup>33</sup> DHA believed that such an approach would save state funds spent on the risk-sharing EMP arrangement with Anthem as well as on the insurer's profit margin on the product. Those who supported the self-insurance option cited the success of the state employee health plan, which recently switched from a fully insured to a self-insured arrangement. They argued that Dirigo should pursue a similar course—possibly through an affiliation with the state employee program and possibly by pooling DirigoChoice participants with state employees. While some saw pooling risk as unlikely (given the differences in the risk and cost profiles of the Dirigo and state employee populations), it seemed feasible to align administrative functions with the state employee program or, at a minimum, to join with the program in contracting with an ASO vendor (currently Anthem for state employees).

Critics, however, argued that a shift to a self-insured arrangement would provide only one-time financial relief and would make no substantial difference in cost trends over time. Moreover, they charged that it would be perilous for the state to accept insurance risk as well as the business risk of operating its own program. They cited the state's well-publicized problems in the MaineCare program: one relating to the trouble-plagued implementation of a new claims payment system and another involving a large backlog in hospital payments.

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<sup>33</sup> The 2003 Dirigo Health Act allowed for a self-insurance option, but only if no bidder came forth or the bidder and the state could not reach mutually agreeable terms. Since Anthem submitted a bid and contracted with the state, the 2003 law had to be changed to allow the program to self-insure.

BOTH problems have undermined confidence in the capabilities of a publicly sponsored program.

Because DHA did not know if it would obtain approval and funds from the state legislature to self-insure DirigoChoice,<sup>34</sup> DHA continued to negotiate with Anthem on the terms of a new contract. When DHA and Anthem could not reach agreement, DHA pursued other options. In September 2007, DHA announced that it was switching the contract to insure the DirigoChoice product from Anthem to Harvard Pilgrim Health Plan, a non-profit plan that has served a very small share of the Maine market. This gives DirigoChoice the possibility of gaining one-time savings from the EMP payments that Anthem required as its price for accepting higher-than-average risk and for attaining a specified profit margin. It remains to be seen whether the new carrier will be more successful than Anthem in marketing DirigoChoice to small businesses in the future.

#### **E. SUBSIDY FINANCING STRATEGY AND ALTERNATIVES UNDER CONSIDERATION**

Unlike Massachusetts and some other states with bad debt and charity care pools, Maine did not have the luxury of turning to an existing source of funds—some of which could draw down additional Medicaid funds—to offset the cost of insurance subsidies to low- and middle-income individuals. Instead, Maine had to rely on its SOP, which was to be funded from assessments on insurers to capture the savings to the system from expanded coverage of the uninsured and from other cost containment initiatives.

Had the number of uninsured who gained coverage under the Dirigo initiatives grown quickly and substantially, and other cost containment efforts yielded more savings, Maine's reliance on its SOP might have worked—up to a point, given the limit on the amount the SOP could raise each year. However, with DirigoChoice not enrolling as many uninsured as expected, and other cost savings difficult to verify, there has been little if any tangible reduction in insurance premium growth.

The low number of uninsured covered by DirigoChoice, in combination with arguments over the accuracy of estimates and projections of other Dirigo Health cost-saving impacts, has meant that the SOP has generated less revenue than needed to subsidize greater enrollment in DirigoChoice. For calendar year 2006, DHA estimated savings of \$110.1 million but was awarded only \$43.7 million by the Superintendent of Insurance. For 2007, DHA estimated savings of \$41.8 million but was awarded only \$34.3 million. The Dirigo Health Board itself found that DirigoChoice's direct impact on reducing bad debt and charity care constituted only about \$2.7 million of the \$41.8 million it claimed was attributable to all Dirigo-related savings initiatives in the second year. Thus, even before the Maine Supreme Court endorsed the legality of the SOP, the search for alternatives had begun.

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<sup>34</sup> Even though LD 431 ultimately passed, authorizing DirigoChoice to be self-insured, the legislature did not authorize the funds needed to establish reserves in case revenues were insufficient to pay claims.

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**Alternative Funding Proposals.** In its January 2007 report, the Blue Ribbon Commission on Dirigo Health “endorsed funding the program from the General Fund, to reflect the importance of the program to all the people of Maine” (DHA 2007). The commission identified as possible sources of revenue for the general fund “taxes on specific behaviors and products that have a negative influence on health”—including tobacco, snacks, soft drinks, beer, and wine. The commission noted that general revenues “need not be the sole source of funding” and recommended that the Dirigo Health Board of Directors meet with interested parties to determine methods “through which bad debt and charity care savings will be captured and redirected.”

In April 2007, the governor announced his proposals for revisions to Dirigo Health financing; legislation incorporating his proposals was introduced in early May. The governor’s proposals would replace the SOP with:

- ***A Surcharge on Payments to Acute Care Hospitals by Insurers and Certain Third-Party Payers.***<sup>35</sup> The surcharge could not be more than the actual total of claims incurred in the previous year by uninsured and previously underinsured Dirigo Health and post-June 2004 MaineCare expansion enrollees, minus the claims that would have been paid for them prior to their enrollment in those plans. The Dirigo Health Board of Directors would set the amount of the surcharge by April 1, 2008, and each April thereafter. Health insurance carriers and providers would be required to “demonstrate that best efforts have been made to ensure that a carrier has recovered surcharge payments . . . through negotiated reimbursement rates that reflect providers’ reductions or stabilization in the cost of bad debt and charity care” that result from Dirigo Health and MaineCare expansion. Moreover, carriers must use “best efforts” to reflect such recoveries in their premiums. The SOP would remain in effect until the surcharge took effect on July 1, 2008.
- ***A Tax on HMOs.*** As of October 1, 2007, a 2 percent tax on “gross direct premiums” would apply to all health maintenance organizations and 85 percent of the revenues from the tax would be deposited in the Dirigo Health Enterprise Fund. A similar tax currently applies only to insurance companies.
- ***An Assessment on Employers not Offering Insurance and Individuals Without Insurance.*** A “health care shared responsibility” program would require employers who do not offer health coverage and individuals who do not have health insurance to make “contributions” to the Dirigo Health Enterprise Fund in amounts to be determined by the Dirigo Health Board of Directors. The contributions would begin for employers on July 1, 2008, and for individuals on January 1, 2009.

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<sup>35</sup> The proposed legislation excluded from this requirement government entities that pay for hospital services under Medicaid, Medicare, and other government programs; it also excluded beneficiaries of those programs.

The governor's office estimated that funding DirigoChoice from July 1, 2008, to June 30, 2009, would require \$27 to \$29 million from the surcharge on payments to hospitals and \$31 to \$38 million from the assessment on employers and employees who do not (respectively) provide or purchase insurance (Maine State Chamber of Commerce 2007). The Governor's office estimated that the total amounts would be sufficient to cover up to 14,500 DirigoChoice enrollees, a modest expansion from the 13,832 beneficiaries enrolled in March 2007.

The need to supplement provider surcharge funds with other taxes illustrates the "structural deficit" that underlay the original DirigoChoice financing plan. While the SOP was intended to make provider cost shifting explicit and capture it for financing expanded coverage, the governor's financing plan demonstrated that the SOP covers only half of needed financing.<sup>36</sup>

The governor's proposed surcharge on hospital payments is conceptually similar to the SOP, although it appears to be modeled after the surcharge on payments to hospitals that funds the Massachusetts Uncompensated Care Pool. While a direct tax on Maine's hospitals might motivate the institutions to economize, both the dominance of a single insurer and existence of provider monopolies in the state would likely lead to hospital attempts to increase the surcharges levied on payers. The impact of a surcharge on insurers and other payers would be largely the same as that of the SOP and represent a tax on estimated savings from expanded health insurance coverage as a consequence of Dirigo Health and the MaineCare expansions.

Depending on how it is calculated, the surcharge might be smaller than the SOP, but its similarity to the surcharge in Massachusetts could increase its acceptability. In place since 1985, both the Massachusetts Uncompensated Care Pool and the hospital surcharge that finances it have become established parts of that state's health care landscape.<sup>37</sup> The circumstances that led to the Massachusetts legislation in 1985 may not, however, apply in Maine in 2007.

The Maine Legislature adjourned in late June 2007 without taking action on the governor's proposals or any other alternative or supplemental source of funding for Dirigo. Discussions of alternative financing sources for Dirigo continue, however, and the governor's proposals remain part of those discussions.

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<sup>36</sup> The SOP, as originally designed, would not have generated sufficient revenue to cover all uninsured individuals in the state with income below 300 percent of FPL. On average, DirigoChoice enrollees require premium subsidies of about \$3,000 per year, with the amount during any period depending on the income levels of current enrollees and the level of subsidy to which they are entitled. But the maximum amount of SOP revenue under the current statute (4 percent of paid claims, or about \$73 million in 2006) would cover only about 20,000 to 25,000 additional people, only a quarter of the estimated 85,000 people with income below 300 percent of FPL in 2006. The statutory limit on the SOP (the aggregate measurable cost savings calculated each year) could, however, be amended to increase revenues.

<sup>37</sup> Massachusetts has used the pool to help finance premium subsidies for the uninsured in the state's new health insurance expansion program.

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Indeed, almost every key informant interviewed for this evaluation sees the search for alternative funding sources as a critical step in advancing DirigoChoice. Program critics and supporters alike tend to believe that some general revenues are needed to sustain DirigoChoice. The strongest advocates of some general revenue funding believe that such financing would demonstrate broad political support for the program. However, as the state faces an ongoing structural budget deficit and revenues consistently fall short of current commitments, the prospect for financing most of the subsidies through general taxes appears unlikely. Ultimately, finding the means to sustain DirigoChoice will depend on the choices that the governor and legislature make among competing priorities.

