

Research & Policy Brief

August 2006

COMPARING THE DIRIGO CHOICE PROGRAM EXPERIENCE WITH OTHER STATE INITIATIVES TARGETED TO SMALL BUSINESSES AND INDIVIDUALS

Introduction

To assess the experience of the DirigoChoice Program, to date, we need a metric against which to measure the program's performance. This policy brief examines the experience of three other state coverage initiatives that have similarities to the structure and goals of the Dirigo Health Reform Initiative. As public/private initiatives specifically targeted to low to moderate income uninsured working populations, these programs can be expected to have experiences different both from the commercial insurance market and from traditional state Medicaid programs. Their track records offer lessons that may provide useful guidance for monitoring the performance of DirigoChoice.

The three programs selected for comparison are the Healthy NY program, the Basic Health Plan in Washington State and New Mexico's State Coverage Initiative. The criteria used in selecting comparison states were that their programs offer eligibility both to small businesses and to individuals, have a means of subsidizing premium and/or other participant costs, and that the state contract with private insurers to offer the state-sponsored product. The three programs provide a wide range of experience. Basic Health in Washington State has been operational since 1988. Healthy NY began in 2001, and the New Mexico State Coverage Initiative, like DirigoChoice, just started in 2005. The basic characteristics of these programs are briefly described below. Then the programs are compared with the DirigoChoice program on a variety of measures including enrollment rates and the public share of program costs.

Healthy NY¹

Healthy NY is an HMO product that all licensed HMOs in the state of New York are mandated to offer to eligible businesses and individuals. The State shares risk for this program and reimburses plans for all claims that fall in a band between \$5,000 and \$75,000 on a per enrollee basis. Premiums are community-rated (as are all small group products in New York) with the plans allowed adjustments only for location (variation by county) and family size.² The plans have a mandatory loss ratio associated with this product and thus must convert the reduced costs associated with the state's cost-sharing into reduced premiums.³ In 2005, the average single premium was \$190, a reduction of about 46 percent of the average New York premium for businesses of smaller than 10 in 2004.⁴

¹ The information on the Healthy NY program presented below is derived from, *Report on the Healthy NY Program, 2005*. Prepared for the state of New York Insurance Department by EP&P Consulting, Inc., December, 31, 2005; and from the Healthy NY website at: www.ins.state.ny.us/website2/hny/english/hny.htm

² With community-rated insurance, premiums are uniform and based on the average costs and experience of the entire enrolled population. With non-community-rated insurance, premiums are adjusted based on a variety of factors (depending on state regulation and industry practice) including age, sex, prior medical history, occupation, size of group, and location.

³ "Loss ratio" is a term for the portion of premiums collected by an insurer that go to pay for medical expenses through claims reimbursement. An 80% loss ratio indicates that 80% of all premium dollars were used for claims payment and that 20% was retained by the carrier. A mandatory loss ratio limits the proportion of premiums that a carrier can retain for administrative costs and profit. In the case of Healthy NY, the mandatory loss ratio assures that carriers don't reap excess profits as a result of the state's cost sharing, but rather lower premiums to reflect their reduced claims experience.

⁴ Based on premium data from the national Medical Expenditure Panel Survey, Insurance Component 2004 survey. AHRQ, US Department of Health and Human Services.

Healthy NY is available to businesses of 50 or fewer employees, statewide, whose workforces have a minimum of 30 percent of employees who earn \$34,000 or less, annually (approximately 350 percent of the federal poverty level for a single individual, and 200 percent FPL for a family of 3). The employer must not have offered insurance for the prior 12 months, or, alternatively, must have contributed less than \$75 per month toward employee premium costs (\$50 in rural counties).

Healthy NY is also a coverage option for sole proprietors and individuals in working households based solely on income criteria (with a maximum income threshold of 250 percent FPL). Non-group enrollees must have been uninsured for the prior year *or* have lost coverage involuntarily (loss or change in employment, a loss of family coverage due to death, divorce or loss of dependency status, or change in residence). Persons with COBRA coverage are allowed to enroll without delay. Based on focus groups and interviews with employers, the Healthy NY evaluators (EP&P Consulting) have recommended that the “look back” period for lack of insurance be removed as an eligibility requirement and that employers with an immediate prior history of coverage be allowed to participate on the same basis as uninsured employers.

