SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE
PREFACE

Lewin/ICF is assisting the Maine Special Select Commission on Access to Health Care in designing a plan to expand access to care. This assistance is being provided through a series of five one-day seminars intended to provide the Commission with a framework for addressing problems of access in the state and to facilitate their design of a plan.

Three of the five seminars have been completed to date. They provided Commission members with background on the problems of lack of access to care, presented insurance and service strategies for addressing the problems, discussed how the strategies could be financed, and developed criteria for evaluating an indigent care plan. The next two seminars will focus on designing the Commission's plan.

The enclosed materials have been prepared for the fourth seminar in the series: Design of a Basic Plan for Addressing Access to Care in Maine. The purpose of this seminar is to begin to move from a range of strategies to structuring a cogent plan. The materials that follow this preface represent a working document prepared by Lewin/ICF; the Commission has not yet discussed its contents. Further, the Commission intends to solicit input from interested community members, advocacy groups, providers, payers, employers, and others.

The first step in designing the plan is to clearly define the populations to be served. The Commission has identified a number of groups with access barriers in the state. The uninsured in Maine are estimated to range from 93,000 to 119,000. In addition, there are thousands more low income insured persons who face access barriers. The Commission must decide whether they are designing a plan to address the needs of all these people or a more targeted plan to address specific groups.

To assist the Commission in this process, we have divided the problem (and the approaches to solving the problem) into three categories:

- **Insured low income persons with access barriers.** These are Medicaid recipients who have difficulty finding providers who will serve them,

the poor elderly on Medicare, and persons who are underinsured for primary and preventive care.

- **Easier-to-Reach Low-Income Uninsured**. These are persons who are relatively easy to identify because they are connected to the workforce or are eligible for Medicaid expansion.

- **Difficult-to-Reach Low-Income Uninsured**. These persons include for example, the unemployed, rural persons, and the homeless.

This categorization is intended to assist the Commission in setting priorities among the population groups who lack access. Taken as a whole they represent universal access. Commission members may move specific subpopulations among the categories if a different grouping is desired.

Expanding access to health care in Maine will likely be achieved through a combination of insurance and service strategies. Once we know which population groups will be served by the plan, an approach combining insurance and service strategies will be designed to address their needs. For each group, limited expansion of insurance would require more substantial service delivery efforts, while major increases in insurance would be complemented by more limited (but essential) service delivery initiatives. With each approach there need to be assurances that the right services are in place to meet the needs of the newly insured as well as of those who remain uninsured. Under any approach, there would be both insurance and service delivery initiatives, since both are integral to developing an indigent care plan.

Note that estimates of the number of people served and costs of the options are **approximations**. They are presented for purposes of assessing and debating the three approaches, and will need to be refined when the Commission's plan has taken final shape.

The meeting on September 29 provides an opportunity to discuss these materials in more detail. Questions, comments, and suggestions are welcome at that time.

SPECIAL SELECT COMMISSION ON ACCESS TO HEALTH CARE
September 29, 1988

Agenda

9:30 - 12:30	Purpose of the Meeting
	Criteria for Designing an Indigent Care Plan
	Framework for Designing and Indigent Care Plan
	Three Approaches for Expanding Access to Health Care in Maine
12:30 - 1:30	Lunch
1:30 - 4:00	Three Approaches for Expanding Access to Health Care in Maine (continued)

PURPOSE OF THE MEETING

- Define the problem we're trying to solve in Maine.
  - -- For which population groups are we designing a plan?
  - -- Universal access versus targeted plan.

- Examine three approaches that solve the problem for particular population groups; taken together they represent universal access.
  - -- Presently insured persons with access barriers.
  - -- Easier-to-reach uninsured persons.
  - -- Difficult-to-reach uninsured persons.

