Discussion Draft
January 12, 1989

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE
PROPOSED INDIGENT CARE PLAN

Over 130,000 Mainers lack health insurance and considerably more face other barriers to access to health care.[1] To identify access problems and recommend solutions, the state legislature established the Special Select Commission on Access to Health Care. This report presents the Commission's proposed indigent care plan. It reflects almost a year of deliberations by the Commission and active participation from a number of interested parties, including the business community; hospitals, physicians, and other provider groups; insurers; and consumers and their advocates. The plan focuses on efforts to expand insurance coverage, supplemented by service delivery initiatives designed to improve access to needed services.

This report describes the components of the Commission's plan and is organized into four sections:

- Section A presents the approach to designing an indigent care plan.
- Section B describes the insurance initiatives.
- Section C describes the service delivery initiatives
- Section D describes how the plan will be administered.

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[1] Based on estimates from the Human Services Development Institute's report Health Insurance Coverage in Maine: An Analysis of the Problems, Its Effects and Potential Solutions. Estimates were adjusted to reflect the lack of insurance in the entire population, including children.

A. APPROACH TO DESIGNING THE INDIGENT CARE PLAN

Early in its deliberative process, the Commission identified the criteria which it would use in designing its indigent care plan. The proposals presented in this report meet those criteria.

The access problems identified by the Commission include financial barriers but are also broader than lack of insurance coverage. Some Mainers have difficulty accessing the health services they need for one or more of the following reasons: a lack of appropriate providers in the community; providers unwilling to treat the medically indigent, including Medicaid recipients; a lack of transportation to health care providers; and providers not available on weekends and in the evening when care is needed, especially by those low-wage employed persons who lose income if they take time off work to seek care.

Neither insurance nor service expansion alone will solve Maine's indigent care problem. Both insurance and service delivery initiatives are integral to the success of an indigent care plan for four reasons:

- Insurance initiatives, while expected to cover many additional people, would still leave a significant number of people uninsured.
- Many of the newly insured would remain uninsured for specific services (e.g., prescription drugs, dental care) and would need a service system in place to provide those services.
- Since many of the low income newly insured would confront deductibles and coinsurance that may make access to care costly and difficult, the availability of care on a reduced fee basis may be a critical factor in these families obtaining timely care.
- Having insurance does not necessarily guarantee that the services are in place or that services are accessible. This is especially true for certain chronic conditions, for AIDS patients, for the homeless, and even for certain types of services such as prenatal care.

1. Criteria Used to Design the Indigent Care Plan

The Commission used a number of criteria as guiding principles in designing the components of the indigent care plan. The criteria are:

- **Expand equal access to appropriate and necessary care.** No one in Maine should be denied access to needed medical care; this care should be received in settings that are appropriate to the nature of the medical condition. For example, emergency rooms are not appropriate settings for ongoing primary care.

- **Assure cost-effective and affordable health care.** Mainers should be able to obtain needed health services at a price they can afford from cost-effective providers.

- **Rely on broad-based financing sources.** Providers, employers, the public sector, and the patients themselves all share in financing indigent health care. Solutions should seek to avoid an imbalance in this distribution.

- **Assure that services are available on a sliding scale.** Patients should be able to obtain care at a price they can afford based on their income.

- **Maintain a mixed system** of insurance and service delivery approaches and public and private sector approaches. Solutions should build on the current mixed public-private system of insurance coverage and service capacity and not duplicate or replace it.

- **Promote preventive and primary care, not just catastrophic.** Solutions should assure that care is received early enough in the stage of the illness to prevent more serious health outcomes and treatment expenses.

- **Maintain and improve quality of care.** The plan should encourage the use of high quality and efficient providers.

- **Encourage reality-based solutions and build on the current system.** The plan should build on existing mechanisms rather than replace them.

- **Be acceptable to health professionals.** The plan should not place onerous requirements on health professionals; it should reimburse providers fairly for treating indigent patients.

- **Prevent an adverse impact on the business community**; it should not be a disincentive for economic development. The plan should not place a disproportionate share of the responsibility of the indigent care solution on the business community and thereby lessen Maine's ability to compete with other states in attracting and retaining job-creating industries.

- **Foster the perception that people be treated fairly.** Business, providers, insurers and consumers should view the plan as fair.

- **Assure administrative feasibility.** Solutions should not be overly complex or pose undue administrative burdens on the health care system.