Participation in Healthy NY started slowly. The program ended the first year with under 6,000 enrolled, and the second year with approximately 22,000. (This is in the context of over one million working uninsured in the state – see Table 1). In 2003, the state made adjustments to the program to increase state cost sharing. The risk band assumed by the state, which had been for per person claims between \$30,000 to \$100,000 was adjusted to the current band of claims between \$5,000 and \$75,000. In response to this change, plans reduced their premiums by approximately 17 percent. Subsequent to this change, enrollment doubled in 2003 and doubled again in 2004.

Enrollment in Healthy NY has consistently been heavily weighted toward individuals. Individuals make up more than 50 percent of the membership and sole proprietors another 18 percent, with small business employees constituting only 26 percent (see Table 1).

Washington Basic Health

Basic Health is a state-sponsored and designed insurance product offered statewide in Washington by HMOs and managed care insurance plans selected on a competitive bid basis. In some counties (but not all), there are multiple carriers offering enrollees a choice of plans. Basic Health is available as an individual enrollment insurance plan for individuals and families whose income is at or below 200 percent of the federal poverty level. The state subsidizes the premiums on a sliding scale. Carriers are allowed to adjust premiums for family size and age based on weights established by the Health Care Authority. Carrier premiums also vary based on their enrollment experience, local medical costs, and plan efficiency. The Washington Health Care Authority establishes the subsidy based on the lowest cost plan in an area. Individuals selecting higher cost plans pay the difference between the established subsidy amount and the full premium out-of-pocket. Washington policymakers have characterized this feature of the plan as “managed competition.”⁵

Basic Health was started as a demonstration project in 1988.⁶ Initial enrollment experience is difficult to compare with DirigoChoice because Basic Health was started in a limited number of counties and

⁵ Source: *A Study of Washington State Basic Health Program*. 2002. State of Washington Health Care Authority available at www.basicealth.hca.wa.gov/doc/ORreport.pdf

⁶ A chronology of the development and changes to the Washington Basic Health Plan is available at www.basicealth.hca.wa.gov/history.shtml

participating providers were allowed to cap enrollment in the initial contractual period. In the first three counties where the program was operational, the early experience was as follows: Spokane County (population 354,100) the enrollment cap of 1,000 was reached in 4 months; Pierce County (population 547,700), the enrollment cap of 5,000 was reached in 18 months; Clallam County (population 54,400) the enrollment cap of 1,000 was not reached in the first three years of program operations.⁷ In 1993 the program was made permanent and opened up to small businesses and higher income individuals on a non-subsidized basis. In 1995, budget appropriations for the program assumed a total enrollment of 200,000 with half of the subsidized enrollment coming through employer groups. Two years later, the employer group enrollment was only approximately 2000 members – one one-hundredth of the budgeted participation. Enrollment of individuals and families, however, was robust, leading to a total enrollment close to the expected level, but costs far above the expected level (because employer contributions were lacking). In the same time period that Basic Health became available to small groups, the Washington legislature repealed mandated benefit provisions that had previously set minimum benefit packages within the commercial market. The private market responded by marketing limited benefit products (for example, excluding maternity benefits). The result was market segmentation with low risk groups gravitating to the limited coverage products and higher risk groups gravitating to comprehensive plans. The subsidized portion of Basic Health was unaffected by this market shift, but the non-subsidized Basic Health Plan experienced adverse risk selection. By 2000, HMOs and insurers were reluctant to bid for the non-subsidized Basic Health business and, to protect the subsidized program, the requirement that companies bid on both lines of business was removed. By 2002, no plans remained that were offering new enrollment into non-subsidized Basic Health and currently less than 1 percent of enrollment is through employer groups.

The demand for the subsidized coverage within Washington's eligible population remains high and, in recent years, total enrollment has been capped based on funding availability as determined by the state budgeting process. Currently, enrollment stands at about 100,000, approximately 1500 of whom are home care workers whose coverage is paid by the Washington Department of Social and Health Services.