## F. CONCLUSION

To keep the premium price affordable and competitive with other products on the market, DirigoChoice has made several mid-course corrections; it created a new plan option for small firms with a higher deductible, and it separated premium rates for small groups and individuals. The program also successfully negotiated a contract with a new insurance carrier, potentially reducing some expenses that formerly covered Anthem's insurance risk and profit margin.

It remains unclear, however, whether these changes will help attract more small firms or prevent an increase in premium rates. Even when small firms are offered significant subsidies, such incentives do not persuade the majority of uninsured firms to offer coverage (Helms et al. 1992; Reschovsky and Hadley 2001). Small firms' diverse workforces mitigate against incentives to participate; if only a couple of workers are uninsured (Kronick 2006), program subsidies benefit too few to make participation worthwhile. In Maine, employers also may be disinclined to participate in DirigoChoice when workers are able to obtain discounted coverage by enrolling as an individual.

Maine's experience reaffirms the difficulty encountered by states in trying to raise small employer offer rates without strong incentives or mandates. It also illustrates that coverage expansion programs without forceful cost control mechanisms will—sooner or later—likely face affordability problems. Maine came up against serious constraints in the types of cost control or price competition it could implement, although states with more competition among providers or plans may have more success in managing costs. The next and final chapter explores other factors that affect the success of subsidized insurance products in states other than Maine.



## CHAPTER VIII

### LESSONS AND RELEVANCE OF MAINE'S EXPERIENCE TO OTHER STATES

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Maine's overall strategy to expand health insurance coverage reflects the state's history of health coverage expansion efforts, its current health care delivery system, and the dynamics of the health insurance market at the time of enactment of the Dirigo Health Reform Act. While unique in some respects, Maine's coverage expansion strategies are similar to those adopted by or under consideration in other states. Many states have created or would like to develop a comprehensive and affordable benefit plan for small businesses, offer income-based premium subsidies to low-income individuals, and finance coverage expansions by shifting funds from one part of the health care financing system to another. Thus, Maine's experience in implementing coverage expansion— independent of the state's comprehensive health system reform—offers important lessons about what could work elsewhere and likely obstacles to success.

The final chapter in this report examines the relevance to other states of Maine's approach to insurance coverage expansion. First, we present a framework for assessing the relevance to other states of any state's approach to and experience with health insurance coverage expansion. We then compare Maine with other states on several dimensions that affect the selection and design of insurance coverage expansion strategies, including the characteristics of the uninsured population and employer composition, health insurance market and regulatory context, and the health care delivery system. Finally, we compare Maine's available financing sources for insurance coverage expansions with those of other states.

#### A. FRAMEWORK FOR ASSESSING RELEVANCE TO OTHER STATES

State policymakers looking to other states for ideas and lessons about how to expand health insurance coverage often turn first to neighboring states or states they consider to be like them in important ways, such as size and political characteristics. They may also look for models in states known for certain types of reforms, such as expansion of Medicaid eligibility to childless adults (for example, Oregon and Tennessee), requirements that employers provide health benefits to workers or pay penalties (for example, Massachusetts

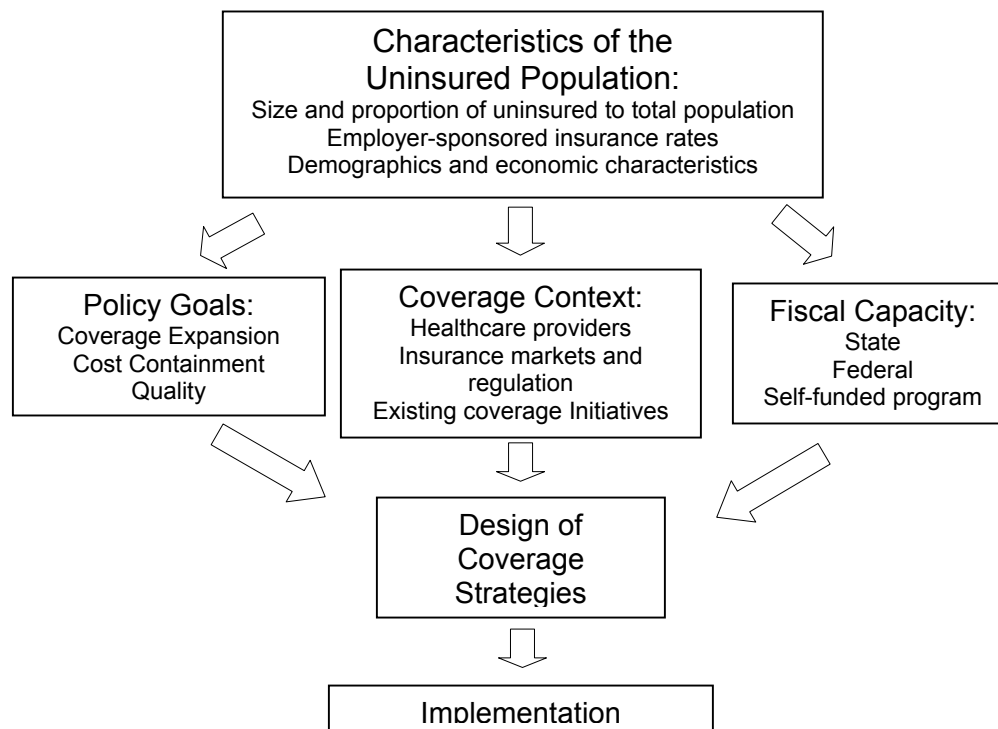
and Hawaii), or reinsurance for products offered to low-income individuals or small firms (New York).

While such comparisons may be useful starting points, they may also be misleading. States in the same geographic region or similar in size or political and economic characteristics may differ in ways that affect the feasibility of adopting particular health coverage strategies or the ability to sustain them. For example, the Massachusetts law requiring employers to provide health coverage to workers encountered less opposition from the employer community than it might elsewhere; employer offer rates were already high in Massachusetts, reducing the number of (and political opposition from) employers that would pay a penalty for not offering insurance to employees.

To determine which strategies for expansion are appropriate and how they should be designed, states must consider several complex and interrelated factors, depicted in Figure VIII.1, including:

- ***Characteristics of the uninsured population***, which reflects employer-sponsored insurance rates, public insurance, program generosity, and demographic and economic characteristics.
- ***Policy goals***, which typically include universal coverage, coverage for all children, and/or the availability of coverage for low-income individuals and families. These goals may reflect preferences regarding the pace or scope of reform: slow-incremental or fast-comprehensive.
- ***Coverage context***, which includes health insurance market concentration and price competition, the nature of the health care delivery system, and existing insurance regulation and experience.
- ***Fiscal capacity***, including the federal Medicaid assistance percentage (FMAP), existing uncompensated care funds, previous federal funding, current tax rates and policy, and the potential for raising additional funds from conventional or new sources.

The remainder of this chapter compares Maine to other states on three of these four dimensions of state efforts to expand coverage—the size and nature of the problem, the coverage context, and state fiscal capacity. The discussion considers the factors’ influence on Maine’s selection and implementation of the Dirigo strategy and how Maine compares to other selected states. It does not discuss policy goals, which are highly dependent on political dynamics.

**Figure VIII.1. Framework for Assessing Health Coverage Expansion Options**

## **B. SIZE AND NATURE OF THE PROBLEM: CHARACTERISTICS OF THE UNINSURED POPULATION**

In 2004-05, less than 12 percent of the non-elderly population in Maine lacked insurance. States that are similar in this regard, such as Wisconsin and Minnesota, have an apparent head start in aspiring to universal coverage. States with more than 20 percent of the population lacking coverage—such as Texas, New Mexico, and Florida—face a bigger challenge in achieving universal coverage. They would likely need to raise new resources or redistribute existing resources to a much greater degree, and enact strong measures to counter a “culture of uninsurance.” Without such measures, such states might need to aim for a more gradual increase in coverage.

The current composition of coverage and reasons for lack of coverage are also important contextual factors. For example, among the six states with fewer than 12 percent of residents uninsured (Table VIII.1, column 1), Maine has the lowest percentage of the non-elderly population with employer-based coverage—62 percent on average between 2003 and 2005 (Fronstin 2006)—and the highest percentage of non-elderly covered by Medicaid—21 percent on average between 2003 and 2005. Thus, to increase coverage rates, Maine recognized that it might have reached its upper bound on Medicaid coverage and thus needed to focus on increasing employer-based coverage.

The underlying distribution of income in a state and the availability of public coverage largely determine the income levels of the uninsured population. In Maine, just 30 percent of the uninsured were in families with income below the poverty line (Table VIII.2).

However, health care costs in Maine were (and remain) extraordinarily high, making private insurance expensive. Consequently, the state focused on populations with somewhat higher income (up to 300 percent of FPL) in order to make significant inroads among the uninsured. In contrast, almost half of the uninsured population in states such as Alabama and Louisiana has income below the poverty line; this difference suggests that strategies to address the uninsured in these states might productively focus on the population at lower income levels.

**Table VIII.1. Proportion of Non-Elderly Population Without Health Insurance 2004–2005**

Less than 12%	12 to 14.9%	15 to 19.9%		20% or More
Hawaii Iowa <b>Maine</b> Minnesota New Hampshire Wisconsin	Connecticut District of Columbia Kansas Massachusetts Michigan Missouri Nebraska New York North Dakota Ohio Pennsylvania South Dakota Rhode Island Vermont Washington	Alabama Alaska Arkansas Colorado Delaware Georgia Idaho Illinois Indiana Kentucky Louisiana	Maryland New Jersey North Carolina Oregon South Caroline Mississippi Tennessee Utah Virginia West Virginia Wyoming	Arizona California Florida Montana Nevada New Mexico Oklahoma Texas

Source: Kaiser Family Foundation State Health Facts, based on March CPS data for 2005 and 2006.

Note: U.S. average is 17 percent.