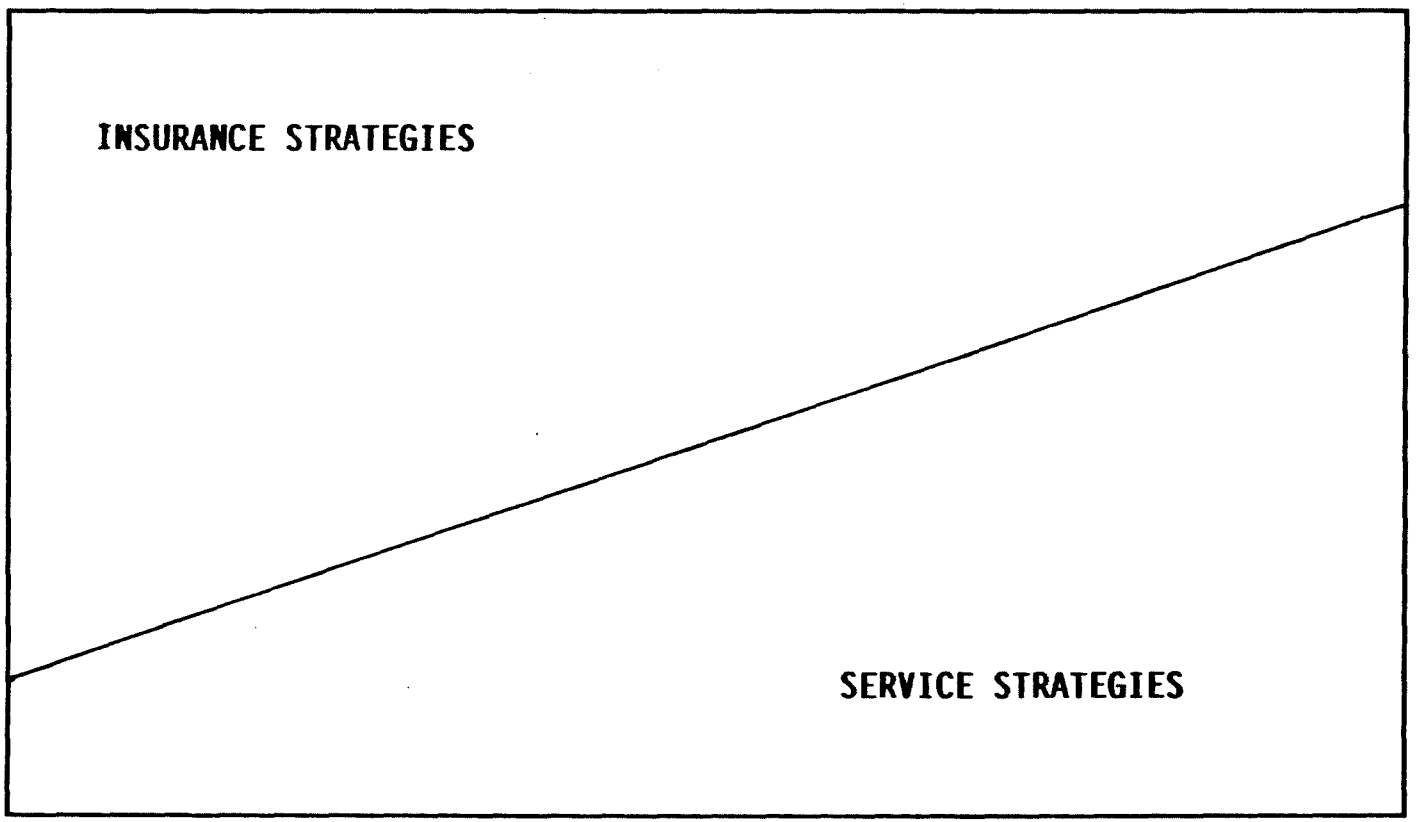
- Discuss these approaches.