New Mexico State Coverage Insurance (NMSCI)

The NMSCI program is a state-sponsored and designed insurance product offered through managed care insurers selected through a competitive bid process. The program is an attempt to blend employer, employee and public funding. The State Coverage Initiative was approved by the federal government as a waiver program under New Mexico's SCHIP⁸ program. For this reason, the federal Medicaid/SCHIP program picks up over 80 percent of the public costs for this program. For individuals who enroll with employer sponsorship, the employer pays \$75 per employee per month and the employee pays on a sliding scale, between \$0 and \$35 per month. Eligibility is limited to persons with income at or below 200 percent of the federal poverty level. There is not a buy-in at cost for persons with incomes above this level. Individuals may also enroll without an employer sponsor. Those with incomes below the federal poverty level pay nothing, between 100 and 150% of FPL, they pay \$95 a month, and between 150 and 200% FPL, they pay \$110. For those above the poverty level, this premium constitutes the employer's share of the premium plus the amount they would pay as an employee.

⁷ Madden, CW, Cheadle A, Diehr, P, et al. "Voluntary public health insurance for low-income families: the decision to enroll." *J Health Politics, Policy and Law*. 1995 Winter; (20(4):955-72.

⁸ SCHIP – State Children's Health Insurance Program is an initiative passed by Congress during the Clinton administration. States design and administer their own programs, within federal guidelines, and the federal government contributes to the cost of the programs at a match rate that is higher than states' Medicaid match rates. Initially targeted just to children, in recent years, states have been allowed to extend coverage to the adult members of the families of these children.

Employees whose employers are unwilling to participate can enroll as individuals as can other persons regardless of employment status, if they meet income guidelines. Individuals whose employers offer group coverage but who have not taken up the coverage due to cost are also eligible to enroll. Individuals cannot have dropped coverage voluntarily within six months of applying. Employers cannot participate if they have voluntarily dropped coverage within twelve months of applying.⁹

The state pays participating plans on a capitation basis, with different negotiated rates for age (with two age cohorts, 19 to 44 and 45 to 64) and gender. In the first year of the program, the base capitation rate was \$355. This rate was raised to \$455 in the second year. The state pays the full negotiated capitation rate for persons with incomes below the federal poverty level and the negotiated rate less the amount charged to employers and employees for those between 100% and 200% of FPL. The plans collect the payments due from the enrollees with premium obligations.¹⁰

New Mexico's SCI program has been operational since July 1, 2005. There are currently four health plans participating and as of August 2006, 4,837 persons were enrolled, 97 percent of these as individuals without employer sponsors.¹¹ The estimated total program cost for the first 8 months of 2006 are \$13,453,000. Of this, less than \$600,000 was covered through contributions by enrollees and employers. On the other hand, over \$10 million was paid with federal dollars.¹²

Discussion

Coverage Among Small Businesses

Table 1, attached, provides a side by side comparison of the eligibility and enrollment experience of DirigoChoice and the three comparison plans. Several trends are apparent. First, the experience of all four programs makes clear that in voluntary enrollment initiatives, response is much greater from individuals and families than from small businesses. While substantial discounts attract some small business participation, the take-up is relatively modest in relation to the number of small businesses without health benefit plans. Many characteristics of small businesses may pose barriers to participation in the insurance market in addition to cost. High employee turnover, seasonal fluctuation in cash flow, and low demand among young employees each might lead to a decision not to offer benefits. In addition, in a small workforce, the need may be spotty. In a business with four employees, for example, if two have coverage through a spouse, the need of the remaining two workers may be insufficient to warrant the cost and administrative time commitment for selecting and administering a health plan.

By comparison with the other states' experience, the DirigoChoice plan has been the most successful in its proportionate representation of businesses. Business enrollees and sole proprietors make up 60 percent of overall membership compared, for example to 44 percent of the Healthy NY plan – a plan authorized initially to reverse erosion in the small group market. (See table 1)

Overall Enrollment Rate

⁹ Source: State Coverage Initiatives Brief: *Profiles in Coverage – New Mexico State Coverage Insurance*.

¹⁰ Source: Communication from Susan DeGrand, New Mexico Medical Assistance Division, Health Services Department, August 15, 2006.

¹¹ Source: *Insure New Mexico! Activity as of August 1, 2006*. Department report shared by Susan DeGrand, New Mexico Department of Health Services.

¹² Cost estimates calculated by the Muskie School based on monthly enrollment figures, payment rates and income distribution data provided by New Mexico's Department of Health Services.