**Table VIII.2. Proportion of Non-Elderly Uninsured with Income Below Federal Poverty Level 2004–2005**

Less than 30%	30 to 34.9%	35 to 39.9%		40% or More
Alaska Delaware Idaho Massachusetts New Hampshire North Dakota Vermont Wyoming	Connecticut Florida Georgia Indiana <b>Maine</b> Minnesota Nebraska New Jersey Oregon Rhode Island Utah Virginia Washington	Arizona Arkansas California Colorado District of Columbia Iowa Kansas Maryland Michigan Missouri Montana Nevada New Mexico	New York North Carolina Ohio Oklahoma Pennsylvania South Carolina South Dakota Tennessee West Virginia Wisconsin	Alabama Hawaii Illinois Kentucky Louisiana Mississippi Texas

Source: Kaiser State Health Facts, based on March CPS data for 2005 and 2006.

Note: U.S. average is 36 percent.

Finally, states that seek to leverage employer-sponsored coverage (as Maine did) need to take into account the current rate of employer offer. States differ in both their relative proportions of small employers among all employers, and rates of plan offer in small firms (Table VIII.3). Both factors may be important in considering whether to pursue an employer-based strategy or a strategy emphasizing individual coverage.

Maine had a much higher proportion of small employers to all employers than the U.S. average, and small employers in Maine in 2004 were less likely to offer health benefits as compared to the U.S. average. Given that self-employed and small firm workers accounted for more than half of uninsured residents, it was both essential and challenging to target these residents for expanded coverage. In states such as Oklahoma and Wyoming, the employer offer rate is even lower than in Maine; small firms offer health insurance less than 30 percent of the time—potentially tipping the balance away from an employer-based strategy. In contrast, states such as Connecticut and New Jersey have particularly high offer rates among small firms, so they may be able to raise the “floor” even higher.

**Table VIII.3. Percent of Private Sector Establishments Offering Health Coverage Among Firms with Fewer than 50 Employees Within a State**

More than 50% Offer	49 to 40% Offer	39 to 30% Offer		Fewer than 30% Offer
Connecticut	Alabama	Alaska	Nevada	Arkansas
Delaware	California	Arizona	New Mexico	Louisiana
District of Columbia	Illinois	Colorado	North Carolina	Mississippi
Hawaii	Kansas	Florida	North Dakota	Montana
Maryland	Kentucky	Georgia	South Carolina	Oklahoma
Massachusetts	Michigan	Idaho	South Dakota	Texas
New Hampshire	Minnesota	Indiana	Tennessee	Wyoming
New Jersey	Missouri	Iowa	Utah	
New York	Ohio	<b>Maine</b>	West Virginia	
Pennsylvania	Oregon	Nebraska		
Rhode Island	Vermont			
	Virginia			
	Washington			
	Wisconsin			

Source: AHRQ, 2004, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC).

Note: U.S. average is 42 percent.

States with relatively few small employers that offer insurance (as in Maine) may face structural or marketplace obstacles to strategies that rely on employers to provide or otherwise finance coverage. However, if employer health insurance coverage is reasonably broad and relatively few employers do not offer insurance (as in Massachusetts), strategies such as “pay or play” (which tax employers that do not offer insurance) would affect relatively few employers and may encounter relatively little opposition. Even though “pay or play” may generate little revenue, it may still be adequate to finance expanded coverage if the number of uninsured requiring a subsidy is also relatively low.

### C. COVERAGE CONTEXT

Before the enactment of Dirigo Health reforms, Maine had put in place extensive regulations governing the small group and individual health insurance markets. The regulations required guaranteed issue to small groups and individuals and placed bands on rating in both markets. Maine is one of just six states that requires guaranteed issue of individual policies by all insurers; insurers may not vary individual rates by more than 20 percent above or below the community rate and then only for approved factors—age, occupation, smoking, family status, and geographic area. In states without such rules, competing health plans can deny coverage to high-risk individuals or price the product so that high-risk individuals cannot afford it.

Maine's regulatory environment gave DirigoChoice an advantage by eliminating the need for extensive underwriting to avoid adverse selection. DirigoChoice had additional advantages over other commercial products in the subsidies it offered to enrollees with income below 300 percent of FPL. Nonetheless, by accepting enrollees on preferential terms (with no pre-existing condition exclusion), DirigoChoice operated at a competitive disadvantage. Insurers could adjust rates and exclude coverage for pre-existing conditions, giving them the ability to steer high-risk people to DirigoChoice.

Other states interested in either subsidized insurance products modeled after DirigoChoice or an insurance pool offering several products for small groups and individuals must consider how to manage high-cost individuals. About half of all states have high-risk pools intended to make health insurance available to high-risk individuals at more affordable premiums. To be effective, though, the pools require large subsidies to finance costs in excess of premiums. In addition, all but three states (and the District of Columbia) restrict insurers' ability to adjust premiums in the small group market (Table VIII.4), but most allow rate bands that make premiums unaffordable to many with chronic health conditions. Few states restrict premium rating in the individual market.

The level of competition among insurers and the characteristics of the health care delivery system may also influence the design and viability of reforms that would expand coverage through subsidized premiums. For example, states in which one insurer dominates the market are at a distinct disadvantage if they want to promote more competition among plans to reduce premiums. In most states, insurance markets are highly concentrated, with the largest two or three carriers accounting for most of the market (AMA 2006; Robinson 2004; Chollet et al. 2003). A recent American Medical Association study classified only five states—New York, Wisconsin, New Jersey, Pennsylvania, Florida—as just moderately concentrated.

Managed care penetration and provider competition also may affect a state's ability to establish and maintain affordable premiums. States characterized by extensive managed care and/or with most of the population concentrated in urban areas may find it relatively easier to obtain concessions from insurers and providers to reduce the cost of coverage expansions. Conversely, rural states (such as Maine) typically have just one hospital and one physician specialty group per market area, making it difficult to negotiate with insurers or providers to support an affordable health insurance product.

**Table VIII.4. Rating Method Used In Small Group Market**

No Rating Restrictions	Rate Bands		Adjusted Community Rating	Pure Community Rating
District of Columbia Hawaii Pennsylvania Virginia	Alaska Arizona Arkansas California Colorado Delaware Florida Georgia Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Michigan Minnesota Mississippi Missouri	Montana Nebraska Nevada New Hampshire New Mexico North Carolina North Dakota Ohio Oklahoma Rhode Island South Carolina South Dakota Tennessee Texas Utah West Virginia Wisconsin Wyoming	Connecticut <b>Maine</b> Maryland Massachusetts New Jersey Oregon Washington	New York Vermont

Source: Kaiser Family Foundation State Health Facts, Data current as of December 2006.

#### D. FISCAL CAPACITY

States that have enacted or are considering health insurance expansion programs are all looking at the same set of potential funding sources:

- Federal funds from Medicaid, the State Children’s Health Insurance Program (SCHIP), and Medicaid disproportionate share hospital (DSH) payments
- Enrollee and employer premiums
- Employer assessments or, alternatively, a “pay or play” requirement
- Taxes or assessments on health care providers and/or insurers
- Special taxes on tobacco, alcohol, and other products that pose health risks
- General fund taxes on income, sales, and/or services

Maine’s financing sources for the DirigoChoice program are roughly similar to those used by Massachusetts and Vermont to finance their programs to expand coverage and much like the programs proposed by the governors of Pennsylvania and California. All of these states use or propose to use federal Medicaid funds (Table VIII.5). In addition, all either use or propose to use enrollee and employer premiums and assessments on employers

that do not provide insurance to employees. Only Massachusetts imposes an assessment on individuals who remain uninsured, although Governor Baldacci had proposed to do the same in Maine. All except California either use or are proposing to use some form of state general fund financing as well as special financing. In Vermont, special financing includes taxes on tobacco; Massachusetts has assessed providers; California's governor has proposed to assess hospitals and physicians. In any state, the amount of funding available from various sources depends on the state's current use of its given funding sources, the potential for expansion, and political and economic feasibility.

**Table VIII.5. Financing Options for Health Insurance Expansions**

Financing Options	Maine	Massachusetts	Vermont	Pennsylvania	California
<b>Federal Funds</b>					
Medicaid/SCHIP expansion	Yes	Yes	Yes	Yes	Yes
DSH	Yes	Yes	No	No	No
Other	HIFA waiver	1115 waiver	1115 waiver	No	Proposed 1115 waiver
Enrollee/Employer Premiums	Yes	Yes	Yes	Proposed	Proposed
Employer Assessments if Employees Not Insured	Proposed	Yes	Yes	Proposed	Proposed
Individual Assessments if Not Insured	Proposed	Yes	No	No	No
Insurer Assessments	Yes	Yes	No	No	No
Provider Assessments	No	No	No	No	Proposed for hospitals and physicians
State General Fund or Tobacco Taxes	Yes	Yes	Tobacco Taxes	Proposed	No

Source: State Coverage Initiatives Web site <http://www.statecoverage.net/index.htm> and state Web sites.

A state's financing options may also depend on the characteristics of its Medicaid program (Table VIII.6). Maine has a relatively high FMAP; the federal government pays 63 percent of every Medicaid dollar and 74 percent of every SCHIP dollar. Other states with a high FMAP also may see opportunities to finance coverage expansions with federal matching funds by expanding Medicaid and/or SCHIP eligibility. However, Maine's Medicaid program was already fairly expansive in that it covered, for example, some childless adults below the poverty level through a federal Medicaid waiver. By 2004, the state's

Medicaid program accounted for over 22 percent of state general fund spending compared to a national average of less than 18 percent, limiting the ability of the state to devote more general revenue funds to further Medicaid expansions. Even if public sentiment supported a greater allocation of funds to the Medicaid program, providers become wary of further expansion when reimbursement rates remain low.