2. Overview of the Plan

The major goal of the indigent care plan is to expand access to health care in Maine. The plan seeks to maximize insurance coverage by providing a subsidized Medicaid like product and establishing incentives to encourage employers to offer insurance. To supplement the insurance initiatives, the plan also includes service delivery initiatives designed to improve access to needed services for the uninsured and the newly insured. For example, it provides resources to help link patients to primary care services.

To expand insurance, the plan: 1) establishes a Medicaid Buy-in option available to all persons below 150 percent of poverty at a sliding scale premium; 2) creates a small group multiple employer trust; and 3) provides a tax credit to encourage small employers to offer insurance.

To expand services, the plan: 1) establishes a program to provide grants to local communities, and 2) establishes a health professions loan repayment program.

B. INSURANCE INITIATIVES

The proposed insurance initiatives build on existing mechanisms, namely the Medicaid program and employer-based insurance. The insurance

expansion consists of a three-tiered approach targeted toward different segments of the uninsured population. The three components of insurance expansion are:

- **Medicaid buy-in**, which is the largest insurance initiative and is targeted toward persons whose incomes are below 150 percent of the poverty level.
- **Small group multiple employer trust**, which is targeted toward groups of fewer than three and firms that are excluded from the commercial insurance market. These firms are excluded because they have too few employees or are considered a high risk business.
- **Tax credit** to encourage small employers to provide insurance. This is focused on covering the uninsured who are employed in firms that currently do not offer insurance.

While these insurance initiatives are targeted toward different segments of the uninsured population, some overlap is likely to exist among those eligible for the Medicaid Buy-in and employer-based incentives. The plan seeks to assure coordination among plan components to maximize coverage, but minimize duplication and inefficiency. Each of the insurance initiatives is described below.

1. Medicaid Buy-In

Maine has traditionally had a comprehensive Medicaid program and has adopted most of the recent optional Medicaid expansion options including the SOBRA provisions.[2] This has permitted the state to leverage federal funds to help pay for care to the poor; 67 percent of its Medicaid services funds are federal. Maine has extended Medicaid eligibility to pregnant women and

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[2] The SOBRA provisions are optional expansions of Medicaid including extending coverage to pregnant women and infants whose incomes are below 185 percent of poverty, children under 8 in families with incomes below the poverty level, and the elderly and disabled with incomes below poverty.

infants below 185 percent of poverty, to children under age 5 who are below the poverty level, and the elderly and disabled who are below the poverty level. The only remaining Medicaid expansion option which would receive federal dollars is to extend eligibility to children between age 5 and 8 who are below poverty.

The Commission proposes to build on the existing Medicaid program by establishing a Medicaid Buy-in program. This initiative would be fully state funded and would enable the low income uninsured to purchase a Medicaid like benefits package on a sliding scale premium related to their income. This approach has five major advantages: 1) it builds on the existing Medicaid infrastructure in Maine; 2) it enables people who lose Medicaid coverage as a result of becoming employed to obtain affordable coverage; 3) it extends Medicaid coverage to other members of a family where infants or young children are already covered through the SOBRA expansion; 4) it offers the Medicaid program to additional population groups, thereby potentially reducing the stigma associated with being on Medicaid; and 5) the state can apply the premiums toward the Medicaid income limits for determining "spend down," and thereby leverage federal dollars for those persons with large medical expenses.

The Medicaid Buy-in would have the same benefit package as the Medicaid program (see Exhibit 1) and would be available to persons below 150 percent of poverty ($17,400 for a family of four) on a sliding premium scale. Persons below 100 percent of poverty would not pay a premium, while persons between 100 and 150 percent of poverty would receive a subsidy on a sliding scale. Two options have been proposed regarding the level of state subsidy. The first is that the average subsidy for those between 100 and 150 percent of poverty would not exceed 50 percent. Another alternative is that an individual's share of the premium would not exceed 3 percent of his/her gross income. The second alternative would require the state to subsidize more than 50 percent of the premium on average.