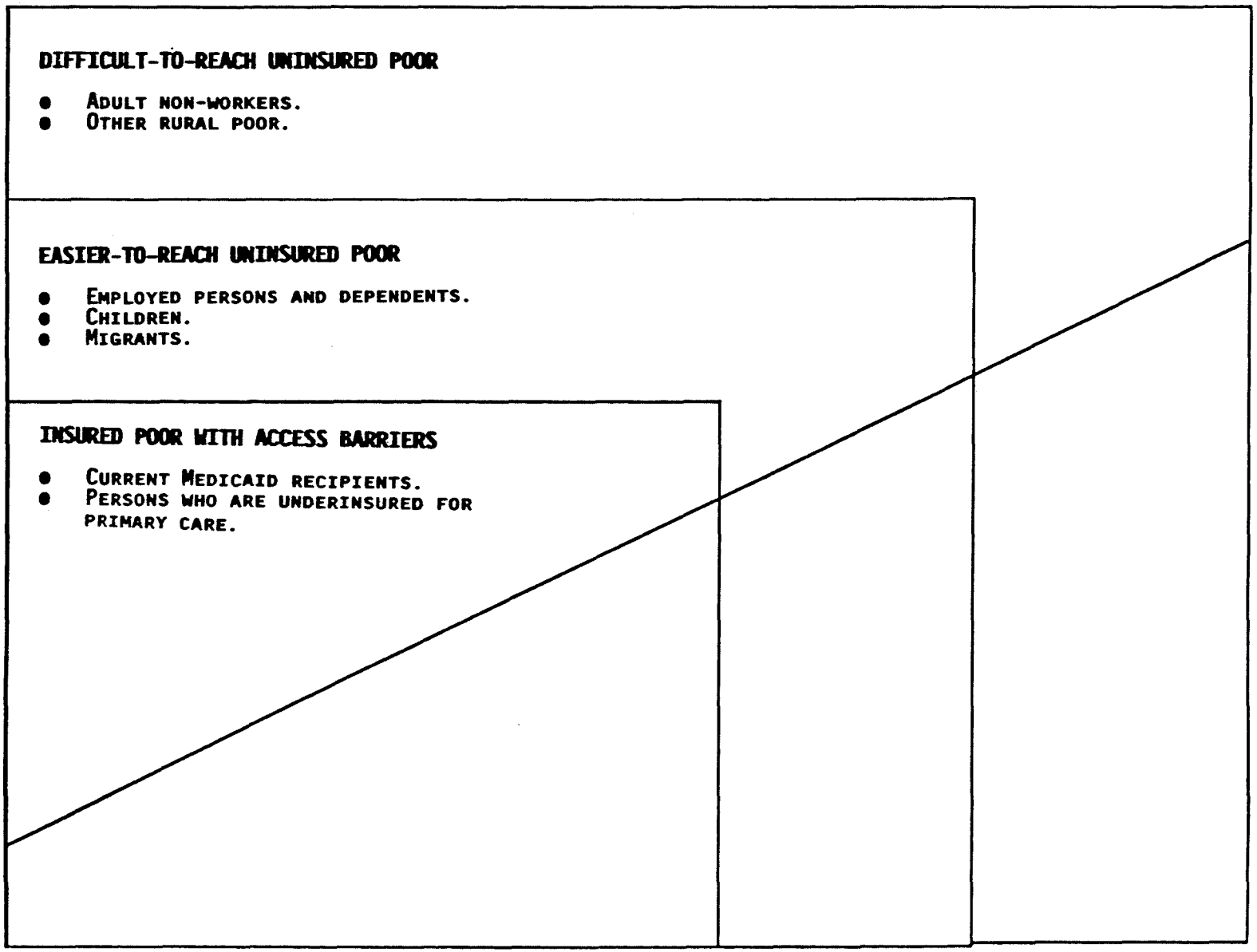
CRITERIA FOR DESIGNING THE COMMISSION'S INDIGENT CARE PLAN

- Expand equal access to appropriate, necessary care.
  - -- Insurance
  - -- Services
- Assure cost effective and affordable health care.
- Financially broad based.
- Services available on a sliding scale.
- Mixed system.
  - -- Insurance/services
  - -- Public/private approaches
- Preventive and primary care, not just catastrophic.
- Maintain/improve quality of care.
- Solutions should be reality-based and built on current system.
  - -- Individual providers.
  - -- Public/private mix.
  - -- Recognize regional differences.
- Solutions should be acceptable to health professionals.
- Not negative to business climate; should not be disincentive for economic development.
- Perception that people are treated fairly.
- Administrative feasibility.

POPULATION GROUPS WHO HAVE ACCESS PROBLEMS

- Insured Low-Income
  - -- Medicaid recipients (e.g., children, pregnant women)
  - -- Persons underinsured for primary care.
  - -- Elderly on Medicare.
- Easier-to Reach Low-Income Uninsured
  - -- Employed
  - -- Children
  - -- Migrants
- Difficult-to-Reach Low-Income Uninsured
  - -- Adult non-workers.
  - -- Isolated rural persons.
  - -- Homeless.