**Table VIII.6. Factors Affecting State Health Insurance Financing Options**

State Characteristics	United States	Maine	Massachusetts	Vermont	Pennsylvania	California
<b>Insurance Costs</b>						
Average Total Single Premium (in dollars) per Enrolled Employee in Small Firms Offering Health Insurance (2004)	\$3,764	\$4,146	\$4,509	\$4,020	\$3,813	\$3,372
<b>Medicaid Coverage, Costs, and Financing</b>						
Percent Non-Elderly Covered by Medicaid (2004–2005)	14%	21%	15%	21%	12%	16%
Medicaid Spending per Enrollee (calendar year 2004)	\$6,119	\$8,237	\$9,150	\$5,977	\$8,181	\$3,664
Federal Percentage Share of Medicaid Spending (fiscal year 2007)	57%	63.3%	50%	58.9%	54.4%	50%
Medicaid Share of State General Fund Spending (state fiscal year 2005)	17.9%	22.2%	14.7%	22.6%	23.6%	15.4%
DSH Payments as a Share of Total Medicaid Spending (fiscal year 2005)	5.6%	2.8%	7.2%	4.1%	5.1%	7.4%

Sources: Kaiser Family Foundation; AHRQ, 2004 MEPS-IC; and Martin et al., 2007.

States with relatively high DSH spending may also have an advantage when considering how to finance coverage expansions. Indeed, Maine used unspent DSH funds to cover childless adults in its Medicaid program.<sup>38</sup> But Maine's total DSH spending is low compared to that of other states—2.8 percent of the Medicaid budget in 2005 compared to 5.6 percent for all states combined and 7.2 percent for Massachusetts. Thus, compared with states such as Massachusetts, Maine has no opportunity to tap DSH funds to finance premium subsidies.

<sup>38</sup> Maine met its budget neutrality requirement in 2002 by using unspent monies in its federal DSH allocation. Under 2003 federal legislation, Maine's DSH allotment increased to \$99 million, giving the state additional federal funds to finance its coverage expansion (Rousseau and Schneider 2004).

In addition, unlike Massachusetts, Maine did not have a dedicated source of funding for an uncompensated care pool. Established in 1985, the Massachusetts Uncompensated Care Pool pays acute care hospitals and community health centers for eligible services provided to low-income uninsured and underinsured individuals. It is financed in part by a surcharge on insurer reimbursements to hospitals, the proceeds of which have been used to draw down federal matching funds. It is similar to the surcharge that Governor Baldacci proposed in 2007 as a substitute for Maine's SOP. As part of its health reform initiative, Massachusetts is shifting some funds from the pool into premium subsidies for the uninsured; the state recognizes that such a shift is politically a much easier proposition than raising new revenues.

In summary, Maine had fewer financing options for new coverage initiatives than did Massachusetts, Vermont, Pennsylvania, or California. Specifically, its options were constrained by an already expansive Medicaid program, relatively low DSH funding, and the lack of available funds that could easily be redirected to finance health care reforms. In large part, these constraints may explain why Maine relied on a new assessment on payers (insurers) to a greater extent than other states.. Massachusetts, as part of its health reforms, instituted some new insurer assessments, but the revenues comprise a smaller proportion of overall funding sources than in Maine (Pryor and Dunham 2006; MA OHHSD undated).

Maine's experience with the SOP offers some important lessons for states that might try to reallocate existing health care spending to finance new coverage. Several of the SOP's intrinsic characteristics made it extremely controversial and seriously weakened state support for it:

- ***Difficulty in Capturing Cost Savings from Health Insurance Expansions.*** Maine's SOP, which is assessed on insurers and third-party administrators, was based on the assumption that payers could extract provider cost savings from reduced bad debt and charity care as coverage expanded and from other cost control efforts, without passing the assessment on to purchasers (employers that sponsor coverage or other policyholders). Maine's experience demonstrates that holding insurers responsible for capturing the savings through provider rate negotiations is a gamble—especially amid limited competition in the insurance market or the delivery system. In other states, insurers may be more willing or able to reflect these savings in lower insurance premiums.
- ***Difficulty in Estimating Savings from Insurance Expansions.*** Intrinsicly, many of the components in the “aggregate measurable cost savings” try to estimate what might have happened in the absence of Dirigo initiatives. Thus, the basis for the SOP is a set of hypothetical events that cannot be directly observed or estimated with a high degree of confidence. In such a situation, those who are disadvantaged by the estimates can be expected to take every opportunity to challenge the basis for the assessment and its calculation.

- ***Unpredictability of Assessments.*** If a board or some similar entity determines the actual amount of the assessment each year, those subject to the assessment will face a challenge in projecting and planning for program costs.
- ***Adequacy of Savings from Reduction in Uncompensated Care.*** If the savings amount is artificially capped, as in Maine, it may be inadequate to finance substantial insurance coverage expansions. Moreover, as providers adjust to the ratcheting down of uncompensated care costs, their savings over time may be lower than their initial savings, just as managed care savings often represent a one-time squeezing down of accumulated inefficiencies associated with fee-for-service and overpayments to providers.

These concerns may explain why none of the other four states examined here has imposed or proposed a new assessment on insurers and why only California has proposed an assessment on providers. In California, the governor has proposed a “contribution” from hospitals (4 percent of gross revenues) and physicians (2 percent of gross revenues) to compensate for the “provider coverage dividend” expected to result from expanded insurance coverage. While the contribution is based on the same rationale that underlies Maine’s SOP, it would address two issues overlooked by the SOP—the difficulty of estimating the basis for the assessment and the predictability to payers. Nevertheless, the fate of the California proposal remained uncertain, at the time of this report, in the face of provider opposition (Mathews and Rundle 2007).

## E. CONCLUSION

Developing a comprehensive, affordable health insurance product for small firms and low-income individuals is difficult in any state. Maine has done relatively well in the context of a high-cost state. Massachusetts has encountered similar challenges in developing affordable plans to offer through its Connector, but at least it dealt with several competing plans—rather than with just one plan as in Maine—that had expressed an interest in accessing a “new” market. Other states need to take into account the characteristics of health insurance markets when setting expectations for enhancing the affordability of their insurance products.

In Maine, as in most states, financing remains the most difficult issue to resolve. Most states operate with constraints on their financial resources that limit their capacity to expand public programs, even amid a strong commitment to maximizing public sector coverage. Most states, like Maine, also believe that excess spending in the existing health care system, and charges for uncompensated care, can be used to fund insurance coverage expansions. Maine’s experience demonstrates that converting the “hidden tax” of such cost shifting to a conscious strategy of financing coverage expansions introduces a series of challenging technical, operational, and political decisions that may be at least as difficult as raising new funds.



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## APPENDIX A

# METHODOLOGY FOR MPR 2006 SURVEY OF SMALL EMPLOYERS IN MAINE ABOUT EMPLOYEE HEALTH BENEFITS AND DIRIGOCHOICE

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### A. INTRODUCTION

When it was enacted in 2003, Maine's health reform law, Dirigo Health, captured the attention of policymakers and health policy analysts across the country. It was the first state since the early 1990s to enact comprehensive health care reform legislation. The law's goals were to (1) make quality, affordable health coverage available to every Maine citizen by 2009; (2) slow the growth of health care costs; and (3) continually improve the quality of care provided to Maine citizens. The plan's centerpiece is an insurance subsidy program, DirigoChoice, which offers affordable health insurance to small businesses and families with low to moderate incomes.

As part of an evaluation of Maine's health reform law, Mathematica Policy Research (MPR) conducted the Dirigo Health Insurance Survey in late 2006 and early 2007. The survey, sponsored jointly by the Commonwealth Foundation and the Robert Wood Johnson Foundation, was a representative survey in the State of Maine of very small businesses with 1 to 50 employees.

Following this overview of the survey objectives, this appendix includes the following sections:

- Section B describes the sample design.
- Section C provides an overview of the questionnaire design.
- Section D describes the data collection, and includes an overview of the locating and fielding protocols.

- Section E is devoted to data editing, and provides information on the coding of verbatim and open-ended responses found in the survey.
- Section F explains the response rate and weighting used in this survey.

## **B. SAMPLE DESIGN**

The purpose of the survey was to compare very small firms having between 1 and 50 employees enrolled in DirigoChoice with similar firms that were eligible but not enrolled. Thus, the sample design for the survey consisted of two populations of small businesses in Maine: those currently enrolled in DirigoChoice and those not currently enrolled. MPR obtained from the State of Maine Dirigo Health Agency a list of all businesses enrolled in the DirigoChoice program. MPR also obtained from Dun and Bradstreet (D&B)<sup>39</sup> a list of all Maine businesses meeting these same selection criteria.

To ensure that the businesses interviewed were eligible for DirigoChoice (whether or not currently enrolled), parameters were established to screen out ineligible firms. Eligible firms met the following criteria:

1. Fewer than 50 but more than 1 employee among all locations for a typical pay period in 2006
2. More than 50 percent of all full-time employees located in Maine
3. Not a wholly owned subsidiary of another company

To generate the sample file of firms not offering DirigoChoice, MPR provided D&B with the above sample criteria; D&B then delivered a file containing 2,229 firms that met the criteria. Of those cases, it was determined that 118 had multiple locations, and MPR randomly selected one Maine location from each of these for inclusion in the sample. MPR next used the State of Maine list of DirigoChoice enrolled firms to identify and delete those firms from the D&B file, thus leaving in the file only those firms that were eligible for DirigoChoice firms but not enrolled. MPR then randomly selected 400 non-DirigoChoice firms into the sample. For most of the establishments in the D&B file, accurate contact and address information was available, but a high proportion (40 percent) were subsequently determined to be ineligible because they did not meet the criteria for the program or were no longer in business. To ensure that we had a sufficient non-DirigoChoice sample size, MPR randomly selected an additional 400 non-DirigoChoice businesses (see Table A.1).

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<sup>39</sup> D&B is a firm that provides reliable information about businesses throughout the country.