EXHIBIT 1

MEDICAID BENEFITS IN MAINE[1]

- Inpatient hospital services
- Outpatient hospital services
- Other laboratory and x-ray services
- Skilled nursing facility services for individuals over age 21
- EPSDT services
- Physicians' services
- Home Health Services for those entitled to SNF care
- Nurse-midwife services
- Podiatrists' services
- Optometrists' services
- Chiropractors' services
- Dental services
- Physical therapy
- Occupational therapy
- Prescription drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Diagnostic services
- Preventive services
- Screening services
- Rehabilitation services
- Intermediate care facility services
- Inpatient psychiatric services for persons under age 22
- Personal care services
- Transportation services
- Case management services
- Rural health clinic services

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[1] These benefits apply to both the categorically needy and the medically needy population.

New beneficiaries with incomes above 150 percent of poverty would not be eligible for the program. However, for those whose incomes increased beyond the eligibility level during their participation in the Medicaid Buy-in program, the program would include a transition period. After meeting certain criteria (e.g., lack of employer insurance) these individuals could continue to participate in the program for up to two years after they were no longer financially eligible. A special appeals process would consider continuing coverage for individuals with no other affordable insurance options.

To discourage individuals from dropping any current insurance in favor of the Medicaid Buy-in program, the plan would encourage coordination with other coverage. For those individuals who have insurance through their employer or who purchase non-group coverage, the Medicaid Buy-in would be secondary, serving as a "wrap-around" for those other insurance products. The Medicaid Buy-in would serve as a wrap-around in four ways: 1) provide coverage for benefits not covered by other plans such as prescription drugs; 2) provide coverage to dependents when employer-based insurance is only available to the employee; 3) subsidize the copayments and deductibles; and 4) subsidize private insurance premiums when the individual's premium share exceeds 3 percent of gross income. By structuring the Medicaid Buy-in as a wrap-around, the program seeks to encourage employers to continue to provide insurance and would not compete with private insurance plans.

The Medicaid Buy-in program is estimated to serve 89,700 persons at a cost of approximately $28 million. Among those expected to purchase the Medicaid Buy-in, 7,100 are children and 82,600 are adults. The majority of those served by the program are likely to be the uninsured, but some are likely to purchase the coverage to supplement current insurance.

2. Small Group Multiple Employer Trust

The plan also includes a small group multiple employer trust (MET) targeted toward small businesses who have particular difficulty accessing

insurance coverage. A MET pools small groups into a large group for the purpose of reducing the cost of insurance. This MET would be comprised of businesses with fewer than three employees, businesses such as lumber that are excluded from the commercial insurance market because they are considered high risk, and non-profit firms with fewer than 20 employees.[3] By reducing the cost of insurance the Commission expects a greater number of these businesses to offer insurance to their employees.

The state would specify the plan design, the benefits, and the firms eligible to participate in the MET, as well as whether the MET would be organized on a statewide or regional basis. By specifying the benefits, the state could assure that the primary care goals of the indigent care plan are met.

To reduce businesses' costs of providing insurance and thus increase the attractiveness of participating in the MET, the Commission is also considering subsidizing reinsurance for the MET. The level of subsidy under consideration is $7.00 per person per month.

The cost of this program depends on whether the state subsidizes the cost of insurance. Without a subsidy, the costs of the program consist of only administration and marketing. With a subsidy the costs of the program depend on the type and level of the subsidy.

3. Tax Credits for Employer-based Insurance

The Commission is also proposing tax credits to encourage small employers to offer insurance. The tax credit would be targeted toward small employers with fewer than 20 employees that do not offer insurance. The tax

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[3] For-profit firms with 3-19 employees would be eligible for the tax credit discussed below; the tax credit is of no benefit to small non-profit organizations (e.g., churches), so they will be eligible to participate in the MET.

credit could take several forms. The state could offer a credit to employers for part of the cost of insurance premiums, or it could offer tax credits for providing particular benefits. The tax credit would apply only to insurance products that meet the state criteria for the MET to assure that coverage for primary care services is included.

C. SERVICE DELIVERY INITIATIVES

Persons who become insured, as well as the remaining uninsured, need providers available and willing to serve them. The expanded Medicaid coverage through the Buy-in program is expected to insure a large number of the uninsured in Maine, yet even many of those currently on Medicaid report difficulty accessing a provider.

In addition, access to needed services is a particular problem in rural areas. Some areas do not have adequate numbers or types of health professionals; lack of transportation may prevent people from reaching providers; and the absence of a "critical mass" of people limits the provision of certain services in rural areas. Even if each person in rural Maine were given insurance coverage, support for the service system would also be needed to assure access to care.