It is, of course, difficult to compare enrollment rates among these programs because the population scale is so different in a state like New York, compared to a state like Maine. In addition, the programs differ with regard to eligibility criteria, a factor that makes exact comparisons difficult. Table 1 provides information on the number of employed uninsured in each state for the purpose of providing a rough scale against which to measure current program enrollment.¹³ Without making exact comparisons, two observations can be made from the experience of these programs and their current enrollment levels. The first observation is that growing enrollment in a new program takes time. The Basic Health Plan, which has been operational for almost 20 years, has by far the greatest “penetration” into the population of low-income uninsured of any of the programs. The fact that the Healthy NY program enrollment was under 6,000 enrollees at the end of the first year (less than DirigoChoice total enrollment after 12 months) and only 20,000 at the end of two years and then accelerated in enrollment further supports the concept of judging a program’s enrollment experience cautiously in its first few years of operation. The second observation is that in relation to the experience of the other state programs, the DirigoChoice program enrollment appears fairly robust for a new program. While the Healthy NY program has one enrollee for every 18 employed uninsured, the DirigoChoice plan has one enrollee for every 8 employed uninsured in Maine. Both programs allow enrollment of higher income participants as part of small business groups, but only Maine allows unsubsidized enrollment of individuals. A comparison of the number of DirigoChoice enrollees excluding the non-subsidized population (20 percent of enrollment) yields a ratio of 1 enrollee for 10 working uninsured – still a figure that compares favorably with the other programs.

The Washington Basic Health Plan, which has an income eligibility threshold but no crowd-out provision¹⁴ and enrolls individuals and families regardless of employment status or availability of employer coverage, nevertheless, started with modest enrollment. In a large county with a population half the size of Maine, the program took a year and a half to reach the plan imposed cap of 5,000. A smaller rural county did not achieve an enrollment of 1,000 in three years. The New Mexico initiative, which has been operational for just over a year, has about 54 percent of the enrollment level that DirigoChoice had at the end of 12 months of operation. The New Mexico SCI has more stringent income eligibility requirements (and a crowd-out provision) and in many ways more closely resembles Maine’s MaineCare expansion for low-income childless adults and SCHIP expansion for parents. Yet, despite a substantially larger low-income population statewide, the New Mexico SCI program’s enrollment is substantially below Maine’s MaineCare experience, as well.

All of these case studies point to the initial difficulties in launching new state initiatives. Unlike Medicaid, which is a familiar program to state citizens, new state initiatives have different names, different rules regarding eligibility, different points of access, and private insurance partners so that their “face” for the consumer is more like private insurance than a public program. States are not skilled in (and under-budgeted for) mass marketing. It takes a while for word-of-mouth to spread awareness of these programs. In addition, many citizens (and especially small businesses) are likely to take a wait-and-see attitude toward a new policy initiative to see if it gains stability and permanence. Skepticism among potential

¹³ This number is provided to establish the differences in scale from state to state – driven both by overall population size and differing rates of insurance coverage. The number of employed uninsured in small businesses with incomes below 300% of the federal poverty level might be a more accurate measure of the target population, but this figure is not readily available at the state level. In addition, because each of these programs offers enrollment to employed individuals as well as small businesses, the number of employed uninsured provides a rough estimate of the pool from which the programs’ enrollment is drawn.

¹⁴ “Crowd-out” is a term that refers to public health coverage programs’ inadvertent incentive for already insured individuals or employers to drop private coverage (if public subsidized coverage is available). As indicated in the program descriptions, above, many state programs respond to this issue by requiring that applicants be uninsured at the time of application and for some period (6 months or 12 months) prior to application. DirigoChoice does not have a crowd-out provision.

enrollees is particularly likely if a program is treated as controversial by policymakers and the press, as has been the case with the DirigoChoice plan. All these factors dictate a slow start. But the experience in Washington and New York provide support for the idea that with a little time, monitoring of experience, and program modifications to correct weaknesses, these public-private partnerships can play a vital role in the overall effort to combat the decline in private insurance.

Cost Experience

Table 2 provides a side-by-side comparison of cost and public/private cost-sharing experience of the four programs. Both the DirigoChoice and Healthy NY programs have devised subsidy designs that result in a contribution of the majority of health coverage costs from program participants – both individuals and employers. In the case of DirigoChoice, a total of \$23,598,639 was paid to Anthem in coverage cost for DirigoChoice enrollees in CY 05 through May 06. Of these coverage costs, \$12,104,746, or 51 percent, were payments from the employers and employees, before subsidies. In the case of Healthy NY, a total of \$115.8 million was collected in premiums from enrollees and their employers in 2004. The state of New York paid out \$31.5 million in stop-loss payments, or 25 percent of total program costs, during this period. Since the participating plans in both New York and Maine load their administrative costs into the premium, these program costs reflect plan administrative expenses, but not state agency administrative costs.¹⁵ These experiences indicate that both the stop-loss mechanism and the sliding scale premium payments are an effective way of stretching state dollars to expand coverage for the working uninsured in situations where federal cost sharing is not available.