**Table A.1. Number of Firms Released by Date and Type**

	First Release: October 18, 2006	Second Release: November 11, 2006	Total
DirigoChoice Firms	713	0	713
D&B Firms, non-DirigoChoice	400	400	800
<b>Total</b>	<b>1,113</b>	<b>400</b>	<b>1,513</b>

The sample file of firms enrolled in DirigoChoice was created using a random sample of 713 businesses enrolled in the program. While randomly drawn, the DirigoChoice sample file contained nearly all enrolled firms, omitting only the 25 that were fielded as part of the pretest.

### C. QUESTIONNAIRE DESIGN

The Dirigo Health Insurance Survey was based on similar survey questionnaires of businesses that dealt with health insurance topics. This similarity in survey design allowed for comparability to larger, nationally representative data, as well as to data from other states.

The survey introduction was used to identify which staff person should respond, and to provide a persuasive explanation of the study. The introduction was based on the format used by the Kauffman Foundation's Firm Survey,<sup>40</sup> which was designed to quickly determine if the person who answered the phone was a gatekeeper or an appropriate respondent. The Kauffman format reduces refusals or hang-ups during introduction by ensuring that the interviewer can get past a gatekeeper and speak with a knowledgeable benefits manager.

Several of the questions found on the survey were taken from the U.S. Census Bureau's 2003 Medical Expenditure Panel Survey (MEPS) Health Insurance Cost Study.<sup>41</sup> These questions included:

1. The total number of employees (asked in the screener).
2. Whether the firm makes available, or contributes to the cost of, any health insurance plans for its active employees (asked in the screener).
3. How many different health plans are offered (asked in the screener).
4. Enrollment questions, asked of those businesses that offer health insurance.

<sup>40</sup> Ballou, Janice, and David DesRoches. "Kauffman Firm Survey Baseline Final Questionnaire." Final questionnaire. Princeton, NJ: Mathematica Policy Research, Inc., July 2005.

<sup>41</sup> For more information, see [http://www.meps.ahrq.gov/mepsweb/survey\\_comp/ic\\_survey/2004/meps10.htm](http://www.meps.ahrq.gov/mepsweb/survey_comp/ic_survey/2004/meps10.htm).

5. The distribution of wages for the company, asked of all respondents.
6. Business characteristics questions, including the number of women, the number of union members, and the number of people over 50 employed by the firm, asked of all respondents.

While MEPS questions were used to determine the distribution of wages at each firm, the wage referents used for these questions were based on the poverty guidelines updated periodically in the Federal Register by the US Department of Health and Human Services (HHS), based on data collected by the Census Bureau's Housing and Economic Statistics Division. Since the Evaluation of Maine's Dirigo Health reforms survey asked about the previous 12 months, and was conducted from late 2006 through early 2007, the HHS Poverty Guidelines for 2006 were used.<sup>42</sup>

Other questions were based on the 2003 MEPS Health Insurance Cost Study Plan Information Questionnaire (MEPS-IC).<sup>43</sup> These included questions asked of businesses that offer insurance and pertained to the cost to the employer of extending coverage to workers.

Questions for those firms not offering health insurance were based on the Kaiser Family Foundation's 2003 Employer Health Benefits Survey.<sup>44</sup> The DirigoChoice survey included an additional residual category for those responses that did not fit into any Kaiser survey response categories. Respondents were given the opportunity to specify some other reason for not offering health insurance.

## **1. Section A (Introduction and Screener)**

The questions in Section A introduced the survey to the respondent and acted as a screener to ensure that the contacted firm was eligible for the study. The section began with an explanation of who was conducting the study, the focus of the survey, and response confidentiality. This section also collected information about whether the interviewer had reached the correct sampled business and whether the person answering the phone was knowledgeable about the business' health insurance coverage and could serve as a respondent. The section also was designed to capture updated contact information, alternative telephone numbers, and other pertinent respondent data.

Following the introduction, the questions in Section A screened the business to determine if it was eligible for the study. First, the respondent was asked the total number of employees at the company at all locations for a typical pay period in 2006. The respondent then was asked about the number of part-time employees (defined in this survey

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<sup>42</sup> Federal Register, Vol. 71, No. 15, January 24, 2006, pp. 3848-3849.

<sup>43</sup> For more information, see [http://www.meps.ahrq.gov/mepsweb/survey\\_comp/ic\\_survey/2003/meps11s.htm](http://www.meps.ahrq.gov/mepsweb/survey_comp/ic_survey/2003/meps11s.htm).

<sup>44</sup> Employer Health Benefits 2003 Annual Survey. *The Kaiser Family Foundation and Health Research and Educational Trust*. Publication Number 3369. <http://www.kff.org/insurance/ehbs2003-1-4.cfm>.

as working fewer than 30 hours per week). These questions ensured that the business had 50 or fewer but at least one full-time employee (other than the owner), making it eligible for DirigoChoice. In addition, respondents were asked if the company employed workers outside of Maine, and if it did, how many employees fit into this category. An electronic calculation then determined whether more than 50 percent of the reported full-time employees were employed outside of Maine. Those firms having zero or fewer than 50 percent of full-time employees outside of Maine could continue through the questionnaire. If these requirements were not met, the interview was terminated, and the business deemed ineligible to participate.

We then verified that we had contacted the business at its company headquarters for those firms with multiple locations. If the respondent answered that the business had multiple locations and the respondent was not at the company's headquarters, the interviewer was prompted to ask for headquarters contact information, including the benefits manager's name and telephone number.

Finally, the respondent was asked if the business was a wholly owned subsidiary. Since this question created some confusion in the pretest, an additional interviewer prompt was included, "That is, does another company own this business?" Businesses that indicated they were wholly owned subsidiaries were deemed ineligible to participate.

Beginning with question A15, the remainder of the questions in the section established whether the company offered health insurance to employees, how many plans were offered if it did, and whether it offered DirigoChoice as an insurance provider. Based on these key questions, the respondents received different modules for the remainder of the survey. (See Figure A.1 for a flow chart of the survey.)

## **2. Section B (Firm Offered DirigoChoice)**

Questions in Section B were asked of those firms responding that they did offer health insurance, and that they offered DirigoChoice. A total of 509 responding firms were routed through Section B. First, questions were asked regarding the management of DirigoChoice, including how many employees and dependents were covered, how much the employer contributed, and whether or not family coverage was offered. The respondents then were asked a series of questions regarding their opinions on DirigoChoice related to the benefits offered, overall satisfaction, and whether their company was likely or unlikely to renew enrollment. Finally, they were asked if they offered any other health plan. Those offering other health plans then were asked a series of questions comparing DirigoChoice to other plans, including issues such as costs to employees, health services included in the plan, and annual deductibles. Whether they offered DirigoChoice alone or other plans as well, all firms next were routed to Section E, described below.

## **3. Section C (Firm Offered Health Insurance, But Not DirigoChoice)**

Questions in Section C were asked of those firms that offered health insurance plans other than DirigoChoice to their employees. A total of 124 firms were routed through

Section C. This section presented questions regarding employee and dependent enrollment, costs to the employer, and whether or not family or employee-plus-one coverage was offered. All firms routed through Section C then were routed to Section E.

#### **4. Section D (Firm Does Not Offer Insurance)**

Questions in Section D were asked of those firms responding that they did not offer health insurance to any of their employees. A total of 143 firms were routed through Section D. Respondents were asked to consider eight common barriers to offering health insurance to employees, and how important or unimportant these barriers were to this firm's decision not to offer it. Respondents then were given the opportunity to list other reasons not already specified. All firms routed through Section D were routed to Section E next.

#### **5. Section E (Opinions About DirigoChoice)**

Regardless of their insurance status, all firms were routed to Section E, which contained a series of questions pertaining to the respondent's attitudes about DirigoChoice. First, those businesses that did not offer DirigoChoice were asked if they had heard of the program. Those that had heard of it were then asked how familiar they were with DirigoChoice. Firms that had not heard of or were unfamiliar with the program then were routed directly to Section F. The remaining firms were asked how they first heard about DirigoChoice as an insurance option for providing employee health benefits, if they thought DirigoChoice was good or bad for their company and employees, and whether or not it should be continued by the State of Maine. Those firms that did not use DirigoChoice (either they offered some other insurance plan or none at all) then were asked whether they had considered DirigoChoice as a health insurance option for employees. Those that had considered it were asked why they did not ultimately apply for it, or why they were no longer enrolled with DirigoChoice<sup>45</sup>. All firms were routed to Section F next.