INSURANCE STRATEGIES
SERVICE STRATEGIES


DIFFICULT-TO-REACH UNINSURED POOR
• Adult non-workers.
• Other rural poor.
EASIER-TO-REACH UNINSURED POOR
• Employed persons and dependents.
• Children.
• Migrants.
INSURED POOR WITH ACCESS BARRIERS
• Current Medicaid recipients.
• Persons who are underinsured for primary care.

INSURED POOR WITH ACCESS BARRIERS

- Medicaid Improvements
  - -- Raise provider fees for some or all providers.
  - -- Adopt all-inclusive fee.
  - -- Reduce provider administrative burden.
  - -- Malpractice reforms (e.g., limits, subsidy).

- Service Delivery Expansion
  - -- Community service delivery grants to provide primary care, outreach, referral, and/or transportation.
  - -- Rural networks for physicians.
  - -- Service contingent health professions program.
  - -- Clearinghouse to disseminate information on available services.

INSURED POOR WITH ACCESS BARRIERS

Option	Population Served	Estimated Number	Estimated Cost
• Medicaid improvements -- Raise provider fees. -- Adopt all-inclusive fee. -- Reduce provider administrative burden. -- Malpractice reforms.	Current Medicaid recipients, e.g., children, pregnant women, handicapped	70,000-90,000 ?	$1m - 3m
• Service Delivery Expansion -- Community service grants. -- Rural networks for physicians. -- Service contingent health professions program. -- Clearinghouse	Underinsured for primary care, e.g., low wage workers with private health insurance	9,000-13,000	$1.4m - 2m

COMMUNITY SERVICE DELIVERY GRANTS

- Local community grants (State?) to provide:
  - -- Primary and preventive services.
  - -- Referral to specialty and inpatient care.
  - -- Prescription drugs.
  - -- Ancillary services.
  - -- Case-finding outreach.
  - -- Health education.

- Grants may be awarded to primary care centers, physician groups, or hospital outpatient departments.

- To qualify for a grant, entity must demonstrate:
  - -- Arrangement for services 24 hours a day, 7 days a week.
  - -- Arrangements to refer patients.
  - -- Full hospital privileges.
  - -- Provision of follow-up care.
  - -- Access to ancillary services.
  - -- Linkages to other social services.
  - -- Acceptance of Medicaid.
  - -- Publicized sliding fee scale.
  - -- Managed care capacity.

- Grants are for three years with annual performance reviews.
- Grants are administered by Health Department.
- Additional targeted assistance may be provided to communities that lack primary care capacity:
  - -- Small grants to coordinate linkages among health providers.
  - -- Grants to expand existing capacity.

SERVICE-CONTINGENT HEALTH PROFESSIONS PROGRAMS

- State agrees to repay health professions education loans up to $20,000 per year in return for service in an underserved area.

- Health professional agrees to serve for a minimum of two years.

- Health professionals who can participate include:

  -- Physicians.
  -- Dentists.
  -- Nurses.
  -- Physical therapists.
  Others?

RURAL NETWORKS FOR PHYSICIANS

- Link rural physicians and hospitals.
  - -- On-call arrangements.
  - -- Coverage for CME, vacations, etc.
  - -- Administrative services, e.g., billing.
- Link to urban centers.
  - -- High-tech diagnostics, e.g., on-line EKG.
  - -- CME
  - -- "Circuit-riding" specialists.
- Eligible grantees for community health services.
  - -- Nutrition.
  - -- Outreach and eligibility.
  - -- Health education.
- Malpractice insurance?

MALPRACTICE REFORMS

- State may be malpractice insurer for providers who serve Medicaid and indigent patients.

- State may set limits on the amount a provider is liable for Medicaid and indigent patients. The state would pay costs above the specified limit.

- Subsidize malpractice premiums for obstetrical coverage for providers in underserved areas.

