Revised
11/29/88

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.

Lewin/ICF

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POPULATION GROUPS WHO HAVE ACCESS PROBLEMS

- Insured With Access Barriers

  -- Medicaid recipients (e.g., children, pregnant women)

  -- Medicare beneficiaries

  -- Persons underinsured for primary care.

  -- Individuals in areas that lack services.

  -- Low-income individuals with high copay/deductibles.

  -- Medically high-risk individuals

- Easier-to Reach Low-Income Uninsured

  -- Employed and dependents
     -- Full-time
     -- Part-time
     -- Seasonal
     -- "Self-proclaimed imortals"

  -- Children

  -- High-risk individuals

  -- Non-dependent students

Revised
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POPULATION GROUPS WHO HAVE ACCESS PROBLEMS (cont.)

- Difficult-to-Reach Uninsured

  -- Adult non-workers.

  -- Isolated rural persons.

  -- Homeless.

  -- Migrants and seasonal workers.

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INSURED WITH ACCESS BARRIERS

- Medicaid Improvements
  - -- Raise provider fees for some or all providers.
  - -- Adopt all-inclusive fee (clinic reimbursement option).
  - -- Reduce provider administrative burden.
  - -- Malpractice reforms (e.g., limits, subsidy).
- Insurance Expansion
  - -- Employer tax credits for providing preventive and primary care benefits.
  - -- Expansion of existing insurance organization.
- 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, and/or insurance options.

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EASIER-TO-REACH UNINSURED POOR

- Medicaid Expansion

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

  -- Medicaid buy-in.

  -- Enhance enrollment efforts.

- Private Insurance Expansion

  -- State-wide pool of small employers.

  -- Subsidized insurance products currently available to small groups and individuals.

  -- Create subsidized insurance product for small groups and individuals.

  -- Expand high-risk insurance program

- Service Delivery Expansion

  -- Community service grants.

  -- Clearinghouse.

  -- Rural networks for physicians.

  -- Service-contingent health professions program.

Lewin/ICF

Revised
11/29/88

DIFFICULT-TO-REACH UNINSURED POOR

- Medicaid Buy-In

- Private Insurance Expansion

  -- Subsidized individual product.

  -- High-risk insurance pool expansion.

- Service Delivery Expansion

  -- Community Service Grants

  -- Service Contingent Program

  -- Outreach

  -- Transportation

  -- Linkages to social and other services

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.

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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.

  -- Coverage of individuals up to 100 percent of poverty, at full subsidy.

  -- Coverage of individuals up to 150 percent of poverty, with sliding scale premium.

  -- Full Medicaid benefits.

  -- Medicaid provider fees: support an increase and review DHS proposal for physician fee change in 1989.

  -- 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. *Lewin/ICF*

Revised
11/29/88

COMMUNITY SERVICE DELIVERY GRANTS

- Local community grants 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.
  - -- 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.

- Additional targeted assistance to provide prevention/health education.

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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?

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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.

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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

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EMPLOYER PAYROLL TAX AND PHYSICIAN FEE

- Employer Payroll Tax

  -- 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

  -- $300-500 licensure fee for physicians.

  -- Used to support service delivery expansion.