In New Mexico, although the intent was to share costs three ways among enrollees, employers and the public sector, employer participation, to date, has been minimal. In addition to the newness of the program, the fact that a business cannot enroll all employees (or the employer) when incomes rise above 200 percent of the federal poverty level, may significantly discourage employer sponsorship of eligible workers. However, the trade-off in New Mexico is that the program has been approved by the federal government as a SCHIP expansion and thus state dollars are matched at a very favorable rate by federal cost sharing.

In Washington, where earlier efforts to encourage small business participation were unsuccessful, the state costs in relation to premium contributions are also much higher than in New York or Maine. Eighty-two percent of premium payments to participating plans come from Washington's Health Care Authority.

Program per capita costs are driven by a variety of factors. Among these are: the richness of the benefit package; the health and resulting health service utilization of program enrollees; medical service prices; administrative efficiencies, or lack thereof; and insurance partner retention (profits) after claims payment and administrative costs. For this reason it is in a sense meaningless to compare premiums or average per capita costs across programs without adjusting for differences in benefits or knowing the health status of enrollees or the characteristics of the health care marketplace in each state. Table 2 provides the base premium cost information for the four programs and, as a point of reference, the average private sector single premium for employer-based coverage for all employers and employees with fewer than 10 employees in each of the states, based on national Medical Expenditure Panel survey data (MEPS). Two additional caveats should be considered in reviewing this comparative information. First, the most recent MEPS data that is available at the state level is 2004, so in the case of Maine and New Mexico, program costs from 2005 are compared with state average costs from 2004, and for Washington, 2006 BHP

¹⁵ State administrative costs for the non-Maine programs are not available because the programs are rolled in with other state programs in large agencies, and costs associated with these particular initiatives cannot be broken out.

premiums are compared with 2004 MEPS data. Second, the state average (MEPS) costs are not adjusted for differences in benefits between employers. So the average cost is as much a reflection of employer choices with regard to benefit design as the other factors that impact on premium.

The MEPS survey reveals that in 2004, of the four states included in this analysis, Maine had the highest average *private* coverage employer benefit costs, both across all sizes of employer and for very small businesses.¹⁶ The extent to which this higher cost is driven by choice of plan and the extent to which it is driven by higher medical care costs or utilization is not known. The DirigoChoice baseline single premium¹⁷ is close to the average commercial single premium for businesses of fewer than 10; but slightly lower. The DirigoChoice plan is made affordable to low-income workers and their families through subsidies both of premium costs and plan deductibles. The Healthy NY premium is substantially discounted in comparison to commercial rates in New York because the state's subsidy is reflected in the premium rate (through reducing the plans' claims costs) rather than in subsidies to enrollees. This method of public funding is advantageous in attracting employer participation because employers, and other higher income employees, can enjoy the the subsidy, as well as lower income enrollees. The disadvantage of this approach is that state dollars are less effectively targeted to only low income persons.

Interestingly, although Washington contracts on a full-risk basis with health plans, the full average premium for BHP is substantially lower (28 percent) than average employer benefit rates in the small group market. BHP offers a comprehensive benefit plan with a \$150 annual deductible and average enrollee out-of-pocket payments of \$450.¹⁸ We do not know the reasons for the low costs. One savings is attributable to the fact that the administrative loading into the premium is only 7 percent, perhaps because the participating plans have no marketing, broker fee, premium billing, or enrollment costs associated with the program.¹⁹ In addition, some of the health plans make extensive use of community health centers in providing services to BHP enrollees, perhaps a lower cost provider than others. It may also be that BHP attracts a disproportionately low-risk population. (The plan imposes a 9 month wait for coverage of pre-existing conditions except maternity and prescriptions – but this may be standard among small group plans in Washington.)

New Mexico's premium costs have been both higher than private sector experience in the state and higher than anticipated by program planners and participating plans – as indicated by the jump in premium from \$355 to \$455 after the first year. This cost experience probably reflects a disproportionate enrollment of less healthy populations – an experience similar to Maine's Medicaid expansion to childless adults.