#### **6. Section F (Business Characteristics)**

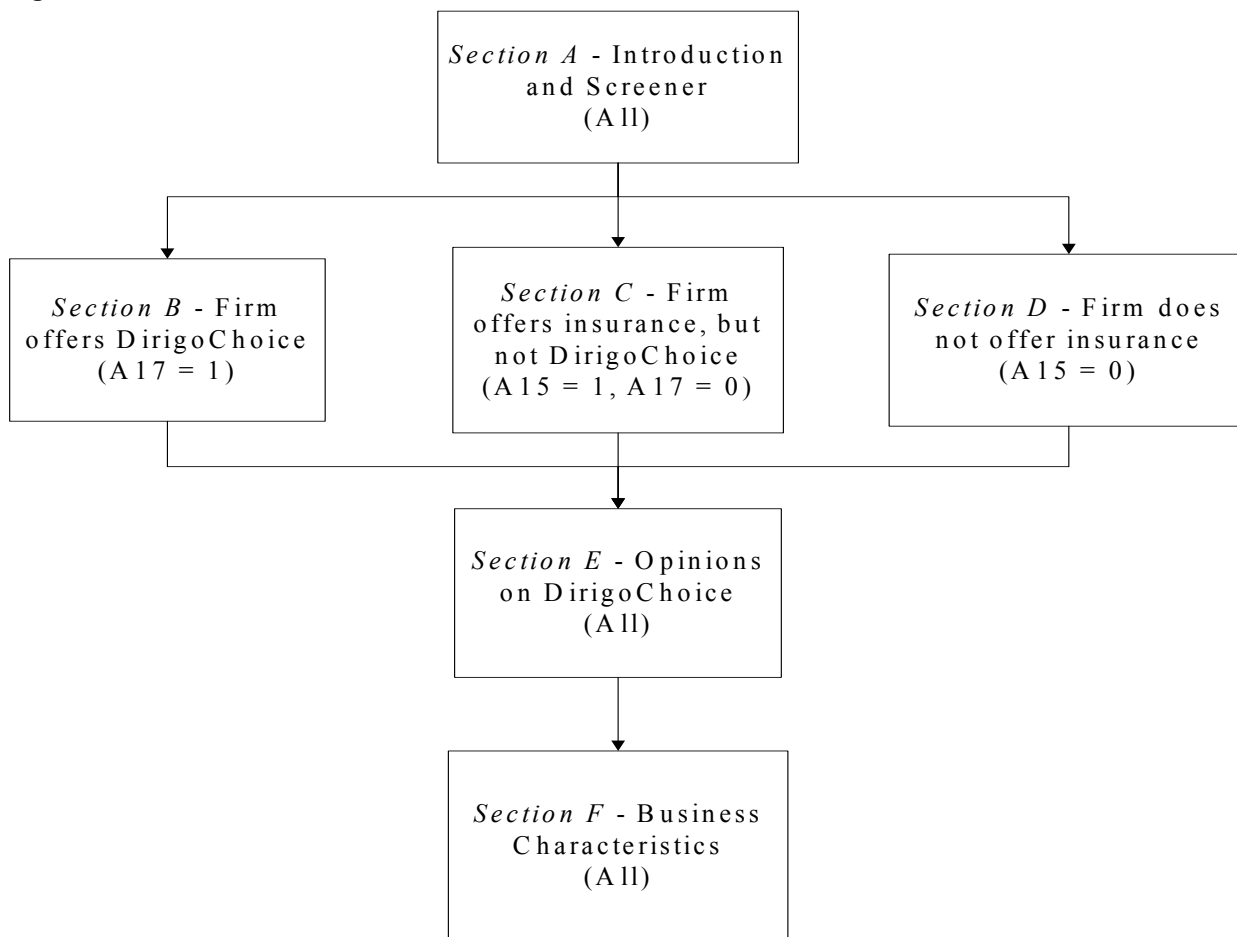
To describe the firms answering this survey, we collected information about several of their characteristics. These included the zip code or city where a business was located, the year it was established, and the type of industry in which it was involved. Three questions then asked about salary information for the firm. The first asked for the number of employees earning less than \$12.00 per hour (less than approximately \$25,000 per year) in 2006. The next question asked was the number of employees at the company who earned between \$12.00 and \$18.50 per hour (earning approximately \$25,000 to \$38,000 per year), followed by one asking the number of employees at the firm earning more than \$18.50 per hour (more than approximately \$38,500 year). The survey ended with questions about the

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<sup>45</sup> A small number of firms had previously enrolled in DirigoChoice had subsequently dropped it and were currently not offering it to workers.

numbers of employees who were women, 50 years or older, or union members. Respondents were asked to give their main role, title, or position at their company.

**Figure A.1. Questionnaire Paths**



#### D. DATA COLLECTION

The survey instrument was programmed in Blaise—a powerful and flexible system used for computer-assisted survey processing—for use in Computer-Assisted Telephone Interviewing (CATI) data collection. By using Blaise software, the programmed instrument included all routing and minimized inappropriate skips throughout the survey. In addition, each case was preloaded with all relevant information, including the name of the firm, telephone number, address, and contact name (if known).

The DirigoChoice instrument also was formatted for self-administration. Since small businesses may perceive any survey as being burdensome, and since the majority of the businesses being contacted were classified as microbusinesses (a business with fewer than 25 employees), the self-administered questionnaire was offered as an alternative to responding via telephone interview. To ensure that comparisons of the data could be made across modes, question format and sequence were kept as equivalent as possible. The self-

administered questionnaire was mailed, faxed, or e-mailed to the respondent. Respondents could then fill out the questionnaire and mail it back in a pre-stamped envelope; fax it back using a toll-free number; or type their answers into the e-mailed document and send it to the study's e-mail account.

### **1. Pretesting**

A total of 75 cases (25 from the Dirigo sample file and 50 from the D&B sample file) were randomly selected to participate in the pretest. About one week before calling was to begin (September 2006), a letter was mailed to each firm informing it that it had been selected for the study. This letter included contact information for MPR, in case the respondent had any questions. Five CATI interviewers were given three hours of training on the study, the instrument, and standard operating procedure for the pretest.

After about a week of pretest calling, 15 firms had responded to the questionnaire. These data were reviewed question by question and within the context of the skips in the instrument. Some questions had higher than expected answers of "don't know," or the respondents refused to answer. These questions either were modified or dropped from the survey. Interviewers also were debriefed about their experiences in making contact with the businesses and keeping them on the phone, any difficulties they had in reading the questionnaire to respondents, and any other problems they identified during the field test period. Using the review of the data and the comments from the interviewers, appropriate changes were made to the instrument.

### **2. Interviewer Training**

Twenty CATI interviewers were trained for the DirigoChoice survey data collection. The training, conducted in one five-hour session, included the background of the project, protocols on refusal conversion, techniques to use when interviewing businesses, and other procedures specific to this study. Interviewers were monitored throughout the field period and given feedback on their performance.

### **3. Fielding the Survey**

Interviewing began on October 17, 2006, and concluded on January 31, 2007, for a total of 15 weeks in the field. Approximately one week before fielding the survey, a letter was sent to each firm with information about the study and contact information for MPR. It also included a list of frequently asked questions and responses that were developed based on the questions posed by respondents during the pretest.

For those firms for which the letters were undeliverable or the telephone number was incorrect or out of service, an attempt was made to obtain updated contact information. Staff used several different tools, such as web searches, contacting the DirigoChoice offices for updates, and using Accurint, a web-based information clearinghouse that contains phone numbers, businesses, and individual names.

Businesses that refused to participate in the study underwent refusal conversion efforts from specially trained CATI interviewers. Near the end of the field period, these cases were randomly assigned to one of two groups. The first group received a standard refusal conversion letter and a follow-up phone call about a week later. The second group received a slightly modified refusal letter and a self-administered paper copy of the questionnaire. Researchers used this experiment to compare conventional telephone followup to self-administered mail followup as a means of converting refusals in a survey of small businesses.

#### 4. Section E Callbacks

Shortly after the field period began, the data collected were reviewed for errors. During this review, MPR staff discovered that a problem with the instrument programming had caused 85 respondents to skip through Section E inappropriately. These respondents were re-contacted to complete this section. By the end of the field period, 53 respondents had been re-contacted. Items in Section E for respondents who could not be re-contacted were labeled as “.M” in the data file to document their inappropriate skip pattern.

#### E. DATA CLEANING AND EDITING

The questionnaire included a number of questions that elicited open-ended responses; these responses were recorded verbatim. To facilitate analytic use of the data, these responses were grouped, in consultation with analytic researchers, and assigned numeric codes when possible. The verbatim responses themselves were excluded from the data files. The methodology used to code these variables is discussed in this section. There were two types of verbatim items:

1. ***Open-ended Items.*** Open-ended items had no response options specified for the question. (For example, “What is the main reason your company chose DirigoChoice?”) For these items, interviewers recorded the verbatim response.
2. ***Other, Specify Items.*** “Other, specify” response options were often included in response options for questions where a non-exhaustive list of possible responses was given. (For example, “Are there any other reasons why your firm does not offer health insurance benefits?”) For these questions, respondents were asked if there was “anything else” or “anyone else,” and then were asked to specify their answers, which the interviewer recorded verbatim.

We reviewed responses to both types of items to determine whether responses could be clustered together and categorized for quantitative analyses, or could be back-coded into existing response options. For some items, additional categories were developed and reviewed with analysts based on common responses. Cases that could not be coded remained as “other.”

Coders then were instructed as to the appropriate methods to translate verbatim qualitative data into aggregated quantitative data. Some responses were back-coded into a given category. Duplicate responses, responses that did not appropriately answer the

question, or those that could not be back-coded into a given category, were simply left as “other.”

Likewise, firms were asked to provide their industry classification, using the North American Industry Classification System (NAICS).<sup>46</sup> The NAICS uses a production-oriented conceptual framework, grouping types of businesses into industries based on the main activity in which they primarily engage. Businesses using similar raw material inputs, similar capital equipment, and similar labor are classified in the same industry. (In other words, businesses that do similar things in similar ways are classified together.) The NAICS uses a six-digit hierarchical coding system to classify all economic activity into twenty industry sectors. Five are mainly goods-producing and fifteen are entirely services-producing sectors.

#### F. RESPONSE RATES AND WEIGHTING

A total of 800 D&B cases and 713 DirigoChoice cases were loaded into Blaise for CATI interviewing, for a combined sample of 1,513 firms. Of the total 1,513 firms, 776 eligible firms were interviewed, but an additional 376 firms were determined to be ineligible. Surveys of the remaining 361 firms were not completed because they refused to participate, could not be located, or could not be interviewed during the field period and their eligibility remained undetermined. The average length of time per completed interview was 11.57 minutes, and the average number of calls per complete was 7.03 calls. The overall weighted response rate was 68.7 percent (see Table A.2).