To alleviate the problems of access to services, the plan calls for a Community Health Program to serve the uninsured and newly insured populations. The state would help fund local health providers who offer care on a sliding scale adjusted to the patient's income. In addition, the plan would establish a health professions loan repayment program to attract health providers to underserved areas of the state.

1. Community Health Program (CHP)

The Community Health Program (CHP) would expand the resources available to local communities through a grant program while encouraging the

development of greater efficiencies in care for the medically indigent. Through CHP the state would help fund existing local health providers or new organizations where existing providers are unwilling or unable to participate, who would directly provide or arrange access to the following services:

- Primary and preventive services.
- Referral to specialty and inpatient care.
- Prescription drugs.
- Ancillary services
- Case finding/outreach to bring people into the system.
- Health education.

These grants could support the direct delivery of primary care services, outreach efforts to bring people into the system, and referrals of patients to other parts of the system.

The precise approach for each grant would depend on available local resources and organizations and the specific needs of the community. No single model for using the grants is specified; instead grants are designed to maximize flexibility and respond to the diverse needs of local communities while still meeting the guidelines established by the CHP program.

Grants for providing access to services would be awarded to health care providers in local communities who display the capacity to provide an organized system of primary care, including direct services in their own organizations and management of patients who require care from other providers such as inpatient hospitals. These could include groups of physicians, organized primary care centers, or hospital outpatient departments. While hospitals could receive the grant for preventive and primary care services they would not use the money to subsidize inpatient services.

Applicants would demonstrate the following in their grant applications, which would then receive objective review by a panel consisting of state officials from the designated lead agency and outside advisors:

- Arrangements for services 24 hours a day, 7 days a week.
- Full hospital privileges for all primary care physicians or arrangements to refer patients for inpatient hospital care and specialist services. Arrangements must be in writing and/or the provider must be able to demonstrate that the patients are being accepted and treated.
- Provision of follow-up care from the hospital and/or specialist to the patient's primary care provider.
- Access to ancillary services including laboratory, pharmacy, and radiology.
- Linkage to WIC, nutritional counseling, and social and other support services.
- Acceptance of Medicaid patients and the uninsured without limits, including public notice of appropriate sliding fee scales.
- A medical records system with arrangements for the transfer of records to the hospital, specialist, and back to the primary care physician.
- Quality assurance mechanisms to evaluate the quality and appropriateness of patient care.
- Capacity for efficiency in managed care.
- Evidence of community-wide input into the design and provision of health services.

Preference would be given to providers who are already experienced in effectively serving the poor.

Grants would be competitive, with priorities and the amounts of award based upon: 1) documented health status needs; 2) documented financial hardship (e.g., area unemployment); 3) low participation by other providers in serving the indigent including Medicaid; and 4) evidence of local commitment.

2. Health Professions Loan Repayment Program

[COMMISSION NEEDS TO DECIDE WHETHER THIS SHOULD BE INCLUDED IN THE PLAN]

In a few areas of the state the access problem is one of absolute lack of health professionals, such as physicians, nurses, and physical and occupational therapists. For some areas, the current efforts to recruit health professionals, coupled with the increasing supply of physicians will be successful, but for other areas it will be difficult to attract health professionals without targeted assistance.

A small health professions loan forgiveness program would provide a supply of providers for the areas that would not otherwise attract providers. Under this program, individuals who are near or at completion of health professions education programs would agree to have the state repay governmental or commercial loans (up to $20,000 annually) obtained for meeting educational costs in return for each year of service they agree to provide in an underserved area. Priority for placement of health professionals would be given to those provider organizations which receive a CHP grant. Loan repayment programs have two major advantages: 1) they allow the state to quickly place health professionals in underserved areas, and 2) they allow the state to take advantage of recent federal legislation establishing a state demonstration program whereby the federal government would pay up to 75 percent of the cost of a state loan repayment program.

The Maine Department of Human Services' Office of Health Planning (OHP) already has been selected as one of seven agencies nationwide to establish a loan repayment demonstration project and receive a 75 percent federal match. This program is expected to fund four physicians and one or two physician extenders who will be placed in underserved areas in the state. The Commission's proposal would build on this program by _____.

D. ADMINISTRATION

[DOES THE COMMISSION WANT TO INCLUDE A SECTION ON ADMINISTRATION?]