Conclusions

The experience, to date, of the DirigoChoice Program is positive when compared with other state programs with similar goals. Early enrollment growth has matched or exceeded the experience in other states and the proportionate participation of small businesses exceeds that of all the other programs.

As of August 1, 2006 DirigoChoice has extended comprehensive coverage to over 11,000 persons while paying 49 percent of coverage costs with dollars from the state appropriation. This ratio is particularly

¹⁶ Based on the MEPS annual survey, Maine has been among the highest cost states for employer-based health benefit costs for at least the last five years.

¹⁷ Under Maine law, the insurer is allowed to adjust the base premium by up to 20 percent for age, geographic location, or size of business.

¹⁸ Source: Communication, Richard Onizuka, Washington Health Care Authority, August 23, 2006.

¹⁹ Source: Richard Onizuka, Washington Health Care Authority.

encouraging when considering the disproportionately low income distribution of enrollees. Half of participants (49 percent as of August 1, 2006) are in the most heavily subsidized income category and all but 20 percent receive some level of subsidy. New Mexico and Washington differ from New York and Maine in that program costs are disproportionately public dollars. The difference between the two eastern US programs and the two western US programs is attributable to two factors: first, the western state programs have income eligibility thresholds that exclude participation by higher income individuals or groups so all participants are subsidized. Second, although both programs allow and have encouraged employer participation in sponsoring and sharing the costs of participants' premiums, the response from employers has been minimal. These two factors are most likely causally related. There is little incentive for employers to contribute to the costs of their employees when they cannot enroll *all* their employees or get coverage themselves (particularly when they know that eligible employees can enroll and receive deep subsidies without employer contributions). The consequence of this strategy is the loss of significant private contributions to program costs and conversely higher state costs. Both Maine and New York have recognized that because low-income employees are distributed in workplaces with a hierarchy of positions and income, public initiatives to extend employer-based coverage in the small group market require more inclusive eligibility requirements. The two states have devised different strategies for targeting public dollars but each strategy has been effective in extending coverage while stimulating the financial participation of employers and employees who may not have been paying into the health care system in the past.

Much of the media commentary and policy discussions about the DirigoChoice program in Maine has been premised on the assumption that the program would enroll a substantial portion of the uninsured in its first year. Held to this standard, the program has been deemed by some as a failure. An analysis of the experience of other states and consideration of the realities of the small group market make clear that this standard is entirely unrealistic. Washington State, which has 100,000 enrollees in the Basic Health Plan, has a rate of uninsurance among non-elderly adults statewide of 19 percent. The evaluators of Healthy NY pointed out that in 2003/2004, the uninsured rate for non-elderly low-income adults in New York state dropped from 39.3 percent to 38.1 percent – a decline of 1.2 percent – during a period when nationally, the average uninsured rate for this population rose from 39.9 percent to 40.1 percent. They comment that New York's experience in 2003/2004 marks the first time the state's rate has dropped below the national average, and surmise that this success is attributable in part to the Healthy NY program. Maine similarly has held the line on uninsured rate in a time when the problem is worsening, nationally. This standard – holding the uninsured rate among adults steady or experiencing a slight decline after 5 years of operation is a more realistic expectation than a significant drop in the uninsured in a single year.

The difficulty in making inroads against the problem of the uninsured is exacerbated by the dynamic within the private insurance market. After a brief hiatus in the early and mid '90's, health care costs, nationally, have been rising unrelentingly at rates that far exceed the growth in the economy or the change in the consumer price index. The reflection of these cost increases in insurance premiums has accelerated the erosion in private insurance. The small group market in Maine, for example, had a net loss of over 27,000 covered persons between 2001 and 2003 – a decline of over 18 percent.²⁰ Thus, state programs that extend new coverage opportunities are fighting against a tide of new recruits to the pool of uninsured.