**Table A.2. Weighted Response Rates by Firm Type**

	Sample Size	Completed Interviews	Ineligible	Unknown Eligibility, Non-Complete	Weighted Response Rate (%)
DirigoChoice Firms	713	544	60	109	84.71
D&B Firms	800	232	316	252	68.50
<b>Total</b>	<b>1513</b>	<b>776</b>	<b>376</b>	<b>361</b>	<b>68.72</b>

The vast majority of respondents (88 percent) completed the survey with a telephone interview (see Table A.3). The remaining 12 percent completed the self-administered version of the questionnaire. Of those who completed the self-administered version, 56 returned it by mail, 41 returned it by fax, and the remaining 3 returned it by e-mail.

<sup>46</sup> See <http://www.naics.com/info.htm> for more information.

**Table A.3. Distribution of Completes by Mode**

	Completes	Percent of Self-Administered Completes	Percent of Total Completes
CATI Completes	680		87.63
Self-Administered via Mail	54	56.25	6.96
Self-Administered via Email	3	3.13	0.01
Self-Administered via Fax	39	40.63	5.03
<b>Total</b>	<b>776</b>		<b>100</b>

To reduce potential for bias when examining data from this study, post-data collection weighting was developed. The initial sampling weight for a firm is the inverse of its probability of selection within the stratum to which it was assigned (DirigoChoice firms, D&B single-location firms, and D&B multi-location firms). The weight is defined as the ratio of the total number of firms in the stratum to the number of firms sampled.

After the sampling weights were calculated, non-response adjustments were computed using a weighting cell adjustment approach. The weighting cells were obtained using the Chi-squared Automatic Interaction Detector (CHAID) algorithm that examined the relationship of response patterns to the firm's characteristics. These included employee category, Metropolitan Statistical Area (MSA) indicator, effective date of the insurance, primary industry code, and starting year. The weighting cells were formed with at least 30 cases and 20 respondents. Because of the small number of multi-location firms, there was only one single weighting cell for these businesses. Within the weighting cell, the adjustment factor was defined as the ratio of the sum of the sampling weight from all cases to the sum of the sampling weights from the respondents and ineligibles. The final non-response adjusted weight was then: the product of the sampling weight and the non-response adjustment factor for completes; and for other sampled firms, zero.



**APPENDIX B**

**MPR SURVEY RESULTS OF SMALL  
EMPLOYERS IN MAINE ABOUT EMPLOYEE  
HEALTH BENEFITS AND DIRIGOCHOICE,  
2007 DETAILED TABLES**

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**Table B.1. Small Employer Firm Characteristics, by Type of Coverage**

Firm Characteristics	Type of Coverage Offered			
	All Firms Responding <sup>a</sup>	DirigoChoice <sup>b</sup>	Another Plan <sup>c</sup>	None
<b>All Firms</b>	773 (100%)	509 (66%)	121 (16%)	143 (18%)
Mean number of employees	8.1	6.7	17.7**	5.0**
Mean number of part-time employees	2.7	1.9	6.7**	2.1
<b>Industry</b>	773 (100%)	509 (100%)	121 (100%)	143 (100%)
Agriculture, forestry, fishing, and hunting	33 (4%)	22 (4%)	3 (2%)	8 (6%)
Mining, utilities, and construction	99 (13%)	76 <sup>+</sup> (15%)	9 <sup>+</sup> (7%)	14 <sup>+</sup> (10%)
Manufacturing	44 (6%)	31 (6%)	5 (4%)	8 (6%)
Retail trade, transportation, and warehousing	154 (20%)	113 (22%)	17 (14%)	24 (17%)
Professional services and management	149 (19%)	89 <sup>++</sup> (17%)	36 <sup>++</sup> (30%)	24 <sup>++</sup> (17%)
Education, health care, and social assistance	70 (9%)	37 <sup>+</sup> (7%)	18 <sup>+</sup> (15%)	15 <sup>+</sup> (10%)
Arts, recreation, and food services	88 (11%)	53 (10%)	11 (9%)	24 (17%)
Public administration	42 (5%)	19 <sup>+</sup> (3%)	11 <sup>+</sup> (9%)	12 <sup>+</sup> (8%)
Other services	94 (12%)	69 (14%)	11 (9%)	14 (10%)
<b>Average Wage</b>				
Mean percent who earn less than \$12 per hour	44%	45%	26%**	55% <sup>†</sup>
Median percent who earn less than \$12 per hour	40%	43%	17%	50%
Mean percent who earn \$12 to \$18 per hour	38%	39%	43%**	33%
Median percent who earn \$12 to \$18 per hour	33%	33%	40%	31%
Mean percent who earn more than \$18 per hour	18%	17%	32%**	12%
Median percent who earn more than \$18 per hour	0%	0%	24%	0%

Table B.1 (continued)

Firm Characteristics	All Firms Responding <sup>a</sup>	Type of Coverage Offered		
		DirigoChoice <sup>b</sup>	Another Plan <sup>c</sup>	None
Mean percent of female employees	49%	47%	54%	51%
Mean percent of employees over age 50	30%	29%	33%	33%
Mean percent of union employees	0%	0%	1%	0%
Mean year firm was established	1985	1988	1972**	1985

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> Three firms did not provide information on the type of coverage offered to their employees and are therefore not included in this table.

<sup>b</sup> Includes 487 firms that offered DirigoChoice as their only plan and 22 firms that offered DirigoChoice as one of multiple plans.

<sup>c</sup> Includes 109 firms that offered only one plan and that plan was not DirigoChoice; and 12 firms that offered multiple plans, none of which were DirigoChoice.

\* $p < .05$ , mean is significantly different from the mean for DirigoChoice firms at the 95% confidence level, based on a Student's t-test.

\*\* $p < .01$ , mean is significantly different from the mean for DirigoChoice firms at the 99% confidence level, based on a Student's t-test.

<sup>+</sup> $p < .05$ , significant difference in firm response by type of coverage at the 95% confidence level, based on chi-square test for differences between observed and expected outcomes.

<sup>++</sup> $p < .01$ , significant difference in firm response by type of coverage at the 99% confidence level, based on chi-square test for differences between observed and expected outcomes.

**Table B.2. Small Employer Firm Knowledge and Opinions About DirigoChoice, by Type of Coverage**

Firms' Responses	All Firms Responding	Type of Coverage Offered <sup>a</sup>			Significant Difference by Type of Coverage
		Dirigo-Choice <sup>b</sup>	Another Plan <sup>c</sup>	None	
<b>All Firms</b>	773 (100%)	509 (66%)	121 (16%)	143 (18%)	
Familiarity with DirigoChoice	209 (100%)		89 (100%)	120 (100%)	NS
Very familiar	39 (19%)		12 (13%)	27 (23%)	
Somewhat familiar	91 (44%)		42 (47%)	49 (41%)	
Somewhat unfamiliar	31 (15%)		12 (13%)	19 (16%)	
Very unfamiliar	34 (16%)		20 (22%)	14 (12%)	
Has never heard of DirigoChoice	14 (7%)		3 (3%)	11 (9%)	
<b>Source of Introduction to DirigoChoice</b>	740 (100%)	495 (100%)	115 (100%)	130 (100%)	±±
Media advertisement	251 (34%)	170 (34%)	37 (32%)	44 (34%)	
Media program	206 (28%)	127 (26%)	37 (32%)	42 (32%)	
Insurance broker or agent	142 (19%)	110 (22%)	22 (19%)	10 (8%)	
Business association	45 (6%)	22 (4%)	7 (6%)	16 (12%)	
Friend or family member	26 (4%)	17 (3%)	4 (3%)	5 (4%)	
Other <sup>d</sup>	70 (9%)	49 (10%)	8 (7%)	13 (10%)	
<b>Opinion of DirigoChoice</b>					
Is/would be good for firm	553 (80%)	461 (94%)	19 (25%)	53 (53%)	±±
Is/would be good for employees	557 (83%)	466 (94%)	23 (31%)	68 (66%)	±±
Should continue in current form	493 (71%)	406 (82%)	32 (38%)	55 (49%)	±±
Should continue with changes <sup>e</sup>	105 (15%)	67 (13%)	15 (18%)	23 (21%)	±±
Should not be continued	95 (14%)	24 (5%)	37 (44%)	34 (30%)	±±

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

**Table B.2** (*continued*)

<sup>a</sup> Three firms did not provide information on the type of coverage offered to their employees and, therefore, are not included in this table.

<sup>b</sup> Includes 487 firms that offered DirigoChoice as their only plan and 22 firms that offered DirigoChoice as one of multiple plans.

<sup>c</sup> Includes 109 firms that offered only one plan and that plan was not DirigoChoice; and 12 firms that offered multiple plans, none of which were DirigoChoice.

<sup>d</sup> Other sources of introduction reported include local politicians, chambers of commerce, and non-profit or advocacy organizations.

<sup>e</sup> This question was not asked of all firms but instead reflects the 105 firms that volunteered their opinion that changes should be made to DirigoChoice if it was continued.

<sup>+</sup>  $p < .05$ , significant difference in firm response by type of coverage at the 95% confidence level, based on chi-square test for differences between observed and expected outcomes.

<sup>++</sup>  $p < .01$ , significant difference in firm response by type of coverage at the 99% confidence level, based on chi-square test for differences between observed and expected outcomes.

NS = differences among firms by type of coverage were not significant.

