MEMORANDUM

To: Special Select Commission on Access to Health Care

From: Kala Ladenheim, Executive Director, Health Policy Advisory Council

Re: Commission's indigent care plan

Date: October 11, 1988

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The Council has received copies of the material dated September 27, but has not had time to meet and discuss these recommendations. The following comments are my own and do not necessarily reflect the views of the Council.

The Committee and the Consultants have put together an impressive listing of options. Unfortunately, our Council met at the same time as the Committee and so no one from the Council was able to attend the September 29 session. These comments may already have been dealt with during the presentation and discussion on that day.

To what extent do these figures represent Maine's actual experience, and to what extent are they national averages? If national, have the estimates been adjusted to reflect Maine's rural mix, population age distribution, employment structure, and the structure of Maine's Medicaid program? Do these represent the under-65 population only, or are poor elderly included, for instance, in the Medicaid underinsured? They are listed in the text, but not on the table. Should the over-65 be treated differently in estimating program costs?

The estimated costs are much lower than one would expect. If this reflects assumptions about the length of time people are uninsured or under-insured, level of co-payment, the uptake rate, ability to implement the program, or cost savings, could you please describe the assumptions made? For example, the cost of Medicaid expansion is estimated at $100/per capita. Does this assume that most people are using it less than a full year, that they are paying 3/4 of the cost themselves, that Federal match pays a large share, that most eligible people will not come into the program, or that this is an unusually healthy group? At a minimum, could you show the number of people to be covered in terms of people/years? If only part of the population at risk is expected to use the program, could you show how many would still be uninsured?

If the low numbers reflect part-year coverage, are we using the right numbers? There are more individuals ever uninsured than always uninsured, while point-in-time estimates (as in the CPS) are intermediate. Which group is being used as the basis of

the estimates of uninsured populations? For instance, the 30,000-40,000 newly insured and migrants may need coverage for 30 to 90 days, by and large. Are they really 1/3 of the estimated 93,000 - 119,000 uninsured in Maine? Inconsistencies in how the uninsured are being counted may mean the proposals are not as comprehensive as they first appear. For instance, if the estimate of the uninsured is a point-in-time estimate and the estimate of the newly insured is ever newly covered over a year, then at a point in time only 4,000 - 10,000 would be newly covered/uninsured. Do the programs reflect the different timing of uninsurance for the different groups, for instance, seasonal labor?

All the per capita estimates seem low, but the ones for the difficult-to-reach uninsured seem particularly low. Can you indicate what part of this population would be served at the cost of $40/capita, and how. I believe that $40/annum is a conservative estimate of the marketing cost alone for individual insurance products. Is that what this proposal is for? If the estimates are based on a net against uncompensated care, could the assumptions be described, and the change in payors and the size of the estimated "woodwork effect" be made explicit? Collections from proposed employer tax and physician tax seem to be at about a level to cover administrative expenses of such a program. Private health insurance costs are, I believe, 6 - 10% of payroll. Since Maine has a particularly high number of self-employed individuals and workers for small employers, a payroll tax would not do well at reaching the group most at risk for being uninsured.

Please indicate the overlap and gaps in the populations to be covered by the various proposals. Although the text seemed to indicate that alternatives were being proposed, the document seems to have divided some, but not all, the uninsured and underinsured into three mutually exclusive groups, and proposed programs for different portions of each group. Please clarify where there are alternatives for specific groups. (I assume this was done at the meeting on the 29th?).

I hope these comments are useful. They are mostly calls for more information. The Consultant undoubtedly has this information and made the very reasonable decision not to overwhelm the Commission with numbers. The caveat about the numbers is taken; however, if choices have to be made, the relative magnitude of the numbers should be right. Some of the numbers seem so counter-intuitive as to require further explanation, and the explanations may reveal information that would help in choosing a mix of strategies. The Commission clearly has a difficult task ahead, and has made a strong start towards laying out its approach to the problem of improving access.