In conclusion, the experience of the DirigoChoice Program compares well with that of other states with access initiatives that have targeted the small group market. This comparative experience may provide a useful yardstick for monitoring Maine's program over the course of the next few years

²⁰ Source: Maine Bureau of Insurance

Contact Information:

*For more information about this study, contact Elizabeth Kilbreth at (207) 780-4467,
BETHK@USM.MAINE.EDU*

Table 1

Side By Side Comparison of State Programs

	DirigoChoice	Healthy NY	Basic Health Washington	New Mexico SCI
Date Started	January 2005	January 2001	January 1989	July, 2005
Current Enrollment	11,131	106,944	~ 100,086 (capped)	4,897
Income eligibility threshold for subsidy	<300% FPL	For businesses: minimum of 30% of employees earn ≤ \$34,000 For individuals and sole props: income ≤ 250% FPL	200% FPL	200% FPL
Ability for higher income to buy in at cost	Yes	For businesses that qualify (see above), entire business gets subsidized rate	No (Yes, previously) ²¹	No
Crowd-out Provisions	No	12 month wait for individuals who voluntarily drop of coverage (COBRA coverage exempted). 12 month wait for businesses that drop coverage (employer contribution of < \$50 - \$75 exempted).	No	6 month wait for individuals who voluntarily drop coverage. 12 month wait for employers who voluntarily drop coverage.
Number of working uninsured in state	90,450	1,803,810	612,240	283,560
Proportionate program size	1 enrollee to 8 uninsured <300% FPL: 1 to 10	1 enrollee to 18 uninsured	1 enrollee to 6 uninsured	1 enrollee to 58 uninsured
Distribution of program membership	Small business 32% Sole prop. 32% Individual 40% -----	Small business 26% Sole prop. 18% Individual 56% -----	Small business < 1% ----- Individual 72% Sponsored ²² 27% -----	Small business 3% ----- Individual 97% -----

²¹ BHP implemented non-subsidized and group enrollment in 1995. Over time, because of adverse risk selection in the non-subsidized pool, participating plans refused to bid on this line of business and by 2003, non-subsidized enrollment had been phased out.

²² Basic Health has a category of enrollment of “sponsored” individuals and families. Native American tribes or nations, local government entities, church groups, health care providers, and non-profits can serve as sponsors. Sponsors are required to pay part or all of the premium on behalf of their sponsored enrollees and assist them with their interactions with the health plan. The intent of the sponsorship program is outreach to hard to reach and hard to serve populations who may be unfamiliar with insurance, have suffered discrimination, or have language barriers. Approximately 17 percent of Basic Health enrollment is “sponsored.”

Table 2

Public and Private Cost Sharing Experience

	DirigoChoice ¹⁹ (CY 05)	Healthy NY (CY 04)	Washington Basic Health	New Mexico SCI (CY 06 – 8mos.)
Employer/Employee premium payments	\$12,104,746	\$95,724,582 ²⁰	\$45,540,000 ²¹	\$591,912 ²²
Subsidies/Stop Loss Payments	\$11,493,893	\$31,494,756	\$207,460,000	\$12,860,623
Total Contracted Program Costs	\$23,598,639	\$127,219,338	\$253,000,000	(8 mos) \$13,452,535
Public Costs as percent of total	49%	25%	82%	95.6% (federal share) ²³ 77%
Average Premium or capitation rate (2005)	\$348.43 ²⁴	\$190	(2006) \$217	Year 1 \$355 Year 2 \$455
Average private sector single premium in state (2004)	All employers < 10 \$343 \$360	All employers < 10 \$321 \$351	All employers < 10 \$302 \$303	All employers < 10 \$283 \$308
Program premium as percent of average small group premium	97%	54%	72%	Year 1 115% Year 2 147%

¹⁹ DirigoChoice annual program cost information from Dirigo Agency report to the Maine Blue Ribbon Commission.

²⁰ All program cost and premium information for Healthy NY obtained from *Report on the Healthy NY Program 2005: Prepared for State of New York Insurance Department*. EP&P Consulting, Inc., December, 2005. Percent calculations developed by the Muskie School.

²¹ Washington Basic Health cost information from Richard Onizuka, Director, Washington Health Care Authority, July 31, 2006.

²² New Mexico SCI capitation and enrollee premium information from Susan DeGrand, Medical Assistance Division, Health Services Department. Calculation of total program and premium payment costs for 2006 developed by the Muskie School based on member/month enrollment in the program. Distribution by subsidy group as of August 2006 was assumed for all of 2006.

²³ As a federally approved Medicaid SCHIP waiver program, New Mexico's SCI receives federal cost sharing at the state's SCHIP match rate, which is 80.36%. Thus, overall, 77% of program costs (80 percent of the state's 95 percent share) are covered by federal dollars.

²⁴ DirigoChoice base premium information from communication with Dirigo Agency Deputy Director.