**Table B.3. Factors Important to Participation of DirigoChoice Firms, by Firm Size**

Factors Important to Participation	All Firms Responding <sup>a</sup>	Firm Size		Significant Difference by Firm Size
		2 to 3 Employees	4 or More Employees	
<b>All Firms</b>	509 (100%)	239 (47%)	270 (53%)	
<b>Primary Reason Firm Chose to Offer DirigoChoice</b>	504 (100%)	237 (100%)	267 (100%)	±
Affordability for firm	300 (60%)	148 (62%)	152 (57%)	
Affordability for employees	46 (9%)	12 (5%)	34 (13%)	
Quality of plan	86 (17%)	42 (18%)	44 (16%)	
Only plan available	34 (7%)	21 (9%)	13 (5%)	
Wanted to support DirigoChoice	9 (2%)	4 (2%)	5 (2%)	
Other	29 (6%)	10 (4%)	19 (7%)	
<b>Importance of Wellness and Preventive Benefits to Firm Participation</b>	503 (100%)	237 (100%)	266 (100%)	NS
Very important	224 (45%)	106 (45%)	118 (44%)	
Somewhat important	195 (39%)	97 (41%)	98 (37%)	
Neither important nor unimportant	39 (8%)	15 (6%)	24 (9%)	
Somewhat unimportant	33 (7%)	15 (6%)	18 (7%)	
Very unimportant	12 (2%)	4 (2%)	8 (3%)	
<b>Importance of “Healthy Me Incentive” to Firm Participation</b>	468 (100%)	223 (100%)	245 (100%)	NS
Very important	78 (17%)	40 (20%)	38 (16%)	
Somewhat important	135 (29%)	57 (26%)	78 (32%)	
Neither important nor unimportant	126 (27%)	66 (30%)	60 (24%)	
Somewhat unimportant	64 (14%)	27 (12%)	37 (15%)	
Very unimportant	65 (14%)	33 (15%)	32 (13%)	

Table B.3 (*continued*)

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> This table reflects the 486 firms that offer DirigoChoice as their only plan; it does not reflect those 22 firms that offered DirigoChoice as one of multiple plans.

<sup>b</sup> Includes both family coverage and employee-plus-one coverage.

<sup>+</sup>  $p < .05$ , significant difference in firm response by firm size at the 95% confidence level, based on chi-square test for differences between observed and expected outcomes.

<sup>++</sup>  $p < .01$ , significant difference in firm response by firm size at the 99% confidence level, based on chi-square test for differences between observed and expected outcomes.

NS = differences among firms by firm size were not significant.

**Table B.4. Primary Reason Firms Did Not Offer DirigoChoice**

Primary Reason for Not Offering DirigoChoice	Total Number of Firms	Number of Firms with Other Coverage	Number of Firms with No Coverage
<b>All Firms</b>	78 (100%)	40 (51%)	38 (49%)
Too costly or not affordable to my company	45 (58%)	19 (48%)	26 (68%)
Benefits offered do not fit my employees' needs	8 (10%)	5 (13%)	3 (8%)
My company did not qualify to enroll in DirigoChoice	6 (8%)	3 (8%)	3 (8%)
Other <sup>a</sup>	19 (24%)	13 (33%)	6 (16%)

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> Other reasons reported by firms for not enrolling in DirigoChoice included insufficient employee interest, concern that premium rates would increase, concern that the future of DirigoChoice was too uncertain, insufficient time to complete the application, deductibles or co-payments not a good fit for employees' needs, and discomfort with government-sponsored or -subsidized insurance. No more than three firms reported any one of these reasons.

**Table B.5. Reasons Firms Do Not Provide Any Coverage, Among Firms Without Employee Health Benefits**

Reasons for Not Providing Coverage	All Firms Reporting	Importance of Reason for Not Offering Coverage			
		Very Important	Some-what Important	Not Too Important	Not Important
Premiums are too high	139 (100%)	116 (83%)	10 (7%)	5 (4%)	8 (6%)
The firm is too small	139 (100%)	77 (55%)	25 (18%)	9 (6%)	29 (21%)
Employees are generally covered under another plan, such as a spouse's or parent's policy	132 (100%)	45 (34%)	25 (19%)	27 (20%)	35 (27%)
The administrative hassle of providing health benefits is too great	13 (100%)	41 (30%)	24 (18%)	22 (16%)	48 (36%)
The firm can attract good employees without having to offer insurance	136 (100%)	30 (22%)	46 (34%)	19 (14%)	41 (30%)
Employee turnover is too great	140 (100%)	17 (12%)	17 (12%)	32 (23%)	73 (51%)
The firm is too newly established	139 (100%)	11 (8%)	12 (9%)	23 (17%)	93 (67%)
The firm has a seriously ill employee	134 (100%)	3 (2%)	4 (3%)	22 (16%)	105 (78%)

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

**Table B.6. Small Employer Plan Enrollment Characteristics, by Type of Coverage**

Small Employer Plan Enrollment Characteristics, by Type of Coverage Plan Enrollment Characteristics	All Firms Responding <sup>a</sup>	Type of Coverage Offered		Significant Difference by Type of Coverage
		DirigoChoice <sup>b</sup>	Another Plan <sup>c</sup>	
<b>All Firms</b>	630 (100%)	509 (81%)	121 (19%)	
<b>Average Employer Contribution to Premium</b>				
Employee only coverage PMPM	\$342 (n=526)	\$336 (n=426)	\$365 (n=100)	*
Employee and dependent coverage PMPM <sup>d</sup>	\$477 (n=349)	\$454 (n=272)	\$557 (n=77)	NS
<b>Average Employee Contribution to Premium</b>				
Employee-only coverage PMPM			\$80 (n=86)	
Employee and dependent coverage PMPM <sup>d</sup>			\$374 (n=78)	
Mean Percent of Employees Enrolled in Plan	62%	63%	60%	NS

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> Table reflects those firms offering coverage; the 143 firms not offering coverage are not included in this table.

<sup>b</sup> Includes 487 firms that offered DirigoChoice as their only plan and 22 firms that offered DirigoChoice as one of multiple plans.

<sup>c</sup> Includes 109 firms that offered only one plan and that plan was not DirigoChoice and 12 firms that offered multiple plans, none of which were DirigoChoice.

<sup>d</sup> Includes both family coverage and employee-plus-one coverage.

\* $p < .05$ , when linear regression model predicting PMPM contributions for a single employee by type of coverage is adjusted to account for firm size.

NS = differences among firms by type of coverage were not significant.

**Table B.7. Dirigo Firms' Experience With Prior Coverage**

Responses to Questions on Prior Coverage	Prior Coverage
<b>All DirigoChoice Firms with Prior Coverage<sup>a</sup></b>	250 (100%)
<b>Number of employees and dependents covered under DirigoChoice compared to prior coverage</b>	201 (100%)
More	40 (20%)
Fewer	22 (11%)
About the same	139 (69%)
<b>Why are there more employees covered under DirigoChoice?</b>	40 (100%)
More employees can afford this plan	24 (60%)
More employees are eligible for coverage or number of employees increased	9 (23%)
Other	7 (18%)
<b>Why are there fewer employees covered under DirigoChoice?</b>	22 (100%)
Employees opted for other insurance plans/covered by spouses' insurance plan	9 (41%)
Normal attrition of employees	7 (32%)
Plan was too expensive for employee	3 (14%)
Other	3 (14%)
<b>How do DirigoChoice health services compare to those under prior coverage?</b>	199 (100%)
Significantly better	49 (25%)
Somewhat better	42 (21%)
About the same	70 (35%)
Somewhat worse	34 (17%)
Significantly worse	4 (2%)
<b>Change in employer contribution for single coverage under DirigoChoice</b>	193 (100%)
Lower	102 (52%)
Higher	32 (16%)
Same as under prior coverage	61 (32%)
Mean difference in lower premium rate with DirigoChoice <sup>b</sup>	\$155 (n=78)
Mean difference in higher premium rates with DirigoChoice <sup>c</sup>	\$191 (n=35)
<b>How do the DirigoChoice annual deductibles compare to those under prior coverage?</b>	193 (100%)
Significantly lower	53 (27%)
Somewhat lower	38 (20%)
About the same	38 (20%)
Somewhat higher	40 (21%)
Significantly higher	24 (12%)

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> Reflects 250 firms out of 487 firms that offered DirigoChoice as their only plan; does not reflect those 22 firms that offered DirigoChoice as one of multiple plans.

<sup>b</sup> This average is sensitive to outliers within the dataset; the median difference for the average lower premium amount is \$102.

<sup>c</sup> This average is sensitive to outliers within the dataset; the median difference for the average lower premium amount is \$100.

**Table B.8. Satisfaction and Likelihood of Renewal Among DirigoChoice Firms, by Firm Size**

Level of Satisfaction and Likelihood of Renewal	All Firms Responding <sup>a</sup>	Firm Size		Significant Difference by Firm Size
		2 to 3 Employees	4 or More Employees	
<b>All Firms</b>	509 (100%)	239 (47%)	270 (53%)	
<b>Satisfaction with DirigoChoice</b>	507 (100%)	239 (100%)	268 (100%)	±±
Very satisfied	181 (36%)	97 (41%)	84 (31%)	
Satisfied	211 (42%)	90 (38%)	121 (45%)	
Neither Satisfied or Dissatisfied	75 (15%)	36 (15%)	39 (15%)	
Dissatisfied	27 (5%)	13 (5%)	14 (5%)	
Very Dissatisfied	13 (3%)	3 (1%)	10 (4%)	
<b>Likelihood of Renewal of Enrollment in DirigoChoice</b>	502 (100)	237 (100%)	265 (100%)	NS
Very likely	387 (77%)	178 (75%)	209 (79%)	
Somewhat likely	83 (17%)	47 (20%)	36 (14%)	
Somewhat unlikely	16 (3%)	6 (3%)	10 (4%)	
Very unlikely	16 (3%)	6 (3%)	10 (4%)	

Source: MPR Survey of Small Employers in Maine About Employee Health Benefits and DirigoChoice 2007.

<sup>a</sup> This table reflects the 486 firms that offer DirigoChoice as their only plan; does not reflect those 22 firms that offered DirigoChoice as one of multiple plans.

<sup>+</sup>  $p < .05$ , significant difference in firm response by firm size at the 95% confidence level, based on chi-square test for differences between observed and expected outcomes.

<sup>++</sup>  $p < .01$ , significant difference in firm response by firm size at the 99% confidence level, based on chi-square test for differences between observed and expected outcomes.

NS = differences among firms by firm size were not significant.