EASIER-TO-REACH UNINSURED POOR

- Medicaid Expansion
  - -- Coverage for children ages 5-8 in families with incomes below poverty level.
  - -- Medicaid buy-in. for whom?
  - -- Enhance enrollment efforts.

- Private Insurance Expansion
  - -- State-wide pool of small employers.
  - -- Subsidized insurance product available to small groups and individuals. RWJ

- Service Delivery Expansion
  - -- Community service grants.
  - -- Clearinghouse.?

EASIER-TO-REACH UNINSURED POOR

Option	Population Served	Estimated Number	Estimated Cost
• Medicaid Expansion -- Coverage for children 5-8 below poverty. -- Medicaid buy-in. -- Enhance enrollment.	For example: • Children age 5-8. • Children between 8-18 between Medicaid eligibility level and the poverty level. • Pregnant women and young children.	5,000-8,000	$500,000-800,000
• Private Insurance Expansion	• Employed persons and their dependents. -- Full-time. -- Part-time. -- Self-employed.	20,000-25,000	$9m - 10.2m
• Service Delivery Expansion	• Newly insured. -- Public -- Private • Migrants	30,000-40,000	$4.5m - 6m

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MEDICAID EXPANSION

- Coverage for children age 5-8 in families with incomes below the poverty level.

- Medicaid Buy-in

  -- State purchases Medicaid premiums for persons below poverty, creating a limited fully state-funded Medicaid program.

  -- Likely recipients would be children between 8 and 18 in families below poverty where one or more members are on Medicaid.

  -- While the program is fully state funded, as soon as a person's medical expenditures exceed Medicaid income limits, spend down may be used and federal matching dollars obtained.

- Enhance enrollment efforts by placing eligibility workers in hospitals and primary care centers.

PRIVATE INSURANCE EXPANSION

- Create a statewide pool for small employers to reduce the cost of insurance premiums.

- Offer a reduced cost product to small employers. Costs to employers would be reduced in one of three ways:

  -- Offer tax credit for health benefits paid by employers to persons below 150 percent of poverty.

  -- State could provide direct premium subsidy for insurance premiums of employees below 150 percent of poverty.

  -- State could match employer premium payments toward health benefits for persons below 150 percent of poverty.

- Offer a subsidized individual product to individuals below 150 percent of poverty.

- Individual and small group product would be linked so that employees moving in and out of the labor force can maintain insurance coverage.

- Subsidy for individual coverage on a sliding scale. At no time will the subsidy be greater than 50 percent of the cost of the premium.

DIFFICULT-TO-REACH UNINSURED POOR

- Private Insurance Expansion
  - -- Subsidized individual product

- Service Delivery Expansion
  - -- Community Service Grants
  - -- Service Contingent Program
  - -- Outreach
  - -- Transportation
  - -- Linkages to social and other services

DIFFICULT-TO-REACH UNINSURED POOR

Option	Population Served	Estimated Number	Estimated Cost
• Private Insurance Expansion -- Subsidized individual product.	Adult non-workers.	2,000-4,000	$80,000-160,000
• Service Delivery Expansion	Adult non-workers. Other rural poor.	28,000-32,000	$7m-8m

FINANCING

USES	SOURCES
A. Insured Poor with Access Barriers	
• Medical Improvements	General Revenues
• Service Delivery Expansion	General Revenues Physician Fee
B. Easier to Reach Uninsured Poor	
• Medicaid Expansion	Federal Match General Revenues Hospital Surcharge (current percent)
• Private Insurance Expansion	General Revenues Employer Payroll Tax
• Service Delivery Expansion	General Revenues Physician Fee
C. Difficult to Reach Uninsured Poor	
• Private Insurance Expansion	General Revenues Employer Payroll Tax
• Service Delivery Expansion	General Revenues Physician Fee

EMPLOYER PAYROLL TAX AND PHYSICIAN FEE

- Employer Payroll Tax

regressive

  -- Employer pays a 1-2 percent tax on payroll for employees up to the Social Security wage limit.

  -- Offset against tax allowed for costs of health benefits paid by the employer.

  -- Tax administered and collected by Maine Bureau of Employment Services.

- Physician Fee

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  -- $300-500 licensure fee for physicians.

  -- Used to support service delivery expansion.